

Rapid Conversion to Telemental Health Services in Response to COVID-19: Experiences of Two Outpatient Mental Health Clinics

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Abstract

Background: The COVID-19 pandemic triggered changes across health care systems, with many sectors seeing significant drops in patient visits. Rapid transition to telemental health (TMH) allowed for the continued delivery of mental health care. Although several guidelines and best practices are available for the methodical development of a TMH service, there are few documented procedures on rapidly converting to fully virtualized services. We discuss how two outpatient mental health clinics at the University of Colorado Anschutz Medical Campus rapidly virtualized clinical services during the COVID-19 pandemic.

Methods: All current clinical appointments were converted to virtual, and all new clinical intakes were scheduled as virtual visits starting March 16, 2020. Virtualization included a modified needs assessment, updated clinic procedures, focused patient and staff training on TMH, and increased frequency of team meetings. We conducted a retrospective evaluation of clinic log and electronic health record data to examine the number of appointments and no-shows before and after COVID-19 virtualization.

Results: Virtualization was operational within two business days. Scheduled appointments decreased 10.6% immediately postvirtualization, followed by an increase of 17.8% across the 6 months postvirtualization. No-show rates dropped from 11.9% pre- to 6.8% postvirtualization, leading to a 26.2% increase in completed visits.

Discussion: Rapid virtualization of mental health services can occur effectively. Wider use and acceptance of TMH, especially to patient-homes, is likely in the foreseeable future as health care providers and systems reconceptualize service delivery. Future research must include analyzing the impact such changes make on clinical outcomes and patient visit volumes.

Keywords: telemedicine, telehealth, telepsychiatry, pandemic, behavioral health

Introduction

Access to mental health care services is especially important during public health emergencies, as disasters and mitigation measures can give rise to serious mental health conditions, exacerbate existing ones, and further amplify access to care challenges.^{1,2} The COVID-19 pandemic is an ongoing public health emergency that has triggered significant changes across societies and health care systems, both from the disease itself and the public health response to the pandemic.³

Many sectors of the health care system saw patient visits drop by close to 60% (in-person and telehealth), due to limitations placed on in-person visits, clinical limitations, and patient concerns of potential virus exposure.⁴ While other areas of health care saw dramatic drops in patient visits, the mental health system, despite known access challenges, was well-positioned to maintain the delivery of service through telemental health (TMH).^{5,6}

TMH, defined here as the use of technology to provide synchronous mental health care at a geographic distance, has a broad evidence base for clinical efficacy and mental health systems efficiency.⁷⁻¹¹ Synchronous TMH services have been historically based on providing care from one clinically supported institutional setting (e.g., hospital or clinic) to another.¹² However, recent and rapid evolutions in communications technologies, including the internet and consumer devices, coupled with TMH-friendly regulatory changes, have fostered an expansion of services beyond traditional clinic walls.¹¹

This expansion has been particularly focused on the delivery of care to patient homes, which has a growing evidence base showing its clinical efficacy across an array of mental health

illnesses, patient populations, and ages.^{13–19} In-home TMH is thus gaining acceptance as an alternative to both in-person care and more traditional clinic-based TMH. This increased acceptance and the adaptability of in-home TMH fostered the mental health care community's ability to adapt quickly to the COVID-19 mitigation strategies.

The current public health crisis has led to calls for a digital health revolution²⁰ and this article is intended to enhance the literature about rapid virtualization. While several guidelines and best practices in the literature help guide the methodical development of a TMH service,^{21,22} procedures to rapidly convert a clinic to fully virtualized services, and maintain them, are not as well studied.⁶ This article provides an overview describing how two outpatient mental health clinics, the Johnson Depression Center (JDC) and the Steven A. Cohen Military Family Clinic (Cohen-AMC), at the University of Colorado Anschutz Medical Campus, rapidly virtualized clinical services and workforce operations during the COVID-19 pandemic.

