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

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Highlights:

- All psychiatrists were offering telemedicine visits to their patients due to the COVID-19 pandemic..
- Perceived positive impacts of telemedicine included insight into the home setting and expanded reach to certain underserved patients.
- Psychiatrists identified several negative impacts including reduced ability to observe nonverbal cues to support diagnosis and treatment.
- The majority of psychiatrists argued 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.

Abstract:

Objective: In response to the COVID-19 pandemic, many psychiatrists have rapidly transitioned to telemedicine. A qualitative study was conducted to understand how this dramatic change in delivery has impacted care, including how telemedicine was provided by psychiatrists, barriers encountered, and plans for the future. 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-April 9, 2020, 20 semi-structured interviews were conducted with outpatient psychiatrists practicing in 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 psychiatrists had been using telemedicine for 2-4 weeks. Telemedicine encompassed video visits, phone visits, or some combination of the two modalities. Although many continued to prefer in-person care and planned to return to in-person care after the pandemic, psychiatrists had largely positive perceptions of the transition. However, several noted challenges such as decreased clinical data for assessment, diminished patient privacy, and increased distractions in the home setting that impacted the quality of provider-patient interactions. Several psychiatrists also pointed that their disadvantaged patients lacked reliable access to a smart phone or computer as well as the Internet. Participants identified a number of promising strategies that helped them improve the quality of telemedicine visits.

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

Introduction

Before the first known case of local transmission of COVID-19 occurred in the U.S. in February 2020, telemental health was already established.[1,2] Telemental health, and telepsychiatry in particular, benefited from a robust evidence base suggesting services provided via video were equivalent to in-person care.[3,4] Nonetheless, relatively few psychiatrists were using telemedicine due to 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 has 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 days. Both clinicians and patients looked for ways to minimize travel outside the home to reduce the risk of transmission. To support this rapid transition, states, 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 for the duration of the public health emergency. For example, the Centers for Medicare and Medicaid Services declared it would reimburse for telemedicine visits in both rural and urban communities, and services could be delivered into patient's homes. In addition, the HHS indicated that it would waive penalties for good faith use of non-HIPAA compliant videoconferencing software during the nationwide public health 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 impacted by COVID-19. Our goal was to describe how telemedicine was provided,

barriers encountered, and plans for the future, to inform the ongoing COVID-19 response and provide lessons learned to psychiatrists who are starting to offer telemedicine.

Methods

Study Participants and Sampling Strategy

From March 31-April 9, 2020, we conducted 20 semi-structured interviews with psychiatrists practicing in outpatient settings. We worked with a research firm with a panel of 730,000 physicians to recruit participants. The panel is composed of physicians who have joined an online platform to access clinical content (news, condition and drug information, journal articles), continuing medical education activities, and clinical tools, and has been used in prior federally-funded research studies.[10,11]

Psychiatrists in the panel were sent an eight-item screener survey to assess eligibility for participation, and those deemed eligible were invited to participate in a 30-minute telephone interview with the study team. We used three inclusion criteria based on the screening survey to identify outpatient psychiatrists transitioning to telemedicine for the first time in the context of the COVID-19 pandemic: 1) 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, Connecticut, Louisiana); 2) limited use of telemedicine prior to the pandemic (<10% of patient encounters); and 3) 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 (Veterans Affairs, Kaiser). Of the 43 psychiatrists who started the screener survey, 20 (47%) were found eligible and consented to participate. We continued to recruit until we reached thematic saturation, defined as the point at which new interviews did not uncover new themes or patterns.

