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Provider Perspectives on Telemental Health Implementation: Lessons Learned During the COVID-19 Pandemic and Paths Forward

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Abstract

After years of slow and fragmented implementation of telemental health (TMH), the COVID-19 pandemic necessitated widespread adoption. With the initial state of public health emergency behind us, we are at a decision point on whether to continue with TMH or return to a largely in-person care model. In this qualitative study, we investigated clinicians' perspectives on advantages and disadvantages of TMH in outpatient mental healthcare as well as considerations for future implementation. We conducted 29 semi-structured interviews with outpatient mental health providers. Data were analyzed using rapid qualitative analysis methodology. Advantages included increased utilization of services, improved therapeutic processes, and improved provider wellbeing. Providers, however, also noted that TMH has some disadvantages in terms of therapeutic processes and provider wellbeing, and they reported technology issues as an additional disadvantage. Overall providers reported they can provide high quality care via TMH, but indicated some patient populations and appointment types are a better fit for in-person services. Most providers preferred a hybrid model of care moving forward with reimbursement discrepancies and out-of-state licensure restrictions as barriers. They indicated that, as TMH becomes a mainstay in psychiatric care, training and professional guidelines will be important. Continued implementation of TMH alongside in-person care is likely to offer improved access and enhanced service quality when applied to the right patient populations and appointment types. Effective implementation may require policy and systems level support on equitable reimbursement rates, out-of-state licensure restrictions and professional guidelines for delivering TMH.

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Keywords

clinician attitudes; telehealth; telemental health; implementation science; qualitative

Telemental health (TMH), i.e., the provision of mental health services such as psychotherapy, medication management, and assessment via real-time videoconferencing or phone, offers a number of benefits to patients. By allowing patients to receive care in their homes or non-specialty clinics, it reduces barriers such as travel time and stigma associated with receiving mental health care in-person. Moreover, it expands specialty services for underserved communities. TMH has demonstrated high patient satisfaction scores, robust clinical outcomes and noninferiority to in-person care (Bashshur et al., 2016; Hilty et al., 2013; Hubley et al., 2016; Kruse et al., 2017; Varker et al., 2019).

Prior to the COVID-19 pandemic, uptake of TMH was slow and fragmented. Studies suggested that just over 20% of psychologists had used TMH at all in their clinical practice (Glueckauf et al., 2018; Pierce et al., 2021) and rates were even lower among psychiatrists (Choi et al., 2019). Negative clinician attitudes toward TMH, insufficient support from clinic and hospital leadership and limited financial reimbursement have been cited as key drivers of low uptake (Adler-Milstein et al., 2014; Wade et al., 2014).

Clinician perspectives on TMH have been mixed. Multiple studies report positive provider attitudes with regard to TMH efficacy and expanded access to care (Gibson et al., 2011; Jameson et al., 2011; Lindsay et al., 2017; Mayworm et al., 2020; Perle et al., 2014; Simms et al., 2011; Starling & Foley, 2006). Providers have also endorsed many concerns, including technological issues, increased hassle and workload, interference with the therapeutic relationship, and liability concerns, especially in the context of risk management (Baird et al., 2018; Elford et al., 2001; Lindsay et al., 2017; Schopp et al., 2000; Shulman et al., 2017; Wagnild et al., 2006). In a systematic review conducted prior to COVID-19, Connolly et al. (Connolly et al., 2020) found that providers tended to prefer in-person appointments over TMH. However, this same review found that providers' attitudes toward TMH often became more positive with experience (Elford et al., 2001; Gibson et al., 2011; Glover et al., 2013; Lindsay et al., 2017).

During the COVID-19 pandemic public safety guidelines necessitated a sustained period of TMH adoption. As such, clinician attitudes, hospital leadership and insurance coverage all converged in support of TMH. In this context, TMH rapidly became the standard of care, with national surveys reporting a 12-fold increase in TMH use among providers (Canady, 2020; Pierce et al., 2021). This shift forced adaptations at the individual and systems level that may be feasible to extend beyond the pandemic.