We briefly describe the steps taken to convert to virtual services, provide pre- and post-COVID data of our service delivery, discuss lessons learned from virtualization, and consider future operational issues such as hybrid in-person/TMH services. This article is not intended to detail all aspects of operating procedures²¹ but rather to provide insight into how two clinics rapidly virtualized care and to discuss outcomes of these changes. This rapid virtualization provides important lessons for the field of TMH on how to refine ongoing delivery of TMH within a broader system of care. We focus on the process of virtualization for individual therapy and medication management visits as informed by research and facilitated by regulations and the support of clinic leadership.

Background

The JDC was established in 2009 as an outpatient clinic specializing in the treatment of affective disorders. The JDC completed over 9,500 individual clinical appointments in the last year, with 65% of patients having private insurance and the rest divided between self-pay and Medicare. The Cohen-AMC is part of the national Cohen Veterans Network and was established in 2018 through a partnership with the JDC leadership team. The Cohen-AMC provides outpatient mental health services to post-9/11 Veterans and their families and completed over 2,500 individual clinical appointments in the last year. Leadership of both clinics recognized the value of in-home TMH and actively supported the provision of direct in-home TMH services more than 2 years before COVID-19, with about 15% of all appointments during that time period conducted via telehealth technologies.

Methods

The World Health Organization (WHO) declared COVID-19 a pandemic on March 11, 2020. Discussions to virtualize all clinical services and workforce operations at JDC and Cohen-AMC were initiated on March 13, 2020, and virtualization was started on March 16, 2020. Patients previously scheduled for in-person visits were contacted and informed about the decision to virtualize. New patients were only given the virtual visit option. Rapid conversion also meant that all providers would see patients from their homes, and that all workforce administrative operations would be moved to a virtual workspace. While some administrative and clinical processes continued to evolve, the virtualization of services was operational across the clinics within two business days. As the virtualization of services was available to all patients and the data and lesson learned are intended to improve specific clinic practice, this project was deemed to not be research under US Department of Health and Human Service regulations. *Table 1* provides an overview of the clinical and workforce considerations we used to rapidly virtualize our services.

NEEDS ASSESSMENT

Existing TMH guidelines suggest conducting a needs assessment before initiating TMH services.²² While both clinics had conducted needs assessments before the pandemic, the rapid transition to virtual services did not provide adequate time to implement another full assessment specific to COVID-19 needs. Instead, clinic leadership conducted a modified and quick assessment of anticipated clinical needs and availability of resources.

- *Clinical Services.* Clinical services needed to include initial assessment and in-take, crisis intervention and ongoing individual therapy, medication management, and supported groups across mental health concerns and patient ages.
- *Personnel Resources.* The majority of administrative and clinical staff were experienced with TMH operations. A few clinicians had limited TMH experience but expressed willingness to provide TMH care with existing patients and later to include TMH intake assessments.
- *Technology Needs.* A TMH system for patient care already existed. Additional communication technologies such as forwarding front desk calls to temporary mobile phones were necessary to maintain a virtual "front desk" and interface between patients and the clinic. Later use of a mobile phone app that cloaked staff phone numbers obviated the use of extra phones. Other modifications were determined for receiving faxes and other nonvirtual communications.

