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Telehealth acceptability and feasibility among people served in a community behavioral health system during the COVID-19 pandemic

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Abstract

Objective

This study examines the acceptability and feasibility of telehealth services shortly after their rapid introduction in a community behavioral health agency as part of the response to the COVID-19 pandemic.

Methods

Individuals receiving services from May 8 to 18, 2020, from behavioral health programs that had introduced telehealth in March 2020 were invited to participate in a survey. Ordinal logistic regressions were used to test for differences responses in three ways: 1. Between program types; 2. Between this 2020 sample and a historical 2018 sample; and 3. Between individuals reported by staff to be distressed or not distressed by the pandemic.

Results

Over 80% of the 1,482 respondents reported that their feeling of being connected to staff, able to get support, and able to get an appointment was at least as great as before the pandemic. Of the 80% of respondents indicating interest in continuing remote services after the pandemic is over, 83.2% preferred a mix of remote and face-to-face services. From February 2020 to April 2020, total service utilization remained stable for Assertive Community Treatment, clinic and treatment apartment programs. There was no increase in mental health-related hospital utilization.

Conclusions

This study suggests telehealth, including telephonic services, to be an acceptable and even preferred mode of service delivery for clients with severe mental illness. Continued investigation into the optimal dosing of face-to-face versus remote services in various settings will be needed to inform practice during and after the COVID-19 pandemic.

Highlights:

- This study examines the acceptability and feasibility of telehealth services shortly after their rapid introduction in a community behavioral health agency as part of the response to the COVID-19 pandemic.
- Individuals served reported that their feeling of being connected to staff, able to get support, and able to get an appointment was at least as great as before the pandemic. The majority of respondents indicated interest in continuing remote services after the pandemic is over
- Total service utilization remained stable for Assertive Community Treatment, clinic and treatment apartment programs. There was no increase in mental health-related hospital utilization.

Introduction

Since social distancing became a part of the defense against the COVID-19 pandemic, many health care providers have closed their doors and deferred procedures in order to protect patients from exposure to infection (1-3) significantly altering the way care is delivered. However, continued management of chronic diseases that increase COVID-19 risk, such as diabetes mellitus and hypertension, remains a crucial part of response to the pandemic. People with serious mental illness, due to a combination of co-morbidities and adverse social determinants of health, such as housing instability, economic hardship and social isolation, may be at particular risk for COVID-19 morbidity and mortality and the social and psychological effects of the pandemic (4). In many states, mental health providers responded to the COVID-19 emergency with rapid and widespread conversion to telehealth, supported by relief from many regulatory and legislative barriers established prior to COVID-19 (5).

Complex, multidisciplinary care management with frequent engagement is essential in order for many people with severe mental illness to recover, maintain a degree of independence and avoid hospitalization (6,7). For individuals served by teams of mental health professionals, such as in Assertive Community Treatment (ACT) or supported housing, these teams may ironically be the greatest potential source of COVID-19 transmission risk. Conversion of these treatment models to telehealth became essential during the pandemic, while facing unique barriers.

A growing body of evidence supports telepsychiatry as comparable to face-to-face psychiatry in clinic settings with regards to outcomes and patient satisfaction (8 - 10). A subset of evidence examines telepsychiatry for the treatment of serious mental illness, finding that most clients appreciate these services (6,11 - 14). Social isolation is a common problem among people with serious mental illness, sometimes compounded by paranoid ideation or negative symptoms (15-21). It is possible that being able to connect with mental health professionals without leaving the home or receiving visitors may offer some relief.

The available studies most frequently involve telepsychiatry offered through videoconferencing or smartphone technology augmenting primarily face-to-face treatment. However, low computer literacy and limited access to internet technology prevalent among individuals with serious mental illness are barriers to telehealth access. Older individuals may experience even greater issues with telehealth access due to difficulties with hearing, speech, vision, and cognitive impairment (21). When New York State expanded regulations allowing its licensed programs to bill Medicaid for telehealth visits in March 2020, in response to the COVID-19 pandemic, telephonic interventions were permitted in order to address technology barriers. Little is known about client preferences and experiences regarding telephonic services, particularly among people with serious mental illness. This study examines the acceptability and feasibility of telehealth service provision shortly after its introduction in a community behavioral health agency. In particular, we examined client

subjective experience, preferences, and satisfaction with services across behavioral health program types, and compared responses with a historical 2018 sample. We also examined utilization patterns for these behavioral health services and for emergency and hospital services.

