

# **Maintaining Client Satisfaction in Behavioral Health Services During COVID-19: Practice Implications for Telehealth**

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## **ABSTRACT**

Rural regions in the U.S. designated as medically underserved areas (MUAs) face disadvantages in accessing healthcare due to the lack of facilities and practitioners compared to more populated urbanized regions. In these MUAs, there is a critical need to continue care for individuals who are currently in treatment, at higher risk of relapse and crisis, and at a geographic disadvantage when seeking health care and behavioral health care services. Given the importance of service continuity, this study examined client satisfaction with telehealth services among clients formerly accessing in-person behavioral health care services in a rural community during the early transitions to telehealth service delivery due to COVID-19. Descriptive statistics, tests of association, and t-tests were used to compare satisfaction among clients formerly utilizing face-to-face services. Survey respondents included 100 clients (43 males and 57 females) at two Southwestern Pennsylvania behavioral health provider program locations who were actively accessing in-person behavioral health services pre-COVID-19 and then continued care via telehealth when COVID-19 precautions prevented clients from in-person sessions. Despite a minority of clients responding that they did not get as much out of telehealth services as they did from face-to-face services ( $N = 13$ ), the level of satisfaction among those who did get as much out of telehealth services ( $N = 87$ ) was substantive ( $\varphi = .48$ ). Findings suggest participants perceived an equitable clinical experience when comparing their past face-to-face behavioral health care services to telehealth.

**Keywords:** client satisfaction; medically underserved area; pandemic; rural; social work

## **INTRODUCTION**

Though COVID-19 has caused disruptions in accessing in-person behavioral health services, it has sparked a surge in telehealth service among clients and practitioners (Lin et al. 2020). Due to COVID-19, restrictions necessitated providers to deploy different modalities for health care delivery such as telehealth - which can include telephonic and real-time video platforms -- in place of in-person interactions. Many behavioral health care service providers and clients were transitioned from in-person to telehealth sessions (Lin 2020; Martins Van Jaarsveld 2020). Use of behavioral telehealth services have also increased due to reports of higher

levels of anxiety due to COVID-related social isolation (Hawari et al. 2021). Due to COVID-19 restrictions, some specialized needs populations, including older adults with higher rates of health problems, were encouraged to avoid areas that were indoors or where groups would congregate such as doctor's offices, hospitals, and mental health treatment facilities due to COVID-19 transmission concerns.

For some telehealth users, it can be a seamless adoption of existing home technology that can result in the ease of efficient and timely access to one's health provider. Reed (2020) has shown that for some clients in rural environments, telehealth has reduced their

commute time to a doctor's office or clinic. Through phone-based and video-based telehealth provision, clients currently in treatment, at a higher risk of relapse and crisis, or at a geographic disadvantage when seeking behavioral health care services could experience a continuity of accessing their services. Telehealth has demonstrated its ability to reach areas experiencing access disparities in need of healthcare (Dearinger 2020), and thus may prompt some to adopt this modality permanently.

The rapid adoption of telehealth in recent studies has shown to provide quality client care comparable to the in-person modality for rural and remote emergency rooms in hospitals (Germain and Yong 2020). Client satisfaction survey results may be used as an indicator to assess the perception of services of providers and their affiliated organizations. However, there remains the need to expand on the perspective of clients and patients in their experiences of telehealth services as influenced by COVID-19.

### **Distinct Health Needs Within Rural Communities**

Rurality is defined to be any population, housing, or territory not in the urban area (U.S. Census Bureau 2021). Inequities in rural areas present distinct hurdles to the health and well-being for rural populations (Henning-Smith 2020). In some rural communities, human service agencies may feel obligated to help residents obtain basic living needs including food supports, weatherization and energy assistance, housing supports, job training, childcare assistance, child welfare assistance, and home visitation programs (Hirko et al. 2020; Rural Health Institute 2021). Rural areas also experience challenges when accessing reliable, fast, and consistent online connectivity (Henning-Smith 2020; Nolan et al. 2017). The underdevelopment of this needed infrastructure then contributes to reduced awareness and disparate use of telehealth since reliable internet is needed to support similar internet-based activities (Drake et al. 2019).