The current study employed qualitative methods to understand outpatient mental health clinicians' perspectives on TMH after almost a year of implementation during COVID-19. We focused on identifying provider perspectives toward (a) the advantages and disadvantages of TMH; (b) the quality of care that can be provided via TMH; and (c) openness to continuing to use TMH moving forward. Our aim was to evaluate whether

providers' perspectives have shifted after this period of sustained use and to develop insights to inform post-pandemic implementation of TMH.

Method

Study Design

Recruitment occurred from October 2020-January 2021 via professional listservs and an online recruitment platform that advertises research opportunities to the Boston healthcare community. Clinicians were eligible if they were (a) licensed in Massachusetts and (b) provided outpatient clinical care since January 2020. Interested participants were screened and consented by phone.

Semi-structured interviews lasted 45–60 minutes. We used an interview guide with open-ended probe and follow-up questions. Participants were reimbursed $50 for participation. This study was approved by the Institutional Review Board of Brigham and Women's Hospital.

Qualitative Analysis

We used rapid qualitative analysis methodology, which allows for timely analysis of qualitative data to inform policy and practices (Hamilton, 2013; Hamilton & Finley, 2019). First, we created a templated summary of each interview transcript. These summaries were organized by codes that aligned with key research questions from the interview guide. We also noted any emergent codes or unique concepts presented in the interview and highlighted several representative quotations. Second, we used these templated summaries to create a matrix in which codes were included as columns and participants as rows. This visual display of our data allowed us to identify similar and different response patterns across participants. Within each code, themes were identified based on repetition and emphasis; authors JL and SC attended a series of meetings to reach consensus on included themes. While this method of qualitative analysis is designed to be efficient, it has been found to yield results that are comparable to traditional qualitative approaches (Gale et al., 2019; Taylor et al., 2018).

Results

Overview

Our sample included 29 mental health providers across a variety of disciplines (see Table 1). All participants reported that they were currently conducting either the majority or all of their sessions via TMH. The most commonly used platforms were Zoom and Doxy.me. All providers reported that use of TMH was absent or very limited prior to COVID-19. Key themes and subthemes are listed below, with illustrative quotations in Table 2.

Advantages of Telemental Health

Increased Utilization

Access.: Nearly every provider reported that increased access for patients was an advantage of TMH. Specific access-related benefits included patients no longer having to find reliable

transportation or childcare, contend with traffic, pay for parking and, in the context of the pandemic, risk their health to attend appointments.

Attendance.: Most participants commented on having fewer no-shows and some commented that TMH sessions are more likely to start on time. Providers reported that only having to switch on a computer was particularly useful for patients who typically struggled to arrive to appointments on time.

Activation Energy.: A number of providers reported that the ease of attending TMH sessions seemed to lower the activation energy required for patients to start or re-engage in therapy.

Therapeutic Processes

Self-Disclosure.: Several providers noted that patients are more willing to discuss uncomfortable topics including suicidal behavior, trauma and substance use via TMH. Some providers noticed a change whereby established patients brought up sensitive topics via TMH that they had not previously mentioned during in-person sessions. Some clinicians stated that patients seemed even more comfortable with self-disclosure via phone (compared to videocall), perhaps due to the increased anonymity of an audio-only encounter.

Clinical insight.: Participants reported that TMH offered opportunities to build rapport in ways that are not possible in person. They reported value in seeing patients' homes, "meeting" family members and pets, and easily collecting collateral reports from family members. Participants noted that this information strengthened their understanding of patient functioning in ways generally not possible during in-person appointments.

Patient-Centered.: A number of providers reported that TMH has allowed for opportunities to better tailor treatment delivery and content. For example, by removing the need to travel to sessions, patients can engage in shorter, more frequent sessions when clinically useful. Some providers reported that when patients were in their natural environment, there were unique opportunities to personalize in-session activities like exposure exercises.

Provider Wellbeing

Workspace.: Some participants discussed workspace quality as an advantage to TMH, stating that their home workspace had a window or better air quality than their traditional office. Providers who typically used office swing space reported that consistently working in one place improved their clinical care because of easier access to materials (e.g., books, handouts).

Work-life balance.: Some participants reported better work-life balance when using TMH. These providers discussed the value of eliminating their commute, fewer workday distractions from co-workers, and being able to take midday breaks from work for exercise or chores.

