Suddenly Becoming a "Virtual Doctor": Experiences of Psychiatrists Transitioning to Telemedicine During the COVID-19 Pandemic

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Objective: In response to the COVID-19 pandemic, many psychiatrists have rapidly transitioned to telemedicine. This qualitative study sought to understand how this dramatic change in delivery has affected mental health care, including modes of telemedicine psychiatrists used, barriers encountered, and future plans. The aim was to inform the ongoing COVID-19 response and pass on lessons learned to psychiatrists who are starting to offer telemedicine.

Methods: From March 31 to April 9, 2020, semistructured interviews were conducted with 20 outpatient psychiatrists practicing in five U.S. states with significant early COVID-19 activity. Inductive and deductive approaches were used to develop interview summaries, and a matrix analysis was conducted to identify and refine themes.

Results: At the time of the interviews, all 20 psychiatrists had been using telemedicine for 2–4 weeks. Telemedicine encompassed video visits, phone visits, or both. Although many continued to prefer in-person care and planned to return to it after the pandemic, psychiatrists largely perceived the transition positively. However, several noted challenges affecting the quality of provider-patient interactions, such as decreased clinical data for assessment, diminished patient privacy, and increased distractions in the patient's home setting. Several psychiatrists noted that their disadvantaged patients lacked reliable access to a smartphone, computer, or the Internet. Participants identified several strategies that helped them improve telemedicine visit quality.

Conclusions: The COVID-19 pandemic has driven a dramatic shift in how psychiatrists deliver care. Findings highlight that although psychiatrists expressed some concerns about the quality of these encounters, the transition has been largely positive for both patients and physicians.

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Before the first known case of local transmission of COVID-19 in the United States in February 2020, telemedicine and telepsychiatry were already established (1, 2). Telepsychiatry, in particular, benefited from a robust evidence base, suggesting that services provided via video were equivalent to in-person care (3, 4). Nonetheless, relatively few psychiatrists were using telemedicine because of regulatory and reimbursement barriers, lack of training, and resistance to practice change (5, 6). Fewer than half of community-based behavioral health organizations offered telemedicine in 2018 (7), and only 5% of psychiatrists who provided care in the Medicare program had provided at least one telemedicine visit (8).

In just one month, the landscape dramatically changed. As COVID-19 illnesses began to spread and shelter-in-place orders were implemented, many psychiatrists had to transition from in-person care to telemedicine over a period of just a few days. Both clinicians and patients looked for ways to minimize travel outside the home to reduce the risk for transmission. To support this rapid transition, U.S. states,

HIGHLIGHTS

- Psychiatrists offered telemedicine visits to their patients because of the COVID-19 pandemic.
- Perceived positive impacts of telemedicine included insight into patients' home settings and expanded reach to certain underserved patients.
- Negative impacts psychiatrists identified included a reduced ability to observe nonverbal cues to support diagnosis and treatment.
- Most psychiatrists noted that given the unprecedented circumstances, the transition to telemedicine in the early weeks of the COVID-19 pandemic went more smoothly than they had expected, and patients voiced satisfaction with virtual care.

the U.S. Department of Health and Human Services (HHS), private payers, and the Drug Enforcement Agency all announced temporary changes to the regulation and reimbursement of telemedicine during the COVID-19 public health emergency. For example, the Centers for Medicare and Medicaid Services declared that it would reimburse for telemedicine visits in both rural and urban communities and that services could be delivered into patients' homes. In addition, HHS waived penalties for good-faith use of non–HIPAA-compliant videoconferencing software during this emergency (9).

To understand the impact of this rapid change in care delivery, we conducted a qualitative study in March 2020 to understand the experiences of psychiatrists offering telemedicine in states heavily affected by COVID-19. Our goal was to describe how telemedicine was provided, what barriers were encountered, and what plans for the future existed to inform the ongoing COVID-19 response and provide the lessons learned to psychiatrists who are starting to offer telemedicine.

