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ORIGINAL PAPER

Federally Qualified Health Centers Use of Telehealth to Deliver Integrated Behavioral Health Care During COVID-19

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Abstract

Federally qualified health centers (FQHCs) that provide comprehensive health services, including integrated behavioral health (IBH), transitioned to deliver care via telehealth during the COVID-19 pandemic. This study explored how FQHCs adapted IBH services using telehealth. A mixed-method design was used, pairing a survey disseminated to FQHC administrators with a structured interview. Of the 46 administrators who participated in the survey, 14 (30.4%) reported delivering IBH using telecommunication prior to the pandemic. Since COVID-19, almost all of the FQHCs surveyed used telecommunication to deliver IBH ($n = 44$, 95.7%). Nine interviews with FQHC administrators resulted in the four themes: telehealth was essential; core components of IBH were impacted; payment parity and reimbursement were a concern; and telehealth addressed workforce issues. Findings confirm the necessity of telehealth for FQHCs during COVID-19. However due to the lack of co-location, warm-handoffs and other core components of IBH were limited.

Keywords Integrated behavioral health · Tele-behavioral health · COVID-19 · Federally qualified health centers

With the COVID-19 outbreak, health settings quickly adapted to providing care while maintaining patient and provider safety (Demeke et al., 2021; Knierim et al., 2021). The pandemic presented significant challenges to federally qualified health centers (FQHCs) in fulfilling their mandate to provide comprehensive health care services, including integrated behavioral health (IBH), to high-need, under-supported communities (Uscher-Pines et al., 2021). Annually, FQHCs serve 9% of the total U.S. population, with a panel of 80% of patients who are either uninsured or Medicare or Medicaid beneficiaries (National Association of Community Health Centers [NACHC], 2020). To bridge physical and behavioral health needs in service delivery, FQHCs often use an IBH model to address physical and behavioral health problems concurrently.

The adoption of IBH in FQHCs expanded significantly in 2014, when the U.S. Health Resources and Services Administration invested $55 million dollars to improve and expand the behavioral health services at existing FQHCs funded by Sect. 220 of the Public Health Service Act (Goldstein, 2017). IBH is a particularly important model to ease access to behavioral health services and ensure coordinated care for medically underserved areas and/or populations. As the safety net health system in the United States, FQHCs provide preventative health, behavioral health, physical health, specialty care, and dental care services while addressing other social risk factors, making them an important center for health care delivery for some of the most vulnerable populations (Geiger, 2005). Increasingly, behavioral health concerns are among the primary reasons people seek care at FQHCs (Kramer et al., 2017). Notably, staff composition within FQHCs has also shifted to meet this increased demand for behavioral health care. As of 2020, 97% of FQHCs reported having a behavioral health provider on staff—a 63% increase from 2010 data (NACHC, 2021). Despite the uptick of IBH, the adoption of tele-behavioral health services (hereafter termed *tele-BH*) has been slow.

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In 2019, less than a quarter of FQHCs used any type of telehealth to provide direct patient care (Cole, 2021). Before the pandemic, telehealth was not standard care among FQHCs, with only some certified rural health centers approved to deliver reimbursable telehealth services (Uscher-Pines et al., 2021). Yet telehealth became a key mechanism for maintaining health care services while complying with social distancing requirements and the suspension of non-emergent in-person appointments during the pandemic (Uscher-Pines et al., 2021; Verma, 2020). Federal and state emergency orders lifted regulations limiting reimbursement for telehealth services, thus enabling health systems to use telecommunications to deliver care and be paid for services delivered in this way (Centers for Medicare & Medicaid Services [CMS], 2020).