Table 1. Key Considerations for Rapid Virtualization of Services

	CLINICAL TELEHEALTH	WORKFORCE VIRTUALIZATION
Overview	Focus on immediate tasks to complete Support what makes sense—do not overcomplicate solutions	
Strategy and protocols	Modify existing clinical protocols—maintain clinical standards Create protocols from existing resources, if needed	Convert existing operating procedures to promote virtual work—focus on what is necessary
Administrative updates	Update clinical workflows, licensure, and regulatory issues Implement communication pathways between clinical and administrative teams	Review administrative processes for teleworking and communication Update clinical processes for billing, scheduling, front desk support, medication refill requests, and prior authorizations
Technical issues	Use HIPAA-compliant solutions as possible Ensure clinical needs can be met including access to EHR Test bandwidth for clinical care Develop communication platforms for clinical consultation	Provide equipment and home setup resources as necessary Develop team communication platforms, preferably web-based Test VPN as needed Ensure appropriate bandwidth
Personnel standards	Evaluate home office as a clinical setting Be mindful of impact of clinical isolation on morale Use technology and flexibility to deliver services that meet patient and provider needs such as “off hour” services	Ensure home office promotes work/life separation Follow telework protocols Be mindful of impact of expanded operational on morale
Patient requirements	Evaluate understanding of virtual care and experience with technology	Provide technical assistance as needed including test calls

EHR, electronic health record; HIPAA, health insurance portability and accountability Act.

- **Clinical Documents.** Secure systems for both clinics were already in place for the safe transmission of patient documents. The Cohen-AMC systems were more systematically integrated into clinic operations before COVID-19, while the JDC had to develop procedures for operational efficiency.
- **Operational Space.** Patient homes were identified as the primary originating site of practice. Provider homes were originally determined as the distant site, with the potential for providers to change locations. All administrative staff were approved by the management for telework assuming work could be completed as expected.
- **Reimbursement and Billing.** New processes were developed to submit weekly logs for insurance reimbursement. Site-specific regulations did not allow for patient credit cards to be kept on file for payments or copayments, nor could payments be taken from remote locations, which created ongoing financial uncertainties.

CONSENTS AND SAFETY PROTOCOLS

The clinics used their existing TMH protocols and modified sections for full virtualization as needed (e.g., lack of in-person communication solutions). Many patients already had signed TMH consents on file; others consented verbally and had their consent documented in the medical record. Patient safety concerns were a specific area of focus, including how to maintain intra-staff, both clinician/clinician and clinician/

administrative, communication virtually in a crisis. Modifications to safety protocols focused on the use of instant messaging, e-mail, and alternative phone systems to facilitate communication in the event of a crisis.

TRAINING AND EDUCATION

Training both patients and clinicians on how to use technology and educating them about TMH is important when implementing a service. The rapid transition to an all virtual workforce required additional training beyond TMH clinical services. Below is an overview of some best practices²³ that were utilized to transition rapidly during COVID-19.

- (1) *Use didactic training materials for topics such as TMH background and evidence.* Most staff were already familiar with TMH; however, conversations about novel TMH situations occurred during staff conference calls.
- (2) *Focus on live, interactive training sessions.* Some patients were unfamiliar or uncomfortable with communication technologies. Those patients were able to participate in a test call with administrative staff before their initial session to ensure comfort with and the ability to use the required technology.
- (3) *Incorporate training into daily activities.* The virtualization of both clinical and administrative services required the use of communication technologies for all interactions. The same technologies used for clinical

care were used for meetings, which gave staff regular opportunities to better familiarize themselves with technological capabilities, including using artificial backgrounds and other aspects of communication such as gaze angle, camera distance, and lighting.

- (4) *Tailor training based on roles.* Some staff gained new skills. For example, the switch from phone-only to video-chat allowed intake coordinators to utilize TMH technologies in ways they had not previously performed their work.

OTHER CONSIDERATIONS

Ongoing all-staff and smaller team meetings were scheduled to discuss lessons learned and allow for opportunities to discuss necessary process modifications. These meetings were held regularly for 2 months and then transitioned to as-needed meetings when fewer modifications were identified. The willingness to engage in and the capacity for rapid learning among staff were vitally important to identify and implement best practices.