METHODS

Study Participants and Sampling Strategy

From March 31 to April 9, 2020, we conducted 20 semistructured interviews with psychiatrists practicing in outpatient settings. To recruit these participants, we worked with a research firm with access to a panel of 730,000 physicians. This panel has been used in previous federally funded research studies and comprises physicians who have joined an online platform to access clinical content (news, condition and drug information, and journal articles), continuing medical education activities, and clinical tools (10, 11).

Psychiatrists on the panel were sent an eight-item screener survey to assess eligibility for participation. We used three inclusion criteria based on this initial survey to identify outpatient psychiatrists who were transitioning to telemedicine for the first time in the context of the COVID-19 pandemic: board-certified psychiatrist currently practicing in one of several select states with significant COVID-19 activity in late March 2020 (New York, California, Washington State, New Jersey, and Louisiana), limited use of telemedicine before the pandemic (<10% of patient encounters), and spent >50% of working hours in an outpatient setting. We excluded psychiatrists who were active duty military and those who were employed in integrated delivery systems with extensive use of telemedicine (i.e., Department of Veterans Affairs and Kaiser Permanente). Those deemed eligible were invited to participate in a 30-minute telephone interview with the study team. Of the 43 psychiatrists who started the screener survey, 20 (47%) were found eligible and consented to be interviewed. We recruited participants until we reached thematic saturation, defined as the point at which new interviews did not uncover new themes or patterns.

Interviews followed a semistructured protocol. Topics included details on practice setting and patient population, experience and perceptions of telemedicine prior to the COVID-19 pandemic, nature of telemedicine use since March 2020 (e.g., modalities, volume, and platforms), barriers encountered in transitioning to telemedicine, perceived impact of telemedicine on the quality of patient interactions, and future plans for telemedicine. Four members of the study team trained in qualitative research conducted the interviews, which were recorded and transcribed. Interviewees were given a $100 gift card for their participation, and they provided verbal informed consent. This study was approved by Harvard University's institutional review board.

Analysis

We conducted a rapid qualitative analysis to ensure that study results could be published in time to inform the COVID-19 response. Rapid research is designed to address the need for timely results in rapidly changing situations. Although some experts have noted challenges in regard to maintaining rigor, multiple studies have shown comparable results between rapid and more in-depth analyses (12, 13).

We conducted the analysis in two steps. First, we developed a templated summary of each interview that was organized by codes mapped to key research questions covered in the interview protocol, as well as novel topics that emerged. We populated the summary with data extracted from interview transcripts and included illustrative quotes. We then conducted a supplemental matrix analysis, in which rows contained all participants and columns listed the salient categories we developed from the codes included in the summaries (14). Such matrices have been used in qualitative data analysis to efficiently identify similarities, differences, and trends in responses across groups of informants (15). A matrix provides a visual data display that enables the search for and a detailed analysis of patterns, themes, and other relationships and informs conclusions (16). Here, the matrix allowed us to interpret each participant's comments in the context of the particular telemedicine modalities and platforms the participant was using. We identified themes through well-established techniques, including repetition (e.g., if a concept was expressed more than three times) and emphasis (e.g., if respondents particularly engaged with or dedicated significant time to a concept).

RESULTS

Twenty psychiatrists from five U.S. states (see Methods) participated in this study. More than half were exclusively in private practice. The others included psychiatrists who practiced in two or more outpatient settings, including private practice, or who worked exclusively for nonprofit agencies, community mental health centers, federally qualified health centers, or hospitals with outpatient clinics (Table 1).

Minimal Use of Telemedicine Before COVID-19

Just under half of the interview participants had some experience with telemedicine before the COVID-19 pandemic.

These psychiatrists generally offered telemedicine in select cases to patients who had moved away, were traveling, or had unique circumstances that prevented in-person visits (e.g., a pregnant patient on bed rest). These telemedicine visits represented only a small fraction of their visit volume before March 2020.

Extensive Use of Telemedicine in March 2020

At the time of the interviews, all psychiatrists in our sample had been delivering telemedicine services for 2–4 weeks, including video visits, phone visits, or a combination of the two modalities (Table 2). Also, although psychiatry is considered an essential service and can be provided in person in all the states in our sample, most of the psychiatrists had transitioned to fully virtual practices. Only a quarter of the participants were seeing any patients in person.