Telehealth grew rapidly during the beginning of the pandemic. It is estimated that 1 in 4 Medicare beneficiaries had at least one telehealth visit between summer and fall 2020 (Koma et al., 2021). Large health systems reported that up to 46% of patients had a telehealth visit in a 12-month period (October 2019–September 2020) during the pandemic (Zachrison et al., 2021). Within FQHCs specifically, use of telehealth for care delivery since the start of the pandemic rapidly accelerated (Demeke et al., 2021; Uscher-Pines et al., 2021). From June to November 2020, 30% of *all* FQHC visits were telehealth visits (Demeke et al., 2021). In some regions, telehealth use at FQHCs was even higher. For example, as of August 2020, California FQHCs used telehealth for almost two-thirds of primary care visits (65.4%) (Uscher-Pines et al., 2021).

The use of telehealth to deliver care during the pandemic has been especially important for accelerating behavioral health services. In the first year of the pandemic, 40% of behavioral health services were delivered via tele-BH (Lo et al., 2022). While tele-BH has decreased over the course of the pandemic, it is estimated that one-third of all behavioral health services are delivered via telecommunication today (Lo et al., 2022). Similarly, FQHCs have leveraged tele-BH to deliver care. In California, more than 70% of behavioral health visits in August of 2020 were delivered via tele-BH (Uscher-Pines et al., 2021).

Although telehealth appears to have filled a gap in service provision during the pandemic, particularly for behavioral health, it remains unclear how FQHCs used telecommunication strategies for IBH. Even before the pandemic's impact, FQHCs varied considerably in their implementation of IBH models (Chaple et al., 2016). IBH models have multiple components, including clinical (e.g., linking patients to community resources), workflow (e.g., standardized screening of patient panel), organizational (e.g., shared electronic health records), and structural factors (e.g., payment; Agency for Healthcare Research and Quality [AHRQ], 2021). Growing support for IBH also prioritized a co-located team of providers working together in a shared physical space; however, the pandemic interrupted co-location (Cooper & Zerden 2021; Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). Due to efforts to reduce close contacts and de-densify clinics, core components of IBH (e.g., shared physical proximity, warm-handoffs connecting patients with the care team, and high-level team communication) shifted as a result of the pandemic, as previously described by Cooper and Zerden (2021).

Given the important role FQHCs play in providing comprehensive care to medically underserved areas and populations, how IBH services have been impacted by the COVID-19 pandemic warrants further exploration. As such, this study explores how FQHCs adapted IBH care delivery during the pandemic, specifically using telecommunication. In particular, this study assessed FQHC-reported barriers to IBH during COVID-19, as well as tele-BH uptake, use, and adaptation. We also discuss goals for the future use of telecommunications at FQHCs to address a worsening behavioral health crisis around the country, particularly among already vulnerable safety-net populations (Panchal et al., 2021).

Methods

This study used a mixed-method explanatory sequential design (Ivankova et al., 2006). To begin, the researchers collected and analyzed quantitative data from the survey and findings were subsequently used to inform qualitative data collection and analysis, which occurred several months later (Ivankova et al., 2006). Quantitative data were collected via an online survey to a convenience sample of FQHC administrators in 12 states (disseminated October–December 2020). In-depth qualitative interviews were conducted with a subsample of the administrators (March–April 2021). The study was reviewed by the IRB at the University of Pittsburgh and was determined to be non-human subjects research. Study investigators and authors have no conflicts of interest to report.

Survey Development

The survey was deployed via Qualtrics and collected descriptive data, including FQHC location, number of clinics, and IBH model. Four sections of questions addressed telecommunication and tele-BH (using items drawn from two existing studies of tele-BH [Lombardi et al., 2022; Mace et al., 2018]): use of telecommunications for IBH during the pandemic; telecommunication methods (audio-only, video, e-mail/text); IBH team members' use of telecommunications; and barriers to tele-BH (e.g., reimbursement, technical challenges).

