POLICY BRIEF

Federally Qualified Health Centers' Adaption to Tele-Behavioral Health and Delivery of Integrated Behavioral Health during the COVID-19 Pandemic

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Project Team Brianna Lombardi, PhD MSW; Lisa de Saxe Zerden, PhD MSW; Catherine Greeno, PhD

Background

The COVID-19 pandemic presented a significant challenge to federally qualified health centers (FQHCs) who provide comprehensive health care services, including the delivery of integrated behavioral health (IBH). FQHCs annually serve 9% of the total U.S. population with a patient panel of over 80% who are uninsured, or are Medicare or Medicaid beneficiaries (National Association of Community Health Centers [NACHC], 2020). FQHCs are the primary resource of behavioral health care in many communities and embed IBH within clinics to increase access and connection to behavioral health services. Tele-behavioral health dramatically increased during the pandemic due to two factors: emergency safety orders that limited in-person clinic capacity, and state and federal emergency mandates that allowed for the reimbursement of services delivered through tele-health that were not previously permissible. Although there was a rapid transition to tele-behavioral health, how the move to tele-behavioral health may have impacted the delivery of IBH services in the FQHC clinics is relatively unknown. This study aimed to explore how FQHCs adapted IBH care delivery during the pandemic. In particular, this study assessed barriers to IBH during COVID-19, as well as tele-behavioral health uptake, use, and adaptation, and goals for future use of tele-communication at FQHCs beyond COVID-19.

Methods

A mixed-method study design was utilized. A web-based survey (via Qualtrics) was developed and disseminated (October to December 2020) to a convenience sample of FQHC administrators in 12 states identified through HRSA's "find a health center" website from which contact information was obtained. FQHC administrators were contacted by email and phone to invite them to participate in the survey. Information on how to participate in the survey was also included in a monthly HRSA newsletter for FQHCs. Respondents who completed the online survey were asked if they were interested in participating in a qualitative interview and those who responded affirmatively were contacted for interviews. A semi-structured interview guide was developed and used and in-depth interviews were recorded via Zoom (February to April 2021). A participant incentive of $25 was offered for the quantitative survey and $50 for in-depth interviews. Quantitative data collected from the surveys were analyzed using descriptive analysis in Stata 16. Qualitative data collected from the interviews were first cleaned, transcribed, and checked for accuracy. Two independent reviewers used thematic coding to read, comment, create, and identify salient themes.

Key Findings

A total of 46 administrators from 10 states participated in the online survey regarding IBH and tele-behavioral health. Most responses were recorded from California (n=12; 26.1%), Kansas (n=10; 21.7%), and Pennsylvania (n=8; 17.4%). Prior to COVID-19, 14 FQHCs (30.4%) delivered IBH care using tele-communication. Since COVID -19, all but two of the FQHCs surveyed used tele-communication to deliver IBH (n=44, 95.7%). All respondents (n=46; 100%) reported patient barriers to tele-health use impacted service delivery, along with some reporting a lack of reimbursement for tele-health services (n=15; 32.6%) and concerns about HIPAA, privacy, or compliance (n=12; 26.1%). [See Table 1 for detailed results].

Table 1: Survey Sample Description (n=46)		
State	**N (46)**	**100%**
Arizona	1	2.2%
California	12	26.1%
Kansas	10	21.7%
Kentucky	1	2.2%
Montana	1	2.3%
New York	4	8.7%
Pennsylvania	8	17.4%
South Carolina	3	6.5%
Texas	4	8.7%
West Virginia	2	4.6%
Number of clinic sites		
1 clinic	8	17.4%
2 to 4 clinics	13	28.3%
5 to 9 clinics	15	32.6%
10 or more clinics	10	21.7%

Nine interviews with FQHC administrators from six states were collected from California (n=3), Kansas (n=2), Arizona (n=1), New York (n=1), Pennsylvania (n=1), and West Virginia (n=1). The following themes were identified:

1) Tele-behavioral health worked to sustain behavioral health service delivery during COVID-19. All interviewed administrators described a quick and overall successful transition to tele-behavioral health to deliver care in response to COVID-19. One participant described this rapid transformation in the following way: “We were doing zero telehealth up until this point and it went from zero to 100, literally in about a 36-hour turnaround time.” The success of transitioning individual behavioral health care was a point of pride for many of the administrators.
2) Core components of IBH were significantly impacted during COVID-19. Most FQHCs de-densified the clinics, and the behavioral health and primary care providers were no longer co-located. The lack of co-location impacted team communication, referrals, and primarily the effectiveness of ‘warm-hand-offs’, a core component of IBH to ensure that patients’ care between providers is seamless. One administrator described the lack of co-location as an issue because the behavioral health team was no longer ‘seen’ in the halls for consultations and referrals: “The problem also with not having [behavioral health] in the clinic… [they] weren’t being seen by the doctors.” Strategies to improve warm-handoffs in a virtual setting were described as not successful as the added steps to do a virtual warm-handoff kept providers from utilizing this resource. One participant described an example of a provider using an electronic device to complete a warm-handoff: “It was inefficient and clunky. I gotta find them and get them on a video feed and now I gotta leave my computer there or I gotta go grab an iPad. Yeah, it was it was clunky.”