Most participants reported conducting video visits with most of their patients, although they generally offered both video and phone visits. Among those offering more than one modality, most allowed their patients to choose the modality. Interview participants noted that when given the option, some patients opted for phone visits, including older patients or patients who were self-conscious about their appearance, had social anxiety disorder, or lacked suitable devices or had only limited broadband connection. Some psychiatrists also reported having to switch to phone visits on encountering technical difficulties during video visits.

Approximately one-third of the interviewed psychiatrists reported using the telephone for most or all visits. Reasons for not offering video visits included confidence that the telephone will work with no technical difficulties, lack of compatible devices or Internet access among underserved patient populations and older adults, familiarity of patients with the telephone, and lack of patient e-mail contact information to send a video link. Most psychiatrists who conducted most of their patient visits by telephone were not actively planning to offer video visits in the coming weeks.

Psychiatrists used several platforms for the video visits, including Zoom, Doxy.me, FaceTime, Skype, Google Meet, WhatsApp, Clocktree, and thera-LINK. Multiple participants mentioned minor technical issues with one or more of these platforms that led them to experiment with new platforms or to offer phone visits. Several appreciated the broadened flexibility to use non–HIPAA-compliant platforms, especially when HIPAA-compliant platforms were overloaded such as during the first weeks of the pandemic.

Impacts of Telemedicine on Psychiatrist-Patient Interactions

Psychiatrists identified numerous positive and negative effects of telemedicine on their practice (Table 3). Positive impacts included being able to see the patient's home environment and greater ease and access to care for some patients. Negative impacts were a reduced ability to observe nonverbal cues providing information for a diagnosis and treatment, less patient privacy, difficulty hearing patients clearly by phone or video, more distractions for patients in their home environment, inability to conduct a physical exam and assess vital signs, difficulty assessing extrapyramidal symptoms from antipsychotics, shorter visits, and challenges in managing time during the visit.

TABLE 1. Characteristics of 20 outpatient psychiatrists interviewed

Characteristic	N	%
State		
New York	8	40
California	6	30
Washington State	3	15
New Jersey	2	10
Louisiana	1	5
Primary practice setting		
Private practice	11	55
Private practice plus other setting	3	15
Hospital outpatient clinic	2	10
Other[a]	4	20
Years in practice		
<10	6	30
10–20	3	15
≥21	11	55
Previous experience with telemedicine[b]		
None	11	55
1%–4%	2	10
5%–10%	7	35

[a] For example, nonprofit agency, community mental health center, or federally qualified health center.
[b] Proportion of patient visits that were conducted via telemedicine before March 2020.

Most participants argued that given the unprecedented circumstances, the transition to telemedicine went more smoothly than they had expected, and they were pleasantly surprised that they could meet patients' needs via telemedicine. As noted by a psychiatrist practicing at a health system in Washington State, "I'm actually stunned at how amazingly well it's gone. . . . It has surprised me that I have been able to feel connected with patients on video." A psychiatrist in private practice in New Jersey said, "I didn't really like technology at all, but it's working quite well for me. I really felt after I did [Zoom sessions], that I could possibly have done this [before COVID-19], because clinically it's working fine."

Positive Patient Response

Most participants said that their patients were responding positively to the switch and had provided good feedback about telemedicine; however, they also pointed out that the positive response may have been driven by patient fears about ongoing access to care during the emergency, rather than by their general acceptance of telemedicine visits.

A psychiatrist in private practice in California reported that patients' responses had been "[U]niformly positive. . . . People are so grateful that I am continuing to be available." A psychiatrist practicing in a New York hospital said, "[Patients] appreciate it because they felt like everything was

TABLE 2. Modalities and platforms used by 20 psychiatrists to conduct patient visits since the start of the COVID-19 pandemic[a]

