

# Behavioral Health Institute Provider Needs Assessment Survey Report

BEHAVIORAL HEALTH INSTITUTE

HARBORVIEW  
MEDICAL CENTER  
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**Behavioral Health Institute – Training, Workforce and Policy Innovation Center, Provider Needs Assessment Survey Report.** Avery M, Norris E, McKee M, Harvell J, Perry S, Shushan S, Mendoza L, Towle C, Brooks L, Vollendroff J.  
Uploaded to the Behavioral Health Institute Website: <https://bhi-telehealthresource.uwmedicine.org/>

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# 1 EXECUTIVE SUMMARY

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To better understand the barriers experienced by community behavioral health providers in Washington State who were transitioning to telehealth-based care, the Harborview Behavioral Health Institute (BHI) administered a survey of behavioral health providers during the initial peak period of COVID-19.

A 20 question, web-based survey of providers was developed and administered during the time period of April 20 – May 22, 2020. Participation was voluntary and distributed statewide through various meetings and communications. We received and analyzed 329 responses, from a total of 204 organizations and/or practices, representing all regions across the state and a diverse mix of provider types including Indian Health Care Providers. The majority of responses were from persons working in specialty mental health and substance use programs, and representing clinicians, leadership, program managers/directors, and other roles. About 10% of responses were from persons working in organizations that are Indian Health Care Providers.

The results of the study document high utilization (approximately 95%) of telephone + video and 90% providing telephone only, 39% were using email, and 36% using text to patient care as well. Only 21% of respondents indicated they were using telehealth prior to the onset of COVID-19.

Barriers faced by patients were reported by the majority of respondents, including limited access to broadband (73%), Laptop or Computer (73%), and Cell Phone (63%). Limited availability of a private location for consultation (64%), and difficulty with adapting to telehealth (68%) were also prominent patient-facing barriers. Top barriers faced by clinicians in providing telehealth include difficulty adapting to telehealth (56%), difficulty contacting patients (53%), need for clinical skills (31%), and lack of access to broadband (26%). Thirteen percent (13%) of providers indicated difficulty with billing and reimbursement.

Most respondents reported that they were already receiving some type of telehealth support, including using free Zoom licenses (51%), receiving telehealth training (23%), special funding (11%), and technical assistance (11%). However, numerous additional support needs were documented, including clinical training, client resources, technical assistance, and financial support.

In addition to challenges, numerous providers described multiple, diverse solutions to addressing the telehealth needs.

**Conclusions and Recommendations:** The vast majority of community behavioral health providers across the state have pivoted to utilization of telehealth-based care, which is particularly notable given the large number of patient, clinician, and provider organization barriers that were documented. We recommend ongoing, systematic support for clinicians and providers to address and resolve these barriers to address urgent needs, normalize and capitalize on new workflows, and sustain observed improvements.

## 2 INTRODUCTION

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The Harborview Medical Center’s Behavioral Health Institute (BHI) created the Behavioral Health Training, Workforce and Policy Innovation Center (BHTWPC) with funding from the Washington State Legislature and utilizing that funding through a contract with the Washington State Health Care Authority. The purpose of BHTWPC is to assist with behavioral health system transformation and improvement by a focus on behavioral health workforce development, training, and policy. The work of the BHI-BHTWPC, along with a coalition of partners, was already underway when the COVID-19 pandemic came into effect in early 2020. The priorities of this project were abruptly re-focused on the disruptions to our communities’ behavioral health systems of care with the onset of COVID-19. As patients and non-essential workers moved into self-isolation, behavioral health clinicians and provider organizations struggled to adapt to provide care while minimizing the risk of infection of both practitioners and patients by direct face to face patient contact. There were concerns that the additive effects of COVID-19 on an already fragile system could result in a care system collapse without the urgently needed support and infrastructure in new technologies and workflows, such as the use of telehealth services.

Thus, the BHI-BHTWPC quickly pivoted its focus to a BH telehealth training and technical assistance (TA) program. The structure of the BHI-BHTWPC project was designed to be highly nimble and productive – with a daily “Rapid Response Team” (RRT) that reported to a weekly Strategic Oversight Committee. For more details about the BHI purpose, organization, and participating partners, please visit the BHI website located at <https://bhi-telehealthresource.uwmedicine.org/>

The rapid, system-wide transition of services from an in-person to a telehealth-based model of care was, and still is, a monumental undertaking. The COVID-19 pandemic had a dramatic impact on BH operations across all disciplines and sectors – e.g. from medical staff to outreach workers, from hospitals/residential to clinics, and from individual practitioners to large organizations. The list of potential needs similarly was large, for example, assistance around changes in funding, regulation, infrastructure, workforce development, policy and training to support providers in adapting to this new landscape. But which of these needs were most common and pressing? To what extent had organizations already had experience with telehealth? How well were others transitioning to telehealth? What were the perceived barriers? What new workflows and other innovations were being tried? And how did these factors differ across different areas of the state?

To get a better understanding of these factors, one of the first efforts of the BHI was to create a needs assessment survey to help identify our state’s behavioral health providers’ needs for telehealth tools, resources, training, technical assistance, and other support.

### 3 METHODS

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The initial list of questions was developed by the BHI Rapid Response Team who are experienced in both telehealth and survey methodology. To maximize the likelihood of full response, we aimed to create a very short survey of 15 – 20 questions. SurveyMonkey was chosen as the platform. The survey opened for response on April 20 and closed on May 22, 2020. An additional question was added one week into the collection period in order to identify tribes and/or Indian Health Care Providers. This brought the final survey length to 20 questions and is estimated to take just under 5 minutes to complete. Refer to Addendum 1 for a full listing of survey questions.

Primary distribution was completed via the WA State Accountable Communities of Health (ACHs) and the Health Care Authority (HCA). The ACHs distributed the survey to their partner provider organizations, and the HCA notified providers of the survey primarily during weekly provider calls, monthly tribal meetings and tribal liaison communications. Other distribution efforts were utilized later in the sampling period, including contacting those providers who requested (but did not activate) free Zoom for Healthcare licenses from the HCA, and more passive distribution and promotion of the survey by members of the SOC. To minimize multiple submissions, individual respondents were barred from submitting more than one response from any one device. However, we did not utilize random samples, blinded data collection, nor to limit the number of responses from single organizations. Thus, we are limited in the ability to use the data to make comparisons between groups of respondents and between regions. In order to obtain enough responses from different parts of the state, we tracked response by ACH and encouraged additional outreach to ACH areas where responses appeared to be low.