Methods

Population

The study invited individuals receiving services from May 8 to 18, 2020 from programs that had introduced telehealth services during the COVID-19 pandemic at a New York City community behavioral health agency. The total census of these programs was 6,546, including 2,668 individuals in treatment programs (mental health clinics, Assertive Community Treatment (ACT), Intensive Mobile Treatment (IMT) and Personal Recovery Oriented Services (PROS) day program), 2,540 in outreach programs (including care coordination and a number of small program types), and 1,796 in housing programs (including Treatment Apartment Program (TAP) and supported housing). Some individuals were enrolled in more than one program. For the 6,546 individuals served by these programs, the majority had a diagnosis of serious mental illness, with 39% diagnosed with a psychotic disorder and 41% diagnosed with mood disorders. The majority of participants identified as Black (60%), with 22% identifying as Hispanic, 14% White, 3% Multi-racial, and 1% Asian. The average age was 45 years (SD 17, range 5 to 93). For the 233 minors, their guardians were asked to participate on their behalf.

Interview Procedures

The survey was administered by clinicians and case managers during scheduled or routine meetings with participants during the study period, whether the meeting occurred telephonically, by videocall, or face-to-face. Clinicians and case managers were provided with a script to introduce the survey, which explicitly stated the survey was voluntary. The survey took approximately 5 minutes to complete, and responses were recorded by the clinicians and case managers in Survey Monkey.

Measures

The agency developed a brief survey to measure participant experience with telehealth services. The first three survey items measured perceived level of connection and support experienced before the pandemic compared to the present.

The next four items were extracted from the agency's annual consumer satisfaction survey to allow for historical data comparison. The following item asked if the individual would like to continue receiving services remotely post-pandemic. If the response was yes, the individual was asked if they would prefer all telehealth or a mixture of telehealth and in-person. The next item asked what type of device was used to engage in telehealth (e.g. phone, laptop, etc.). The clinician or case manager was then asked to rate their perception of the individual's level of distress related to the COVID-19 pandemic.

Monthly aggregate service utilization data for Medicaid-reimbursable programs including clinics, ACT, PROS and TAP, were extracted from electronic health records to examine changes in client access to and engagement in telehealth and face-to-face services during the period immediately before and after the beginning of the pandemic, February 1 to April 30, 2020. Self-reported emergency and inpatient utilization data were obtained from the electronic health record's Healthy Living Questionnaire, administered quarterly or semiannually in all participating programs other than IMT and care coordination, for the periods January-April 2019 and January-April 2020, to enable comparison.

Data Analysis

All collected data were coded and recorded into a computer data file and analyzed using SPSS Statistics. Data were aggregated by program type (treatment, outreach and housing), and ordinal logistic regressions were used to test for differences among program types on responses to the 5-point likert-rated survey questions. Ordinal logistic regressions were used to identify differences between historical responses to the client satisfaction survey items in 2018 and responses during the study period in 2020. Ordinal logistic regressions were also used to determine whether provider-rated client distress due to the pandemic was correlated with experience of services and satisfaction. Results were considered statistically significant if $p < .01$, to account for multiple testing. Service utilization frequency data were summarized in graphs.

Institutional Review Board

This study was performed as part of routine agency performance improvement. Institutional review was not required.

Responsibility and Conflicts of Interest

The authors certify their responsibility for the study and final manuscript and have no known conflicts of interest to declare.

Results

Survey Participation

A total of 1,482 individuals responded, including 363 individuals in treatment programs, 225 in outreach programs, and 894 in housing programs (24.5%, 15.2% and 60.3% of total survey participants, respectively), and representing about 37.7% of individuals scheduled for visits during the study period. Estimated survey participation rates by program type can be found in the online supplement to this article, with a higher participation rate in housing programs than in other programs.

Comparison of responses by type of program

Survey responses are detailed in Table 1 and separated by program type. For the overall sample, the majority of participants responding that their feeling connected to staff (84.8%), able to get support when needed (89.6%), and able to get an appointment when wanted (81.8%) was the same as or more than before the pandemic.