Participant	Primary practice setting	Telemedicine modality (%)		Video platform
		Phone	Video	
1	Private	0	100	thera-LINK
2	Private	25	75	Zoom
3	Private	5	95	Doxy.me, FaceTime
4	Private	25	75	Doxy.me, Skype, FaceTime
5	Private	30	70	Zoom, FaceTime, WhatsApp
6	Private	100	0	NA
7	Private	10	90	Doxy.me
8	Private	1	99	Doxy.me, Zoom, FaceTime
9	Private	2	98	Zoom, Doxy.me
10	Private	5	95	Clocktree, Google Meet
11	Private	33	67	FaceTime, Zoom
12	Community mental health agency and private	90	10	Zoom
13	Hospital outpatient clinics and private	35	65	Zoom and FaceTime (hospital clinics), Skype (private practice)
14	Community mental health center and private	100	0	NA
15	Federally qualified health center	5	95	Doxy.me
16	Hospital outpatient clinics	10	90	Zoom
17	Hospital outpatient clinics	100	0	NA
18	Nonprofit agency contracted with Medicaid	98	2	Zoom
19	Nonprofit clinic	100	0	NA
20	Community mental health center	95	5	Zoom

[a] NA, not applicable.

going to be canceled, they wouldn't be called . . . their meds would not be refilled. . . . So when we call, they feel so appreciative." As a psychiatrist from a nonprofit clinic in New York summarized, "Patients have been very happy that they've been able to get seen or treated in any manner, shape, or form . . . and not having to go into the doctor's office."

Sustainability of the Telemedicine Model

Psychiatrists in private practice expressed more concerns about the impact of telemedicine on revenue and on the sustainability of the delivery model, most likely because this group of psychiatrists has a more direct role in managing billing than do those in other practice settings. Several participants in private practice mentioned that the payers they worked with had not been transparent about reimbursement. Lack of clarity on what treatment would be covered, coupled with the fact that these participants had not yet submitted claims for March at the time of the interview, created uncertainty about the impact of telemedicine on practice revenue. As explained by a psychiatrist in private practice in California, "I haven't heard any specific feedback yet from the insurances that I'm dealing with as to whether or not their reimbursements are going to be any different for video services than they would've been for in-office visits. I've actually been holding off on doing my claims submissions for March until I get some clarification about that. And I'm going to need to send those claims in momentarily. [I need] to try to investigate what the coding changes need to be and what the likely reimbursement changes are going to be."

A different psychiatrist in private practice in California stated, "[A payer] just sent an e-mail . . . that was written in legalese. [It] said, 'We will cover this, but essentially some plans may not cover it.' What are you supposed to do with that information?"

Multiple participants across practice settings commented that they were currently busy with existing patients and that it was challenging for them to engage new patients via telemedicine. Most participants were accepting new patients and successfully evaluating them via video or phone. However, some were not, and they pointed out that continued reliance on telemedicine could threaten sustainability of their practice in the long term. According to a psychiatrist in private practice in Washington State, "I haven't done any new patients yet because I can't quite figure out how to evaluate somebody over the phone." A psychiatrist in private practice in California said, "I can sustain my practice now, but [growing the practice] will be hard."

Plans for Telemedicine After COVID-19

The psychiatrists in our sample expressed a strong preference to return to in-person care after the pandemic. Reasons for this preference included the ritual of going to an office, the fact that the office is a private and safe space, and, for some, the perceived inferior quality of physician-patient interactions via telemedicine. One psychiatrist employed by a university hospital in Washington mentioned that her hospital will likely return to requiring in-person visits to recoup a facility fee. Many of the psychiatrists in private practice, nonetheless, expressed an interest in continuing with some telemedicine, explaining that in the future they may offer it to patients who face logistical challenges of presenting in person. As explained by a psychiatrist in private practice in New York, "I definitely would want to go back to only using it when necessary and still would prefer patients to come to my office. But I do think I'm more

TABLE 3. Impacts of telemedicine on the quality of psychiatrist-patient interactions