In-Depth Interviews

A semi-structured guide was developed for in-depth interviews with FQHC administrators. Open-ended questions addressed three topics: (1) Ways the FQHC adapted to delivering IBH via telehealth (i.e., *How has tele-communications been used at your FQHC during COVID-19?*; *What are the telecommunication methods IBH providers use now versus pre-pandemic?)*; (2) Barriers to IBH delivery (i.e., *Tell us more about* any *technology barriers, training barriers, client-facing barriers, administrative barriers)*; and (3) FQHCs' perspective on long-term use of tele-communication for IBH (i.e., *What is your organization's long-term plan to use telecommunication for care?*; *What are the future barriers you see to your plan for telecommunication for IBH?).*

Interviews were approximately 30 min in length, conducted via Zoom, and recorded with participants' permission. The same member of the study team (a PhD researcher) conducted all in-depth interviews to ensure continuity in how each interview was conducted.

Study Sample and Recruitment

We used the U.S. Health Resources & Services Administration's (HRSA) *Find a Health Center* website (https://findahealthcenter.hrsa.gov/) to identify FQHC organizations for study recruitment (HRSA, n.d.). Twelve states were randomly selected using a random number generator from a stratified list of states across all ten U.S. Health and Human Service regions. The publicly available contact information for FQHC administrators was obtained from HRSA and FQHC websites. FQHC administrators received an e-mailed request for study participation containing a link to the survey. If a phone number was available, potential participants were also recruited via telephone. An additional recruitment strategy included an invitation to join the study in the monthly HRSA letter to FQHCs. At the completion of the on-line survey, respondents were asked to participate in a video-call interview to further describe pandemic-related adaptations to IBH via tele-IBH. Overall, nine interviews were scheduled with willing respondents via e-mail. After participants consented, interviews were audio recorded via Zoom. Participants received a $25 incentive for the survey and $50 for the interview.

Analysis

Descriptive analyses of survey data were performed using Stata 16 and are presented in subsequent tables. Once qualitative interview data were cleaned, transcribed, and checked for accuracy, two members of the team worked independently to conduct thematic content analysis in accordance with the six interactive phases of qualitative coding (Labra et al., 2019). Each coder read and commented on each interview transcript. Deductive analysis was used to categorize data based on interview-guide domains (Bingham & Witkowsky, 2022). Emerging themes and concepts were identified, and the two coders developed a shared codebook using a word processing program to generate and capture initial codes based on all contextual data (Fereday & Muir-Cochrane, 2006; Labra et al., 2019). Reviewers met to discuss codes iteratively, resolve discrepancies in coding, and organize codes into broader themes.

Results

In all, 46 administrators from 10 states completed the survey examining ways their FQHC adapted IBH services during the pandemic (Table 1). The greatest number of respondents were from California ($n=12$; 26.1%), Kansas ($n=10$; 21.7%), and Pennsylvania ($n=8$; 17.4%). Composition of FQHCs ranged from large organizations with 10 or more clinic sites ($n=10$; 21.7%) to single-site centers ($n=18$, 17.4%). All participants indicated their FQHC delivered IBH care.

Before the pandemic, 14 FQHCs (30.4%) delivered IBH care using telehealth strategies; during the pandemic, all but two of the FQHCs ($n=44$, 95.7%) offered tele-BH via multiple methods, including video conferencing, audio-only, text messaging, and e-mail. Tele-BH was delivered by various IBH team members, including medical providers (77%), IBH specialists (98%), and psychiatric consultants (50%). Tele-BH was supported by other providers such as medical assistants, case managers, and alcohol/drug counselors.

Table 1 Study sample characteristics

State	*N*	100%
Arizona	1	2.17
California	12	26.09
Kansas	10	21.74
Kentucky	1	2.17
Montana	1	2.17
New York	4	8.70
Pennsylvania	8	17.39
South Carolina	3	6.52
Texas	4	8.70
West Virginia	2	4.35
Number of clinic sites		
1 clinic	8	17.39
2 to 4 clinics	13	28.26
5 to 9 clinics	15	32.60
10 or more clinics	10	21.74

In line with study aims, participants were asked to report barriers to the delivery of tele-BH. All respondents ($n=46$; 100%) reported patient-related barriers to telehealth use which impacted service delivery including patients' lack of a computer or access to broadband, or patients' technology literacy/ability to use virtual platforms. Other commonly identified barriers to delivery were reimbursement for telehealth services and concerns of HIPAA compliance (Table 2).