Disadvantages of Telemental Health

Therapeutic Process

Privacy.: Many providers expressed concerns that TMH sessions are less private than in-person care. Providers reported that patients frequently did not use a private space for sessions. Many described instances when patients would not openly discuss certain issues because they were afraid of being overheard, as well as times when patients discussed sensitive issues in front of family members. Providers indicated that only a minority of patients expressed concern about the security of TMH platforms.

Distractibility – Patient/Provider.: Many providers commented on their patients being distracted during TMH sessions partly owing to notifications on the screen and partly owing to the more casual feel of TMH sessions. Common distractions included on-screen notifications (e.g., text messages, emails) and patients engaging in other activities during session (e.g., cooking, laundry). Providers also commented that they too were more likely to be distracted when conducting TMH sessions as compared to in-person sessions (e.g., viewing email alerts).

Limited Visual Cues.: Most providers discussed difficulty conducting mental status exams and noticing nonverbal cues or changes in physique via TMH. Providers discussed the value of in-person sessions for assessing weight for patients with eating disorders and identifying self-harm. Some providers reported that they were more likely to miss subtle nonverbal cues during TMH sessions that help them build rapport and understand symptom severity.

Risk Management.: Most providers reported that they felt it was more difficult to manage patient risk via TMH. Providers noted that they would have less support if they needed to section a patient remotely and that the logistics would be more complicated. Additionally, providers reported concern about the internet failing or patients actively choosing to end sessions during risk assessments. Providers also expressed concern about not knowing a patient's location in the event of an emergency.

Technology Issues

Consistent connectivity.: Providers' biggest technology-related concern was sound or video cutting out or lagging during sessions. Providers commented on the negative impact this can have on rapport and progress in session, and described instances of this happening while patients were talking about highly sensitive issues like trauma or risk.

File sharing.: Many providers indicated that sharing homework worksheets or other clinical resources was more difficult remotely, as it was hard to identify methods for secure exchange of such resources.

Equity.: While increased access was overwhelmingly reported as an advantage of TMH, some providers reported that inserting technology into therapy produces inequity in access based on technology ownership and literacy. Specifically, they reported that lower socioeconomic status patients may not have appropriate devices, data plans or internet connection to engage in TMH. Similarly, they reported that many older patients may

not have the technological know-how to use video platforms effectively. These providers discussed the need for flexibility to provide care via telephone rather than videocall in these instances.

Provider Wellbeing

Provider Privacy.: A number of providers reported that conducting TMH sessions in their homes felt invasive. Some noted that they did not have a good space for conducting TMH. Other reported that allowing patients to see parts of their homes or hear things like a child crying in the background disclosed information about their personal lives that typically would have remained private.

Professional Connections.: Several providers noted reduced opportunities to connect with colleagues when conducting TMH from home. They described an absence of clinical support such as impromptu case consultations and the ability to get another set of eyes on concerning patients. Providers also discussed the value of popping into a colleague's office to decompress after a difficult session.

Separation of Work and Home.: Several providers indicated that a side effect of the shift to TMH from home has been that they feel less separation between their work lives and home lives. Some providers reported that this negatively impacted their work satisfaction and produced higher compassion fatigue compared to conducting sessions at work.

Quality of Telemental Health Care

High Quality—The majority of providers reported that, while there were advantages and disadvantages, the overall quality of care provided via TMH was the same or slightly better than in-person. Only two providers reported feeling as though the quality of care they could provide via TMH was worse and both attributed this to feeling that the interpersonal richness of the in-person therapy experience could not be replicated via TMH.

Context Matters—When asked about quality of care provided via TMH, many providers commented that it depends on the patient population and type of session. Providers seemed less confident about the quality of TMH care for patients with more severe impairment. Some prescribers reported that medication management was easier to conduct via TMH than therapy. Others reported that TMH may be particularly useful for patients with significant transportation and childcare barriers. Finally, many providers reported that initial sessions with new patients are best done in person, as the nonverbal information collected in these appointments is invaluable.

New Outlook—Many participants reported that they were pleased that the pandemic had opened the door to TMH by forcing them to gain experience. These providers indicated that, prior to COVID-19, both they and their patients assumed that the efficacy and interpersonal richness of treatment would be diminished by TMH, but they have been pleasantly surprised by the advantages of TMH services.

