Support for Behavioral Health Providers During Public Health Emergencies

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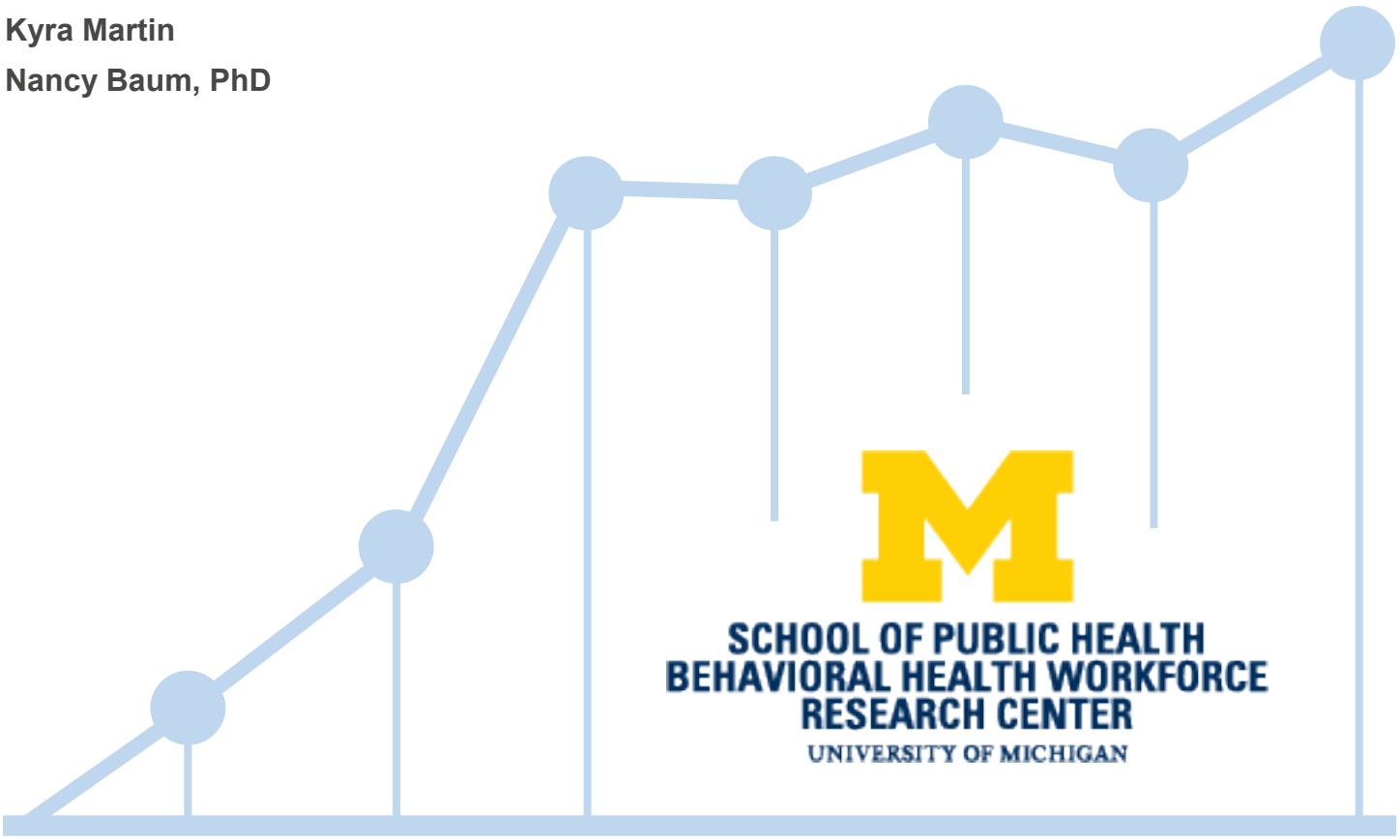

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Introduction

The coronavirus disease 2019 (COVID-19) pandemic has exacerbated the psychological suffering of many and has contributed to an increase in anxiety and depressive disorders in the U.S.[1] Recent studies have largely focused on the stressors experienced by frontline medical workers,[2] yet support for behavioral health providers is also crucial, given that they experienced significant stress and burnout prior to and during the pandemic.[3,4] The pandemic also necessitated a rapid shift to telehealth for many behavioral health providers, compounding already challenging work environments.[5]

Results of a recent online survey measuring the impact of the COVID-19 pandemic on the mental health of behavioral health providers indicate that respondents experienced feelings of distress, depression, anxiety, isolation, and fear.[6] Of the 137 surveyed providers, 82% reported that the pandemic negatively affected their ability to deliver care to their clients. The study highlighted the transition from in-person care delivery to telehealth services made by behavioral health providers during the pandemic, as well as the additional efforts needed to support their education and training in delivering care during future emergencies.

