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Provider Perspectives on Delivering Telemental Health Services in Rural North Carolina: Field Report

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Provision of behavioral health care in the United States has long been subject to a range of systemic and structural barriers impacting availability, access, and acceptability, particularly in rural settings. Telehealth is one way to facilitate access and continuity of care for all individuals during the COVID-19 pandemic and beyond. To inform ongoing and future implementation of telehealth, particularly among Hispanic/Latinx rural populations, we gathered provider perspectives from a North Carolina nonprofit organization that provides and advances behavioral health treatment for rural residing Spanish-speaking individuals and families. Providers completed a semistructured interview and repeated qualitative monthly survey on implementation "peaks and valleys" to describe challenges encountered and strategies enacted related to recruitment and accessibility, privacy, data systems and internal infrastructure, therapeutic process, and reimbursement. A rapid qualitative analysis approach was conducted to identify and organize themes across all provider interviews and qualitative surveys. Key themes around telehealth implementation were identified across three main categories: (a) establishing technology-based infrastructure, (b) maintaining provider engagement, and (c) maintaining client engagement. Implications for future telehealth implementation are discussed.

Public Health Significance Statement
Provider perspectives offer important insights on the implementation of telemental health services critical for working in underserved areas. These provider insights can help address the significant shortage of mental health professionals in rural regions. Understanding factors associated with provider burden can increase willingness to embrace technology and innovative approaches, which enhances the overall quality and effectiveness of telemental health services, improving health outcomes for rural communities.

Keywords: Latinx, mental health, telehealth, rural services, provider engagement

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continued

Provision of behavioral health care in the United States has long been subject to a range of systemic and structural factors impacting availability, access, and acceptability. Barriers to treatment are especially pronounced in rural settings and among minoritized populations adversely affected by social determinants of health, such as increased poverty or unemployment. The COVID-19 pandemic exacerbated many of the existing weaknesses in the health care system, prompting the need for innovative methods in service delivery. Telehealth is one way to facilitate utilization and continuity of care to all individuals during the pandemic and beyond (Schroeder et al., 2021).

Rural regions have historically reported a severe shortage of mental health professionals (Thomas et al., 2009). Specialized, trauma-informed care services are even more limited in rural areas, despite rates of interpersonal violence equal to or greater than those in urban areas (Gray et al., 2015). Moreover, there is a well-documented disparity in mental health services available to Hispanic/Latinx populations who need Spanish-speaking providers (Castaño et al., 2007). Indeed, aligning services to be culturally and linguistically appropriate is a critical step in the provision of effective interventions (Gamst et al., 2002).

Providing behavioral health care to those in need of services is further limited by challenges in treatment access. Rural settings have greater poverty, higher rates of unemployment, and lower rates of insurance coverage, all of which restrict residents' ability to travel to and pay for quality health services (Gray et al., 2015). Hispanic/Latinx populations have heightened likelihood to experience these and additional challenges. For example, nearly one in four Latinx individuals resides in poverty (Lewis, 2017). The population has, on average, higher unemployment and uninsured rates than other racial/ethnic groups (Lewis, 2017) and is disproportionately affected by labor market cycles. Recent research identified Hispanic/Latinx as the population most severely impacted by COVID-19 (Couch et al., 2020), resulting in the Hispanic/Latinx unemployment rate becoming the highest of all racial and ethnic groups for the first time in recorded history. Many employed individuals are also essential workers, and limited flexibility in work schedules further amplifies disparities in access to mental health care (Martyr et al., 2019).

Another barrier to service delivery in rural settings is treatment acceptability—whether a client deems treatment to be relevant, helpful, and worthwhile; whether privacy and anonymity can be protected (Gray et al., 2015; Substance Abuse and Mental Health Services Administration (SAMHSA), 2016; Werth et al., 2010); and whether the client can avoid being racially or ethnically marginalized. For example, rural communities might have only one behavioral health specialist, so regular visits in small communities might be difficult to keep private.

Telehealth can facilitate the provision of services by connecting clients to providers from different sites and to behavioral health specialists to whom they otherwise would not have access. This is especially important for Hispanic/Latinx clients in rural areas, who may encounter cultural or language barriers on top of those posed by the geographic location (Couch et al., 2020). Telehealth can ensure access, continuity of care, and, more recently during the COVID-19 pandemic, ensure the safety of clients and providers.