Preferences for Continuation

Hybrid Model—27 of 29 participants expressed that they hope to continue with a hybrid model. The remaining two indicated that they hope to continue using exclusively TMH. Some providers discussed the value of an in-person initial assessment including for patients who would ultimately be treated via TMH. Additionally, many providers indicated that they only plan to use TMH with patients who they consider clinically appropriate (i.e., lower risk, less distractable).

Barriers - Billing—The foremost barrier to continued TMH use was limited insurance reimbursement. Many expressed concern that payers will either stop reimbursing or reimburse at lower rates for TMH once the pandemic ends. Providers stated this would make TMH infeasible.

Barriers - Out-of-state Licensure Restrictions—Providers reported that TMH was more feasible during the pandemic when restrictions on providing care to out-of-state patients were temporarily relaxed. Providers reported that, with these restrictions reinstated, TMH will not offer the same continuity of care. They also discussed feeling frustrated by what seem like arbitrary rules around a patient's location during a virtual session, especially when patients live in closely neighboring states or are students who go home for the summer or adults who travel for work.

Guidance—Many providers reported that offering (and perhaps mandating) TMH training would be helpful, since TMH was typically not incorporated into their graduate training. Providers commented on wanting a handbook of best practices that would offer technical, legal and ethical standards for using TMH. Some indicated that there should be training specific to the technical aspects of working with TMH platforms.

Discussion

This qualitative investigation of providers' perspectives on TMH during the COVID-19 pandemic can serve to guide post-pandemic implementation. Several important takeaways can be drawn from our findings.

Providers Believe TMH Offers High-Quality, Accessible Care and Hope to Keep Using it

Providers overwhelmingly reported that they have found TMH effective and would like to continue using it even after the pandemic is behind us. Consistent with previous literature (Gibson et al., 2011; Jameson et al., 2011; Lindsay et al., 2017; Mayworm et al., 2020; Perle et al., 2014; Simms et al., 2011; Starling & Foley, 2006), increased access and appointment attendance were clear advantages, but there were also a number of advantages related to clinical processes. This suggests TMH could serve to enrich clinical processes even when the majority of care is delivered in-person.

Consistent with previous literature, gaining experience appears to have produced more favorable perspectives toward TMH (Elford et al., 2001; Gibson et al., 2011; Glover et al., 2013; Lindsay et al., 2017). Based on these findings, we would also hypothesize that

implementation of other clinical technologies may be smoother after providers overcome the initial learning curve inherent to adopting new tools.

TMH is Not One-Size-Fits-All

Provider responses clearly indicated that context matters when considering the utility of TMH. Two factors seemed to determine whether providers saw TMH as a good fit for a given patient: (1) appointment type, with some providers noting that in-person appointments would be preferable for initial assessments; and (2) patient type, with many providers noting that certain characteristics such as attentional difficulties, risk concerns and limited technology access/literacy may not be a good fit.

TMH Requires Special Attention to Privacy

Providers consistently commented that it is not possible to achieve the same level of control over privacy via TMH as is offered in a clinician's office. Privacy concerns included patients not having appropriate, private space for sessions and patients viewing TMH as more casual and therefore not prioritizing privacy. These challenges may call for a re-evaluation of service agreements in the context of TMH and discussion of whether it is the provider's responsibility to establish minimum necessary privacy conditions. Privacy concerns also underscore the importance of continuing to offer in-person treatment for certain patients. Offering telehealth rooms in publicly accessible locations with strong internet connectivity (e.g., libraries) could also serve as a successful strategy to ensure privacy and increase access to care; this model has been championed by the Department of Veterans Affairs (*Offering Veterans VA Care Closer to Home*).

TMH May Have Benefits for Provider Wellbeing, but There are Caveats

Providers discussed advantages and disadvantages of TMH with regard to their wellbeing, and organizations would be well-served to consider these when establishing TMH policies. Advantages included removing commute time and the ability to do chores during workday breaks. Disadvantages involved limited work-life separation and fewer professional connections during the workday. To the extent that TMH from home continues to be offered, it is clear that organizations and individuals will have to think proactively and creatively in order to maintain the level of professional community and work-home boundaries required to facilitate strong clinical work and provider wellbeing.