Characteristic	Illustrative quote
Positive impact	
Helpful to see patient's home environment	"One advantage is that I get to see people in their environment, [which] gives me a little bit of extra information, and . . . often they are in the middle of work, so now I see them in a more informal environment."
	"If their home is disheveled, I can see that, so that's useful. Sometimes I do have patients whose apartments are a mess. With those patients, I . . . do one video session just to see what their homes look like, to get that information, the reality of the situation and how bad it really is."
Some patients are more relaxed at home or over the phone and can be more forthcoming	"They're more relaxed, and so they tell you a lot more about things you would not otherwise hear about, just because it's like you're a friend on the phone."
	"I definitely had one patient with social anxiety who told me that was explicitly why he wanted to do a phone session, and [he] was much more forthcoming than he's been before."
Improved access for certain underserved patients who could not be seen in person before the pandemic because of logistical challenges	"I've been able to reach some people . . . who may be wouldn't have come, because they weren't that motivated or they had forgotten about the appointment. But because I did call them at home and they weren't otherwise busy, even though they wouldn't have planned to come into the clinic, I reached them, and they were willing to speak with me."
	"It's allowed us to engage with the patients that previously were having problems engaging because of either logistics or time."
Negative impact	
Less information to support diagnosis and treatment and inability to use all senses	"It makes my job a little bit harder because especially for newer clients when I'm trying to do an assessment, I'm losing a lot of information [by not observing] them directly and their mannerisms, especially if patients may have psychosis."
	"It definitely affects the efficacy of the assessments. Especially for intakes, I don't even know who this patient is, and sometimes, especially when I want to choose a medication, . . I am trying to figure out if they have obesity, [which] is more difficult now. And I really like interacting with people—the facial expression is very important to me—I'm missing this part with telemedicine."
	"There's an austerity that . . . creates a distance. Sometimes it's harder to tell if someone tearing up . . ., [which is a] big red flag that says, 'Go. Follow that. What's going on now?' That's a really important visual cue. Sometimes, you just can't see quite as well, or just the connection isn't as good. Some of the nuance around more subtle emotion is lost."
	"There's a lot of information you can't get [via video]. Also, it must be in person for forensic evaluation; if someone's in jail, I have to go see them [there]. None of the jails that I work with at this point have video capacity. If you're trying to assess if someone's malingering or lying, you've got to [meet them] in person."
	"I want to see the patient in the waiting room, how they're interacting with other human beings. I want to hear their voice through the door, if they're arguing with the nurse. I want to watch them, the nature of their gait when they walk into the room. I want to see how much effort it takes them to sit down or get out of a chair. I want to smell them . . . if they're malodorous or not. I want to see if [someone] has gone through a lot of effort of putting cologne on. I want to use all my senses in this experience."
Less privacy in the home setting	"Right now, patients have to go hide in the bathroom, and they might be talking about their family members who they're having conflicts with, and they have to whisper. When they're in my office, they don't have to worry about [this]."
	"There's a few people for whom their home and the people they live with doesn't feel as comfortable or private of a place to talk as the clinic."
	"I have patients who are sitting in the closet when they're doing a Zoom call with me, or people who go out on a walk, not because they prefer the telephone, but because it's the only way they cannot be overheard."
Challenges with hearing patients clearly by phone or video	"Some people have a problem speaking clearly, and this is probably a characteristic of their illness or just their communication style. But that can be very difficult over the phone. I sometimes have to ask people, 'Can you speak clearly?' or, 'Can you just try to speak a little bit louder?'"

continued

TABLE 3, *continued*

Characteristic	Illustrative quote
More distractions in the home setting	"Some people really struggle, and it seems that it's hard for them to stay present or just focus on what we're doing. Maybe they're trying to multitask. Maybe they're not really comfortable." "You're not quite as emotionally connected to a person when they're on video, and it's easier to get distracted." "This is a doctor's appointment. It's kind of a big deal. It's not you talking to your mom on the phone twice a day. You get this once every 3 months, and you need to pay attention. You can't be putting the laundry in the dryer."
Inability to do a physical exam and take vitals	"I can't do certain things like blood pressure . . . , which I like to take when people are on medications that can affect blood pressure. That's a concern, so I've just been having people monitor it on their own instead." "Just checking vitals . . . that's really challenging."
Difficulty to assess movement disorders induced by antipsychotic medications	"When I'm prescribing antipsychotics . . . I don't yet have a modality for evaluating patients for symptoms of any movement disorder by video. I do have them perform a couple of maneuvers to see if I can elicit any symptoms or signs of extrapyramidal symptoms. But I haven't yet come across a standardized proven version of being able to do that by video that would substitute for a live examination, because a few maneuvers . . . require me to physically examine the patient." "I have a patient who is on Haldol, [and] it's been hard to look for any [extrapyramidal symptoms]."
Visits tend to be shorter and do not go into as much depth	"I started with phone appointments, and some of them . . . would shorten the session and stop early, but if they do FaceTime, they get more engaged with the process." "The [video and phone] sessions tend to be shorter sometimes, and I feel in person, you might be able to get more information." "So far, especially when they're [on the] telephone, [it is more of] a check-in."
Difficulty to manage time in telemedicine visits	"They'll talk on and on [on the phone]—it's hard to stop them at the end of a session . . . but the video really does help. You can see them. They can see you." "It is difficult to end sessions. In person, at the end of the hour, I lean forward in my chair, and I don't have to say anything."