With COVID-19 forcing the rapid, organization-wide shift to telehealth, more providers, administrators, and clients than anticipated were required to quickly adjust to a new way of delivering and receiving care. This offered many opportunities to uncover lessons for the longer term implementation of telehealth. COVID-19 revealed many weaknesses in all aspects of health care, underscored the need for refined telehealth program structures, and highlighted how much more vulnerable our vulnerable populations really are. Given indications that telehealth will continue to be implemented

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postpandemic, broadly, as well as the advantages afforded to rural communities with regard to access and continuity of care, specifically, there is a need for understanding the unique needs of working with Hispanic/Latinx clients presenting to mental health clinics. Also, in the United States, contemporary residential demographics show a growing number of Hispanic/Latinx (from here on referred to as Latinx for consistency) individuals living in rural areas (Warren et al., 2014). This growth outpaces all other racial and ethnic groups (Lichter & Johnson, 2020). Recent articles provide guidelines for working with individuals in telehealth settings (Sugarman & Busch, 2023). In this field report, we describe perspectives from a range of mental health service providers and ancillary staff working with Latinx rural clients in North Carolina using telehealth.

Method

Provider Organization

The study sample includes bilingual Spanish and English mental health providers from a North Carolina nonprofit organization that offers and advances bilingual and culturally informed behavioral health treatment for underserved Spanish-speaking individuals and families throughout the state. Although headquarters are in Durham, NC, El Futuro serves over 30 counties in the state (especially the surrounding counties of Chattham, Granville, Franklin). Many of the individuals served via telehealth described in this report live in rural areas outside the main offices. For this article, rural areas are defined as less than 500 people per square mile (Ratcliffe et al., 2016). El Futuro has built a strong reputation with the Latinx community and allied partner organizations and treats about 2,000 Latinx individuals per year. A large percentage of treated individuals have experienced multiple, profound, or chronic traumatic events, such as abuse or neglect, or have been victims of various forms of crime. El Futuro provides outpatient individual, family, and group therapy; case management services; and individual psychiatry. In 2017, El Futuro began its telemental health program mainly to increase its reach to rural individuals and now refers to this expanded programming as TeleFuturo. TeleFuturo is an integrated hybrid program of technology-based visits and in-person services to meet the needs of rural clients referred from throughout North Carolina. Authors received funding from the National Institutes of Justice in 2019 to conduct a study on telehealth service provision in rural areas. Because of the COVID-19 pandemic stay-in-place orders imposed in the early stage of the grant, the program shifted to all virtual service delivery, and providers and clients implemented/received TeleFuturo programming in their homes.

Provider Participants

Provider participants included eight providers at the community-based organization as well as individuals who were in leadership and administrative roles. We included perspectives from two psychiatrists, two clinical psychologists, and four licensed mental health counselors. Providers were selected based on (a) type of provider/specialty area, (b) some experience with telehealth, (c) considerable experience working with Latinx client populations in rural settings (at least 2 years), (d) bilingual in Spanish and English, and (e) certified in at least one evidence-based intervention.

Provider Interviews

Telehealth service provider interviews were informed by feedback provided by El Futuro leadership. El Futuro's clinical program director provided a list of potential respondents. Recommended respondents included the clinical supervisor and clinic manager and other service providers who represented a variety of perspectives regarding evaluation, program implementation, and data collection and the different intervention types: psychiatry, psychotherapy, case management, youth-focused, and adult-focused. Interviews were conducted via Zoom and spanned 30 min to 1 hr in length. Respondents answered questions about their role in the organization, responsibilities around data collection and documentation, treatment services provided, barriers and facilitators of using telehealth services, and evidence-based practices delivered.

Select program staff also completed a form on implementation "Peaks and Valleys" to provide qualitative monthly information on telehealth challenges encountered, and strategies enacted, in

relation to the following categories of telehealth implementation: recruitment and accessibility, privacy, data systems and internal infrastructure, therapeutic process, and finances. "Peaks and Valleys" forms were completed monthly from September 2019 to July 2021 during clinical supervision meetings. Structured monitoring and feedback from partners on a monthly basis allowed a more regular bidirectional exchange of information across several areas beyond information captured in "snapshots" from the interviews.