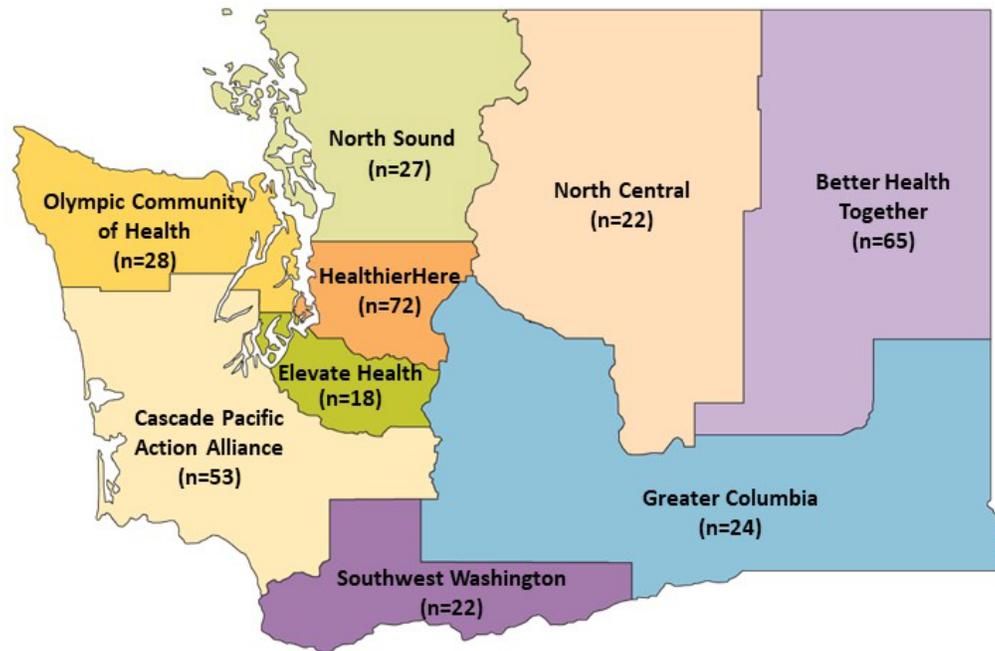
Our survey asked respondents to identify their ACH affiliation as our method of regionalizing responses. However, about 41% of respondents indicated they did not know their ACH affiliation and an additional 10% of respondents indicated “none”. To identify the state region of those responses, we used that primary address of the respondent’s organization to identify county and ACH for distribution analysis and in regional comparison tables.

## 4 RESULTS

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### 4.1 NUMBER AND DISTRIBUTION OF RESPONSES

Figure 1: Telehealth Needs Assessment Survey – Statewide Distribution of Responses (n = Responses)



Thirty survey respondents also self-identified as Indian Health Care Providers.

We received a total of 329 responses to the survey, from a total of 204 organizations and/or practices, with numerous responses from provider organizations across all ACHs/regions (including Indian Health Care Providers). As can be seen in Figure 1, there appeared to be good distribution of survey responses from all ACH regions of the state and thus this survey likely achieved adequate representation of opinion from across the state.<sup>1</sup>

#### 4.1.1 Type of Organization

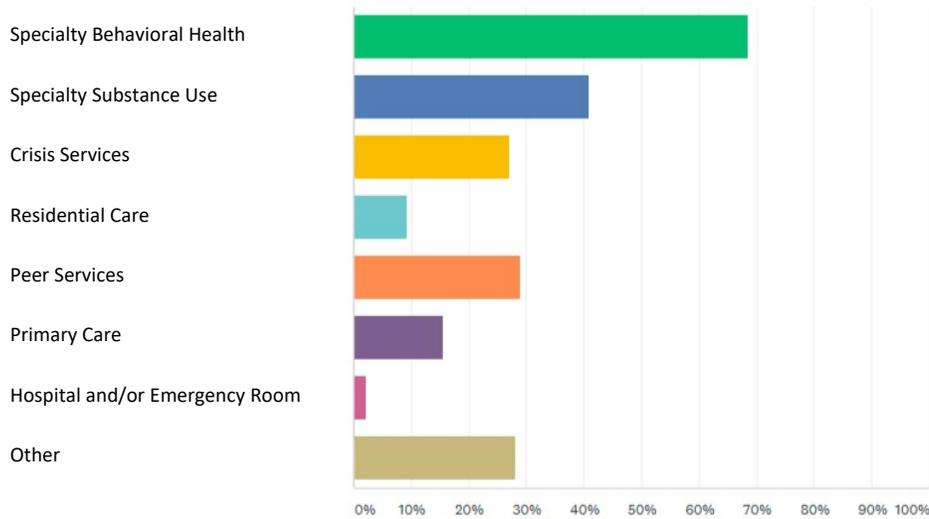
Figure 2 displays the distribution of responses according to type of organization. Respondents were asked to check all organization types that apply. Most respondents indicated they are from Specialty Behavioral Health, Specialty Substance Use, or both. There were also responses from (in descending order) organizations providing Peer Services, Crisis Services, Primary Care and Residential Care. There were also a small number from Hospital and/or Emergency Rooms. Thirty percent (n=92) respondents selected “Other” as their organizational type, including 34 from some type of behavioral health organization, 12 from a primary care/integrated care/physical health provider, 4 from

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<sup>1</sup> The sum of regional and IHCP counts is larger than survey responses (329) due to some respondents indicating multiple ACHs.

hospital/residential provider, 1 dental provider, and 36 from other community service providers. This mix of respondents is consistent with the intended purpose for this tool and with our distribution plan.

*Figure 2 – Service Organization by Type*



#### 4.1.2 Accountable Communities of Health (ACHs) and Indian Health Care Providers (IHCP)

As can be seen in the Table 1, representatives affiliated with all ACHs responded to the survey. IHCPs represent about 10% of survey responses (n = 30), as depicted in Figure 3.

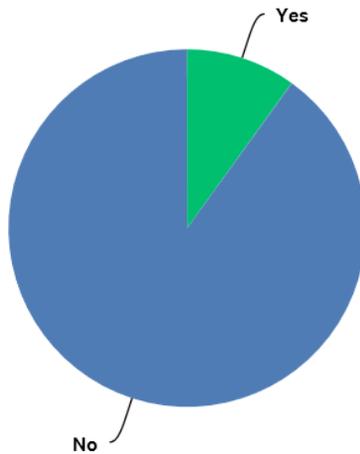
*Table 1, Accountable Communities of Health (ACHs)*

ANSWER CHOICES	RESPONSES	
Better Health Together	10.03%	33
Cascade Pacific Action Alliance	8.81%	29
Greater Columbia	5.47%	18
HealthierHere	7.90%	26
North Central	5.17%	17
North Sound	5.17%	17
Olympic	3.34%	11
Pierce County	3.34%	11
Southwest Washington	5.17%	17
I don't know	41.03%	135
None	11.25%	37
Other (please specify)	Responses	3.95%
<b>Total Respondents: 329</b>		

Figure 3, Indian Health Care Providers<sup>2</sup>

Are you employed by or representing an Indian Health Care Provider?