The goal of this project was to understand the impact of public health emergencies—such as the COVID-19 pandemic—on behavioral health providers and the care they provide to patients. To that end, this study examined the following research questions:

1. What supports are in place for behavioral health providers to manage burnout and stress during public health emergencies such as the COVID-19 pandemic?
2. What supports are available to assist with necessary shifts in service delivery, such as the transition from in-person care to telehealth services?
3. What are the long-term implications of the shift to telehealth for behavioral health providers and patients?

Methods

Literature Review

We conducted a comprehensive literature review focused on the impact of the COVID-19 pandemic on behavioral health providers. We examined literature on best practices for addressing burnout and workplace stress for behavioral health providers, shifts in service delivery and relevant policy changes during the pandemic, and supports and resources available to help providers adjust to these changes.

To ensure we were capturing literature relevant to the COVID-19 pandemic, we initially focused our search to identify articles published in 2020 or later. However, owing to a dearth of COVID-19 research on the population of interest (behavioral health providers), we expanded our search to include articles on burnout in the behavioral health workforce from 2012 to the present. As the context surrounding COVID-19 and the provision of care is rapidly evolving, we included both peer-reviewed and gray literature sources, such as handbooks, toolkits, presentations, press releases, and other sources as relevant. Databases and search terms included in the review are presented in Appendix A. Appendix B includes a summary of policy changes and emergency reforms implemented because of COVID-19 that impacted behavioral health providers.

Qualitative Data Collection and Analysis

We then developed a semi-structured interview protocol informed by our literature review. We conducted key informant interviews with stakeholders and experts familiar with burnout, the transition to telehealth during the pandemic, and types of support available to the behavioral health workforce. Potential interviewees were identified through the literature, recommendations from other interviewees (snowball sampling), and existing relationships between the authors and behavioral health organizations and providers. Interviews lasted approximately 45 minutes and were recorded to ensure the data accurately captured each

interviewee's perspective and experience. Three analysts met biweekly to discuss interviews, early findings, and emerging themes. A codebook was developed jointly between two analysts after six completed interviews and was revised as necessary during analysis. Two analysts conducted a thematic analysis using the codebook and came to a consensus on findings through discussion. Interviews were reviewed by a third analyst, who contributed to summarizing findings. The interview protocol and selected interview participants are presented in Appendix C and D, respectively.

This study (HUM00213274) was deemed "not regulated" by the University of Michigan IRBMED.

Literature Review

Burnout

Burnout is a syndrome defined in the International Classification of Diseases (ICD-11) as experiencing feelings of exhaustion, cynicism, and ineffectiveness due to chronic workplace stress.[7] Among behavioral health providers, burnout is typically described as experiencing emotional exhaustion, cynicism or depersonalization, and reduced personal accomplishment due to work-related stress.[8,9] These three components of burnout come from the Maslach Burnout Inventory, a widely used scale originally developed for human services workers.[10,11] Other scales commonly used include the Copenhagen Work Burnout Inventory, Oldenburg Burnout Inventory, and Counselor Burnout Inventory.[12]

Impact on Behavioral Health Providers

Although literature concerning the effects of the ongoing COVID-19 pandemic on burnout among behavioral health providers is limited, a variety of studies suggest that burnout can affect physical and mental health for many professionals.[13] Though there is similarly limited research into the effects of burnout on quality of care, it is associated with negative feelings toward mental health consumers, as well as provider absenteeism and turnover.[14] A survey of 93 community mental health providers found that COVID-19-related work changes significantly affected turnover intentions because of increased burnout.[15]

Workload also plays a role in burnout among behavioral health providers. Even before 2020, the U.S. had a critical behavioral healthcare workforce shortage. The scarcity of providers has since been exacerbated by increasing patient need as rates of anxiety, depression, substance use disorder, and other behavioral health concerns have climbed during the pandemic.[16] Though numbers differ across sources, the Health Resources and Services Administration (HRSA) reported that in 2022, a total of 154 million Americans are in Mental Health Professional Shortage Areas, with >7,000 additional practitioners needed.[17]