Procedure

The clinical program director first emailed potential participants among staff to notify them of the purpose and timeline of interviews. Follow-up emails were sent to schedule one-on-one interviews. Prior to the start of each interview, we received verbal consent from each participant. Interviewers noted that participation in the interview was voluntary, and refusal to participate would not impact their employment. Interviews were conducted between June 2020 and September 2021.

Qualitative Data Analysis

The coding team used a rapid qualitative analysis approach (Hamilton, 2013) to identify and organize themes across the seven telehealth service provider interviews. To begin, the lead coder developed a transcript summary template containing domains addressed in the interviews. All four coders on the team used the template to independently summarize the detailed notes from one interview, sorting interview topics and notes into the various domains. The team met to compare and discuss their results, and the template was revised and annotated to ensure greater consensus across coders moving forward. The team repeated this process with a second set of notes. After this second and final test of the template, the coders' summaries were added to a matrix to facilitate an examination of the content in the domains across all coders. The remaining five interviews were then divided among the team members for individual summarizing. Once all interviews were summarized, the remaining summaries were added to the matrix. At this point, we obtained transcripts for each interview. Using the matrix, the coding team engaged in an iterative process, reading through the domains across all interviews to identify additional, cross-cutting themes and to develop analytic memos. The team exchanged their memos in a quality-checking process and established a final set of themes with supporting evidence in the form of participant quotations.

The team extracted and analyzed qualitative information from the interviews and implementation peaks and valleys forms in a similar fashion. Specifically, data were summarized in a matrix to visualize changes in implementation challenges and strategies over time across the domains. Findings were separated into categories of general implementation and specific to COVID-19.

Results

In what follows, we describe key themes identified across three elements of telehealth implementation: (a) establishing technology-based infrastructure, (b) maintaining provider engagement, and (c) maintaining client engagement. Although many of the results reflect the unique situation created by the COVID-19 pandemic, they have the potential to offer insights on the application of telehealth, in general. Also, although our focus was on working with Latinx population, many insights are relevant to working with clients in general as well and not unique to individuals who identify as Latinx.

Establishing Technology-Based Infrastructure

Implementing telehealth requires establishing a technology-based infrastructure to allow clients and providers in remote locations to connect and communicate clearly and securely. One of the benefits of telehealth, particularly for clients in rural areas, is that it eliminates the need to travel—sometimes great distances—to receive care. However, access to the needed technology can pose a challenge for some low-bandwidth clients, and internet connectivity has historically been an issue in many rural areas like those served by El Futuro (Gray et al., 2015; Hirko et al., 2020). Consistent with the literature on telehealth (Gray et al., 2015), one of the most common barriers for clients and providers at the beginning of program implementation was limited internet

connectivity and access to technology. The pandemic amplified connectivity issues as multiple household members, observing social-distancing/shelter-in-place guidance, competed for internet bandwidth. Issues with internet connectivity presented challenges not only with clients being able to access appointments but also with providers and clients being able to complete a therapy session uninterrupted. As one therapist described it,

> The technological interactions can really impact the treatment because if the technology goes down and you just can't get reconnected, that's a disruption in the treatment. I mean, and that always, it will happen, it happens to every client, and it happens to every clinician at least once.

To mitigate some of the issues associated with these new telehealth modality challenges, providers and leadership stressed that a clinical practice must have adequate administrative staff trained in the use of the selected telehealth technology and able to support clients and providers in using the technology. When asked for their advice on establishing a telehealth program, one participant highlighted the importance of having "a dedicated team to just help with the logistics, to help the client be able to connect so that you don't put that stress on the clinician," adding that "the clinician is already stressed enough with the clinical visit." This recommendation extended to satellite offices, where clients may come into the office to connect with a remote clinician. According to one therapist,

> It would be really nice to have somebody, and someone that's just there and available and accessible if there's an emergency, and not somebody that's kind of running around doing another job with this, like, tacked on to their other responsibilities.