Many U.S. rural towns are characterized by unique circumstances that can negatively influence their access to health care services. Families and children in rural regions of the U.S. often face more disadvantages to

accessing healthcare than higher populated urbanized regions due to the lack of available facilities and practitioners. Many disadvantaged rural spaces have been designated by the U.S. Health Resources and Service Administration (HRSA) as “medically-underserved areas” (MUAs) (Batsis et al. 2019). As of 2020, there are 1,960 MUAs in the United States. Nationally, there are over 14 million people living in a medically underserved area. There are also areas known as health professional shortage areas (HPSA) which are areas that do not have enough medical professionals, such as dentists, mental health professionals, and primary care physicians. Nationally, a total of 82 million people reside among 7,241 HPSA designated areas where there remains a need for 14,854 health care practitioners, 6,561 mental health care practitioners, and 10,801 dental health care practitioners (Bureau of Health Workforce et al. 2021). According to Malayala et al. (2021), HPSA's experiences of shortages continue to worsen as recruitment of more physicians have been lacking.

### **Telehealth Challenges Faced by Older Adults Due to COVID-19**

COVID-19 has negatively impacted healthcare access specifically for rural older adults (Lam et al. 2020; Geerlings et al. 2018). A recent cross-sectional study of participants ages 65 or older discovered that 40% of the aging population in this study (N = 4,525), were not prepared for telehealth (Lam et al. 2020). Within rural communities, older adults are particularly vulnerable to inequalities due to limited internet connectivity, a lack of accessible Wi-Fi, and poor video bandwidth. Difficulties stemming from age-related needs including reductions in range of hearing, speech, and visual acuity, in addition to the lack of internet-enabled devices and services such as email, texting, or web browsing were the most common problems for the aging community in regard to telehealth use (Lam et al. 2021; Blanford et al. 2020; Beaunoyer et al. 2020). This “digital divide,” between rural and urban geographies experience social and economic determinants differently. For older adults who are not digital natives, they may experience these obstacles differently with the impact within rural and medically underserved areas as

more substantial (Clare 2021; Blanford et al. 2020; Beauvoyet et al. 2020).

### **Telehealth and Clients' Satisfaction**

The influence of COVID-19 offers a renewed context to measure client satisfaction for behavioral health services. For some, COVID-19 meant rapid adoption of telehealth where continuity-of-care was not synonymous with quality-of-care. However, telehealth could also mean effective communication from primary and behavioral healthcare, the satisfaction of patients, and the engagement process between the staff and the client (Clare 2021). In another recent study by Bilomoria and colleagues (2021) client experiences were assessed pre-pandemic and post-pandemic and examined how likely the patient was to recommend (1) "the clinic for care" and (2) "the provider." The study compared client experiences for individuals who had telehealth visits between November 1, 2019 – March 16, 2020, and two comparison groups: (1) individuals who has in person visits pre-COVID-19 and (2) individuals who has in-person visits between March 17, 2020 – April 28, 2020. This study found that both in-person and telehealth visit scores during the COVID-19 pandemic were significantly higher in satisfaction rates than pre-COVID-19 in-person visits. In other studies, patients and nurses who utilized telehealth were also satisfied and several health subspecialty fields were willing to adopt telehealth as a service modality (Batsis et al. 2019; Andrews et al. 2020).

Given the challenges to continue to deliver quality health care, and particularly behavioral health care, among rural client populations, client satisfaction remains an area of interest as it may serve as an indicator of service engagement and client outcomes. Thus, this study sought to examine the levels of behavioral health service satisfaction among a cohort of clients who were transitioned into a telehealth service delivery model as a necessity due to COVID-19 precautions. It was hypothesized that older clients may experience lower levels of satisfaction, and also hypothesized that clients previously in face-to-face services would be more satisfied with telehealth services.

## **METHODS**

This study used a cross-sectional survey design to examine client satisfaction with telehealth services among clients formerly accessing in-person behavioral health care services. Survey respondents included 100 clients (43 males and 57 females) at two clinic locations. This study was approved by the Institutional Review Board at California University of Pennsylvania.