Qualitative data were collected via interviews with nine FQHC administrators from six states: California ($n=3$), Kansas ($n=2$), Arizona ($n=1$), New York ($n=1$), Pennsylvania ($n=1$), and West Virginia ($n=1$). Our analysis identified five themes: tele-BH is essential to providing IBH during the pandemic; audio-only is needed to reach some clients; core IBH components are significantly affected, especially warm-handoffs; concerns emerged regarding payment parity and long-term reimbursement security; and tele-BH helped address workforce issues.

Theme 1: Tele-BH Is Essential to Providing IBH Care During COVID-19

Despite challenges, all FQHCs were able to rollout tele-BH services quickly and largely effectively. Simply put, without telehealth options, clients would not have received care. This was also evident in survey results, which found that use of tele-BH jumped from 30.4% before the pandemic to almost 96% since the start of COVID-19 (Table 2). One administrator described the rapid transition to tele-BH saying, "*We were doing zero telehealth up until this point and it went from 0 to 100, literally a 36-hour turnaround time*."

FQHCs' successful transition to telehealth benefitted from existing co-located models that had already implemented IBH. As one respondent described, IBH providers were able to quickly transition from in-person therapy to video and audio communication, possibly more rapidly than medical health providers:

> *Out of the agency itself, this department, behavioral health, we were the only department … able to just take off … [without] interruption with our client schedule. …It's continuing …in the direction that it should be. I think it [successful transition] had to do with being proactive.*

Administrators indicated tele-BH increased clients' options for receiving care, with many clients preferring to receive care via telecommunication. One administrator stated,

> *We do have a certain group of patients that actually prefer that [tele-visits]. More prefer in-person, but we still have some that like to do either audio or video, and we actually had some that [tele-visits] turned out to be a better venue for them for transportation reasons [and] just for the way that they prefer to communicate.*

Theme 2: Audio-Only Is Needed to Reach Clients

Although respondents identified the utility of tele-BH during COVID-19, they also highlighted short- and long-term barriers to tele-IBH, primarily the need for audio-only

Table 2 Federally qualified health centers' use of tele-behavioral health, types of telecommunication used, IBH team members' use of telecommunication, and barriers to tele-behavioral health

	46 (100%)
Used Tele-Behavioral Health Before COVID-19	14 (30.4%)
Used Tele-Behavioral Health Since the Beginning of COVID-19	44 (95.7%)
Types of Telecommunication Used	44 (100%)
Audio (no visual)	36 (81.6%)
Email and/or Text	8 (18.2%)
Video	39 (88.6%)
Team Members Using Telecommunication to Deliver IBH	44 (100%)
Medical Provider	34 (77.3%)
Behavioral Health Specialist	43 (97.7%)
Psychiatric Consultant	22 (50.0%)
Other team member	3 (6.5%)
Barriers that Impacted the Use of Telehealth to Provide Integrated Behavioral Health during COVID-19	46 (100%)
Concerns regarding HIPAA, client privacy, or 42 CFR Part 2 compliance	12 (26.1%)
Concern of compliance regulation	6 (13.0%)
Patient barriers to telehealth use (e.g., no access to technology, broadband)	46 (100%)
Cost of maintenance	4 (8.7%)
Cost of equipment (e.g., hardware, software)	6 (13.0%)
Lack of reimbursement for telehealth services	15 (32.6%)

telecommunication. All administrators interviewed mentioned that video-only communication posed a major limitation because many clients needed an audio-only option given their connectivity/technology issues or preferences. Respondents described tele-BH challenges that made audio-only a necessity in order to reach clients: "*Many [clients] don't have the capacity for visual and audio virtual sessions, but they all have the capacity for phone calls… There are very few that didn't have a phone, so we were able to do phone sessions.*"