Ongoing Training

The adoption and customization of data systems and infrastructures (e.g., Zoom, file sharing services) brought along associated technological issues that were addressed successfully via one-on-one trainings, video tutorials, and troubleshooting with the software's support team as needed. Moreover, providers were given support, including new training, appropriate policy updates, and sufficient equipment to successfully conduct telehealth from various locations. As the COVID-19 pandemic wore on, the organization attempted to address some client connectivity issues by offering clients the option to park their cars near the organization's main office and connect to the organization's wireless internet for their teletherapy sessions. A main recommendation from providers was the availability of ongoing training with platform used as updates occur. Ongoing training to ensure the intersection of technological and clinical competencies is also key.

Maintaining Provider Engagement

The interviews revealed that conducting therapy via video or phone requires providers to develop new technological skills, therapeutic techniques, and protocols, particularly for gaining trust and ensuring remote clients' privacy and safety. An underlying challenge cited by providers in the early stages of telehealth implementation centered on establishing and maintaining rapport with clients over video. This challenge was less pronounced among providers with more experience with telehealth and lessened as providers became more comfortable with the technology. The virtual environment limited clinicians' abilities to make eye contact with clients or monitor subtle, nonverbal cues. According to one provider, "If I talk to the camera then I also can't—I want to maintain that eye contact and not look over at my screen and start typing on the notes." Another provider added, "It's an artificial focus, and so we're looking at people's faces the entire session … it's tough, it's exhausting for the clinician to be that focused for that long for that many clients in a row." Providers also had to adjust to not being able to easily see the small movements of clients on which they routinely rely for additional information. In the absence of information typically provided by body language, one observed, "I think we're all getting a little bit more used to how do you judge facial expressions." Moreover, some therapeutic techniques had to be adapted for telehealth, or—in the case of some practices, like creative arts or eye movement desensitization and reprocessing—abandoned altogether. One unique stressor of the pandemic was the lack of time therapists were given to build these skills and processes before being thrust into teletherapy delivery. One provider observed, "we are basically getting certified in telehealth while we're doing it," adding that "we are overhauling our entire skillset

to become a different kind of clinician because we have to."

Some aspects of treatment, such as medication checks, were reported to be easier with telehealth since it allows clients easy access to their medications when they are home. However, other aspects are more difficult; for example, unless clients have specific equipment at home, providers are not able to check vital signs. Some of the providers interviewed shared that teletherapy was more time-consuming because of the additional preparation required for each session and the additional communication with satellite clinics and clients between sessions. The ability to have additional communication with clients was viewed as both a positive and a negative. While more time-consuming, it also permitted efficient sharing of resources and follow-up. Some of the providers also acknowledged that client treatment itself could take more time via teletherapy. For children, especially, treating trauma was thought to take additional time via telehealth. One provider expressed concerns about being able to adequately address the safety needs of clients who were remote, saying,

> Whereas we have protocols for managing suicidality in the clinic and that involves involuntary commitment and doing safety planning and all those things, it's a little bit precarious to have your client out in the world and you know they're having these thoughts. … It's just a different sensation of, I can't maintain the same level of safety of my clients as I could when I was seeing them regularly in the clinic.

Some of the approaches the providers used to address the challenges they encountered with telehealth included taking time in advance of sessions to prepare materials and activities suitable for virtual use and pinpointing the key components of different therapeutic models that can be delivered via telehealth. The providers we interviewed further recommended that therapists should have plans in place with clients for any issues that arise with connectivity during a session, and they should have a dedicated workspace at home. This point is specific to working during the COVID-19 pandemic. Initially, we proposed telehealth service provision in a designated telehealth space within the clinic. Considering the capacity that has been built by therapists providing TeleFuturo and those across the nation responding to the pandemic, this is still strongly recommended to ensure the privacy needed by victims of crimes specifically but also all telehealth clients in general.