### **Sampling and Survey Participants**

Cluster random sampling was used to select clients to participate in the study. The sampling frame included all active clients from two locations of a Southwestern Pennsylvania behavioral health provider who were receiving in-person behavioral health services pre-COVID-19 and then continued care via telephone or video-based telehealth when COVID-19 precautions prevented clients from attending in-person sessions. 100 clients were invited via email to participate in a satisfaction survey which was administered by an employee of the organization who was not the client's behavioral health provider.

### **Survey Instrument**

The study utilized a 16-item survey that measures clients' perceptions of satisfaction in their receipt of telehealth services in behavioral health, inclusive of phone or video-based modalities. Participants of the study responded to survey questions focused on areas of satisfaction such as: overall satisfaction, understanding of telehealth services, comparison of in-person clinical encounters with those via telehealth platforms, and likelihood of recommendation of telehealth services at their provider. Most items used a Likert-scale for participants to select responses such as Very satisfied (5), Somewhat satisfied (4), Neither satisfied or dissatisfied (3), Somewhat dissatisfied (2), and Very dissatisfied (1). Demographic information was collected including age, gender, and location of clinic. The survey was administered from October 22<sup>nd</sup>, 2020 to November 12<sup>th</sup>, 2020, after the clients' transition from in-person services to telehealth services. Verbal informed consent was obtained from all study

participants via phone. For consented study participants, the survey instrument was distributed via email for participants' completion. Participants generally completed the survey within 10 minutes.

Table 1. Demographics of study participants (n=100)

	Total	Median
Gender		
Males	43	
Females	57	
Age (years)		35-44
18 – 34	35	
35 – 44	44	
45 and older	21	

Table 2. Satisfaction level compared to age groups.

Survey question	n	Age (in years)			$\chi^2$	p	$\phi$
		18-34	35-44	45+			
“Please rate your overall level of satisfaction with your telehealth at SITE.”					2.37	.306	NA
Very dissatisfied	0						
Somewhat dissatisfied	0						
Neither satisfied or dissatisfied	0						
Somewhat satisfied	7	1	5	1			
Very satisfied	93	34	39	20			

Note: NA=not applicable

Table 3. Satisfaction level compared to gender.

Survey question	n	Gender		$\chi^2$	p	$\phi$
		Male	Female			
“Please rate your overall level of satisfaction with your telehealth at SITE.”				.614	.433	NA
Very dissatisfied	0					
Somewhat dissatisfied	0					
Neither satisfied or dissatisfied	0					
Somewhat satisfied	7	4	3			
Very satisfied	93	39	54			

NA: Not applicable

Table 4. Satisfaction level compared to levels of clients' perception of services

Survey question	n	“Do you find that you get as much out of telehealth services as you did from your face-to-face services?”		$\chi^2$	<i>p</i>	$\phi$
		Yes	No			
“Please rate your overall level of satisfaction with your telehealth at SITE.”				22.7	<.001	.48
Very dissatisfied	0					
Somewhat dissatisfied	0					
Neither satisfied or dissatisfied	0					
Somewhat satisfied	7	2	5			
Very satisfied	93	85	8			

Table 5. Preference for treatment options by age group comparison

Survey question	n	Age (in years)		$\chi^2$	<i>p</i>	$\phi$
		18-44	45 or older			
“If given the option, would you prefer telehealth or face to face options for treatment?”				1.44	.229	NA
Telehealth	54	40	14			
Face-to-face	44	37	7			

NA: Not applicable

## RESULTS

Descriptive statistics were conducted to identify the characteristics of the study population. Overall, the study population consisted of 43 males and 57 females with a median age range of 35-44 years. There were no statistical differences across study participants' gender and age between the two study sites. Table 1 demonstrates the demographics of clients' age and gender. Satisfaction levels are compared by age and presented in Table 2, and satisfaction levels are compared by gender and presented in Table 3. Finally, Table 4 demonstrates satisfaction levels compared to levels of clients' perception of services, and Table 5 provides clients' preference for treatment option by age group comparisons.