DATA ANALYSES

We conducted a **retrospective evaluation** of clinic log and **electronic health record (EHR)** data, examining the number of visits and no-shows before and after COVID-19 virtualization. The JDC utilizes a clinic log in addition to an EHR. The clinic log is updated for each completed visit, cancellation, or no-show and provides a more user-friendly option to evaluate the target data. The log is checked against the EHR by administrative staff for verification. The Cohen-AMC utilizes a different EHR and provides monthly data reports. The clinic log and EHR data were then combined in aggregate, as appropriate, for final analyses. Data were limited to individual treatment appointments. No-shows were considered appointments that were cancelled late or when the patient failed to attend. Data that could not be combined are noted below.

Results

Patients who did not choose to convert previously scheduled in-person appointments to TMH were asked to provide a reason why to determine if clinic staff could further assist. The primary reasons patients gave were already existing video fatigue, concerns over lack of privacy, and technology limitations.

PRE-COVID-19 VISITS

To provide a baseline, we examined appointments by month back to the beginning of calendar year 2020, when about 19% of all sessions were TMH. In January, 963 visits were scheduled

(45.9 per day) and 854 were completed (40.7 per day; 88.7% completion rate). In February, 875 visits were scheduled (46.1 per day) and 765 were completed (40.3 per day; 87.4% completion rate). The overall no-show rate across both months was 11.9%, with TMH no-show rates higher at 16.1%.

VIRTUALIZATION

We examined appointments in two business week blocks immediately before virtualization (March 2–13, 2020), immediately following virtualization (March 16–27, 2020) virtualization, and 4 weeks after virtualization (March 30–April 10, 2020). A total of 499 appointments (49.9 per day) were scheduled in the 2 weeks before virtualization, including 84 TMH appointments (16.8% of all scheduled appointments). There were 57 total no-shows (11.4%), including 14 TMH no-shows (16.7%) for a total of 442 completed appointments. Four hundred forty-six appointments (44.6 per day) were scheduled during the 2-week block immediately following virtualization, which represents a 10.6% decrease in scheduled appointments compared with the prior 2 weeks. A total of 32 scheduled appointments were no-shows (7.2%), for a total of 414 completed sessions.

Despite the improvement in no-show rates, completed visits decreased 6.33% from immediately pre- to immediately post-virtualization. Following the initial dip in scheduled appointments, visits increased to 490 scheduled sessions (49.0 per day) with a 7.8% no-show rate for a total of 452 completed appointments (45.2 per day) at 4 weeks postvirtualization. Appointment volume in April exceeded the daily rates for both January and February, suggesting that clinic volume was back to, and beginning to exceed, immediately pre-COVID rates within a month of virtualization. *Figure 1* shows scheduled visits and no-show rates for the virtualization period.

POST-COVID-19 APPOINTMENTS

Data were examined in monthly time frames beginning with April 2020 and extending through the end of September 2020. The overall monthly average of scheduled appointments increased to 1,168 scheduled post-COVID-19 virtualization, with no-show rates decreasing to a range of 5.5–8.5%. The daily mean of scheduled visits increased 17.8% from 46.5 across January and February to 54.8 across 6 months post-COVID virtualization. The decrease in no-show rates led to a 26.2% increase in completed visits from a mean of 40.5 per day the first 2 months of the year to a mean of 51.1 post-COVID. One notable change specific to the JDC was that the number of TMH sessions for patients with Medicare increased over 2,800% from about 3 per month to 88 per month post-COVID-19. *Figure 2* shows scheduled appointments and no-show rates for 6 months post-COVID.