Answered: 291 Skipped: 38



#### 4.1.3 Organizational Role

As displayed in Figure 4, the largest number of responses were from Clinicians, which included care managers, case managers, therapists, RN, ARNP, MD, etc. This group represented 41% of the respondents. The next largest groups were Executive Leadership and then Program Director / Manager representing 16% and 15% respectively. A smaller percentage of responses were from Clinical Supervisors and Quality Improvement Director / Manager (6% and 2% respectively). Among the 65 persons who chose “other” – Other clinician or service provider (39), Administration or Quality Improvement (15), Administrative Assistant (4), Primary Care Provider (2), and RN/Nurse (1). Thus, respondents generally were equally divided between clinician and administrative roles.

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<sup>2</sup> Question was added to the survey after the initial release. Therefore, there were some respondents that did not receive the question, and one IHCP was identified in the initial responses.

Figure 4 Self-identified roles for survey respondents.

What title best describes your role at your organization?

Answered: 329 Skipped: 0



ANSWER CHOICES	RESPONSES	
Executive Leadership	16.41%	54
Program Director / Manager	14.89%	49
Quality Improvement Director / Manager	2.13%	7
Clinical Supervisor	5.78%	19
Clinician (Care Manager, Case Manager, Therapist, RN, ARNP, MD, etc.)	41.03%	135
Other (please specify)	19.76%	65
<b>TOTAL</b>		<b>329</b>

## 4.2 TELEHEALTH TECHNOLOGY USED

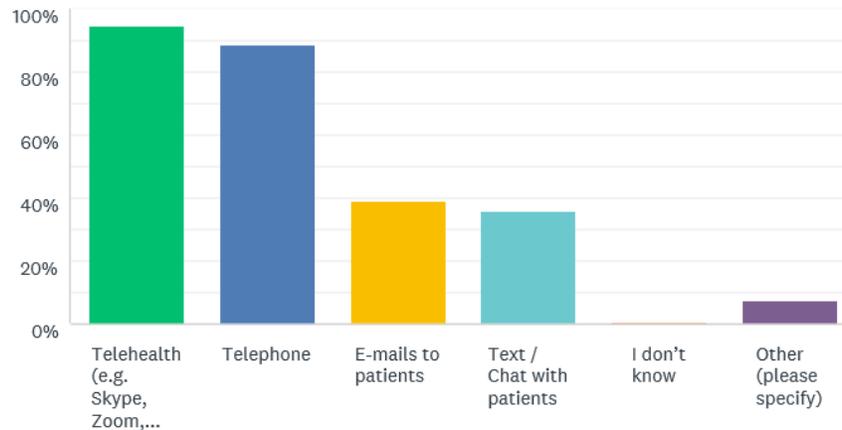
Several questions were asked to evaluate organizations' historic and future planned use of telehealth as well as the use of telehealth platforms and preferences. A significant number (almost 95%) of respondents indicated that their organization is using audio/video telehealth technology. And almost 90% were using telephone without video for services as well.

A considerable number were also utilizing text and email to provide services (36% and 39%, respectively). These responses suggest that there is a fair amount of adaption and innovation occurring to meet patient needs. This activity may also be partially explained by the quick action of the Washington State Health Care Authority to address clinician telehealth barriers early in the pandemic and assist providers and patients in this transition by expanding the definition of allowed telehealth services to include these alternative forms of patient care and providing Zoom for Healthcare licenses free of charge to providers and delivering thousands of smartphones and data plans to patients.

**Figure 5 Telehealth Technology Use**

What telehealth / telephone technologies has your organization recently utilized on a regular basis to provide clinical services? Check all that apply.

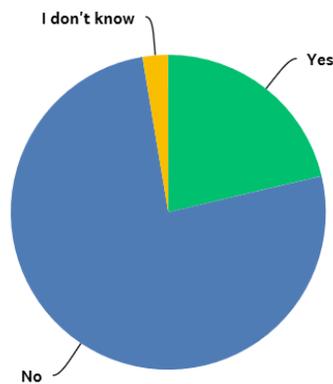
Answered: 324 Skipped: 5



**Figure 6, Percentage Using Telehealth Prior to COVID-19**

Was your organization using a telehealth platform prior to COVID-19?

Answered: 305 Skipped: 24



ANSWER CHOICES	RESPONSES	
Yes	21.31%	65
No	76.07%	232
I don't know	2.62%	8
<b>TOTAL</b>		<b>305</b>

As can be seen in Figure 6, only about one out of five (21%) of respondents indicated their organization was using a telehealth platform prior to COVID-19. This data supports our early impressions that the

behavioral health system and workforce has had to make a sudden transformation to use of a telehealth.

Providers from organizations that were already doing telehealth may have been less likely to perceive benefit of our program, and thus less likely to respond to our survey. However, it is still remarkable that nearly all the respondents reported that their organization was using telehealth (e.g. Skype, Zoom, etc.) at the time of completing the survey. Though the response pool was likely selected from persons who were more likely to be using or considering telehealth early, this is still a dramatic figure in comparison to only one out of five respondent organizations had used telehealth prior to COVID-19.

This survey did not employ the appropriate sampling methods to statistically compare responses across groups. However, it is still notable that we saw variation among respondents across ACHs with regard to Pre-COVID-19 use of telehealth – ranging from as low as 4% to as high as 44%. Those differences are shown in Table 2, below. These results suggest that various providers may be in very different circumstances with regard to telehealth needs – with some regions having much less experience and in the “startup” phase with potentially more support needs. Other regions appear to have more telehealth experience – and perhaps less need for support. These higher-experience providers could potentially also serve as a resource for sharing expertise with other less-experienced providers and regions of the state.

*Table 2, Percentage of respondents that indicated that their organization WAS using telehealth prior to the COVID-19 pandemic.*

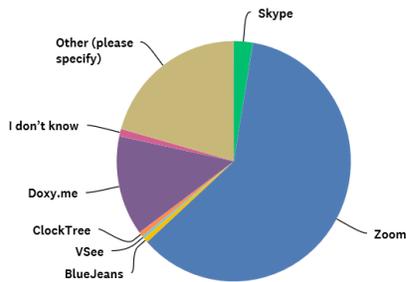
<b>ACH/Entity</b>	<b>Percent</b>
<b>Pierce County</b>	44%
<b>North Sound</b>	42%
<b>North Central</b>	35%
<b>Cascade Pacific</b>	29%
<b>Olympic</b>	28%
<b>SWWA</b>	25%
<b>Greater Columbia</b>	23%
<b>Healthier Here</b>	15%
<b>Better Health Together</b>	7%
<b>IHCPs</b>	4%

### 4.3 TELEHEALTH PLATFORMS

*Figure 7, Platforms used or being considered.*

Which telehealth platform does your organization use?

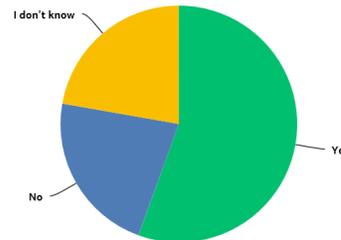
Answered: 305 Skipped: 24



*Figure 8, Plans to begin using telehealth platform*

Does your organization have plans to begin using a telehealth platform soon (e.g. Skype, Zoom, BlueJeans, VSee, ClockTree, etc.)?