Then,  $\chi^2$  tests of association were conducted to examine for associations between program sites, gender, among age categories, and overall satisfaction with a significance level set at  $p < .05$ . Cramer's V and  $\phi$  were assessed for effect magnitude, when applicable. Independent *t*-tests were conducted to test for mean differences in satisfaction of telehealth overall, comparing in-person with telehealth, and preference between telehealth and in-person between clients aged less than 44 years and 45 years and more.

A  $\chi^2$  test of independence was performed to examine for any association of clients' reported age at each program site, and to examine the proportion of clients' gender at each program site. The relation between these variables were not statistically significant, respectively,  $\chi^2$  (2,  $N = 100$ ) = .788,  $p = .674$ ;  $\chi^2$  (1,  $N = 100$ ) = .001,  $p = .974$ .

Next, a  $\chi^2$  test of independence was performed to examine for any association between overall level of satisfaction with telehealth services and age, and to examine for any relationship between overall level of satisfaction with telehealth services and gender. The relation between these variables were not statistically significant, respectively,  $\chi^2(2, N = 100) = 2.37, p = .306$ ;  $\chi^2(1, N = 100) = .614, p = .433$ . A final  $\chi^2$  test of independence was performed to examine for an association between overall level of satisfaction with telehealth services and whether clients responded “yes” or “no” when surveyed, “*Do you find that you get as much out of telehealth services as you did from your face-to-face services?*” The association between these variables was statistically significant,  $\chi^2(1, N = 100) = 22.7, p < .001$ . Despite a minority of clients responding that they did not get as much out of telehealth services as they did from face-to-face services ( $N = 13$ ), the level of satisfaction among those who did get as much out of telehealth services ( $N = 87$ ) was substantive ( $\phi = .48$ ). Finally, the association between clients’ choice if given the option between telehealth and face-to-face and clients’ age (18 – 44 years, 45 years or more) was not statistically significant,  $\chi^2(1, N = 98) = 1.44, p = .229$ . While 44 clients preferred face-to-face and 54 clients preferred telehealth, it was notable that in both age groups, there was a numerically higher count for telehealth preference compared to face-to-face.

The 79 clients who were between the ages of 18 - 44 years ( $M = 4.92, SD = .367$ ) compared to the 21 clients aged 45 years or more ( $M = 4.95, SD = .218$ ) were not significantly different in their levels of satisfaction  $t(98) = -.448, p = .655$ . The 79 clients who were between the ages of 18 - 44 years ( $M = 1.11, SD = .320$ ) compared to the 21 clients aged 45 years or more ( $M = 1.19, SD = .402$ ) were not significantly different in their response to “*Do you find that you get as much out of telehealth services as you did from your face-to-face services?*”,  $t(98) = -.922, p = .359$ . Finally, clients aged 18 – 44 years ( $M = 1.48, SD = .503$ ) and clients aged 45 years or more ( $M = 1.33, SD = .483$ ) were not significantly different in their response to “*If given the*

*option, would you prefer telehealth or face-to-face options for treatment?*”

## DISCUSSION

Findings from our study suggest that participants perceived an equitable clinical experience when comparing their past face-to-face behavioral health care services to telehealth services following precautions related to COVID-19. In our study, given no significant differences in satisfaction level and comparison between face-to-face and telehealth by age, clinical interpretations and quality of care suggestions are offered. In the case of the program sites in this study, the lack of statistically significant differences suggest that clients are perceiving a level of care commensurate with their in-person experience.