Interviews followed a semi-structured protocol. Topics included 1) details on practice setting and patient population; 2) experience and perceptions of telemedicine prior to the COVID-19 pandemic; 3) nature of telemedicine use since March 2020 (e.g., modalities, volume, platforms);

4) barriers encountered in transitioning to telemedicine; 5) perceived impact of telemedicine on the quality of patient interactions; and 6) future plans for telemedicine. Four members of the study team trained in qualitative research conducted the interviews. Interviews 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'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 around 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, listing all participants as rows and salient categories that we developed from codes included in the site summaries as columns.[14] Matrices have been used in qualitative data analysis to streamline the process of identifying similarities, differences, and trends in responses across groups of informants.[15] A matrix provides a visual display of data that facilitates the search for and a detailed analysis of patterns, themes, and other relationships and informs subsequent conclusions.[16] In this particular case, the matrix allowed us to interpret each participant's comments in the context of the particular telemedicine modalities and platforms they were using. Themes were identified through well-established techniques, including repetition (e.g., if a concept was expressed more than three times) and emphasis (e.g., if respondents were particularly opinionated about or dedicated significant time to a concept).

Results

Twenty psychiatrists from five states participated in the study. More than half were exclusively in private practice. The rest of the sample 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 Prior to COVID-19

Just under half of the interview participants had some experience with telemedicine prior to the COVID-19 pandemic. These psychiatrists generally offered telemedicine in select cases to patients who had moved away, were travelling, or had unique circumstances that prevented in-person visits (e.g., pregnant patient on bedrest). These telemedicine visits represented only a fraction of their visit volume before March 2020.

Extensive Use of Telemedicine in March 2020

At the time of the interviews, all psychiatrists in the sample had been delivering telemedicine services for 2-4 weeks, including video visits, phone visits, or some 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 the majority of their patients, though psychiatrists generally offered both video and phone visits. Among those offering more than one modality, most allowed patients to decide which modality they preferred. Interview participants explained that when given the option, some older patients, patients who were self-conscious about their appearance, patients with social anxiety disorder, and patients without devices or with limited broadband opted for phone visits. Some psychiatrists also needed to switch to phone visits when they faced technical difficulties during video visits.

Approximately one-third of interview participants reported using the telephone for most or all visits. Reasons for not offering video visits included: 1) confidence that the telephone will work,

and no technical difficulties will arise; 2) lack of compatible devices and/or Internet access among underserved populations and older adults; 3) patient familiarity with the telephone; and 4) lack of access to patient emails to send a video link. Most psychiatrists conducting the majority of patient visits by telephone were not actively planning to offer video visits in coming weeks.

Psychiatrists used several platforms for 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 offer phone visits. Several appreciated the new flexibility to use non-HIPAA compliant platforms, especially in cases where HIPAA-compliant platforms were overloaded (and not functioning well) in the first weeks of the pandemic.

Positive and Negative Impact of Telemedicine on Psychiatrist-Patient interactions

Psychiatrists identified numerous ways in which telemedicine both negatively and positively impacted their practice (Table 3). Positive impacts included benefits of seeing the home environment and greater ease and access for some patients. Negative impacts included: 1) reduced ability to observe nonverbal cues to support diagnosis and treatment; 2) less patient privacy; 3) challenges with hearing patients clearly by phone or video; 4) more distractions for patients in the home environment; 5) inability to do a physical exam and take vitals; 6) difficulty in assessing extrapyramidal symptoms from anti-psychotics; 7) shorter visits; and 8) challenges in managing time within the visit.

The majority 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 described 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 as connected as I have with patients on video." A psychiatrist in private practice in New Jersey said, "I didn't really like technology at all, but to be honest it's working quite well for me. Like the Zoom sessions, I really felt after I did it that I could possibly have done this [before COVID-19], because clinically it's working fine."

Positive Patient Response

Most participants explained 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 be driven by patient fears about ongoing access to care during the emergency rather than the acceptability of telemedicine visits.