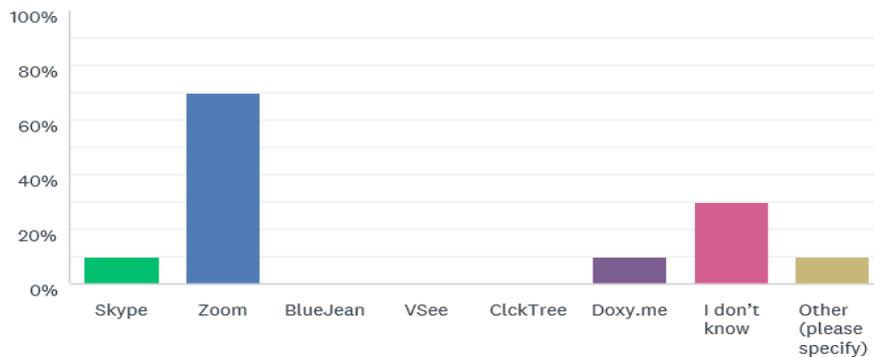
Answered: 18 Skipped: 311



*Figure 9, Platforms being considered*

What telehealth platform(s) is your organization considering? Check all that apply.

Answered: 10 Skipped: 319



We asked these three platform questions to get a sense of what technology was being used. This information was needed to prepare for which platform(s) would be best for demonstration purposes in our technical assistance/training webinars and other support activities. As can be seen from Figure 7, above, the majority of organizations that were providing telehealth were using Zoom. Of the approximately 5% of organizations that had not yet started doing telehealth, most were considering implementing telehealth, primarily via the Zoom platform. Thus, at least among the respondents, the Zoom platform appears to be the predominant platform being used.

### 4.4 BILLING DIFFICULTIES, CLINICAL & PATIENT BARRIERS

Figure 10 shows that approximately one out of every eight of respondents indicated they were having trouble with telehealth billing and reimbursement. Those respondents that selected “yes” to this billing

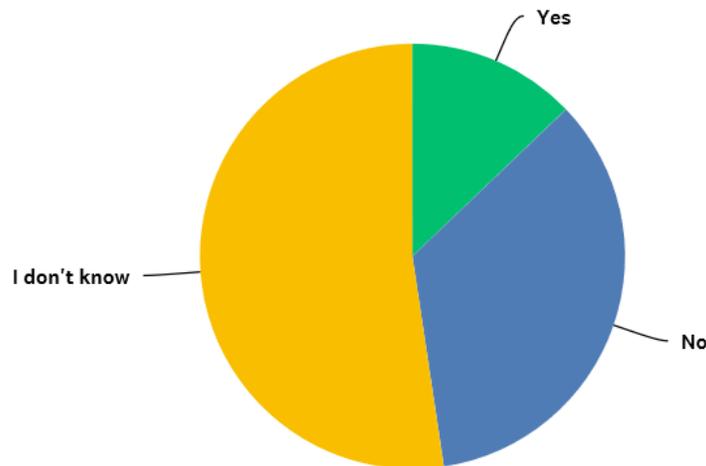
difficulties question were asked to give more details. Themes of those details, depicted in Chart 1 include inconsistent rules across payers, payment delays and denials, parity, unclear payer communication, provider (internal) operational challenges, and other challenges. As illustrated in the following chart, the category of inconsistent rules was the most frequently identified challenge.

Over half of the respondents answered “I don’t know” when asked if their organization was experiencing any difficulty with telehealth billing and reimbursement. Many of these respondents likely were in work roles that were operationally distant from their organization’s billing department. Others reported that it was too soon to determine specific challenges, possibly due to the lag in billing process. The lag in receiving payment may also be supported by our observation that a good portion of the respondents who did report a billing difficulty completed the survey later in the survey period.

*Figure 10, Organization experiencing billing difficulties*

Is your organization experiencing any difficulty with telehealth billing and reimbursement?

Answered: 319 Skipped: 10



**Chart 1: Billing Difficulties, Text Responses**

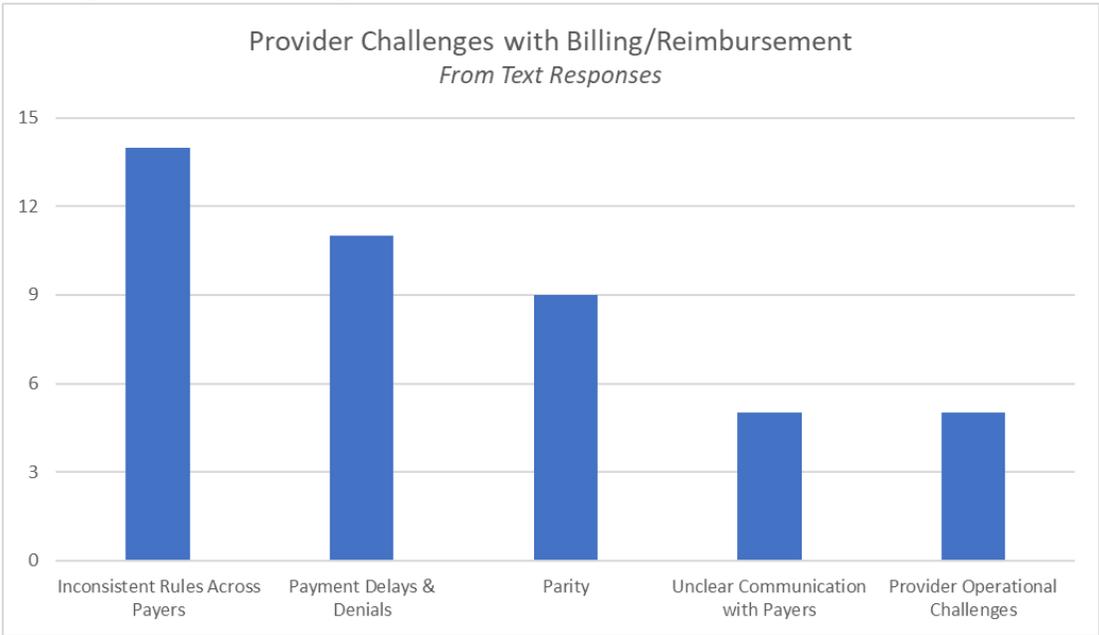


Chart 1 summarizes themes from those respondents who did report difficulty with billing or reimbursement. Predominant themes include inconsistent rules across payers, payment delays and denials, parity, communications, and operational challenges. Individual concerns not shown in the chart included: cost sharing responsibilities, time thresholds to bill, confusion within a payer organization (getting different answers depending on who you talk to), and some lack of parity with different codes for Medicaid. Over 50% of the text response difficulties came in the last few days of the survey, perhaps because these providers were further into their attempts to be reimbursed for these services.