The Future of TMH Implementation will be Impacted by Systems-Level Variables More so than Provider-Level Variables

While providers indicated that they would like to continue using TMH, they reported several systems-level factors that could impact care delivery. Many stated that they could not continue TMH if reimbursement rates change. Similarly, out-of-state licensure restrictions pose difficulty for engaging in TMH. These restrictions may be particularly challenging in geographic locations close to state borders, where many people cross state lines each day and may not live in the state that their provider is licensed in. Sustained adoption of TMH may be heavily impacted by these systems-level variables.

Providers Want More TMH Training

Providers seemed to accept the limited training to date, given rapid implementation driven by the pandemic, but they expressed a desire for increased training moving forward. This includes guidance on ethical and legal topics such as how to manage privacy and risk, how to build alliance via TMH, managing provider distraction in sessions, setting firm boundaries, and navigating technical issues such as sending forms securely. Providers have begun to develop innovative best practices to address these concerns during the unprecedented shift to TMH during the COVID-19 pandemic; professional organizations should draw from this wealth of experience when developing standardized guidelines to inform the future of TMH care.

Limitations

Our study is limited by only including providers from an urban setting with multiple major medical centers, so it is unclear whether findings would generalize to providers in other locations. Additionally, this study was conducted during a second wave of COVID-19. While COVID-19 was the impetus behind widespread adoption of TMH and we hypothesize that insights gained from this situationally-forced implementation can inform continued use, aspects of providers' experiences have likely been colored by the pandemic. Continued evaluation of TMH best practices will be important to ensure we are adequately optimizing for post-pandemic patient and provider needs. Finally, while some providers treated adults and children, our investigation focused primarily on adult patients. Additional considerations may emerge in pediatric populations.

Conclusions

Overall, this study provides rich information that can inform policy and best-practice guidelines to support continued implementation of TMH. Findings indicate that TMH use during the pandemic has positively shifted providers' perspectives, such that providers see many benefits of this modality and expect that TMH is likely to be an important part of their practice moving forward. Findings also suggest that it will be important to institute regulatory policies that support use of TMH (e.g., reimbursement equity), establish guidelines on appropriate use of TMH, and support provider wellbeing when working remotely. Future work should evaluate provider perspectives in other geographic settings and continue to monitor attitudes towards TMH and changes in care delivery models post-pandemic.

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Impact Statement:

This qualitative study evaluated mental health clinicians' attitudes toward telemental health (TMH) after a period of use necessitated by the COVID-19 pandemic. Findings indicate that clinicians see substantial clinical advantages to continuing TMH services post-pandemic. Most clinicians, however, emphasized that some services should still be offered in person and infrastructure to support TMH use—such as professional guidelines and reimbursement equity—will be essential moving forward.

Table 1

Demographic Characteristics

Characteristic	N	%
Age		
<30	2	7.0
30–49	20	68.9
50+	7	24.1
Gender		
Male	7	24.1
Female	22	75.9
Race		
White	23	79.3
Black/African American	1	3.4
Hispanic/Latino	2	6.9
Asian or Pacific Islander Native	2	6.9
Other	1	3.4
English as a first language	28	96.6
Full-time Clinician	25	86.2
Highest Level of Education		
Non-Doctoral Degree (e.g., LMHC, LICSW)	10	34.5
PhD/PsyD/EdD	10	34.5
MD	8	27.6
MD/PhD	1	3.4
Work Setting *		
Academic Medical Center	18	62.1
Primary Care Clinic	1	3.4
University Counseling Center	3	10.3
Private or Group Practice	8	27.6
Other	3	10.3
Nonclinical responsibilities *		
Research	7	24.1
Teaching	5	17.2
Education/Supervision of Trainees	8	27.6
Clinic Administration/Leadership	5	17.2
Administrative	7	24.1
Industry/Consultant	3	10.3
Years Working		
< 1–3 years	6	20.7
3–7 years	9	31.0
More than 7 years	14	48.3

Note.

*Reflects that categories are not mutually exclusive (i.e., participants were instructed to check all that apply).