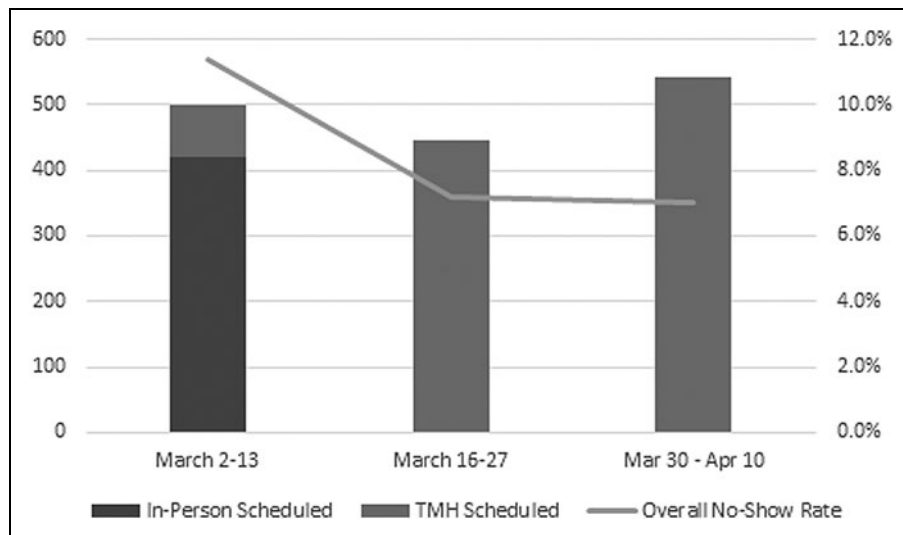


Fig. 1. Scheduled appointments and no-show rates per 2-week period pre-, during, and postvirtualization.

Discussion

Before the COVID-19 pandemic, little had been written on how to rapidly convert entire clinics to fully virtualized services, especially during a public health emergency. The impact of such rapid virtualization on administrative operations, no-show rates, appointment completion, and clinic processes was also unknown. Our data suggest that patients were willing to accept in-home TMH as an alternative to in-person appointments, eventually demonstrating higher completion rates and

fewer no-shows. An initial drop in visits was followed by a sustained increase in both scheduled and completed visits over 6 months following virtualization, including a no-show rate that has remained below 10%.

It is not clear why TMH no-show rates were higher previrtualization. It is likely that moving to fully virtual services enhanced operational efficiencies with TMH, and, as the only option for care, patients were more likely to attend appointments. With virtualization occurring primarily from provider homes to patient homes, the data further suggest that delivering TMH from and into previously defined “nontraditional” locations is sustainable. Moreover, in-home TMH should be considered for ongoing, standard-of-care operations to maintain and increase delivery of care.

The high TMH appointment completion rate for many patients was likely due to the temporary lifting of restrictions on telehealth in response to the public health emergency declarations. This was notable in the increase in patients with Medicare who were able to receive TMH services at the JDC. Other notable flexibilities have included the lifting of geographic and physical location restrictions, reimbursement for audio-only appointments, and the temporary removal of the requirement for a face-to-face evaluation before prescribing controlled substances.

It is unclear whether these regulatory changes will remain, revert back to pre-COVID-19 limitations, or be further modified, but their immediate positive impact in increasing access to TMH is readily apparent. The available data suggest that the temporary restrictions benefited patients in their ability to access clinicians, and clinicians benefited by receiving reimbursement for their services.

LIMITATIONS

The JDC and Cohen-AMC are two clinics within a university system, and thus, there are limitations as to how well others