A psychiatrist in private practice in California reported that the patient response had been "uniformly positive… people are so grateful that I am continuing to be available." As described by a psychiatrist practicing in a New York hospital, "They [patients] appreciate it because they felt like everything was going to be canceled, they wouldn't be called… their meds would not be refilled… So then we call, they feel so appreciative." A psychiatrist from non-profit 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 they play a more direct role in managing billing than do psychiatrists in other practice settings. Several participants in private practice mentioned that the payers they worked had not been transparent about reimbursement. Lack of clarity on what would be covered, coupled with the fact that they had not yet submitted claims for March, created uncertainty about the impact of telemedicine on practice revenue. As explained by a psychiatrist in private practice in California,

> I haven't really heard any specific feedback yet about the insurances that I'm dealing with, as to whether or not their reimbursements are going to be any different for video services then they would've been for in office visits. And so, 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. So it is on my to do list to try to investigate a) what the coding changes need to be and b) what the likely reimbursement changes are going to be, if any.

A different psychiatrist in private practice in California stated, "[A payer] just sent an email, just like a form email that was written in legalese. So that said, 'We will cover this, but essentially some plans may not cover it.' And so, what are you supposed to do with that information? It's like, 'Okay, well we will see them and then hope you do cover it.'"

Multiple interview participants across practice settings commented that although they were currently busy with existing patients, it was challenging to engage new patients via telemedicine. Most participants were taking on new patients and successfully evaluating them via video or phone; however, some were not, and pointed out that continued reliance on telemedicine could threaten practice sustainability 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 pointed out, "I can sustain my practice now, but practice development [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 include 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 with logistical challenges rather than cancel scheduled visits. As explained by a psychiatrist in private practice in New York, "When we can be out, 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 comfortable with it. If someone, for instance, needed to reschedule, I might be like, '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. Table 4 presents eight strategies that interview participants credited with improving the quality and conduct of telemedicine visits. Example strategies include 1) identify patients "at risk" of having difficulty with video visits (e.g., older adults, adults with cognitive impairments) in advance of the visit, and explore if there is someone in their environment who can aid them; and 2) start each visit asking the patient whether they are concerned about privacy, and if yes, help them identify a private place such as a car.

Discussion

The COVID-19 pandemic has driven a rapid transition to telemedicine among psychiatrists.[17,18] In our semi-structured interviews, we found that although many continued to prefer in-person care, psychiatrists in our sample were able to switch to telemedicine and had largely positive perceptions of the transition. However, several noted challenges such as decreased clinical data for assessment, diminished patient privacy, and increased distractions in the home setting that impacted the quality of provider-patient interactions. Several psychiatrists were concerned that many of their disadvantaged patients lacked reliable access to a smart phone or computer as well as the Internet.

This study explored early experiences with telemedicine during the COVID-19 pandemic. However, whether psychiatrists will continue to have favorable experiences as time goes on is unclear. 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 describe experiences and track them 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 lead to a permanent change in clinical practice.[19] There are many unknowns. We do not know how long strict social distancing will last and whether the temporary policies currently in place to facilitate telemedicine use will remain or be rolled back. Nonetheless, our study suggests that while many psychiatrists in private practice are interested in delivering some telemedicine in the

future, the preference of most is to return to providing in-person care. The psychiatrists who served underserved populations and older adults were uncertain about the long-term viability of telemedicine given lack of resources to support changes in how clinics and health systems communicate with patients (e.g., need for greater use of email to send a link for a Zoom visit).

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

This study identified several possible strategies to facilitate telemedicine use which may be informative for psychiatrists who are just beginning to offer telepsychiatry. Some of these strategies may help increase patient comfort and acceptance of telemedicine. At the time of data collection, psychiatrists generally perceived that patients were satisfied with telemedicine. However, this is in the context of the pandemic with 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, since 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 cannot speak to the experiences of psychiatrists in other states or practice settings. Over half of our sample worked in private practice, and we may be limited in our ability to determine implications for telemedicine implementation in hospitals and other types of community-based settings. Third, given that interviews were brief, participants occasionally lumped video visits and phone visits together when discussing patient response to telemedicine and the impact of telemedicine on quality rather than distinguish between the two modalities. Fourth, we are describing experiences from the first few weeks of the pandemic, and perceptions will likely change over time.