Factors associated with burnout may include high work demands, role conflict, role ambiguity, and other organizational factors.[18] Among behavioral health providers at the Veterans Health Administration, workload was the strongest predictor of burnout.[19] In addition, behavioral health providers may be more likely than other providers to experience burnout due to the nature of their work, including frequent client interaction, exposure to issues such as suicidality and trauma, and limited financial resources.[20-23]

Interventions Addressing Provider Burnout

Interventions to decrease burnout among behavioral health providers address the issue through one of two strategies: addressing organizational factors (such as reducing workload and increasing job resources) or addressing individual factors (such as improving resilience and coping).[24] However, there are few burnout interventions targeted specifically toward behavioral health providers. In a meta-analysis of 27 studies conducted pre-pandemic, burnout interventions significantly reduced levels of emotional exhaustion and depersonalization among psychotherapists.[25]

The American Psychological Association (APA) and Substance Abuse and Mental Health Services Administration (SAMHSA) both have resources and recommendations available for how to address burnout. One of the most commonly recommended strategies to address burnout associated with the COVID-19 pandemic is self-care. This often includes meditation, proper sleep hygiene, physical exercise, and other

enjoyable activities away from work. Self-care is specifically recommended for psychotherapists given the hazards of their work, including physical and emotional isolation and stress due to patient behaviors.[26]

In 2021, the U.S. Department of Health and Human Services (HHS), through HRSA, announced that over 3 years, $103 million would be allocated toward programs that reduce burnout and promote mental health and wellness among all health workers.[27] Additional federal funding to further preserve the behavioral healthcare workforce and improve well-being is expected in the near future. The Biden-Harris FY23 Budget will include $700 million for programs that provide training and funding to mental health and substance abuse clinicians dedicated to practicing in underserved areas.[28] In addition, HHS is expected to allocate $225 million to training programs to increase the number of community health workers and improve access to behavioral health support in underserved communities.[29]

Shifts in Service Delivery Resulting from COVID-19

With the onset of the pandemic causing shutdowns in many non-emergency healthcare settings and other in-person restrictions to prevent the spread of COVID-19, the shift in service delivery to telehealth from in-person care happened almost immediately. However, despite the technology existing for many years prior to the COVID-19 pandemic, few medical or behavioral healthcare providers utilized telehealth with regularity.

Provider Telehealth Utilization

In a qualitative study of the experiences of outpatient psychiatrists, less than half had experience with telemedicine before the COVID-19 pandemic,[30] yet when the pandemic hit the U.S., it was crucial for behavioral health providers to adapt to conducting telehealth visits to serve their patients. One longitudinal study showed from 2020 to 2021, telehealth availability increased by 77% in mental health treatment facilities and 143% in substance use disorder treatment facilities.[31] In another national survey of>2,600 licensed psychologists, 7.1% reported using telepsychology prior to the COVID-19 pandemic, which increased to 85.5% during the pandemic.[32] There was significant variation in how prepared providers were to make this shift from in-person services to telehealth services. The greatest increases in telepsychology use occurred among female psychologists,[33] those with training and organizational support in telehealth, and those who treated patients for relationship issues and anxiety.[34]

Telehealth Training for Providers

The Mental Health Technology Transfer Center Network (MHTTC) is one of three technical support organizations funded by SAMHSA that "...work[s] with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals."[35] Throughout the pandemic, the MHTTCs—along with their addiction (ATTC) and prevention (PTTC) focused counterparts—have offered webinars and training sessions to providers in their networks on a variety of topics including billing, troubleshooting, and the basics of delivering psychotherapy via telehealth.

Provider Perspectives on Telehealth

A qualitative study interviewing 20 psychiatrists in early 2020 noted that although the transition had gone relatively smoothly, most wanted to return to delivering care in person.[36] Another study that interviewed 20 Medication for Opioid Use Disorder providers reported all were in favor of continuing newly flexible regulations, including the decision by SAMHSA[37] to waive the in-person medical evaluation requirement for providers prescribing buprenorphine. However, providers had mixed views on how they would implement telehealth long-term in their practices.[38] In a 2021 study on addiction treatment and telehealth, interview subjects (addiction treatment stakeholders and providers) and survey respondents (addiction treatment providers) felt telehealth had the potential to benefit both patients and providers with greater engagement and increased flexibility. Still, there were concerns that virtual delivery of care was not as effective as in-person care.[39]

Policy Changes Due to COVID-19

As the COVID-19 pandemic took hold in the U.S., federal and state regulators, as well as public and private payers, made several adjustments to accommodate the changing needs in the healthcare landscape. Developing policies related to telehealth services were of particular importance to ensure that patients continued to receive care and that providers were paid for services. This was particularly challenging, as policies around telehealth had not been adopted widely or supported consistently in the U.S. prior to the pandemic. To accommodate the sudden shift in service delivery, many policy changes were implemented as emergency reforms. Policies to support telehealth generally fell into the following categories: changes in coverage, changes in reimbursement, reforms related to privacy/technology, and changes in prescribing practices.