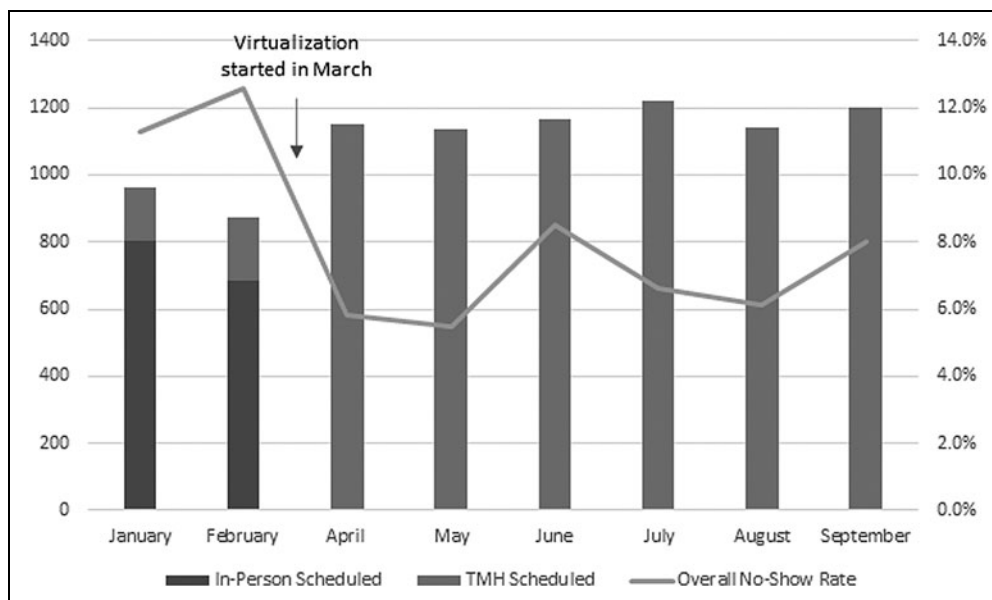


Fig. 2. Scheduled appointments and no-show rates by month. March is not included due to the transition to virtualization.

may implement TMH services. While both clinics completed all virtualization steps, previous experience with TMH and the organizational commitment to take timely actions may impact generalization of our experiences. The data presented are descriptive and do not control for real-world variables such as fluctuations in staffing and seasonal changes in need for services. Future research will need to focus on clinical outcomes rather than only examining clinical volume. Despite these limitations, the processes identified here provide a basis for best practices and the data provide evidence for a successful transition.

NEXT STEPS

This article was intended to provide an overview of procedures and lessons learned to support mental health systems as they undergo rapid transformation to fully virtualized services during the current pandemic. We expect much wider use and acceptance of TMH, especially provider-home to patient-home care as health care providers and systems reconceptualize how, when, and where services are provided. It will be important to use the lessons learned here and from others^{5,6,24,25} to continue to improve access and quality in ways that optimize patient benefit. This includes understanding patient and provider perspectives to better conceptualize a more fluid, hybrid in-person/TMH care model that could occur within and beyond traditional clinical settings.

While the current data are supportive of TMH, mental health professionals will need to continue important discussions about the most effective delivery of services. Therapeutic appropriateness should be considered such that rather than focus solely on in-person services or associate TMH with a one-size fits all approach, flexibility is used to promote the appropriate care modality when and where it makes sense. Access to technology remains uneven such that not all patients are appropriate for TMH services. Furthermore, clinical judgment to continue with an appointment should be used when technology is suboptimal. Finally, while TMH services may reduce overall system cost, other factors may negatively affect the willingness to maintain TMH services, including the low rates of mental health reimbursement in general, the lack of true TMH parity in many states, and the inability to capture facility fees and other aspects of the full cost of care.

SUMMARY

Implementation of TMH services historically has required months of planning, staff training, and process development before services are initiated. Two university-based clinics with existing TMH services underwent rapid virtualization. Key lessons learned include the need for having strong organizational

leadership, staff willingness and commitment to take the timely actions necessary to virtualize, familiarity with TMH services and existing protocols, rapid communication between staff, and the ability to understand and utilize regulatory flexibilities. Future models of care include hybrid in-person/TMH services that will likely be organized along two pathways. One pathway is a traditional approach of more gradual change and independent adoption by systems or individual providers. The other approach is implementing the lessons learned during this pandemic to prepare for future potential emergencies and best patient benefit. We recommend the latter approach.

Disclosure Statement

J.H.S. works with AccessCare a provider of telebehavioral health services and has received royalties from the American Psychiatric Association Publishing and Springer Press.

Funding Information

No external funding was received for this work.

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Received: July 21, 2020

Revised: November 1, 2020

Accepted: November 3, 2020

Online Publication Date: December 28, 2020