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

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Table 1: Participant Characteristics

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 + other setting	3	15
Hospital outpatient clinic	2	10
Other (e.g., non-profit agency, community mental health center, federally qualified health center)	4	20
Years in Practice		
≤10	6	30
10-20	3	15
21+	11	55
Prior Experience with Telemedicine*		
0	11	55
1-4%	2	10
5-10%	7	35

*% of patient visits that were delivered via telemedicine prior to March 2020

Table 2: Modalities and Platforms

Participant #	Primary Practice Setting(s)	Telemedicine Modalities		Video Platforms
		Phone %	Video %	
1	Private Practice	0%	100%	Thera-link
2	Private Practice	25%	75%	Zoom
3	Private Practice	5%	95%	Doxy.me; FaceTime
4	Private Practice	25%	75%	Doxy.me; Skype; FaceTime
5	Private Practice	30%	70%	Zoom; FaceTime; WhatsApp
6	Private Practice	100%	0%	
7	Private Practice	10%	90%	Doxy.me
8	Private Practice	1%	99%	Doxy.me; Zoom; FaceTime
9	Private Practice	2%	98%	Zoom; Doxy.me
10	Private Practice	5%	95%	Clocktree; Google Meet
11	Private Practice	33%	66%	FaceTime; Zoom
12	Community Mental Health Agency and Private Practice	90%	10%	Zoom

13	Hospital outpatient clinics and private practice	35%	65%	Zoom and FaceTime (hospital clinics); Skype (private practice)
14	Community mental health center and private practice	100%	0%	
15	Federally qualified health center	5%	95%	Doxy.me
16	Hospital outpatient clinics	10%	90%	Zoom
17	Hospital outpatient clinics	100%	0%	
18	Nonprofit agency contracted with Medicaid	98%	2%	Zoom
19	Non-profit clinic	100%	0%	
20	Community mental health center	95%	5%	Zoom

Table 3: Impacts of Telemedicine on the Quality of Psychiatrist-Patient Interactions

Impacts	Illustrative Quotes
Positive Impacts on Quality of Psychiatrist-Patient interactions	
Helpful to see patient's home environment	"One advantage is that I really get to see people in their environment, so that gives me a little bit of an extra information and they are less, not that people come in in a formal attire, but often, they are in the midst of, in the middle of work, so now I see them in a more informal environment. That's more information." -Participant #8 in private practice in California
	"If their home is disheveled, you can see that, so that's useful. I mean, sometimes I do have patients who I know their apartments are a mess. With those patients, I should, even when this is over, 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." - Participant #4 in private practice in New York
Some patients are more relaxed at home or over the phone and can be more forthcoming	"In other ways 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, so it has plus and minuses." -Participant #11 in private practice in Washington state.
	"I definitely had one patient with social anxiety who told me that was explicitly why he wanted to do a phone session and was actually much more forthcoming than he's been before." - Participant #3 in private practice in New York.
Improved access for certain underserved patients who could not be seen in-person prior to the pandemic due to logistical challenges	"I've been able to reach some people for intake for new clients who maybe wouldn't have come, because they weren't that motivated, but because I did call them at home 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." -Participant #18 working for a non-profit agency in California.
	"It's allowed us a chance to engage with the patients that previously were having problems engaging because of either logistics or time." -Participant #15 working for a federally qualified health center in New York
Negative Impacts on Quality of Psychiatrist-Patient Interactions	
Less information to support diagnosis and treatment/inability to use all senses	"From a clinician perspective, it makes my job a little bit harder because especially for newer clients where I'm trying to do an assessment, I'm losing a lot of information of being able to observe them directly and their mannerisms and again, especially if patients maybe have psychosis and you're trying to assess, well did I just not