Another respondent shared:

> *It [tele-visit software] 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."*

Others noted that clients had access to basic technology, and many relied on prepaid phones. This common theme was also identified in survey findings (see Table 2). Notably, 100% of survey respondents felt patient barriers were one of the biggest barriers to telehealth utilization (Table 2). As one respondent put it,

> *In my experience… even our folks that are pretty low-socioeconomic status have enough technology that they can do telehealth. Many of them have a smartphone that's not the newest, but it works. Many of them have a laptop that's not the newest, but it works. We are advocating for audio-only visit access to be extended as well for those folks that do have, for example, the Obama phones or just something really basic, but it's enough they can do a phone call.*

Interviewees also noted that video sessions raised concerns about client safety, a sub-theme that was also noted by a quarter of survey respondents. Specifically, one administrator shared:

> *For patients for whom it's not safe to do a video call, they might be able to get away with an audio call — put on the headphones and go to the park like they're going to go for a jog and talk to their therapist about their domestic violence situation or whatever.*

One respondent described how the flexibility to do audio, video, or in-person visits helped to engage patients in care:

> *We find it [telehealth] extremely useful to those patients, particularly elderly patients that may not want to come in, patients that have transportation problems … We have some patients that don't want to be videoed, they don't want face-to-face because they feel it may be an intrusion in their home setting... But we do have patients that want to be seen face-to-face, and we can accommodate all.…*

Theme 3: Significant Impacts to Core Components of IBH

Although delivery of individual behavioral health sessions continued successfully during the pandemic, many IBH team functions were adversely impacted by the transition to tele-BH and remote care. Most IBH providers worked off-site via tele-visits, meaning the IBH team transitioned from a physically co-located space to having some members working in the clinic and some working from home. As one respondent described, changes in physical location added difficulty to team communication and referrals:

> *The problem …with not having us [Behavioral health clinicians] in the clinic… we weren't being seen by the doctors… when we were [on-site], … they could stop us in the hall, just and say, "Hey, what do you think about this person?" … They trusted us, you know, they trusted our sense of things.*

Other core components of IBH include screening for service needs and a warm-handoff of clients who might benefit from IBH services. Many of the administrators described trying various approaches to a virtual warm-handoff, but most had limited success. One respondent described their attempt to create a virtual waiting room:

> *I set up a system for warm-handoffs during COVID that just hasn't been used. I set up a [virtual] behavioral health room, which was meant like a gathering place for warm-handoffs, then it would be the same kind of process where if there was a warm-handoff, our coordinator would be called, and an available clinician would go to that special [virtual] room, …then the patient would theoretically enter that room and they could do a video warm-handoff. I don't think [it] …got used very much.… Many of the patients wanted to use telephones—so, we would have to call them back. Our numbers of warm-handoffs since COVID have dropped dramatically.*

When probed why this innovative model did not work, this participant outlined the extra steps that made the virtual process onerous for primary care providers (PCPs):

> *Well, I do know why the [virtual] room didn't work—it's because it took extra effort on the PCP side… simple logistical issues. They didn't want to put cameras on the computers in the patient rooms because they disappeared [read stolen or misplaced]. … So that means if there was going to be a warm handoff, the MA [medical assistant] would have to go get a camera…*

so it was like all these extra steps they just weren't going to do... So COVID really did make it a lot more complex."