Table 2

Quotations Illustrating Key Themes

Theme	Example quotations
Advantages of Telemental Health	
Increased Utilization	
Access	"Advantages are that—you know—care is more accessible to certain people who have a hard time with busy schedules, with transportation, with certain types of anxiety. And I've seen actually a couple of patients do really well with engaging with weekly therapy…these are people who have been recommended to do CBT by many doctors in the past for *years* and never engaged because—you know—going to therapy weekly is a lot. And so, they were able to do that [with telehealth]." (MD)
Attendance	"The biggest one is that the no-show rates have plummeted because if I have a patient who forgets their appointment, I call them. And most of the time they're at home and they can just log on to Zoom and we start a little late as opposed to they miss the whole appointment. That's a huge advantage especially in psychiatry, especially for some of our underserved populations, where keeping track of appointments can be really burdensome." (MD)
Activation Energy	"If something heavy is going on, to go to an office and kind of face that, you know, "I have to go in and talk about this thing" or trauma…I think it's less of that if it's over Zoom." (LMHC)
	"Initial remote evaluation diminishes the barrier, I think, for most people to reach out and have an evaluation. The activation energy that it takes to find a clinician that accepts your insurance, and is accepting new patients, and to get the referral process done, and then to book an appointment, and then to get to downtown Boston even during the pandemic, to pay for parking, to get there on time is a huge activation energy it takes to get to treatment." (MD)
Therapeutic Process	
Self-Disclosure	"It was easier to access the really challenging things because [the patient was] alone and so during those times you see them look away from the computer …it was almost like they would be able to fully allow that emotional experience to happen and process it. Where in person, I found people to feel the need to posture or maybe try to be socially appropriate." (PhD)
Clinical Insight	"I think actually seeing people in their own environments, sometimes there's additional information that comes from that…I've seen how nice some people's homes are. I've seen what they enjoy, like gardening, they've e showed me things that they are proud of. I think that's a part of someone's life that we don't get in an office so that's actually been really nice too and it's a part of treatment and it helps me understand what drives this person in a way I couldn't have understood before." (MD)
Patient-Centered	"It's so much easier to just do a 15-minute check on Monday and then check in again on Friday, whereas opposed to maybe a year ago, you'd do just one visit. And I think it's kind of funny – like I have a bunch of patients…like 45 minutes/an hour away, and these days it seems kind of crazy that they would drive all the way to [clinic], park, meet with me for 15 minutes/20 minutes and then go home." (MD)
	"I think in some ways, you could use the platform in a creative way. Like if patients are avoiding tasks, having them work through them in-session—in real time—in a way that wouldn't be possible coming into the office. Or if there's some type of in-home exposure work, that might be part of the therapy. … so I think that's also an advantage that it allows for more of an *in vivo* environment for an intervention that you can't really…I mean, you could *emulate* in the office, but not really have in the same way as being in someone's house." (PhD)
Provider Wellbeing	
Workspace	"When I see patients at [clinic]… I actually have to walk over to a separate building for consult rooms. And, if I need a certain like material or worksheet, I really have to think about it in advance, and sometimes it becomes irrelevant during session, or I actually need something else. And now, with telemedicine, there's a lot more flexibility. If something comes up during a session and I need a certain material or worksheet, it's right there on my computer and I can screenshare with the patient. That's been another huge advantage." (PhD)
Work-Life Balance	"I also find that I myself like that I don't have to—you know—get dressed up every day and fight traffic to get into the office to go see patients. I think it puts me in a more relaxed state in the morning." (PsyD)
	"Working from home, I don't get as interrupted as much, you know, 'cause at work, people are – you know – they'll come by, "oh, can I talk to you for a minute?" Or I'm running to and from meetings, and then you run into people… and not commuting has been good" (MD)