	hear that clearly or was it something that really just didn't make sense? - Participant # 18working for a non-profit agency in California.
	“It definitely affects the efficacy of the assessments, to me. Especially for intakes, I don't even know who this patient is and how they look, and sometimes, especially when I want to choose a medication, I ask their height, their weight. I am trying to figure out if they have obesity or something, it is more difficult now, in this way. And also in general, I really like interacting with people, the facial expression's very important to me, so I'm missing this part, is definitely not great with telemedicine.” - Participant #17 employed by a New York hospital
	“There's an austerity to it that is ... there's just it creates a distance. Sometimes it's harder to tell is someone tearing up because things like that, if someone tears up, that's like big red flag that says, "Go. Follow that. What's going on now?" That's a really important ... one of the visual cues as an example. Sometimes, you just can't see quite as well, it's not as favorable or just the connection isn't as good. Some of the nuance around more subtle emotion, I think, is lost.”- Participant #2 in private practice in California
	“There's a lot of information you can't get [via video]. Also, must be in person for forensic evaluation- like if someone's in jail, I have to go see them in jail. None of the jails that I work with at this point have video capacity. And just trying to think, if someone's, some of the forensic evaluations, like if you're trying to assess if someone's in the malingering or lying, you've got to be in person.”- Participant # 1 in private practice in California
	“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 for them to sit down or get out of a chair. I want to, and this is a little gross, but it's reality, I want to smell them. You know what I mean by that. I want to smell if they're malodorous or not. I want to see if the lady has gone through a lot of effort, or the gentleman, of putting cologne on. I want to use all my senses, in this experience.” – Participant #6 in private practice in New York
Less privacy in the home setting	“Right now patients have to go hide in the bathroom, right, and they might be talking about their family members who they're having conflicts with and they have to kind of whisper. And when they're in my office they don't have to worry about who's listening.” - Participant # 11 in private practice in Washington state.
	“There's a few people for whom their home and the people they live with doesn't feel as comfortable of a place to talk or as private of a place to talk as coming into the clinic.”- Participant #18 working for a non-profit agency in California.
	“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 can not be overheard.” - Participant #2 in private practice in California
Challenges with hearing patients clearly by phone or video	“So at first for some people they also seem to have a problem sort of speaking clearly and this is probably more a characteristic of maybe their illness or just their communication style. But that can be very difficult over the phone too. And so I sometimes have to ask people, can you speak clearly? Can you keep a stronger voice? Or can you

	just try to speak a little bit louder?" - Participant #18 working for a non-profit agency in California.
More distractions in the home setting	"And then for some people they really, they do struggle and it seems that it's hard for them to sort of stay present or just sort of focus on what we're doing. Maybe they're trying to multitask. Maybe they're not really comfortable." - Participant #18 working for a non-profit agency in California.
	"It's like you're not quite as emotionally connected to a person when they're on video and it's easier to get distracted." - Participant #7 in private practice in Louisiana
	"But just attention, 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 three months and you need to pay attention. You can't be putting the laundry in the dryer. And I think that as someone who puts the laundry in the dryer when I'm on the phone all the time."- Participant #1 in private practice in California
Inability to do a physical exam and take vitals	"I can't do certain things like blood pressure like I would like to do, I'd like to follow blood pressure when people are on medications that can potentially affect blood pressures. That's a little bit of a concern, so I've just been having people monitor it on their own instead." - Participant # 7 in private practice in Louisiana
	"But then in terms of the tangibles, like just checking vitals…that's really challenging."- Participant #14 in a community mental health center in New York
Difficult to assess movement disorders induced by anti-psychotic medications	"When I'm prescribing anti psychotics… I don't yet have a comfortable modality for evaluating patients for symptoms of any movement disorder by video. I mean I do have them perform a couple of maneuvers to just see if I can illicit 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 there are a few maneuvers that I like to do in the office that actually require me to actually physically examine the patient." - Participant #10 in private practice in California
	"And I have a patient that is on Haldol so it's been hard to look for any symptoms of EPS very well." - Participant # 9 in private practice in New York
Visits tend to be shorter and do not go into as much depth	"I started with phone appointments and some of them really…they would sort of shorten the session and stop early, but if they could do FaceTime they could get more engaged with the process." - Participant #11 in private practice in Washington state.
	"The [video and phone] sessions tend to be shorter sometimes, but I feel in-person you might be able to get more information." - Participant #4 in private practice in New York
	"So far it seems like especially when they're telephone, are experienced more as a check-in." - Participant #14 in a community mental health agency in New York
Difficult to manage time in telemedicine visits	"So they'll talk on and on [on the phone], it's hard to stop them at the end of a session and, but the video really does help. You can see them, they can see you." - Participant # 11 in private practice in Washington state.
	"It is difficult to end sessions. In-person, I do this thing at the end of the hour with patients where I lean forward in my chair and I don't have to say anything." - Participant #2 in private practice in California