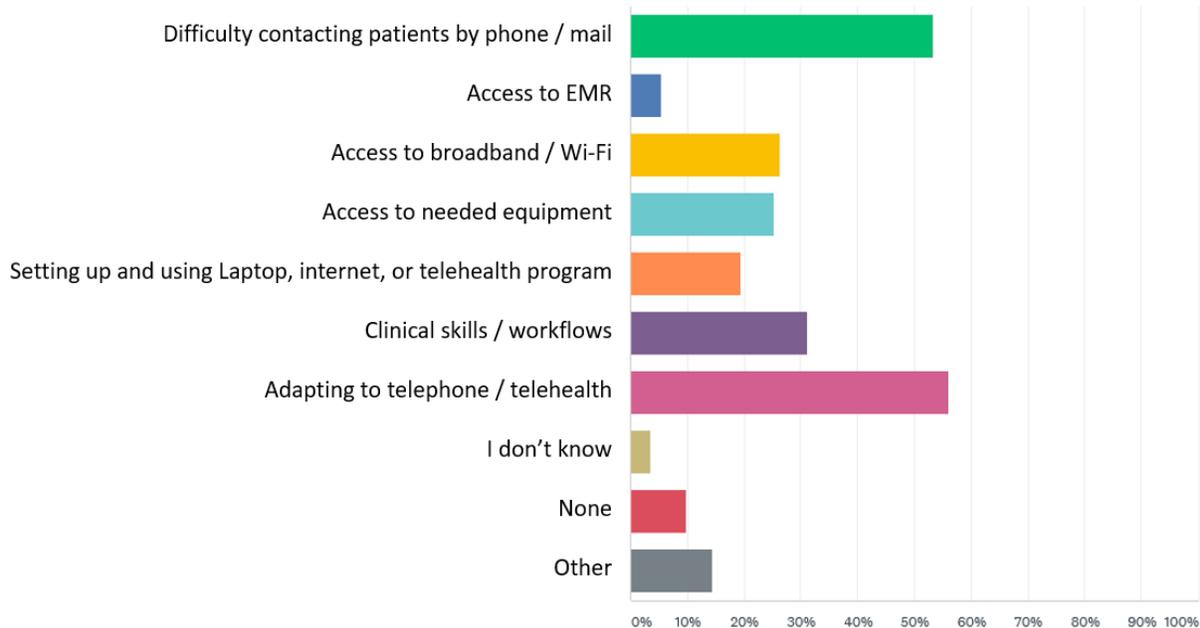
**4.5 CLINICIAN BARRIERS TO PROVIDING TELEHEALTH / TELEPHONE SERVICES**

As seen in Figure 11, the most frequent barriers to clinicians for providing telehealth services include difficulty contacting patients by phone/mail, followed by difficulties in adapting to telephone/telehealth, clinical skills and workflows. There were also common but less frequent challenges for clinicians with access to broadband/Wi-Fi, access to needed equipment (e.g. telephone, cellphone, laptop, computer), and setting up and using laptops, internet or telehealth platform.

**Figure 11, Clinician Barriers to Telehealth / Telephone**

What barriers are your organization's clinicians experiencing in being able to provide telehealth / telephone services? Check all that apply.

Answered: 307 Skipped: 22



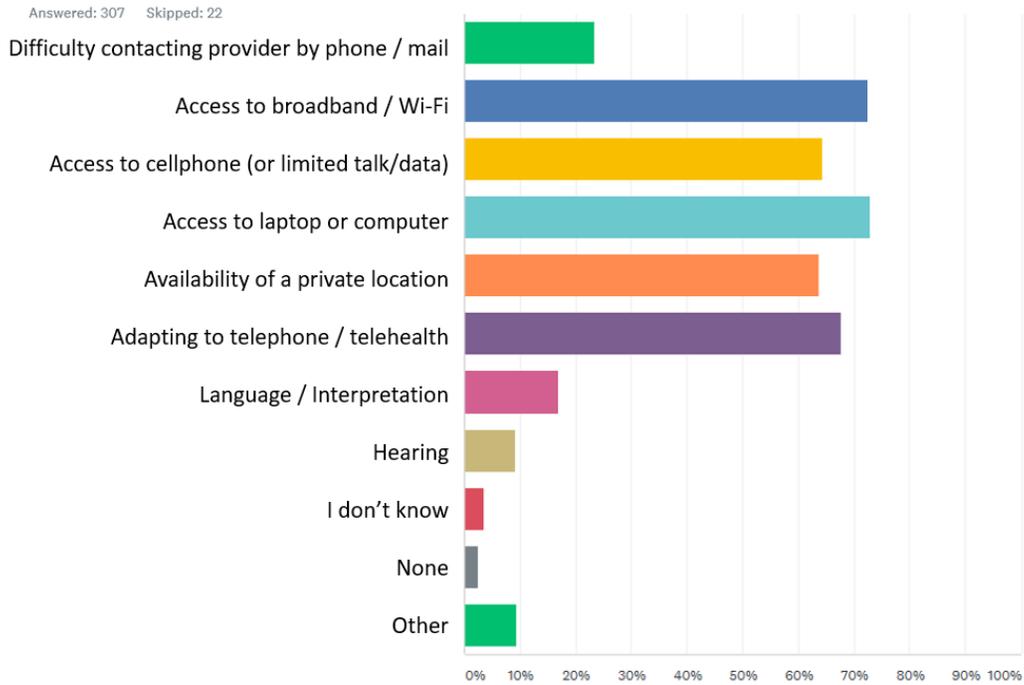
ANSWER CHOICES	RESPONSES	
Difficulty contacting patients by phone / mail	53.42%	164
Access to EMR	5.54%	17
Access to broadband / Wi-Fi	26.38%	81
Access to needed equipment (e.g. telephone, cellphone, laptop, computer)	25.41%	78
Setting up and using laptop, internet, or telehealth program	19.54%	60
Clinical skills/workflows needed for transition to telephone / telehealth	31.27%	96
Adapting to telephone / telehealth	56.03%	172
I don't know	3.58%	11
None	9.77%	30
Other (please specify)	<a href="#">Responses</a>	14.33% 44
<b>Total Respondents: 307</b>		

Respondents who selected “other” challenges were asked to qualify their responses. Many of these responses were written in a request for training and technical assistance and will be covered in greater detail in the request for additional support section later in this document. In general, themes of these qualified responses include supporting clinical workflows, skills using telehealth technology, and different patient populations (e.g. children, adults, etc.).

## 4.6 PATIENT BARRIERS

**Figure 12 – Patient Barrier to Telehealth / Telephone**

What barriers to telehealth / telephone services are your organization's patients experiencing? Check all that apply.