Changes in Coverage

Prior to the pandemic, most private and public payers did not cover telehealth visits for behavioral health in the same way that in-person visits were covered. During the pandemic, coverage reforms happened at both the federal and state levels.[40] Every state issued some type of policy change to provide coverage parity for telehealth services during the pandemic.[41] In addition, 22 states changed laws or policies during the pandemic to provide more robust telehealth care, including requiring insurance coverage for audio-only telehealth and requiring insurers to have parity in cost sharing for telemedicine services.[42]

The provision of "direct-to-consumer" telehealth was generally not covered by health insurance payers prior to the pandemic. This reform allowed the patient to be seen via telehealth in their home, as opposed to at a designated healthcare facility. Health insurers also expanded the provider types and services eligible for telehealth, expanded coverage for substance use disorder treatment, and relaxed geographic restrictions that required clinicians and patients to be in the same state during treatment.[43]

Changes in Reimbursement

In addition to providing coverage parity for telehealth and in-person visits, health insurers began to provide payment parity for telehealth services.[44] This allowed providers to bill health insurance companies for telehealth services at the same rate they would bill for in-person services. In addition, some payers issued waivers for patient cost sharing (out-of-pocket costs including coinsurance, copayments, and deductibles).[45,46] Medicare payment for telehealth visits was raised to the same level as in-person visits and Medicaid distributed funds to providers to match historically billed payments not tied to fee-for-service visits.[47] It is unclear whether these changes will continue after the public health emergency ends.

Privacy/Technology Reforms

To support the rapid transition to telehealth, federal regulations were temporarily relaxed to allow for the use of mainstream video conferencing software, such as Zoom, Microsoft Teams, and FaceTime.[48] Previous regulations required the use of Health Insurance Portability and Accountability Act of 1996 (HIPAA) –compliant telehealth platforms by service providers. Some providers and patients continue to be wary about the security of telehealth—particularly among communities historically marginalized by the healthcare system.

Changes in Prescribing Practices

With the declaration of the public health emergency, the Drug Enforcement Administration (DEA), in conjunction with HHS, shifted policy to allow for some virtual prescribing. During the public health emergency, authorized practitioners can prescribe a controlled substance to a patient using telemedicine, even if the patient is not at a hospital or clinic registered with the DEA. In addition, qualifying practitioners can prescribe buprenorphine to new and existing patients with opioid use disorder based on a telephone evaluation.[49] However, some concerns about over-prescribing and fraud remain.

Gaps in the Literature

Literature describing the effects of the COVID-19 pandemic on burnout among behavioral health providers are limited at the time of this analysis, while the public health emergency due to the pandemic is still in effect. Much of the recent research and actions focus on burnout among frontline physical health providers directly treating COVID-19 patients, including nurses, physicians, and respiratory therapists.[50] There is a need to understand how the pandemic has impacted burnout experienced by behavioral health providers and how burnout affects their ability to provide quality care as well. In addition, research focused on the long-term efficacy and effectiveness of telehealth in the behavioral health field, both on patients and on behavioral health providers, is in its infancy and should be further developed to inform significant policy changes.

Qualitative Analysis

Our research team identified 28 potential interview participants from the literature, snowball sampling, and existing relationships with behavioral health organizations and providers. Of the 28 identified participants, we completed 12 key informant interviews with experts and providers in the behavioral health workforce. Our team reached out to potential interview participants via e-mail three or more times. A few potential participants declined to participate owing to a lack of availability in their schedules, and some declined because they did not believe they had appropriate content expertise. Details regarding interview subjects are presented in Appendix D. We completed a thematic analysis to identify common findings among interview subjects, presented below. Findings fell into three major thematic categories: burnout among behavioral health providers exacerbated by the pandemic, shifts in service delivery mode for behavioral health care, and the impact of reimbursement and policy changes on the behavioral health workforce.