Ordinal regressions were conducted to determine whether program type affected responses to the survey questions, and odds ratios can be found in the online supplement to this article. The Housing and Outreach groups were less likely than the Treatment groups to report, "I can get an appointment when I want" (OR .64, $p=.000$; OR .36, $p=.000$). The Housing group was more likely than the Treatment group to report that staff were sensitive to traumatic experiences (OR 2.11, $p=.000$) and that clients were in distress (OR 1.77, $p=.000$). The Outreach group was less likely than the Treatment group to report, "The quality of my life is improving" (OR .58, $p=.000$).

Comparison of client satisfaction survey items by year

Responses to questions from the annual client satisfaction survey for the 2018 versus the 2020 independent samples are detailed in Table 2. Ordinal logistic regressions were used to determine whether there was a relationship between the year and survey responses, and odds ratios can be found in the online supplement to this article. Clients were more likely to report that their quality of life was improving in 2020 than in 2018 (OR 1.280, $p=.000$).

Comparison of survey responses by staff-reported client distress

Staff reported that clients were distressed (very mildly to severely) by the COVID-19 pandemic in 60.1% of survey responses. Survey responses for clients reported to be distressed versus not distressed and detailed in Table 3. Ordinal logistic regressions were used to determine whether there was a relationship between distress and survey responses, and odds ratios can be found in the online supplement to this article. Clients reported to be not distressed were more likely than those distressed to agree that they feel connected to staff (OR 1.381, $p=.001$), able to get support when needed (OR 1.454, $p=.000$), able to get an appointment when wanted (OR 1.487, $p=.000$), comfortable asking questions, and that their quality of life is improving compared to before the pandemic (OR 1.856, $p=.000$).

Continuation of telehealth and use of technology

Eighty percent of respondents (1,182) indicated they would be interested in continuing to receive services remotely after the COVID-19 pandemic is over, with 984 (83.2%) preferring a mix of remote and face-to-face and 198 (16.8%) preferring all services be completed remotely. There were no significant differences by type of program. The devices used for telehealth included smartphones (53%), basic cellphones (29%), land line phones (16%) and computers (2%), though almost all services were provided with audio call and not video call.

Service Utilization

The number of face-to-face and telehealth services provided from January to April 2020 was obtained for a subset of Medicaid reimbursable programs, showing an increase in overall service provision for ACT but a large decrease for PROS; clinics and TAP remained roughly stable (Figure 1).

The frequency of self-reported emergency and inpatient service utilization is shown in Figure 2. We observe a slight decrease in utilization for mental health reasons between 2019 and 2020, and an increase in utilization for physical health reasons.

Discussion

This investigation of client perceptions regarding telehealth is notable for its focus on people with serious mental illness across multiple program types, including office-based and community-based care, with some longitudinal data

comparison. The rapid conversion to telehealth in March 2020 bypassed the usual processes by which behavioral health agencies seek client buy-in before implementing new services. Consistent with previous studies of telepsychiatry (6,11-14), the high level of perceived support and satisfaction with telehealth services, largely regardless of program type, is promising, with no worsening of satisfaction noted during the pandemic in 2020 when compared with historical (2018) responses.

Mental health care settings that have made large-scale use of telehealth are increasingly confident in developing and sharing adaptations to virtual care delivery (23), which can be used to accommodate the significant number of clients who requested to continue exclusively with telehealth services after the pandemic. However, for some of these clients, this preference may not be clinically viable. For example, clients requiring direct inspection of living conditions, visualization of mental status, and private locations for telehealth visits, or accommodations for hearing or speech disabilities or cognitive impairment, cannot be adequately served without face-to-face visits at least part of the time. Telehealth may be used as an augmentation for face-to-face visits, and determining the “dosing” of telehealth visits will require more experience and research (6). Examining the impact of video versus phone visits, and the replacement of office versus field visits, will be important. Notably, replacing office visits with a video visits may offer a glimpse of a client’s home life that enhances a provider’s understanding of the client’s situation, whereas when replacing a field visit with a phone call, it is likely that information is lost. There may also be differences when a client interacts with one provider via telehealth, versus when they are served by individual members of a team of providers.

We are not aware of another investigation of the impact of client distress on the perception of telehealth. The negative impact of staff-rated distress on client-rated perceived support suggests the need to increase support for clients perceived to be distressed. On the other hand, the relative stability of emergency and hospital utilization compared to the same period in 2019 is reassuring. Outcomes of other rapid conversions to telehealth also demonstrate the capacity for safe, equitable care delivery (24).