**Table 3 – Patient Barriers to Telehealth / Telephone**

ANSWER CHOICES	RESPONSES
Difficulty contacting health care providers by phone / mail	23.45% 72
Access to broadband / Wi-Fi	72.64% 223
Access to cellphone (or limited talk/data plans)	64.50% 198
Access to laptop or computer	72.96% 224
Availability of a private location, childcare needs, or other personal barriers to care	63.84% 196
Adapting to telephone / telehealth	67.75% 208
Language / interpretation	16.94% 52
Hearing	9.12% 28
I don't know	3.58% 11
None	2.61% 8
Other (please specify)	<a href="#">Responses</a> 9.45% 29
<b>Total Respondents: 307</b>	

As can be seen in Figure 12 and Table 3, patient barriers were indicated at a much higher frequency as compared to clinician barriers, with five different barrier types endorsed by more than 60% of respondents. These barrier types include both technology barriers and workflow barriers:

The 3 technology barriers for patients regarding the use of telehealth include:

- Access to broadband/Wi-Fi (reported for approximately 73% of patients)
- Access to laptop/computer (reported for approximately 73% of patients)
- Access to cell phones (reported for approximately 65% of patients)

The workflow barriers for patients that were identified by survey respondents include:

- Challenges adapting to the use of telehealth/telephone (reported for 68% of patients)
- Limits on the availability of a private location, childcare needs, other personal barriers (reported for almost 62% of patients)

Respondents who selected “Other” as a response to patient barriers were encouraged to qualify their answers. We received 29 such responses.

These qualitative responses regarding patient technology barriers for using telehealth closely mirrored the quantitative findings reported in the above table. Several respondents noted barriers of specific patient groups – most notable among individuals experiencing homelessness. Those groups have particular needs, including;

- Lack of access to reliable broadband/Wi-Fi;
- Lack of access to hardware (computers, laptops, tablets, Smartphones, headphones) and telehealth software; and
- Lack of sufficient funds to afford equipment and/or monthly data plans, especially for low income individuals, including Medicaid eligible persons.

In addition to reporting barriers for patients in using telehealth, several respondents noted the value/benefits of using telehealth (e.g., enabling access to behavioral health services for persons living in rural areas who would otherwise be challenged to afford transportation costs for face-to-face encounters) and many expressed a desire for telehealth (including the use of telephone/audio-only) to continue beyond the public health emergency.

#### **4.7 SUPPORT AND SUPPORT RESOURCES AND NEEDS**

Before asking about training and resource needs, we first inquired what support, training, or assistance organizations were already receiving. Over half of respondents indicated that they had already received some sort of assistance as indicated in Table 4. The most common support was access to one of the free Zoom for Healthcare licenses that was being offered by the Washington Healthcare Authority. The second most common response was formal telehealth teaching resources.

*Table 4 Current Support.*

<b>Answer Choice:</b>	<b>Percent</b>
Free Zoom license from State	51%
Telehealth Teaching	23%
I don't know	20%
None	15%
Special telehealth implementation funding	11%
Technical Assistance	11%
Free Laptops from State	6%
Other	4%

Respondents were then provided an open-response option for suggestions and requests for telehealth training, resources and technical assistance – and about one-half of all respondent (n = 164) did so. Client needs were unquestionably the top concern for providers who cited inequities in access to equipment and broadband internet service, as documented above. Other less-frequent patient concerns included training on troubleshooting technology issues, and accommodations such as closed captioning.

We thematically analyzed the remaining topics (after also combining with the support requests mentioned in the “clinician barriers” section). The responses fell into the following categories:\*

Clinical Topics	Technical / Financial Topics
<ul style="list-style-type: none"> <li>• Provider (general telehealth) training</li> <li>• Client resources</li> <li>• Supporting intakes and check-ins</li> <li>• Client engagement techniques</li> <li>• Delivering individual and group therapy</li> <li>• Managing boundaries</li> <li>• Providing coping strategies</li> <li>• Increasing therapeutic value for clients</li> <li>• Ensuring/arranging for privacy during telehealth encounter</li> <li>• Telehealth with non-English speaking patients</li> <li>• Telehealth for special patient populations:               <ul style="list-style-type: none"> <li>○ Children</li> <li>○ Adolescents</li> <li>○ Young adults</li> <li>○ Persons experiencing homelessness</li> <li>○ Couples/Families</li> <li>○ Non-English Speakers</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Provider (general) technical assistance</li> <li>• ‘Plain Language’ resource materials</li> <li>• Obtaining telehealth consent</li> <li>• Billing support</li> <li>• Financial support to offset the cost of shifting to telehealth</li> <li>• Documenting telehealth services</li> <li>• Telehealth and electronic medical records</li> <li>• Establishing new workflows</li> <li>• Using electronic forms</li> <li>• Guidance on HIPAA/42 CFR Part 2</li> <li>• Need for interpretive services</li> </ul>

\*Less frequent training/TA/concerns mentioned included the costs of converting a practice to telehealth, particularly as the business struggles for cash flow, and the need for change management to help clinical staff transition to the new ways of providing service.

#### 4.8 COMMENTS AND INNOVATIONS

The final question in the survey inquired about innovative solutions and/or to share any closing questions or comments. We received 109 written responses to this question (220 skipped this question).

Respondents to the behavioral health survey highlighted several innovations that had been adapted to increase efficiency, effectiveness or improve client access and engagement through telehealth. These innovations were often presented with energy and pride, as exemplified in the sidebars. Innovations included the following ideas:

Innovations were reported in the following categories:

- Screen sharing to complete assessments and applications
- Lobby computer kiosks for client use
- Client computer resource centers
- Loaned computers to client
- Using telehealth Apps
- Use of electronic forms
- Providing patient-facing instructional handouts and videos

*“We are making conference calls with non-computer using, non-English speaking family to a psychiatric services provider for their inpatient child while sitting in cars in a parking lot – both to maintain social distancing and observe non-verbal clues to support needs”.*

*“We have some ‘loaner’ iPhones we are utilizing and trying to come up with an easy to follow instruction checklist.”*

- “Drive up” clinics
- Zoom office hours for clients
- Providing computer technical support for clients
- Use of patient portals
- Computer-based therapeutic games for youth and adolescents
- Interactive tools during telehealth visits
- Providing interpreter services over telehealth
- Using Zoom ‘Whiteboard’ for team meetings and group supervision

#### 4.9 VARIATION IN PERCEIVED BARRIERS ACROSS REGIONS IN WASHINGTON STATE

Though we did not employ rigorous sampling methods in this survey, it was still interesting to see the consistency of responses that we received across ACH areas of the state and between tribal and Indian Health Care Provider organizations, as displayed in Table 5. In general, the patterns of perceived barriers were similar across ACH regions. Patient access to broadband was the top barrier with access to laptop and cellphones as second and third noted for most regions/provider type. Patient access to private location for consultation and adaption to telehealth were also often considered to be significant barriers. Table 6 list the top barriers by region and provider type.