### Importance of Clinical Rapport in the Therapeutic Relationship

Findings from our study suggest a successful perceived transfer of the quality of therapeutic relationship between the practitioners and their clients. One aspect of this study’s host organization is its commitment to developing strong therapeutic rapport with their clients. On-site, the therapeutic relationship with clients had been cultivated and sustained pre-COVID-19 via their in-person services, and then when via telehealth, clients experienced a continuity of care with little to no interruption. Building a therapeutic relationship is a necessary step in the recovery process within behavioral health services, and for this treatment to be productive; therefore, trust is vital (Price 2017). Geller (2020) noted that strong, continuous relationships must have empathetic rapport, genuineness, and trust. Therefore, an individual seeking therapy with their clinician together must establish a sense of mutual safety and stability when taking part in a professional therapeutic relationship. COVID-19 challenged existing therapeutic relationships and clinical rapport and to successfully transfer this relationship across a computer or telephone medium with the additional adherence to care continuity, the necessity of the emotional bond of trust, caring, and respect is critical (Hilty et al. 2013; Gellar 2020).

At our research site, their efforts to ensure client satisfaction and quality of care during COVID-19 behavioral health care delivery required professionals to augment clinical strategies into a virtual space where physicality and depth of space and sound are different. While typical in-person therapy had incorporated the close physical proximity and observations of clients' non-verbal cues and facial affect, telehealth therapies now required clinicians to innovate their strategies to ensure the successful translation of their interpersonal and therapeutic relationship. Some clinical skills to extend the interpersonal relationship via video-based telehealth include maintaining eye contact within the virtual environment which requires a clinician to plan and anticipate clients' needs with a keen sensitivity to the limitation of physical cues. Within a phone-based telehealth session, clinicians can innovate to enhance the role of audio and verbal cues in the telehealth virtual space. For example, utilizing active listening in clinical exchanges which are facilitated through the style of Motivational Interviewing may help encourage more verbal interactions and the experience of an empathetic atmosphere (Nemec et al. 2017). Motivational Interviewing is also geared to help clients reflect on wanted change and to resolve ambivalence, which can also be helpful to continue to engage clients through any indifference and intolerance towards telehealth sessions. Additional strategies for increasing verbal and audible interactions with clients include a combination of summarizing statements, encouraged reflection, and sustaining phrases that are non-judgmental and non-confrontational.

Another important consideration for the delivery of quality telehealth care is the assurance of client dignity. Client dignity is defined as the right to be valued and respected and to be treated ethically. In the context of telehealth, client dignity is an essential feature for practitioners to honor and transmit through the telehealth medium because it extends to the client the opportunity to continue to feel safe and a sense of stability in the therapeutic relationship so that the therapy can thrive (Price 2017). Thus, for a newer modality like telehealth to fulfill a client's clinical needs, the agency's operational goals, and to be perceived at a high satisfaction by the patient, the

importance and influence of a strong therapeutic relationship could not be more underscored.

## CONCLUSION

Telehealth is a service modality that will likely continue for its ease of access, efficiency, and immediacy of care. However, with this increased use, practitioners must also examine whether the quality of care will also be consistent and adjusted for use across a variety of patient population ages, varied levels of treatment motivation, cost, scarcity of technical support, and hearing and visual acuity (Haque 2020; Kruse et al. 2020). For example, possessing the appropriate technology, ensuring patient privacy and security, access to assistive devices for those who require modified devices or assistance with visual and auditory acuity, and building awareness about stress tied to technology use are some of the areas to address. Some technical issues may emerge that may be challenging for some clients. Telehealth also requires professionals to be adequately skilled and prepared to utilize this modality with strategies including supporting the workforce in rapid training, customer care and technical support, and scaling to meet client demand.

Based on the results of this study we concur with Batsis et al. (2019) that participants received an equitable clinical experience when comparing their past face-to-face behavioral health care services to telehealth. While this delivery modality for health and behavioral health treatment has made it possible to deliver care, there remain other concerns and research opportunities. For example, ethical codes for practitioners are not developed for application during a pandemic. Moreover, there are key differences in care delivery between phone-based telehealth, video-based telehealth, and in-person services, and the knowledge base is weak in regard to the delivery services during a pandemic.

Limitations to this study include a small representation within the sample of clients aged 55 years or more. Future studies would encourage more clients of this age group to explore the experiences of telehealth satisfaction. Social desirability may also be a limitation as higher satisfaction scores be due

to society feeling more lenient or more benevolent to health care workers during the pandemic (Bilimoria et al. 2021).

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