The stable or increased numbers of total visits for clinic, ACT and TAP programs supports the continued telehealth provision in these programs, if the reimbursement for telehealth continues to be viable. It also suggests a benefit to some clients in increasing their access to care beyond pre-pandemic standards. Other venues have reported increases in outpatient attendance consistent with our results (23). While individual telehealth care models showed promise, group models such as PROS and day programs do not easily lend themselves to a rapid conversion to telehealth, as evidenced by decreased visit numbers. The culture change to provision of groups via phone or videocall was very challenging, with availability of technology and the high degree of necessary coordination being the main barriers. Once a group telehealth

model is better established at this agency and others, comparison of telehealth satisfaction in individual versus group settings will be useful.

A subset of the population lacked access to any device. To increase participation in telehealth services, the agency provided 97 individuals with mobile phones and arranged use of communal phones and devices. As all programs begin to accrue the necessary technology, it seems likely that the frequency and quality of telehealth will increase. However, while many clients were noted to have smartphones, anecdotal reports suggest data plans supporting videocall capability are hard to sustain financially for most of the people in this population. This assertion needs to be examined in a follow-up survey, with further exploration of technology needs and opportunities. In the meantime, the feasibility and acceptability data from this study suggest that regulators and funders should continue to reimburse telephonic services to support access to care among people with severe mental illness.

While the sample size is large, the short survey period reduced the participation rate as a proportion of the total census, with possible selection bias towards individuals who had made themselves available for telehealth services and were willing to cooperate with a survey administered in a telehealth session. A notable omission was that whether the survey was administered in person or via a telehealth session, and whether via video or audiocall, was not recorded.

Demographic data were also not recorded for survey respondents, limiting the ability to generalize the results to the total population. However, demographic data available for the total population does support generalizability to other behavioral health populations. Another source of bias was that survey responses were recorded by staff interviewing their own clients- this likely impacted the correlation found between staff-rated client distress and the client's satisfaction and quality of life responses, in particular. The challenges in obtaining data from a clientele frequently lacking access to the internet and with literacy issues continues to impact the quality of community research. In this instance, it was important to obtain data quickly to inform the agency's practices and to advocate for regulatory changes to improve community-based telehealth in an impactful way. This survey was administered only two months after telehealth began to be offered; repeated survey administration will be necessary to understand client preferences, outcomes and risks in the longer term.

Conclusions

This study suggests that people served in a variety of behavioral health treatment programs find telehealth, including telephonic services, to be an acceptable and even preferred mode of service delivery, while service utilization numbers demonstrate its feasibility in individual care settings but possibly not in group programs. Continued investigation into the optimal dosing of face-to-face versus telephone and video call services, in office-based, community-based and group-

based settings, and viable billing models for these services, will be needed to inform practice during and after the COVID-19 pandemic ends.

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Table 1. Survey responses by program type

Question and Responses	Treatment		Housing		Outreach	
	N	%	N	%	N	%
I feel connected to my case manager/therapist/doctor/nurse/team						
A Lot Less	14	3.9	26	2.9	10	4.4
A Little Less	49	13.5	90	10.1	33	14.7
The Same	186	51.4	517	58	125	55.6
A Little More	56	15.5	164	18.4	31	13.8
A Lot More	57	15.7	95	10.7	26	11.6
I can get support when I need it						
A Lot Less	12	3.3	17	1.9	2	0.9
A Little Less	23	6.4	62	6.9	34	15.1
The Same	214	59.4	543	60.8	125	55.6
A Little More	55	15.3	181	20.3	41	18.2
A Lot More	56	15.6	90	10.1	23	10.2
I can get an appointment when I want						
A Lot Less	11	3.1	42	4.7	11	4.9
A Little Less	24	6.7	118	13.2	58	25.8
The Same	233	65.1	560	62.7	122	54.2
A Little More	41	11.5	110	12.3	12	5.3
A Lot More	49	13.7	63	7.1	22	9.8
I feel comfortable asking about treatment and medications						
A Lot Less	3	0.8	8	0.9	2	0.9
A Little Less	8	2.2	15	1.7	4	1.8
The Same	24	6.7	66	7.4	23	10.3
A Little More	183	51.1	537	60.1	129	57.6
A Lot More	140	39.1	268	30	66	29.5
Staff talk to me about specific goals for my health						
A Lot Less	3	0.8	3	0.3	1	0.4
A Little Less	10	2.8	13	1.5	1	0.4
The Same	14	3.9	56	6.3	14	6.2
A Little More	209	57.7	553	62	134	59.6
A Lot More	126	34.8	267	29.9	75	33.3
Staff are sensitive to my traumatic or difficult experiences						
A Lot Less	3	0.8	3	0.3	1	0.4
A Little Less	15	4.2	13	1.5	6	2.7
The Same	33	9.2	50	5.6	22	9.8
A Little More	180	50.4	584	65.6	127	56.7
A Lot More	126	35.3	240	27	68	30.4
The quality of my life is improving						
A Lot Less	5	1.4	11	1.2	6	2.7
A Little Less	31	8.6	51	5.7	16	7.1
The Same	72	19.9	176	19.7	78	34.8
A Little More	168	46.4	491	54.9	91	40.6
A Lot More	86	23.8	165	18.5	33	14.7
Staff: Please assess the degree to which your client is experiencing distress because of the pandemic						
A Lot Less	25	6.9	25	2.8	6	2.7