Theme	Example quotations
Disadvantages of Telemental Health	
Therapeutic Process	
Privacy	"I think there are sort of borderline cases where people are pretty comfortable in the room, but they're concerned that like maybe some things they're saying in the room can be overheard, and then there's kind of like background unease around that…it can be hard for me to get clear on how big an impact that's having on the work" (LICSW)
	"Many of my patients have like people walking around in the back, and I'm like 'ah, we're talking about like your childhood sexual abuse, like why is the kid in the room again?... I don't think [these are] purposeful but [they] are just problematic. I think it speaks to the safety of the room." (MD)
Distractibility - Patient	"I'm thinking of the folks… with, uh, ADD and ADHD… there are notifications popping up and …maybe someone without that diagnosis…can sort of ignore a notification and watch it go away [but it is] unbelievably challenging for some of the patients I work with. Um, and so, having the screen where they work and do all those other things being the same screen they're trying to do therapy on can be really, really tough." (PhD)
	"I think the other disadvantage – there's this perception from patients that these are very casual appointments. So, there's this attitude of like 'oh, yeah, sure. I can talk now. That's fine. Let me just put these brownies in the oven,' whereas if you have an appointment on the books – and you have to travel to it – that's not going to get in the way in the same fashion." (MD)
Distractibility - Provider	"[My workplace] put out this suggestion for Zoom etiquette…to try to use that package as closely as possible to human interaction sitting in front of someone – keeping your camera on, trying to stay engaged, trying to not be distracted. We would normally do all of these things if we were sitting in front of a patient. Um, but I think the temptation, if we were on a videocall or even a phone call, with a patient is that you can get distracted, you don't pay as much attention to the person or, what they're saying. So trying to replicate what we would normally do in person via video, I think is another strategy that I've been trying to use." (MD)
Limited Visual Cues	"Patients don't really give you the full story of what's happening, and it's hard to see if they're…controlling what you see on the screen and what you hear. So, I have a patient who I just realized is much more anxious and depressed than they ever let on to me. In our past visits, they've said that they're fine, and I can't get a sense of how they appear because they turn the camera off or point it up to the ceiling…If that person were in my office, I would be able to tell. It wouldn't be as easy to hide how badly they were feeling, or how severe their symptoms were." (MD)
	"I feel like the communication bandwidth is more restricted. You can—I feel like I can—get more emotional information from somebody's posture or body language when I can see more of them" (LICSW)
Risk Management	"If you're sitting with somebody and they may need to be sectioned…that's one of the benefits of working from a hospital where, you know, it's much easier, you know, because you've got security if you need them… You can literally walk them down to the ED. The logistics of sectioning somebody remotely are more complicated." (LICSW)
	"I have one patient who is probably my most severe who I worry a little bit about suicidal ideation and it is a little strange that there's this person I'm responsible for that I've never met and I've only seen on a screen…If something goes wrong, it's a really big deal and that just feels different than someone I've sat with in my office...I think it's just easier, it's, um, the person just feels more real." (PhD)
Technology Issues	
Consistent connectivity	"…the technology glitches make it hard, make you miss seeing people in person because you don't freeze when you're seeing somebody in person and so, you can be at any point in the conversation, you know sensitive subject, and then suddenly somebody's gone." (PsyD)
	"Having a bad connection…is probably *worse* than us not meeting because we're just like freezing, and we can't get anything done." (MD)
File Sharing	"So, even if I emailed them something, an application, and it was a pdf form or a word form. A lot of people printed it out but then they had no way of returning it to me..they couldn't scan it back in." (LCSW)
Equity	"What I also find challenging is like a lot of our patients don't have stable internet access…since a lot of our patients are a little bit lower socioeconomic status, they have issues like, they're either like in car next to the library trying to get Internet or people are like on their cellphone and because they don't have a computer." (MD)
	"I think we're at a place where a lot of people—even if they are financially disadvantaged—might still have smartphones, but that's not always the case, you know? Folks who have flip phones or non-smartphones or they run out of data or, um, they don't have good WiFi." (LICSW)
Provider Wellbeing	