Burnout Among Behavioral Health Providers Exacerbated by the Pandemic

The emotionally difficult and stressful labor done by the behavioral health workforce was compounded by the COVID-19 pandemic. As noted in the literature, burnout is a large factor in behavioral health workers leaving their jobs—several of our interview subjects confirmed that there was especially high turnover during the pandemic. Although there was no uniform response to questions about burnout, half of the interview participants suggested that low salaries in the behavioral health field are an important obstacle in recruitment and retention. Significant decreases in workforce size due to stress and low pay then puts additional stress on remaining providers, creating a cycle of burnout.

Burnout can be addressed at both the individual and organizational/systems levels. Given the number of organizational and environmental factors that are related to burnout, the individuals we interviewed recommended organizational changes over individual-level interventions.[51] Despite the preference for organizational interventions, nine interviewees confirmed that burnout supports often focus on wellness, resilience, and other individual-level factors, while less focus is put on systemic issues. Systemic factors that affect burnout include the ability to manage one's own schedule, having a balanced or reduced workload, and the ability to take time off. Multiple participants reported that top-down support from organizational leaders and having access to peer support are particularly useful when coping with emotionally difficult and stressful work. Importantly, a number of interviewees emphasized that common self-care interventions, such as meditation, promotion of sleep hygiene, and expressing gratitude, were not effective in reducing chronic burnout for behavioral health providers. Surface-level wellness strategies aimed at individuals, like free food or time for meditation, highlight a disconnect between what leaders believe will be effective and what providers themselves experience. According to our data, though likely well-intentioned, the interventions do not get to the root of the issue, which stems from overwork and low pay.

Low compensation for behavioral health providers came up numerous times in our interviews,

especially when discussing social workers, non-PhD therapists, peer providers, and unlicensed community behavioral health providers. Chronically low salaries can lead to financial instability and can make providers feel undervalued and unappreciated. These low wages coupled with a high-stress work environment often challenge recruitment and retention efforts in the behavioral health workforce. Some providers leave their positions in underfunded community organizations serving high-need clients to work in private practice, which typically offers higher pay and more flexibility. Others leave the workforce altogether. Despite many interview subjects noting the general dedication behavioral health providers have to their work, this dedication will not prevent turnover if low salaries do not cover the cost of living or compensate providers adequately.

Shifts in Service Delivery Mode for Behavioral Health Care

The ability to deliver services remotely was beneficial to providers on numerous levels. Multiple interviewees reported that the shift to telehealth from face-to-face care reduced "no show" rates, which have historically been very high for behavioral health appointments. A lower "no show" rate may have allowed providers to continue to deliver and bill for services throughout the public health emergency at levels similar to pre-pandemic levels. Several interviewees reported an appreciation for the flexibility of remote or hybrid work, contributing to a more positive work experience. More than half of our interview participants (n=7) believe a hybrid model of telehealth and in-person care will be the norm moving forward.

Despite the many advantages of telehealth, 11 of 12 interview participants stressed that some types of therapies, services, and client populations are not well suited for virtual care delivery. Some highlighted incompatible treatments were inpatient care and tactile or group therapies. Respondents also discussed the difficulty with effectively observing certain patients during sessions via telehealth and emphasized that additional research into the long-term effectiveness of telehealth should be conducted to inform permanent policy changes or workplace recommendations.

Interviewees reported a lack of adequate training following the service delivery shift from in-person to telehealth services. Existing telehealth training resources have focused primarily on the basic use of technology, but interviewees said there are limited education opportunities around best practices for teletherapy. A few interview subjects made clear that behavioral healthcare strategies are not all directly transferable between modalities. Virtual patient appointments can pose challenges that in-person appointments do not, including difficulty reading facial expressions, maintaining privacy, and facilitating group activities. Yet, instead of modifying their practice, providers have largely been implementing their regular in-person care strategies via telehealth. There is a sense that providers have not yet prioritized learning and implementing telehealth-specific approaches. A few interview subjects also pointed out that even if the training was available, attendance was limited because it was time-consuming and burdensome for an already over-taxed workforce.