A Little Less	61	16.9	77	8.6	14	6.2
The Same	95	26.2	186	20.9	47	20.9
A Little More	70	19.3	211	23.7	76	33.8
A Lot More	111	30.7	392	44	82	36.4

Table 2. Survey responses by year

Question and Responses	2018		2020	
	N	%	N	%
I feel comfortable asking about treatment and medications				
Strongly Disagree	12	1.3	13	0.9
Disagree	22	2.5	27	1.8
Neither	77	8.6	113	7.7
Agree	476	53.4	847	57.5
Strongly Agree	305	34.2	473	32.1
Staff talk to me about specific goals for my health				
Strongly Disagree	12	1.3	7	0.5
Disagree	19	2.1	24	1.6
Neither	55	6.2	84	5.7
Agree	510	57	893	60.5
Strongly Agree	298	33.3	468	31.7
Staff are sensitive to my traumatic or difficult experiences				
Strongly Disagree	17	1.9	7	0.5
Disagree	20	2.2	34	2.3
Neither	78	8.7	105	7.2
Agree	490	54.9	888	60.5
Strongly Agree	287	32.2	434	29.6
The quality of my life is improving				
Strongly Disagree	18	2.1	22	1.5
Disagree	32	3.8	98	6.6
Neither	143	16.9	326	22.1
Agree	396	46.7	747	50.6
Strongly Agree	259	30.5	284	19.2

Table 3. Survey responses by distress

Question and Responses	Distressed		Not Distressed	
	N	%	N	%
I feel connected to my case manager/therapist/doctor/nurse/team				
A Lot Less	41	4.5	10	1.6
A Little Less	130	14.2	44	7.2
The Same	484	53	371	61.1
A Little More	156	17.1	101	16.6
A Lot More	103	11.3	81	13.3
I can get support when I need it				
A Lot Less	23	2.5	8	1.3
A Little Less	95	10.4	29	4.8
The Same	541	59.2	368	60.9
A Little More	163	17.8	117	19.4
A Lot More	92	10.1	82	13.6
I can get an appointment when I want				
A Lot Less	54	5.9	13	2.1
A Little Less	144	15.8	67	11.1
The Same	545	59.8	393	64.9
A Little More	96	10.5	71	11.7
A Lot More	73	8	62	10.2
I feel comfortable asking about treatment and medications				
A Lot Less	9	1	4	0.7
A Little Less	21	2.3	7	1.2
The Same	77	8.4	37	6.1
A Little More	520	57	353	58.4
A Lot More	285	31.3	203	33.6
Staff talk to me about specific goals for my health				
A Lot Less	7	0.8	0	0
A Little Less	14	1.5	13	2.1
The Same	56	6.1	29	4.8
A Little More	550	60.2	369	60.8
A Lot More	287	31.4	196	32.3
Staff are sensitive to my traumatic or difficult experiences				
A Lot Less	6	0.7	1	0.2
A Little Less	24	2.6	12	2
The Same	61	6.7	47	7.8
A Little More	551	60.5	359	59.5
A Lot More	268	29.5	184	30.5
The quality of my life is improving				
A Lot Less	19	2.1	3	0.5
A Little Less	85	9.3	17	2.8
The Same	219	23.9	117	19.3
A Little More	447	48.8	322	53.1
A Lot More	146	15.9	147	24.3

Figures

Figure 1. Face-to-face and telehealth services provided, by program type and month

Figure 2. Emergency and inpatient utilization 2019 versus 2020