*Table 5, Summary of Barriers - Responses by ACH Region and Indian Health Care Provider Status<sup>3</sup>*

	Number of Responses	Difficulty with Billing?	Contacting Patients	Access to EMR	Access to broadband	Equipment Access	Setup	Clinical Skills / Workflows	Adapting to telehealth	Contacting Providers	Broadband	Cellphone Access	Laptop Access	Privacy	Adapting to Tele	Language / Interpretation	Hearing
	n	Clinician Barriers								Patient Barriers							
Better Health Together	65	5%	53%	9%	38%	27%	16%	33%	56%	20%	63%	66%	64%	56%	58%	5%	9%
Cascade Pacific	53	19%	63%	6%	22%	16%	22%	33%	63%	28%	82%	82%	76%	67%	77%	22%	12%
Greater Columbia	24	26%	52%	0%	18%	26%	13%	26%	44%	17%	70%	57%	88%	44%	65%	13%	9%
HealthierHere	72	9%	46%	4%	19%	30%	17%	28%	47%	26%	69%	53%	63%	65%	66%	24%	8%
North Central	22	16%	65%	10%	15%	10%	10%	34%	65%	15%	61%	70%	75%	55%	70%	21%	10%
North Sound	27	11%	43%	0%	27%	46%	31%	23%	46%	8%	88%	62%	89%	81%	66%	16%	4%
Olympic	28	18%	63%	7%	22%	19%	19%	15%	51%	26%	74%	68%	63%	59%	51%	11%	15%
Pierce County	18	11%	48%	0%	24%	12%	11%	30%	65%	24%	59%	59%	71%	58%	65%	12%	0%
SWWA	22	5%	38%	5%	34%	14%	34%	38%	67%	19%	86%	72%	72%	72%	76%	33%	5%
IHCP	30	4%	81%	12%	15%	31%	19%	27%	69%	38%	69%	73%	69%	77%	62%	4%	12%
Grand Total	366	11%	54%	6%	24%	24%	19%	29%	55%	23%	71%	65%	70%	63%	64%	16%	9%

*Table 6, Top Barriers*

Better Health Together	Broadband, Cellphone Access, Laptop Access
Cascade Pacific	Broadband, Cellphone Access, Adapting to Telehealth
Greater Columbia	Broadband, Laptop Access, Adapting to Telehealth
Healthier Here	Broadband, Laptop Access, Adapting to Telehealth
North Central	Broadband, Cellphone Access, Laptop Access, Adapting to Telehealth
North Sound	Broadband, Laptop Access, Privacy for Consultations
Olympic	Broadband, Cellphone Access, Laptop Access
Pierce County	Cellphone Access, Laptop Access, Adapting to Telehealth
SWWA	Broadband, Cellphone Access, Laptop Access, Privacy for Consultations, Adapting to Telehealth
IHCP	Broadband, Cellphone Access, Laptop Access, Privacy for Consultations

<sup>3</sup> Percentage of respondents from region indicating the respective barrier to care. Dark red indicates the largest percentage, colors get lighter as percentage decreases, then transition to dark green for the lowest percentage.

## 5 DISCUSSION – RECOMMENDATIONS – NEXT STEPS

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We are impressed by the richness of data that we received from the many busy clinicians, leaders, clinical support staff and other persons who responded to our survey request. As we reviewed and analyzed this information, we considered the following system priorities:

1. Priority #1: Assist BH provider organizations, clinicians, and clients around **URGENT TRAINING, TECHNICAL ASSISTANCE, and INFRASTRUCTURE NEEDS** as they transition to the use of telehealth-based care in response to necessary precautions and restrictions brought about by the COVID-19 Pandemic,
2. Priority #2: Assist BH organizations, clinicians, and clients to **NORMALIZE AND CAPITALIZE ON IMPROVEMENTS** that are a secondary benefit of these system transformations, and
3. Priority #3: Assist the system, organizations, clinicians, and clients to **SUSTAIN** improvements even when programs are able to resume in-person routine services.

Our first efforts were to assist with priority #1, in recognition, partnership, and collaboration with other resources offered in and around the state. Our presumption was that there has been a dramatic transition in how care is provided – that would certainly require equally dramatic transition toward new care models and workflows, along with new staffing, communications, training, technical assistance, and infrastructure needs. The BHI moved quickly as a result of early survey responses (as well as other provider communications) to establish a telehealth resource website. And, in partnership with the Northwest Mental Health Technology and Transfer Center (NWMHTTC) we established a quick telehealth “how to” interactive-webinar series to provide clinicians with a free ‘deeper dive’ training experience. This training curriculum and the online materials was informed by the early results of this survey.

In order for organizations to be successful in transitioning to the ‘new normal’ of service delivery, numerous barriers and needs described will need to be addressed and resolved.

### 5.1 ADDRESS DIFFICULTIES IN TELEHEALTH BILLING AND REIMBURSEMENT

We were happy to see that more respondents appeared to be successful in submitting telehealth billing than those who experienced problems. However, there were still a notable number of identified billing difficulties that fell into a range of categories. We recommend that there be early follow up with those providers to review and resolve those difficulties.

### 5.2 ADDRESS AND RESOLVE CLINICIAN BARRIERS TO ADOPTING TELEHEALTH

We learned that there was a great need to assist providers in the transition to telehealth – they needed support in adapting to telehealth, including the new clinical skills and workflows. This was not a surprise to our telehealth experts, who note that there are numerous fundamental differences in how behavioral care is provided using telehealth as compared to in-person visits. Given the situation imposed by the COVID-19 pandemic, the survey respondents submitted a good list of training, technical assistance, and infrastructure needs for consideration (see Figure 11, on page 16)

### 5.3 ADDRESS AND RESOLVE PATIENT BARRIERS TO ADOPTING TELEHEALTH

This survey was purposely targeted toward Medicaid behavioral health providers who serve a client population that is already disproportionately impacted by financial stress, food and housing insecurity, health disparities and other restrictions to service access. We expect that those disparities also impact access to telehealth technology.

*“Access to in-depth resources and guides [have been] very helpful. Information on basics of how to use TH technology, how to coach clients on using TH for first time, [along with] best practices for modifying workflows and clinical services.”*

Perhaps most significantly, we learned that providers perceived a great deal of barriers in connecting with patients via telehealth. The shift to providing services remotely using telehealth technology no doubt resulted in disruption of normal processes for connecting and engaging with patients and making service appointments. Over half (53%) of respondents reported difficulty in contacting patients by phone or email. In addition, greater than 60% of respondents identified patient barriers in four other categories: Access to cellphones, access to laptop or computer, availability of a private location (or other personal barriers) and adapting to telehealth in general. Taken in sum, these barriers clearly present challenges to providing service. Certain patient groups or populations appear to have the highest challenges – such as persons experiencing homelessness, disenfranchised patients, or poorly-engaged persons. Although research data suggests that telehealth services are effective across a wide range of diagnoses and patient presentations, the question remained whether some patients are better engaged and served using telehealth; with additional challenges noted around other patient groups, such as those with severe and persistent mental illness (SPMI) or patients with cognitive impairment.