3) Patient and payment barriers were a concern for long-term use of tele-behavioral health, but FQHCs are hopeful about and desire to continue its use. Barriers described by respondents included continued patient challenges to utilizing tele-behavioral health services, tele-health payment parity and reimbursement issues, and finding skilled providers familiar with integrated models of care and comfort working in FQHC settings. All administrators interviewed described the concern that video-only communication options were a major limitation; many clients needed the option for audio-only due to technical difficulties, connectivity issues, or preference. For example one respondent shared the following about the need for audio-only: “[video] just didn't work very well for the first, however long, so the fallback was always the phone. I think the phone ended up being almost 40% of all those tele visits, it's because people would say ‘okay if we can’t get this to work, we’ll just get on the phone.” Regulation and payment were on the minds of respondents as described in the following quote from an administrator in California: “We were set to do that [use tele-communication] before COVID and we're going to continue to do it after COVID. The main thing is, whether they'll pay for it?”

Conclusions & Policy Implications

Overall study findings suggest that tele-behavioral health was essential to providing IBH services at FQHCs during COVID-19. This study along with others demonstrate that providers and administrators want tele-behavioral health to be an option for care beyond the pandemic (Guinart et al., 2021; Lombardi et al., 2021; Schoebel et al., 2021). However, it is expected that tele-health and tele-behavioral health may not have been equally accessed particularly for high-need and under-resourced communities like those served by FQHCs (Cole, 2021; Sachs et al., 2021). All respondents indicated clients access to and knowledge of needed technology negatively impacted the delivery of tele-behavioral health. Most FQHCs in the study also used audio-only tele-behavioral because of limited broadband internet in the community, lack of patient video capabilities, and at times client preference. State and federal assistance is needed to build the infrastructure to support clients and communities technology needs to maintain tele-health. Further, audio-only tele-behavioral health is necessary until the infrastructure exists for video based services.

In addition to supporting patient access to the technology needed for tele-behavioral health, securing long-term payment parity for tele-behavioral health is required for services to be maintained. FQHC administrators in this study indicated the lack of having a clear path forward regarding payment and reimbursement keeps the clinics from being able to deeply root plans for the use of tele-behavioral health in the future. Securing payment parity could maximize the success of tele-behavioral health, as clinics can plan to include tele-behavioral health into workflows and hiring for additional behavioral health providers. Fortunately, many states are enacting laws that require payment parity for tele-health services for state Medicaid beneficiaries (Center for Connected Health Policy, 2021). However, the state of tele-health coverage beyond the pandemic is a patchwork and remains unclear. Clarity on long-term payment reimbursement and parity across insurance types will likely benefit FQHCs and other health entities in deciding how to use tele-behavioral health in the future.

Although tele-behavioral health for individual care was successful for FQHCs, other components of IBH were impacted during the pandemic. As many behavioral health providers were working off-site of the clinic, FQHC administrators indicated established workflows and team communication were complicated. Co-location of behavioral health and physical health providers increases the opportunities to collaborate, communicate, and coordinate patient care (Rumball-Smith et al., 2014). One function of co-location is the ability to complete warm hand-offs in which physical providers bring in behavioral health or social care providers to connect with the patient in real-time. However, due to the lack of co-location during the pandemic warm-handoffs were severely limited. It is unknown how these impacted IBH components will translate to patient outcomes, but it is a concerning trend after many years of building IBH workflows and investment in this model in FQHC clinics. Future work is greatly needed to understand how to harness the success of tele-behavioral health and combine with remote interprofessional team-based care.

Acknowledgements

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $900,000. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

References

1. Center for Connected Health Policy (2021). Telehealth Legislation and Regulation. https://track.govhawk.com/reports/24PKO/public
2. Cole M. Disparities in telehealth use during COVID-19 across Federally Qualified Health Centers: Findings from National Survey Data. *Health Serv. Res*. 2021;56:29-30.
3. Guinart D, Marcy P, Hauser M, Dwyer M, Kane JM. Mental Health Care Providers' Attitudes Toward Telepsychiatry: A Systemwide, Multisite Survey During the COVID-19 Pandemic. *Psychiatr Serv*. 2021;72 (6):704-707. doi:10.1176/appi.ps.202000441
4. Lombardi BM, Zerden LD, Thyberg C. Social work answers the (video) call: Tele-behavioral health use during COVID-19. *J SOC SOC WORK RES* . 2021. https://doi.org/10.1086/715621
5. National Association of Community Health Centers. Community health center chartbook 2020. 2020. https://www.nachc.org/wp-content/uploads/2020/01/Chartbook-2020-Final.pdf. Accessed March 23, 2022.
6. Rumball-Smith J, Wodchis WP, Koné A, Kenealy T, Barnsley J, Ashton T. Under the same roof: Co-location of practitioners within primary care is associated with specialized chronic care management. *BMC family practice.* 2014;15,149. https://doi.org/10.1186/1471-2296-15-149
7. Sachs JW, Graven P, Gold JA, Kassakian SZ. Disparities in telephone and video telehealth engagement during the COVID-19 pandemic. *JAMIA Open*. 2021;4(3):ooab056. Published 2021 Aug 2. doi:10.1093/jamiaopen/ooab056
8. Schoebel V, Wayment C, Gaiser M, Page C, Buche J, Beck AJ. Telebehavioral Health During the COVID-19 Pandemic: A Qualitative Analysis of Provider Experiences and Perspectives [published online ahead of print, 2021 May 21]. *Telemed J E Health*. 2021;10.1089/tmj.2021.0121. doi:10.1089/tmj.2021.0121