comfortable with it. If someone needed to reschedule, I might [say], 'Well, we can just do a video session,' because I know it can work."

Lessons Learned

Psychiatrists shared lessons learned in rapidly transitioning to telemedicine that may be informative for clinicians who have yet to transition to it. Table 4 presents eight strategies that interview participants credited with improving the quality and conduct of telemedicine visits. One strategy includes identifying patients at risk for having difficulty with video visits (e.g., older adults and adults with cognitive impairments) before the visit and exploring whether someone in their environment could aid them. Another would be to start each visit by asking patients whether they are concerned about privacy, and if yes, help them identify a private place, such as a car, to conduct the visit.

DISCUSSION

The COVID-19 pandemic has driven a rapid transition to telemedicine among psychiatrists (17, 18). In our semi-structured interviews with 20 psychiatrists from five states, we found that although many of them continued to prefer in-person care, several of them could switch to telemedicine and perceived this transition largely positively. However, they noted some challenges, such as fewer clinical data available for assessment, diminished patient privacy, and increased distractions in the patients' home settings that affected the quality of provider-patient interactions. Several psychiatrists were concerned that many of their disadvantaged patients lacked reliable access to a smartphone, computer, or the Internet.

Because this study explored early experiences with telemedicine during the COVID-19 pandemic, it is unclear whether psychiatrists will continue to have favorable experiences with this technology as time goes on. The mental health needs of their patients are likely to grow, given isolation, financial hardship, and widespread illness. Given this massive natural experiment in rapid telemedicine deployment, it is critical to continue to record psychiatrists' experiences with it and track these experiences over time.

One open question is whether psychiatrists will continue to use telemedicine after the pandemic ends. Some telemedicine advocates have stated that the shift seen during the pandemic will permanently alter how clinical practice is conducted (19). There are many unknowns, however. We do not know how long strict physical distancing will last and whether the temporary policies currently in place to facilitate telemedicine use will remain or be rolled back. Nonetheless, the observations in our study suggest that although many psychiatrists in private practice are interested in

TABLE 4. Strategies for improving the quality of telemedicine visits and advice for psychiatrists who are starting to offer telemedicine