Reimbursements

In addition to establishing a telehealth infrastructure through software and data systems, El Futuro had to adjust its billing process multiple times over the course of the pandemic to reflect changes to federal and state reimbursement policies. In many ways, COVID-19 era changes to expand Medicare/Medicaid eligibility of telehealth appointments helped to mitigate one of the most frequently cited challenges of telehealth provision: lack of insurance reimbursement (e.g., Brophy, 2017; Lin et al., 2021). However, partners noted the challenge of keeping up with rapid changes to Medicaid and telehealth reimbursement, as well as the people power needed to research and test current procedural terminology codes. At times, superbills/current procedural terminology codes were denied due to inconsistencies between managed care organizations' internal processes and Department of Health and Human Services regulations, which required multiple phone calls to managed care organization representatives to resolve issues. With the broadening of what was considered reimbursable, telehealth became much more widely available to clients and providers. During our interviews, participants voiced concern about the future of telehealth reimbursement policy and the effects on the organization's services. In response to this uncertainty, El Futuro planned multiple reentry paths to navigate a possible extension of billing codes or a return to prepandemic functioning. Since the public health emergency has been lifted (May 2023), many of the flexibilities allowed during the pandemic will remain in place until December 21, 2024.

Maintaining Client Engagement

Providers shared their perspectives on clients' receptivity to telehealth. Despite barriers, the organization saw a more than 40% increase in appointments in the 18 months following the unexpected transition to offering only telehealth appointments. Some clients responded better to or preferred telehealth, while others found it less desirable or unworkable. According to one provider, survey data in the early months of the pandemic (April 2020) showed that most people preferred to be seen in person, but about 15%–20% preferred video appointments. These

differences appeared related to multiple factors, including the client's age, diagnosis, and privacy concerns. As more in-person options became available (April 2022), about 40% of clients preferred video appointments for factors not related to the pandemic.

Client age was related to quality and accessibility of sessions conducted by video at both ends of the client age spectrum. Multiple therapists described the additional work required to engage children and adolescents in teletherapy. Therapists had to adapt to children's shorter attention spans, limits on which therapeutic techniques and materials (e.g., games, drawings) could easily be used in a virtual appointment, the challenge of trying to engage parents/guardians in virtual sessions, and children's general lack of familiarity with the medium. More than one therapist commented that children and youth also seemed particularly distracted by their own image during video calls.

At the other end of the age spectrum, therapists struggled at times to help older clients connect to teletherapy and feel confident and comfortable using the technology. One therapist observed that for older clients, teletherapy seemed like a "much more isolating experience as opposed to kind of like a cathartic experience." This therapist found the lack of physical connection (e.g., passing a tissue box or holding the client's hand) particularly difficult with older clients and took extra care to build rapport with them in other ways, like asking about their interests. However, one provider noted that "one plus I would say for older adults is that it's been easier for me to get collateral information from family members that are in the house," family members who would not typically be accessible during in-person visits.

Another factor that contributed to telehealth use and outcomes was client diagnosis. Therapists found that for some clients, like those with autism, teletherapy was preferable. For others, like clients with attention-deficit/hyperactivity disorder or those who experience paranoia, telehealth was more difficult. "Clients with psychosis might be more evasive, so you spend a lot more time like, not even assessing, but trying to engage," commented one therapist.

Moreover, clients had varying levels of privacy-related concerns. Particularly during the pandemic, when clients were frequently sharing space with family members, finding a private space to attend appointments, and keeping the nature of the appointment confidential could be difficult. Therapists occasionally had to encourage clients to find a private place in which to conduct their appointments. This was a more pressing concern for clients who already felt unsafe at home. Providers speculated that privacy was also a particular concern for a portion of clients who were un- or underdocumented. "They might be a little concerned about using the phone for a video appointment and, like, who knows where my information is going or am I being recorded," said one therapist. For this reason, therapists suspect some clients preferred phone-only appointments. When these concerns surfaced, therapists took extra care to reassure clients about the steps being taken to protect their confidentiality. This was different than the use of audio due to low bandwidth. During the later stages of the pandemic, the organization also began opening their building 1 day per week to allow interested clients to join telehealth appointments with remote therapists from inside the rural site offices. One participant shared,

> They can come in and we connect them to their clinician that's still at home … because, especially for victims of crime, we've noticed that they—it's not comfortable or even safe for them to be at home having these conversations.

This in-clinic option presumably helped to address some of the clients' concerns with privacy and issues with connectivity.