Similarly, another respondent described the ungainly process for PCPs to make a warm handoff to the IBH team during a tele-visit: "*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.*"

Theme 4: Payment Parity and Long-Term Reimbursement Security

In more than one-third of survey responses, lack of reimbursement for telehealth services was identified as a barrier to providing IBH via telecommunication. Similarly, administrators also described this barrier during in-depth interviews. FQHC administrators were hopeful tele-BH would continue post-pandemic, but also worried about payment parity and reimbursement for tele-health. One respondent noted that payment mechanisms is key to future use of tele-IBH: "*We were set to [use telecommunication] before COVID and we're going to continue to do it after COVID. The main thing is, whether they'll [insurance plans] pay for it.*" Among administrators, ensuring payment parity for tele-BH posed a major concern. One respondent's comments summarized the concerns of many, noting that payment parity is critical because telehealth is not a less expensive model:

[We're] fighting [for] payment parity. You know, the problem is Blue Cross Blue Shield in our state has such a huge influence, and they don't want it … [telehealth] doesn't reduce our costs — we still have the same facility, the same staff, but now we have to provide this technology, pieces of infrastructure, that cost us even more.

Theme 5: Telehealth Addressed Workforce Issues

Although the survey did not ask about workforce issues related to tele-BH, this emerged as a final theme during the in-depth interviews. For instance, several administrators noted telehealth options improved their ability to hire IBH staff, especially bilingual providers. One administrator explained that providing IBH via tele-visits allowed their center to hire Spanish-speaking IBH providers living out of the local area: "*These providers are bilingual… to have bilingual providers, we really had to cast our net far and wide— and have been successful.*" Additionally, tele-BH allowed workers to live in various places, providing workers with more geographic mobility than may have been previously permitted when people had to live within a reasonable driving distance to the clinic where they worked.

Discussion

Certainly, the need for behavioral health services did not diminish during the pandemic. On the contrary, research suggests that the need for behavioral health services increased dramatically as mental health challenges and substance misuse escalated among the U.S. population (Czeisler et al., 2020; Panchal et al., 2021; WHO, 2020). FQHCs responded to pandemic-related challenges by rapidly transitioning to service delivery using telecommunication (Demeke et al., 2021; Uscher-Pines et al., 2021). Our findings highlight how FQHCs leveraged telecommunication to deliver IBH and summarize the strengths and limitations of using telecommunication to deliver IBH, as reported by administrators.

Overall, study findings align with those of other recent work suggesting that patients not only regard tele-BH as an acceptable method for receiving care, but in fact frequently prefer this mode of care (Guinart et al., 2021; Lombardi et al., 2022). Moreover, findings indicate that providers find tele-BH a helpful option and FQHC administrators noted that tele-visits benefit patients by increasing accessibility. Additionally, administrators noted that tele-BH reduced no-show rates, echoing prior reports in the literature (Drerup et al., 2021). Overall, the expansion of telehealth gave providers additional tools to provide treatment, which can increase patient satisfaction (Kruse et al., 2017). Several studies of IBH providers across disciplines have documented providers' overwhelming support for adding telecommunication options for care (Guinart et al., 2021; Lombardi et al., 2022; Schoebel et al., 2021).

Although patients and providers value telehealth options, this study identified substantial barriers to telecommunication, including technology issues, most notably for clients with limited access to and/or lack of familiarity with video-conferencing software. Recent studies cite the nation's lack of broadband access in many rural regions across the U.S. as a significant barrier to tele-BH (Lieneck et al., 2021; Rodriguez et al., 2021) *if* reimbursement is to be limited to video-only tele-visits, which require strong internet connections (Benda et al., 2020). Our findings show that audio-only visits were not only a preferred mode among some clients but also a good backup if problems arose during a video session. Future investigations should consider if all patient populations are equally able to access telehealth services and if telehealth is suitable for patients across regional, racial, ethnic, and socioeconomic groups.