Strategy	Quote or specific application of strategy
Start each visit asking whether the patient is concerned about privacy and take steps to ensure that the patient is in a private place. If there is no privacy, reschedule the session.	"I always ask people if they're comfortable with the level of privacy they have, and we try to problem solve if they say no. Maybe they say yes, but then they worry that somebody is listening or overhearing them."
Brainstorm with patients about their options for finding a private place for visits. Some patients have used their car, a closet, or a bathroom or have gone on a walk. Offer these options to patients.	"People have been creative. I've had a couple of patients go to their car outside their house . . . so that they could have some quiet and are able to concentrate on the visit."
	"I would encourage practitioners to encourage their patients to be as creative as necessary to establish that safe space where they can have their psychiatry sessions. I've had patients who didn't feel that they had enough privacy in their own homes, but they would either sit in the car in the driveway, or they would drive to a place where they felt that there was privacy, and they would sit in their car with their smartphone or their iPad, and we would do telepsychiatry."
Ask the patient for his or her location and a call-back number at the start of each session. This will be helpful if you are disconnected, or if there is an emergency.	"Patients need to tell me where they are. I think Medi-Cal is expecting us to document it, and if there's an emergency situation, we do know their location, and we can send first responders."
	"We're actually entering the actual address of each patient at the time of the phone call or the video call."
Conduct video visits from the same spot in the home or office, rather than switching locations. This is reassuring for patients.	"[At home] I'm going to set up in exactly the same place every time."
Provide FAQs that explain how to change the background (i.e., options to not show your surroundings) on platforms like Zoom, because some patients are self-conscious about video and don't want the clinician to see their home environment.	"I have suspected that a few patients don't want to do a video session because they don't want me to see their space."
Call each patient before the telemedicine visit to explain what to expect and why telemedicine is being used.	"It is very important to inform the patients in advance . . . because especially in psychiatry, [patients] don't like short notices. Some patients get nervous when they are not familiar with the situation, but when they [know] what is going to happen, they feel much more comfortable and make themselves available."
	"They also get a phone call ahead of time telling them not to come into the office and that I'll reach out to them at their appointment time."
Identify patients "at risk" of having difficulty with video visits (e.g., older adults and adults with cognitive impairments), explore whether someone in their environment could aid them, and conduct test calls with this population.	"I had one patient [with whom] I did FaceTime, and her daughter showed her . . . If there was somebody who can help them work through it, it's easier."
	"We really took our time identifying the patients that are most at risk and explored how we can guide them over one, two, or three phone calls or see if somebody in their environment can assist them. We also have case managers that can visit [and help] patients."
Choose a platform that ensures that the patient will not see your personal phone number, or work out a process to block your personal phone number.	"The biggest issue that I contend with is that FaceTime for the most part requires the patient to see your cell phone. And I don't use my personal cell phone for psychiatric patients I see."
	"For telephone calls, I've been using my home phone and blocking its number."

delivering some telemedicine in the future, most prefer returning to in-person care. The psychiatrists who served underserved populations and older adults were uncertain about the long-term viability of telemedicine, given the lack of resources to support changes in how clinics and health systems communicate with patients (e.g., via e-mails to send a link for a Zoom visit).

Some of the psychiatrists in our study were primarily offering telephone or video visits. Although most preferred video technology, they felt that telephone visits often were an acceptable substitute for in-person visits. Also, some of their patients could not use video visits. Before the COVID-19 pandemic, most payers did not reimburse for telephone visits. Our findings suggest that reimbursing only for video visits may prevent a significant number of psychiatrists and patients from accessing telemedicine services.

This study identified several possible strategies for effective telemedicine use that may be informative for psychiatrists who are just beginning to offer telepsychiatry. Some of these strategies may help increase patients' comfort with and acceptance of telemedicine. At the time of our data collection, the psychiatrists we interviewed generally noted that patients were satisfied with telemedicine. However, this observation was in the context of the pandemic, which limited options for in-person care. It remains to be seen how patient preferences evolve over time. Future research should address patients' experiences and satisfaction with the transition to telemedicine.

Our study had several limitations. First, we conducted a rapid qualitative analysis to disseminate findings quickly. However, because we aimed to describe experiences rather than generate a theory about telemedicine delivery, we argue

that our analysis achieved an appropriate balance between rigor and timeliness. Second, we limited our sample to psychiatrists in certain COVID-19 hotspots who practiced in outpatient settings, and we cannot speak to the experiences of those in other states or practice settings. The psychiatrists in more than half of our sample worked in private practice, possibly limiting the implications of our findings for telemedicine implementation in hospitals and other types of community-based settings. Third, given that we conducted brief interviews, participants occasionally lumped video visits and phone visits together when discussing patients' responses to telemedicine and its impact on quality, rather than distinguishing between the two modalities. Fourth, we describe experiences from the first few weeks of the pandemic, and perceptions of telemedicine will likely change over time.

CONCLUSIONS

The COVID-19 pandemic has driven a dramatic shift in how psychiatrists deliver care. Our findings on the rapid adoption of telemedicine for care delivery during the pandemic highlight that although psychiatrists expressed some concerns about the quality of telemedicine-mediated encounters, the transition has been largely positive for both patients and physicians.

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