Despite these challenges, therapists remarked that some clients responded better to or preferred telehealth, and, for all clients, teletherapy during the pandemic was better than the alternative of no therapy. As one therapist reflected,

> Our office is closed, we have to do it over video, so best quality of care is video versus nothing of course … but, if there were all the options available, I still think that for some clients best quality of care might be video.

One therapist whose role consists mainly of telehealth provision observed,

> There are some challenges with telehealth, but once we get past the kind of initial, like just getting comfortable with the technology and get to know each other, I don't think it makes a difference in the rapport or in the treatment.

In addition to helping to troubleshoot or respond to emergent issues, administrative staff were viewed as essential in orienting clients to the

telehealth process and the technology prior to their joining a session with a therapist. At satellite offices,

> They're kind of providing that warm handoff to the therapist, but also providing some education about what the session is going to be like … it's just so, so important that someone is there, and a warm body, to kind of make, help with that bridge to the therapist.

One therapist said. In providing this presession education, the administrative staff person helps to ensure that the therapist and client can "get right to the session," without having to spend as much time orienting to the technology. As with in-person service delivery, administrative staff continued to be instrumental in ensuring that clients scheduled and attended telehealth appointments.

In general, teletherapy allowed some clients to overcome regular barriers to care, such as transportation issues, work and school conflicts, lack of childcare, and even confidentiality concerns. For clients without a driver's license, for example, or for those who lived at a great distance or were nervous about receiving therapy from a provider in their own close-knit, rural community, telehealth was preferable. Although some clients may have encountered more challenges adapting to telehealth, for the most part, clients routinely showed up for appointments and engaged in treatment. One provider we interviewed expressed how impressed they were by "how disclosing and seemingly honest people are with their symptoms," noting that after the first interview, clients generally seemed comfortable with the format.

Discussion

The United States has slowly transitioned back to in-person care, but many clients in rural settings will continue to have issues accessing a range of mental health services. Many of the insights shared by providers have implications for next steps beyond the pandemic. Organizations should continue to map the needs of providers delivering technology-based services and support needed to keep their clients safe while ensuring their privacy and promoting positive change in their lives. Most of these recommendations are actionable and specific to working with Latinx clients but certainly apply to other client populations.

Using telehealth has multiple impacts on providers. Trying to engage clients over video is often difficult and a burden on already-taxed providers. It can be difficult to establish therapeutic alliance with new clients with no in-person interaction. Providers have concerns about missing nonverbal cues that would be more easily noticed during in-person visits. Telehealth limits the types of modalities providers can use, and they would benefit from a better understanding of which modalities work best for telehealth and which are not appropriate for use in telehealth. Some aspects of treatment, such as medication checks, are easier with telehealth since it allows clients easy access to their medications when they are home. However, other aspects are more difficult, such as speaking with other family members (when relevant), and unless clients have specific equipment at home, providers are not able to check vital signs. Telehealth requires providers to develop new skills, new techniques, and safety protocols. It may help to have a dedicated workspace that mimics the therapeutic environment. Providers also need to increase their technical troubleshooting skills to assist clients when needed. Extra work is required of providers outside of sessions to prepare materials in advance and communicate more frequently with clients. To mitigate some of the issues associated with these new challenges, providers need support, including new training, appropriate policy updates, support staff to assist with scheduling and technology issues, and sufficient technological skills and equipment to successfully conduct telehealth from various locations.

Ideally, telehealth programs should be developed intentionally, with input from clinicians and other providers who routinely work in rural areas, careful consideration of the needed infrastructure, and with the client population's specific needs and capacity in mind. All staff, providers, administrators, and technology support staff should receive thorough and continued training in the organization's systems and protocols so that, as one participant asserted, "all your team is following the same, so the client is getting the same experience no matter who they talk to." Providers stressed that the client experience must mimic the in-person experience to the extent possible, and clients should be provided a thorough introduction to teletherapy and planful aftercare. Clinicians should be

provided with high-quality equipment, training on videoconferencing and various therapeutic models that are more effective for telehealth, and guidance on how to adapt their workflows and toolkits for virtual appointments. And although clinicians might not share physical space with each other when delivering telehealth, there is still a strong need for clinical meetings and consultation, like the ones in the community-based organization we worked with has continued to provide its staff. These meetings serve as opportunities for clinicians to share ideas with each other and for the organization to examine what is working well with the telehealth program and what may need adjusting. As one provider observed about rural service provision, "Working with victims of crime can be draining emotionally and now you're working alone, you're at home solo all the time." The provider continued, "Operational and clinical discussions, that's key to me, not only to feel like you have the support but that you are like not isolated, no working alone … and also so changes can be implemented in a timely manner."