Impact of Reimbursement and Policy Changes on the Behavioral Health Workforce

The suddenness of the pandemic necessitated swift policy changes to accommodate the new service delivery methods. However, the dissemination and communication of these changes were not always clear or consistent. Multiple interview participants noted that figuring out new billing systems or codes was challenging, and one noted they received conflicting guidance from the federal and state levels. Further, several providers and researchers highlighted long-term concerns around telehealth reimbursement more broadly. Until insurance coverage for telehealth is expanded permanently, behavioral health workers cannot guarantee their ability to provide care virtually. This has implications for organizations' willingness to invest time and financial resources into training for providers.

Advocacy and support organizations, such as the American Psychological Association and SAMHSA, have worked diligently during the pandemic to provide resources for providers related to changes in behavioral health policy. They have conducted webinars, posted Q&A's, and provided opportunities for

the behavioral health workforce to learn about policy changes. Some of these opportunities included e-mail newsletters, mini-training sessions, and downloadable resources. Interviewees expressed that these organizations often filled gaps in understanding for providers related to policy changes—particularly during the pandemic.

Discussion

Burnout

Behavioral health providers have faced unique challenges during the pandemic, including a shrinking workforce and rapidly increasing patient base. The individuals we interviewed suggested providers did not receive adequate support to respond to these changes. Burnout can lead to compassion fatigue and even negatively impact patient care, which makes it critically important to address.[52] One interview participant voiced the inherent tension in the behavioral health workforce between the increase in demand for services and desire to help as many people as possible with the need to protect providers' own well-being.

As discussed previously, most widespread burnout interventions are targeted toward frontline physical healthcare workers. Although the $103 million from the American Rescue Plan intended to strengthen resiliency and reduce burnout in the health field is critical, the funds do not specifically address the unique needs of behavioral health providers. In addition, the burnout reduction approaches that exist tend to focus primarily on individual well-being rather than on systemic reforms, despite some research suggesting that organizational changes may be more effective. However, there is a lack of research testing organizational interventions through controlled trials.[53] Further research is needed to understand which burnout interventions are most effective across provider types, given the unique experiences of the behavioral health workforce.

Shifts in Service Delivery Resulting from COVID-19

The switch from in-person to telehealth care has demonstrated several advantages. Behavioral health providers in our interviews, as well as the reviewed literature, highlighted that the increased workday flexibility and reduced commutes, in conjunction with a decreased number of "no-shows," have allowed providers to be more efficient with their time. On the other hand, technology remains an issue for many clients and providers, both in terms of access and technical literacy. This issue is magnified in rural and low-income communities, particularly communities of color that the healthcare system has historically marginalized, creating disparities in behavioral healthcare delivery. Older patients, homeless or incarcerated patients, and Native American patients were highlighted by our interviewees as populations particularly vulnerable to falling through the cracks with virtual care.

Reimbursement and Policy Changes Due to COVID-19

Though the pandemic forced significant and rapid policy changes around telehealth, it remains unclear whether these changes will continue when the public health emergency for COVID-19 ends. Although the public health emergency was most recently renewed on July 15, 2022,[54] several interview subjects spoke about the uncertainty around the permanence of coverage reimbursement policies implemented during the pandemic. Low wages are already a critical factor in burnout and the loss of employees in this field. Without clear coverage guidelines and adequate reimbursement for telehealth services, the workforce shortage could worsen.

Limitations

This study has a number of limitations. First, we were only able to interview 12 of the 28 potential interview participants. Although we identified as much relevant literature as possible, the ongoing nature of the pandemic may mean that important insights have not yet been realized and described in the published

literature. Finally, the majority of our interview participants represent researchers and the experience of providers at higher licensure levels, so we may not have fully and accurately captured the experiences of unlicensed community behavioral health providers.

Conclusion

The COVID-19 pandemic has brought much-needed attention to the phenomenon of burnout, particularly among healthcare workers. However, more research is needed to determine the best ways to support behavioral health providers specifically. In addition, the transition to telehealth has been largely positive for behavioral health providers, but there are a number of challenges that must be addressed as telehealth becomes a mainstream service modality. More research is needed to identify best practices for telehealth delivery of behavioral health services, ensuring providers understand the nuances required for effective teletherapy, especially for populations that have been disproportionately negatively impacted during the COVID-19 pandemic. In the behavioral health workforce, this includes lower licensure (or unlicensed) providers, peer counselors, and community behavioral health providers. Finally, if there are permanent extensions of policies that establish coverage and payment parity for telehealth, provider organizations should invest in effective ways to support their staff in this new element of the behavioral healthcare landscape.

