# **POLICY BRIEF**

Telebehavioral Diagnoses and Procedures from March to September 2020 in Five States



**Project Team** 

Victoria Schoebel, MPH Jessica Buche, MPH, MA Isabella Ginsberg Jason Goldwater Yael Harris Nebi Girma, MPH Kyle Grazier, DrPH, MPH, MS

## Background

The importance of accessible mental health (MH) services for individuals with symptoms of depression or anxiety has been well documented, with evidence of an additional estimated 80 million adults reporting symptoms of depression or anxiety during the coronavirus disease 2019 (COVID-19) pandemic. Fundamental to these services is the ability to enact adequate policy changes to make telebehavioral health services more readily available to clients and providers. To further understand the changes in MH services during the past 2 years and the surrounding policy implementations, the University of Michigan Behavioral Health Workforce Research Center partnered with Laurel Health Advisors to learn more about where telebehavioral health services are being used during the COVID-19 pandemic. By understanding these experiences, we can begin to examine the circumstances of telebehavioral health utilization during this time of increased social isolation and multifaceted community and workforce stress.

### Methods

We analyzed data from data from over 1.4 million telehealth encounters collected between March and September 2020. These data were extracted from five healthcare institutions in five states and contain a large array of diagnoses and procedures for which telehealth were used during this time frame. A descriptive analysis was conducted on encounter-level data to demonstrate the number of telehealth visits in each healthcare institution from March to September 2020.

## Findings

States included in the data had low rates of MH/substance use disorder (SUD) procedures as a proportion of all procedures, with multiple states consistently staying under 10% of all procedures. Arizona was the only state where MH/SUD procedures were regularly over 50% of all procedures during the months March to September. Included states also had low rates of MH/SUD as a proportion of all diagnoses with multiple states staying consistently below 30% of all diagnoses (Figure 2). Arizona was the only state where MH/SUD diagnoses were regularly over 60% of all diagnoses during March to September.

In addition, states had low rates of MH/SUD procedures per county resident populations, with multiple states consistently staying under .003 procedures per county resident (Figure 3). Arizona was the only state where MH/SUD procedures per resident was regularly over .003 during March to September. States also had low rates of MH/SUD diagnoses per county resident population, with multiple states consistently staying under .003 procedures per county resident population, with multiple states consistently staying under .003 procedures per county resident (Figure 4). Arizona, again, was the only state where MH/SUD diagnoses per resident were regularly over .004 during March to September. States ranged from New York at .0002 in March to Arizona at .009 in April (Figure 3).

## **Conclusions**

Overall, our findings suggest that trends in MH and SUD diagnoses and procedures as a proportion of all diagnoses and procedures remained relatively consistent throughout the 7-month study period. Behavioral health diagnoses and procedures make up less than half of all diagnoses and procedures in all states, though some variation exists. Arizona is the exception, where over half of all diagnoses and procedures are related to behavioral health.

We observe similar findings regarding our results per county population. There is minimal change in the number of behavioral health diagnoses and procedure per county population in all states except Arizona. In these states, rates are consistently lower than 0.004 for both diagnoses and procedures. In Arizona, we observe two important differences. First, the rate is considerably higher. Second, the rate takes an inverted U-shaped distribution. The rate was lowest at the beginning (March) and end of the study period (September). The rate trend increased between March and April before declining between April and September. While increases also occurred in the number of behavioral diagnoses and procedures per county population in Missouri and Wisconsin, the increases are of a smaller magnitude.

Our findings encourage future researchers to examine why Arizona was (and maybe is) an outlier. The trends in Figures 3 and 4 suggest that the onset of the COVID-19 pandemic was associated with an increase in the number of diagnoses and procedures that then diluted to pre-pandemic levels by September 2020, though we have no data on later months. This finding in combination with the lack of a trend observed in the rate per all diagnoses and procedures in Figures 1 and 2 suggests that the COVID-19 pandemic may have impacted the numbers for the overall and behavioral health diagnoses and procedures in similar ways. Thus, the more interesting question is why Arizona was an outlier before the pandemic began. We hope researchers explore this question.

There are a few notable limitations to this study. First, while we examine data from five states, the data are not national. We make no claims that any of the trends observed in this study represent national patterns. Further, as our data come from a single healthcare organization within the state, it may not be represented of the state. Second, we note that a limitation of these data is that we converted the number of MH/SUD diagnoses and procedures from the universe of diagnoses of procedures at the three-digit ZIP code level to the county level for the figures using rate per county population. It is important to note that multiple counties can be in a three-digit ZIP code area, and counties can also be split and in multiple three-digit ZIP codes.

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