Limitations

This field report provides valuable insights into provider perspectives for working with Latinx individuals in telehealth settings. Some limitations of this report are noted for readers to consider. First, our sample size of providers was rather small. We selected these providers based on characteristics related to the type of provider (psychiatrist, clinician, counselor), so we had representation of each of the following: (a) specialty area, (b) some experience with telehealth, (c) considerable experience working with Latinx client populations and in rural settings (at least 2 years), (d) bilingual in Spanish and English, and (e) certified in at least one evidence-based intervention. A limitation to consider is the possibility that different perspectives would have emerged with providers with less experience in any of these areas. Future research should routinely assess provider perspectives to continue to build this area in the scientific literature.

In the past 2 years, the rapid uptake of telehealth service provision has opened many possibilities for reaching rural individuals. Although reimbursement privileges continue to evolve, there is little question that telehealth can circumvent many of the regular barriers to care individuals living in rural settings consistently experience including transportation issues, work and school conflicts, lack of childcare, and even confidentiality concerns. Provider perspectives can inform and refine the implementation of telehealth services to promote the availability, access, and acceptability of behavioral health services for all, including underserved communities (Jensen et al., 2020; Pullen et al., 2021; Saavedra et al., 2019; Shreck et al., 2020). These findings can help to facilitate and support telehealth implementation in underserved communities to promote the availability, access, and acceptability of behavioral health services for all during the pandemic and beyond. Future research should incorporate both a client and provider perspective into telehealth models to attend to the burden and challenges providers experience. In our experience, this facilitated capacity building and comfort with the modality that ultimately enhances the experience for clients, which would not have feasible in-person options due to rural residence.

References

Brophy, P. D. (2017). Overview on the challenges and benefits of using telehealth tools in a pediatric population. *Advances in Chronic Kidney Disease*, *24*(1), 17–21. https://doi.org/10.1053/j.ackd.2016.12.003

Castaño, M. T., Biever, J. L., González, C. G., & Anderson, K. B. (2007). Challenges of providing mental health services in Spanish. *Professional Psychology, Research and Practice*, *38*(6), 667–673. https://doi.org/10.1037/0735-7028.38.6.667

Couch, K. A., Fairlie, R. W., & Xu, H. (2020). Early evidence of the impacts of COVID-19 on minority unemployment. *Journal of Public Economics*, *192*, Article 104287. https://doi.org/10.1016/j.jpubeco.2020.104287

Gamst, G., Dana, R. H., Aghop, D. K., Arago'n, M., Arellano, L. M., & Kramer, T. (2002). Effects of Latino acculturation and ethnic identity on mental health outcomes. *Hispanic Journal of Behavioral Sciences*, *24*(4), 479–504. https://doi.org/10.1177/0739986302238216

Gray, M. J., Hassija, C. M., Jaconis, M., Barrett, C., Zheng, P., Steinmetz, S., & James, T. (2015). Provision of evidence-based therapies to rural survivors of domestic violence and sexual assault via telehealth: Treatment outcomes and clinical training benefits. *Training and Education in*

Professional Psychology, *9*(3), 235–241. https://doi.org/10.1037/tep0000083

Hamilton, A. (2013). *Qualitative methods in rapid turn-around health services research*. VA HSR&D National Cyberseminar Series: Spotlight on Women's Health. https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/video_archive.cfm?SessionID=780

Hirko, K. A., Kerver, J. M., Ford, S., Szafranski, C., Beckett, J., Kitchen, C., & Wendling, A. L. (2020). Telehealth in response to the COVID-19 pandemic: Implications for rural health disparities. *Journal of the American Medical Informatics Association*, *27*(11), 1816–1818. https://doi.org/10.1093/jamia/ocaa156

Jensen, E. J., Wieling, E., & Mendenhall, T. (2020). A phenomenological study of clinicians' perspectives on barriers to rural mental health care. *Rural Mental Health*, *44*(1), 51–61. https://doi.org/10.1037/rmh0000125

Lewis, M. L. (2017). Rural healthcare access for Hispanics in the United States: Barriers and possible solutions. *Sincronía*, *21*, 297–311.