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Appendix A: Literature Review Search Strategy

Table 1: Literature Review Search Strategy

Databases	Search Terms
PubMed, Google Scholar, University of Michigan libraries, gray literature Google search	"burnout" OR "stress" OR "burden", AND "supports" OR "programs", AND "mental health provider" OR "behavioral health provider" OR "substance use disorder provider" OR "counselor" or "therapist" AND "COVID-19" or "pandemic"
PubMed, Google Scholar, gray literature Google search	"telehealth" OR "telemedicine" OR "remote" or "virtual" OR "telepsych*", AND "provider" OR "professional" or "clinician", AND "behavioral health" OR "mental health" OR "substance use disorder" OR "SUD" or "therapist", AND "educat*" OR "communicat*", AND "payment" OR "compensation" OR "reimburse*"
Google Scholar, Google search, gray literature	"supports for behavioral health providers" OR "support for behavioral health providers during COVID-19" OR "transitions to telehealth", AND "behavioral health providers" OR "Impact of COVID-19", AND "transition to telehealth" OR "transition to telehealth", AND "behavioral health providers" OR "transition of mental health service delivery", AND "COVID-19 impact" OR "behavioral health provider perspectives", AND "transition to telehealth"

Appendix B: Policy Changes and Emergency Reforms Due to COVID-19 Impacting Behavioral Health Providers

Table 2: Policy Changes and Emergency Reforms Due to COVID-19 Impacting Behavioral Health Providers

Policy Reform Category	Specific Policy Changes/Emergency Reforms
Changes in coverage	Insurance coverage parity for telehealth and in-person visits
Changes in coverage	Coverage of “direct-to-consumer” telehealth services (i.e., in a patient’s home)
Changes in coverage	Expansion of eligible provider types/services for telehealth
Changes in coverage	Expanded coverage for substance use disorder treatment
Changes in coverage	Relaxed existing geographic restrictions that require clinicians and patients be in the same state
Changes in reimbursement	Payment parity for telehealth and in-person visits
Changes in reimbursement	Reduction/waivers for provider cost sharing
Changes in reimbursement	Temporary distribution of historically billed Medicaid payments not tied to fee-for-service visits
Privacy/technology reforms	Relaxation of HIPAA-compliant telehealth platform regulations
Changes in prescribing practices	Prescribing of medication-assisted treatment via telehealth
Changes in prescribing practices	Relaxed prior authorization requirements

Appendix C: Interview Protocol—Support for Behavioral Health Providers During Public Health Emergencies

Introduction

The aim of this study is to identify best practices for supporting providers in the behavioral health workforce, particularly during public health emergencies such as the COVID-19 pandemic. The purpose of this call is to gain information and insights from you about evidence of increased burden of the pandemic on behavioral health providers, the resulting effects on their ability to deliver services, and on best practices in supporting behavioral health providers. You can choose whether or not to participate in this research (IRB #HUM00213274). This study is funded by HRSA, through the University of Michigan's Behavioral Health Workforce Research Center*.

*If you would like more information about the BHWRC and the Director, Dr. Kyle Grazier, please let me know and I will provide you with that information.

Questions

1. Briefly, what is your role at [organization]?

Domain 1: Burnout

Audience: advocacy groups, providers, researchers

2. What supports are in place for behavioral health providers to manage burnout and stress during public health emergencies such as the COVID-19 pandemic?
    1. Supports in general
    2. Supports within their own organizations
3. What types of interventions/supports have been most effective in reducing burnout due to the COVID-19 pandemic?
4. How does burnout from the COVID-19 pandemic affect providers' ability to provide care?
5. What are some unique challenges related to burnout for behavioral health providers (compared to other healthcare workers)?

Domain 2: Shifts in service delivery

Audience: advocacy groups, providers/provider groups, researchers

6. How has the shift to telehealth during the pandemic changed the quality of services/care delivered?
7. What supports existed to help guide providers through the transition to telehealth?
    1. What new supports were put in place?
8. What are best practices for providing support for shifts in service delivery?
9. What are the long-term implications of the shift to telehealth?
    1. For patients?
    2. For providers?

Domain 3: Reimbursement and policy

Audience: Provider/provider organization leadership, researchers

10. How did [organizations/your organization] implement changes to reimbursement policy?
    1. How did [organizations/your organization] provide support for reimbursement questions?
    2. What challenges were encountered?
    3. What was done well?
11. How often did [organizations/your organization] communicate with their providers regarding changes in service delivery models and reimbursement/payment?
12. What is your opinion on the timeliness and clarity of the guidance issued by [organizations/your organization]?
13. How often did providers seek guidance outside of their organization? (e.g., government websites, professional society websites, etc.)