Theme	Example quotations
Provider Privacy	"When I'm in my own house and I'm Zooming with a person…I almost felt that I was being intruded upon. Like you're Zooming into the emergency department, and somebody's staring at you that's really angry, that doesn't want to be evaluated, and I'm in my bedroom." (LMHC)
	"Being on video in each other's homes, there's a level of intrusiveness too, both for the provider and for patients…there's been this loss of neutral territory, that we were afforded in like a clinic-based setting." (MD)
Professional Connections	"I really missed my coworkers, because back when I was at the clinic—our desks were together—and we'd always kind of debrief with each other after sessions. But now, it can be hard because I'll just go from Zoom meeting to Zoom meeting and just really kind of, by myself, sit with whatever I just processed with the patient." (LICSW)
	"[I]t is a little bit more isolating, and it's definitely tough to do this work exclusively from home, without sort of having that - being surrounded by that infrastructure of your colleagues and your institution…the day-to-day of doing this work from my home…it's becoming pretty hard." (PhD)
Separation of Work and Home	"The other thing that comes to mind is the difficulty of separating work from home...there's literally no separation of physical space. I work and then I move a few feet and then that's my down time so hearing about trauma for eight hours a day in my typically safe space, that was a really hard adjustment to make. …I always found the separation, like the psychological weight easier." (PhD)
Quality of Care with Telemental Health	
High Quality	"I think that for the reasons that we kind of discussed – which is like the greater flexibility, more continuity of care, having more ease with which to share materials – I actually feel that [the quality of care has] improved overall which is also something I really wasn't expecting." (PhD)
	"I'd say probably, on average, [the quality of care has] been pretty much the same...there may be circumstances where it's actually *better*… and that may be more just 'cause we've been able to see [patients] more frequently." (MD)
Context Matters	"For example, there's a patient that…I think would probably do better in person because she really struggles with attention. She gets really distracted by things going on in her home. But, at the same time, if I was seeing her in person, I wouldn't be seeing her as frequently. So, I think it's mixed. I do think that would be something to think about – like how we ensure that a patient is a good fit for telehealth and that they wouldn't be a better fit for in-person treatment." (PhD)
	"It's somewhat individually based (*pause*), I think a broad sweep would be it's the same…worse when someone's in crisis…better for some, access for some has improved…we can meet more frequently." (EdD)
New Outlook	[Regarding views on TMH in the past] "…a lot of providers having a lot of just stigma around it and them seeing that it's so helpful. So, I think that's the biggest thing. And I also think like patients seeing that this is a possibility, that they can do this, that therapy is easier to incorporate into their lives because they have a way of doing it. I think those are huge benefits." (LICSW)
	"I think, going into it, I had the thought that it would be a lot different or awkward or…it just wouldn't work as well as meeting in person…that pretty quickly faded away, and it sort of feels like very similar work or richer work in some ways. So, I think, if anything, I became much more favorability disposed to virtual care…there are a lot of advantages to it that were unknown to me prior to like diving into it head-first." (PhD)
Preferences for Continuation	
Hybrid Model	"I think that it would be best if I always had a hybrid option, for me and also for patients…if there is a patient where it's clinically more appropriate for them to come into the office, I want to be able to offer that…and vice-versa for patients where it's easier for them to be at home…I like the idea of [providers] having options." (LICSW)
Barriers - Billing	"There can't be a difference in reimbursement…because then you're tipping the scale one way or another. Both modalities have to be able to be reimbursed equally...And that determination is up to the clinician – whether that clinician is a social worker, a doctor, a nurse, an NP, whatever. But that's going to be up to the professional organizations and, frankly, the insurance organizations because if they tip the scale one way, people will usually go the way towards where the money is – and organizations do. So that's my fear, is that they will tip the scale towards in-person, and we will lose the people that would've benefited from this. But it should be a clinical decision, just like a medication." (MD)
Barriers - Out-of-State Restrictions	"The other challenge is that folks were practicing across state lines…their patients would be in other states and that was allowed for a while. And then, they rescinded all the emergency licenses." (LICSW)
	"It's a little bit complicated but we're not really supposed to be doing virtual care with people in other states…sometimes the work around is to have them come to the clinic in person." (MD)

Theme	Example quotations
Guidance	"A refresher would be nice as far as the confidentiality and those rules with liability. What if I start talking about something really intimate and someone walks in the room? And the patient – the person I'm talking to isn't okay with it at that moment, but they were okay with it earlier—you know—before they thought that person was home?...Am I liable?…it would be nice to know I think more of the legal stuff as a clinician." (LMHC)
	"It's hard to anticipate what the problems are going to be until you're in it and we know a lot more now. So for training purposes we probably could prepare people." (EdD)

Note. Degree has been included at the end of a quote to give a sense of context