Lichter, D. T., & Johnson, K. M. (2020). A demographic lifeline? Immigration and Hispanic population growth in rural America. *Population Research and Policy Review*, *39*(5), 785–803. https://doi.org/10.1007/s11113-020-09605-8

Lin, Y., Monnette, A., & Shi, L. (2021). Effects of medicaid expansion on poverty disparities in health insurance coverage. *International Journal for Equity in Health*, *20*(1), Article 171. https://doi.org/10.1186/s12939-021-01486-3

Martyr, M. A., Kivlighan, D. M., III, & Ali, S. R. (2019). The role of telepsychology training clinics in addressing health disparities with rural Latinx immigrant communities. *Translational Issues in Psychological Science*, *5*(4), 346–354. https://doi.org/10.1037/tps0000208

Pullen, S. J., Horgan, L., Romanelli, L. H., Radin, A., Gardner, K., Edwards, C., Crapo, T., Bolen, B., Huck, B., Wells, K., & Lochman, J. (2021). The effectiveness of training rural mental health clinicians to treat disruptive behavior disorders. *Rural Mental Health*, *45*(4), 288–296. https://doi.org/10.1037/rmh0000173

Ratcliffe, M., Burd, C., Holder, K., & Fields, A. (2016). *Defining rural at the U.S. Census Bureau*. ACSGEO-1. U.S. Census Bureau.

Saavedra, L. M., Morgan-Lopez, A. A., Yaros, A. C., Buben, A., & Trudeau, J. V. (2019). *Provider resistance to evidence-based practice in schools: Why it happens and how to plan for it in evaluations*. RTI Press. https://doi.org/10.3768/rtipress.2019.rb.0020.1905

Schroeder, S., Roberts, H., Heitkamp, T., Clarke, B., Gotham, H. J., & Franta, E. (2021). Rural mental health care during a global health pandemic: Addressing and supporting the rapid transition to tele-mental health. *Rural Mental Health*, *45*(1), 1–13. https://doi.org/10.1037/rmh0000169

Shreck, E., Nehrig, N., Schneider, J. A., Palfrey, A., Buckley, J., Jordan, B., Ashkenazi, S., Wash, L., Baer, A. L., & Chen, C. K. (2020). Barriers and facilitators to implementing a U.S. Department of Veterans Affairs Telemental Health (TMH) program for rural veterans. *Rural Mental Health*, *44*(1), 1–15. https://doi.org/10.1037/rmh0000129

Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). Rural behavioral health: Telehealth challenges and opportunities (SMA16-4989). *In Brief*, *9*(2), 1–13. https://store.samhsa.gov/product/In-Brief-Rural-Behavioral-Health-Telehealth-Challenges-and-Opportunities/SMA16-4989

Sugarman, D. E., & Busch, A. B. (2023). Telemental health for clinical assessment and treatment. *The BMJ*, *380*, Article e072398. https://doi.org/10.1136/bmj-2022-072398

Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services*, *60*(10), 1323–1328. https://doi.org/10.1176/ps.2009.60.10.1323

Warren, J. C., Smalley, B., Rimando, M., & Barefoot, K. N. (2014). Rural minority health: Race, ethnicity, and sexual orientation. In J. C. Warren & K. B. Smalley (Eds.), *Rural public health: Best practices and preventive models* (pp. 203–225). Springer. https://doi.org/10.1891/9780826108951.0014

Werth, J. L., Jr., Hastings, S. L., & Riding-Malon, R. (2010). Ethical challenges of practicing in rural areas. *Journal of Clinical Psychology*, *66*(5), 537–548. https://doi.org/10.1002/jclp.20681

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