### 5.4 SUPPORT ESSENTIAL POLICY FLEXIBILITIES AND ADDRESS GAPS IN BROADBAND FOR TELEHEALTH

As noted, survey respondents reported using cell phones and laptops to enable the telehealth. Respondents also noted gaps in broadband as a barrier for patients and providers. The use of audio-only telehealth was permitted by one of the temporary changes in telehealth policy due to requirements for social distancing in response to the COVID-19 public health crisis, and as noted in Figure 5 almost 90% of respondents are using telephone without video for services. To enable widespread use of telehealth in the near and mid-term, it will be necessary to retain the flexible telehealth policy permitting audio-only telehealth. While addressing gaps in broadband is needed to support audio-visual telehealth services statewide, to do so will take time.

### 5.5 PROVIDE ONGOING WORKFORCE TRAINING TO SUPPORT DEVELOPMENT OF TELEHEALTH SKILLS AND COMPETENCIES

As described above, one of the first uses of the survey data was taken by the BHI training workgroup in their work to develop the curriculum for their twice-weekly intensive telehealth training series. Topics included supporting intakes, providing different types of services, providing care to different populations, and other clinical topics. Many of these trainings have already been provided (through a technical assistance/training webinar series partnership between the BHI and the UW Northwest Mental Health Technology Transfer Center. However, it is unlikely that a “One and Done” webinar series will fully meet the care transformation needs of a statewide BH workforce. There is much work to be done

at multiple levels and by multiple entities. This formal didactic-style training of a webinar series needs to be followed up with practice, technical assistance, and supervision and mentoring. Finally, training is needed to support providers with the integration of documentation related telehealth visits into providers' electronic medical records and supporting implementation of innovative digital technology solutions.

## 5.6 MAINTAIN AND SUSTAIN THE IMPROVEMENTS THAT ARE A SECONDARY BENEFIT OF THE SUDDEN TRANSITION

Although our survey did not specifically ask this question, a number of respondents commented on the secondary benefits they were observing as part of the system transformations they were seeing. Some respondents expressed concern about the inefficiencies and costs that would result if the use of telehealth were only a temporary solution used only during the public health emergency. During the COVID-19 pandemic, the federal government and other states including Washington began efforts to maintain and sustain access to behavioral health through use of telemedicine and telehealth by relaxing and/or waiving certain regulations. In addition to the survey, as an additional and aligned effort, the BHI has created a summary of the temporarily relaxed regulations to educate and advise advocacy efforts. An executive summary is available on the BHI website: <https://bhi-telehealthresource.uwmedicine.org/>

## 5.7 SUPPORT AND SUSTAIN INNOVATION

We were delighted to hear of the many creative innovations that providers were trying out during COVID-19 – many of which seem long-sighted and clearly could benefit patients going forward. Priority #3: Assist the system, organizations, clinicians, and clients to SUSTAIN these changes with the inevitable policy and regulatory changes in coming months and years. Some respondents expressed an intention to continue adapted practices beyond the pandemic, because of their effectiveness at engaging clients in ways that exceed pre-pandemic levels. The pandemic highlighted existing inequities in access (due to social, cultural, and economic factors such as language, access to transportation, broadband, and technologies). However, provider investments in new workflows, adapted forms, repurposed office space, and technology will act as a bridge to service for some population groups who are reporting increased satisfaction with new options.

*“We are developing client “wellness kits” and dropping them at their homes. The client and the direct service provider then discuss the contents of the wellness kits during sessions. The presence of the wellness kit lends to longer, more meaningful tele-health sessions.”*

## 6 SUMMARY AND ACKNOWLEDGEMENTS

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The Behavioral Health Training, Workforce and Policy Innovation Center (BHTWPC), part of the Harborview Behavioral Health Institute (BHI) created and administered a survey of behavioral health providers with funding from the Washington State Legislature utilized through a contract with the Health Care Authority. The survey was conducted over the months of April and May 2020, during the initial peak period of COVID-19 in Washington. We received and analyzed 329 responses representing all ACH regions and both tribal and non-tribal health care providers. The results of the study document high utilization of telehealth-based care, the majority in response to COVID-19. Numerous types of barriers were documented, including billing, clinician, and patient factors. We also received numerous examples of adaptive and innovative solutions to care as providers pivoted to telehealth-based services.

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We are grateful to the many clinicians, supervisors, leaders, and clinical support persons who graciously responded to our survey request. We are also grateful to the many Participating Partners (listed below), the Washington State Governor's Office of Broadband, as well as the Strategic Oversight Committee subset of this group who provided support, assistance, guidance and/or oversight to this project:

- Accountable Communities of Health of Washington
- Advancing Integrated Mental Health Solutions (AIMS Center)
- American Indian Health Commission for Washington State
- Association of Alcoholism and Addiction Programs of WA
- Behavioral Research in Technology and Engineering Center
- Harborview Medical Center - Behavioral Health, Training, Workforce and Policy Center
- Health Care Authority/Division of Behavioral Health and Recovery and Clinical Quality and Care Transformation
- King County Behavioral Health and Recovery Division
- Northwest Addiction Technology Transfer Center
- Northwest Mental Health Technology Transfer Center
- Northwest Regional Telehealth Resource Center
- SEIU
- University of Washington BRITE Center
- University of Washington Digital Health
- Veterans Administration Puget Sound
- Washington Association for Community Health
- Washington Council for Behavioral Health
- Washington State Managed Care Organizations: Amerigroup, Community Health Plan of Washington, Coordinated Care, Molina Healthcare, United Healthcare
- Washington State Telehealth Collaborative
- Washington Recovery Alliance
- Washington State Hospital Association

## 7 ADDENDUM

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### 7.1 SURVEY TOOL QUESTIONS

The 19 questions (and branching logic) were as follows:

1. What is your name?
2. What is your e-mail address?
3. Do you want to join the Behavioral Health Institute (BHI) mailing list?
4. Are you employed by or representing an Indian Health Care Provider?
5. What is the name of your organization?
6. What title best describes your role at your organization?
7. What service type(s) describes your organization? Check all that apply.
8. What is your organization's ACH affiliation(s)? Check all that apply.
9. What telehealth / telephone technologies has your organization recently utilized on a regular basis to provide clinical services? Check all that apply.
  - ↳ If Telehealth was selected then,
    10. Which telehealth platform does your organization use?
    11. Was your organization using a telehealth platform prior to COVID-19?
  - ↳ If Telehealth was not selected then,
    12. Does your organization have plans to begin using a telehealth platform soon (e.g. Skype, Zoom, BlueJeans, VSee, ClockTree, etc.)?
    13. What telehealth platform(s) is your organization considering? Check all that apply.
14. What telehealth-related training and support does your organization already receive? Check all that apply.
15. Is your organization experiencing any difficulty with telehealth billing and reimbursement?
16. Please describe what difficulty your organization has with telehealth billing and reimbursement.
17. What barriers are your organization's clinicians experiencing in being able to provide telehealth / telephone services? Check all that apply.
18. What barriers to telehealth / telephone services are your organization's patients experiencing? Check all that apply.
19. What additional resources, technical assistance, or training is needed to address challenges and increase your organization's ability to provide telehealth / telephone services?
20. Describe any innovative solutions your organization is testing / implementing or share any closing questions or comments.

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