Tele-BH for one-to-one psychotherapy is an effective treatment modality (Aboujaoude et al., 2015; Hilty et al., 2013) that has proven to be particularly advantageous during the pandemic (Lombardi et al., 2022; Schoebel et al.,

2021). However, the transition to tele-BH also posed challenges to FQHC's ability to maintain critical components of IBH. A core feature of IBH is the presence of a co-located and coordinated team of providers. Indeed, evidence suggests that a shared physical space enhances communication and supports collaboration (Bonciani et al., 2018; Platt et al., 2018). However, efforts to follow social distancing guidelines and reduce clinic occupancy density during the pandemic meant that many IBH teams were moved off-site while physical health providers remained in the clinic. Co-location supports providers' ability to use warm handoffs to connect clients with behavioral health providers and other members of the care team. Warm handoffs are an important IBH component because the handoff reduces communication breakdowns, increases patient engagement, and builds relationships between patients and providers (AHRQ, 2017). Typically, warm handoffs provide PCPs with a way to transition patients with behavioral health needs or psychosocial issues to behavioral health providers without needing to have pre-set appointments (Robinson & Reiter, 2007). Almost all respondents indicated that their clinic had experienced a significant decline in the number of warm-handoff referrals to behavioral health providers during the past year of the pandemic. Many respondents described strategies they used to replicate warm handoffs virtually, but these attempts were complicated by technological issues and health provider preferences. Additional research is needed to understand how innovative team models can be applied to sustain the benefits of IBH models as telehealth use continues to expand.

All respondents indicated a desire for tele-BH to continue as a care option beyond the pandemic. However, without payment parity for tele-BH, many clinics will likely return to prioritizing in-person visits. Although most states require *service parity* for telehealth (meaning insurance must cover the same services whether offered in-person or via telecommunication), most states do not have similar payment parity requirements for telehealth. Payment parity is important for FQHCs because even if IBH providers offer care off-site through tele-visits, the FQHCs must cover the expenses of maintaining a physical space for health providers. Given the expanded delivery options, FQHCs will face ongoing overhead expenses for physical locations and increasing costs related to greater use of technology (Ellimoottil, 2021). FQHCs already operate on razor-thin margins (Wright et al., 2021); therefore, financially supporting tele-BH through payment parity will support FQHCs in fulfilling their mandate to provide care to underserved communities and the safety net population.

Notably, we found strong support for tele-BH among FQHC administrators because this option enhanced their ability to diversify their workforce. For example, telehealth created opportunities for administrators to recruit and hire staff living outside the local area, which has proven especially beneficial in hiring bilingual providers. Future work must investigate how telehealth can assist in addressing the IBH workforce shortage by supporting providers working remotely from other communities. Previous work has recognized the satisfaction and experiences of providers in safety-net practices through federal programs such as the National Health Service Corps (Pathman et al., 2022; Yun et al., 2021). Findings from this study relate to these recruitment and incentive efforts because telehealth can improve organizational flexibility and in turn sustain and support the workforce serving FQHCs and other safety-net settings.

Limitations

Study findings reflect the responses of the represented FQHCs but are not generalizable to all health centers. Future work is needed to understand how FQHCs adapted in States beyond the ones included in this study. A deeper understanding of the national experiences of FQHCs during the COVID-19 pandemic are greatly needed. Claims data can assist researchers in examining how telehealth was used to implement IBH in other health centers, as well as how telehealth might have been shaped by regional variations in COVID-19. Self-selection of the study sample might have biased the study findings, in that participants working in FQHCs delivering IBH and tele-BH might have been more likely to respond to the e-mail recruitment. Additionally, given that responses were collected in the midst of the pandemic, data from participants may not be generalizable to others who might have differently experienced the delivery of IBH care during COVID-19.

Conclusion

The COVID-19 pandemic fundamentally and permanently changed how behavioral health services are delivered across the U.S. Overall, tele-BH care appears to be an effective strategy for providing individual behavioral health services. However, limitations exist in the use of telecommunication for IBH services, especially regarding its core components of team collaboration and communication. Sustaining the benefits of tele-BH will be important to address the behavioral health crisis among the U.S. population. Future research is needed to develop innovative methods that use telecommunication strategies to deliver IBH while successfully maintaining the critical components of team-based care. Policies that support payment and delivery of behavioral health care via tele-BH will be central to maintaining progress made in expanding access to care.

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