Appendix D: Interview Participant Information

Researchers

Interview Subject Category: Researchers
This group will provide background information on burnout among mental health providers, how burnout may affect quality of care, and evidence-based burnout interventions for mental health providers. Additionally, researchers can provide insights into how policy changes and changes in care delivery (such as telehealth) may affect the ability of provid-

Participant	Title	Institution	Relevance to project
Michael Chaple, PhD	Assistant Professor, Dept. of Psychiatry	Columbia University	Director of Northeast and Caribbean Addiction Technology Transfer Center (ATTC). Research includes training and technical assistance for behavioral health providers, specifically substance use disorder providers.
Kenneth Gill, PhD	Associate Dean, Professor, and Chairperson, Dept. of Psychiatric Rehabilitation and Counseling Professions	Rutgers University	PI and Co-Director of Northeast and Caribbean Region Mental Health Technology Transfer Center (MHTTC). Program prepares future practitioners (undergraduate and graduate level) for psychiatric rehabilitation work.
Todd Molfenter, PhD	Senior Scientist, Center for Health Enhancement Systems Studies	University of Wisconsin	Director of Great Lakes MHTTC. Conducted research on the use of telehealth in mental health services during and after COVID-19.
Ann Murphy, PhD	Associate Professor, Dept. of Psychiatric Rehabilitation and Counseling Services	Rutgers University	Co-Director of Northeast and Caribbean MHTTC. Research on challenges experienced by behavioral health organizations in New York resulting from COVID-19.
Michelle Salyers, PhD	Director, ACT Center of Indiana; Professor and Director of the Clinical Psychology Program	Indiana University–Purdue University Indianapolis	Research focuses on burnout, specifically in the behavioral health field. Lead researcher of a burnout reduction intervention called BREATHE, currently under evaluation.
Anne Helene Skinstad, PhD	Clinical Professor, Dept. of Community & Behavioral Health, College of Public Health	University of Iowa	Project Director of the National American Indian & Alaska Native Addiction, Mental Health and Prevention Technology Transfer Centers (ATTC, MHTTC, and PTTC). Research focuses on behavioral health in special populations, including Native American populations.
Kara Zivin, PhD	Professor of Psychiatry, Obstetrics and Gynecology, and Health Management and Policy	University of Michigan	Lead author on a mixed methods study protocol investigating burnout among mental health providers across Veterans Health Administration facilities over time.

Advocacy Groups

Interview Subject Category: Advocacy Groups This group will provide information on how the COVID-19 pandemic and subsequent transitions in care delivery have affected behavioral health providers, including what types of support/resources were made available and challenges encountered.			
Participant	**Title**	**Institution**	**Relevance to project**
Oscar Morgan	Executive Director	Danya Institute	Director of the Central East MHTTC. Danya Institute's mission is to accelerate adoption of evidence-based practices in the field of behavioral health; operates SAMHSA Technology Transfer Centers.
C. Vaile Wright, PhD	Senior Director of the Office of Health Care Innovation	American Psychological Association (APA)	APA fielded two surveys over the course of the pandemic related to telehealth, provider burnout, and work stressors.

Providers/Provider Organizations

Interview Subject Category: Providers/Provider Organizations This group will provide insight into levels of burnout experienced by behavioral health providers and information on programs that can support behavioral health providers during times of major transition such as the COVID-19 pandemic. Provider organizations can also speak about challenges and best practices specific to their organization type.			
Participant	**Title**	**Institution**	**Relevance to project**
Anna Byberg, LMSW	President	Dawn Farm	Dawn Farm is a non-profit organization in Washtenaw County, Michigan that provides treatment and recovery support services for people with substance abuse.
Sansea Jacobson, MD	Director, Child and Adolescent Psychiatry Fellowship & Triple Board Program	University of Pittsburgh Medical Center	Executive Committee of UPMC Physician Thrive, an initiative to promote physician well-being and professional fulfillment. Co-chair of the UPMC Graduate Medical Education WELL committee, overseeing wellness initiatives for medical students.
Gina Perez, MD	Associate Professor of Psychiatry and Director of Telepsychiatry	University of Pittsburgh Medical Center	Conducted research on the transition to telehealth and future considerations and implications for the transition in care delivery.