Table 4: Promising Strategies/Advice

Strategy	**Quote/Specific Application of Strategy**
Start each visit asking the patient whether they are concerned about their privacy ad take steps to ensure that they are in a private place. If they do not have 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, but maybe they say yes, but really then do 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, closet, or bathroom or 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 and do the visit from the car so that they could have quiet and be able to concentrate on the visit."
	"I would encourage practitioners to encourage their patients to be as creative as necessary in order to be able to establish that safe space where they can have their psychiatry sessions. So like I've had patients who didn't feel that they had enough privacy in their own homes, but what they would do is they would either sit in the car in the driveway or they would actually drive to a place where they felt that there was a lot of privacy and they would just sit in their car with their smart phone or their iPad and we would do tele psychiatry with the patient sitting in their car. Which I think is actually very clever."
Ask the patient for their 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. And we do that in case, one, is because I think Medi-Cal is expecting us to document it. And two, because in case there's an emergency situation, we do know their location and we can send first responders."
	"So we're actually entering the actual address of each patients at the time of the phone call, of the video call."
Psychiatrists should conduct video visits from the same spot in their home or office rather than switch locations. This is reassuring for patients.	"[At home] I'm going to set up in exactly the same place every time."
Some patients are self-conscious about video and don't want the clinician to see the inside of their home. Provide FAQs that explains how to change the background (i.e., options to not show your surroundings) in platforms like Zoom.	"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 prior to the telemedicine visit to explain what to expect and why telemedicine is being used.	"It is very important to inform the patients in advance. I appreciated the help from the front desk, because when they expect it, especially in psychiatry, they don't like short notices. Not all of them, but some patients get nervous when they are not familiar with the situation, but when they know, when they expect what is going to

	happen, they feel much more comfortable and they make themselves available as well."
	"And they also get a phone call ahead of time telling them not to come into the office and that I'll reach to them at their appointment time."
Identify patient "at risk" of having difficulty with video visits (e.g., older adults, adults with cognitive impairments) and explore if there is someone in their environment who can aid them. Also, do test calls with this population.	"I had one patient who I did do FaceTime with, and her daughter came in and showed her…if there was somebody who can help them work through it, it's easier than they would think it is. I don't know if that's a way. I don't know if there's a way to kind of encourage, explain it, have it explained to them or a service that they could use that would make it clear."
	"We really took our time identifying the patients that are most at risk and we actually out reached to them and explored how we can help them implement by guiding them over maybe one, two, or even three phone calls or see if somebody in their environment can assist them. We also have case managers that do have the ability to visit patients. We call them care navigators. Sometimes they're able to physically help patients."
Choose a platform where you can ensure that the patient will not see your personal phone number or work out 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 usually see your cell phone. And I don't use my personal cell phone for psychiatric patients you see."
	"For telephone calls, I've just been using my home phone and blocking the number."