Telebehavioral Health: Accessing Behavioral Healthcare Before, During, and After the COVID-19 Pandemic

COVID-19 Impact Analysis of FEMA Region 8 States

March 2021

Region 8 Interagency Recovery Coordination (IRC)

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2. Introduction

2.1.   Purpose

The Region 8 Deep Dive is a white paper focused on specific, disaster-impacted topics of interest to Region 8 partners. FEMA's Region 8 covers portions of the Upper Midwest and the Intermountain West and includes the states of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming and 33 federally recognized tribes. The Region 8 Interagency Recovery Coordination (IRC) cell is a regional coordinated effort that leverages the whole community to identify and share state, tribal, and local long-term recovery issues, and to integrate, coordinate, and facilitate access to resources, funding, solutions, partnerships, and collaboration in support of community-driven solutions that facilitate Region 8 recovery.

This Deep Dive Impact Analysis was undertaken by the FEMA Region 8 IRC cell, under the guidance of and close collaboration with Region 8 partners of the Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR), the Office of the Assistant Secretary for Health (OASH), and the Substance Abuse and Mental Health Services Administration (SAMHSA). This Deep Dive serves as a high-level analysis of the impacts of the COVID-19 pandemic on the behavioral healthcare infrastructure in Region 8 states. The purpose of this document is to inform planning assumptions and facilitate understanding of these issues for emergency managers, recovery coordinators and planners, public health coordinators, and other key stakeholders. The findings of this analysis can be used to inform their strategic thinking as they build telebehavioral infrastructure and identify COVID-19 pandemic disaster recovery gaps.

Through completing this exercise, contributors to this document have highlighted the recent rise in telehealth and telebehavioral health as a means of providing care. This analysis discusses ways in which the shift to a virtual world has both exposed barriers to care and facilitated improvements in the delivery of behavioral healthcare services. Some high-level findings of this document include:

Rise in prevalence of behavioral health symptoms, including elevated depression and anxiety, and increased substance use related to the stress, isolation, and economic distress precipitated by the COVID-19 pandemic.

- Increase in morbidity and mortality among populations experiencing chronic behavioral health needs, namely a rise in drug overdose and suicide related deaths.
- Modification of federal and state policies and programs to accommodate funding for and facilitate access to telehealth and telebehavioral health to reduce barriers to care during this time of crisis and in response to the ongoing public health emergency.
- Persistence of barriers to behavioral healthcare in some Region 8 populations due to physical distance, eligibility requirements (including behavioral health reimbursement practices that rely on particular types of diagnoses to deliver care); lack of financial resources (including whether a person/household has access to health insurance, is eligible for Medicaid/Medicare and/or has finances to pay out-of-pocket to cover gaps in coverage); and lack of funding infrastructure to

integrate behavioral health promotion and prevention activities in non-disaster related health and behavioral health care systems.[1]

- Progress in the development of infrastructure, funding, and policies necessary to develop and apply telehealth to integrated healthcare settings, including behavioral healthcare, resulting in improved opportunities for access to behavioral healthcare resources, particularly for rural communities.
- Implementation of Crisis Counseling Assistance and Training Program (CCP) to provide outreach and psychoeducation to distressed populations, by promoting mental health awareness and strength-based approaches to behavioral health.

2.2.   Background

Nearly a year after the first stay at home orders were issued in March 2020, the nation continues to struggle with the impacts of the COVID-19 pandemic. In Region 8, as in most of the country, the toll has been heavy. As of March 7th, 2021, there have been a total of 55,389 hospitalizations, and 13,399 reported deaths due to COVID-19 in Region 8.[2] Furthermore, the pandemic has wreaked havoc on the national economy, with great implications for states, tribes and local communities.

While the impacts of the COVID-19 pandemic on individuals and communities are many and varied, one of the most omnipresent issues is its impacts on behavioral health. Among reports of increased levels of stress, anxiety, depression, and substance use, one team of researchers has even coined the term "COVID Stress Syndrome," to describe this population level phenomenon.[3] While increases in stress and anxiety among many American communities can be a cause for concern, we must be careful not to pathologize relatively normal reactions to difficult situations, including those caused by the COVID-19 pandemic. However, it is important to acknowledge that prolonged, stress inducing situations, such as the social and economic difficulties caused by the current pandemic, may have a role in inducing or escalating need for behavioral healthcare. Furthermore, social inequity has exacerbated the stressors of the pandemic in certain communities more than others, particularly communities with higher rates of poverty, communities of color, Native American, and rural communities.

While stress and anxiety related to the COVID-19 pandemic are not to be disregarded, the pandemic has been particularly devastating for individuals experiencing more severe behavioral health disorders. As an example, according to the Colorado Department of Public Health and Environment (CDPHE), Colorado experienced a record high rate of drug overdose deaths in 2020. Preliminary totals suggest that there were 1,216 overdose deaths in the state in 2020 compared to 1,062 in

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[1] Kaul, R and Sherman, R, (2017). Where Emergency Management and Disaster Behavioral Health Meet: Through a Disaster Behavioral Health Lens, *Integrated Emergency Management and Disaster Behavioral Health: One Picture Through Two Lenses*, ed. Brian W. Flynn and Ronald Sherman.

[2] FEMA. Region 8 COVID Dashboard, 20210126

[3] Taylor, S. Landry, C.A., Paluszek, M.M., et al. (2020). COVID Stress syndrome: Concept, structure, and correlates. *Depression & Anxiety*, 37(8):706-714.

2019.[4] Even prior to the beginning of the COVID-19 pandemic, the United States was confronting multiple health epidemics related to mental health and substance use disorders. In fact, according to the CDC, drug overdose deaths in the United States have been at epidemic levels since the 1990s. This underlying epidemic has been marked by overdose deaths primarily related to prescription opioids, heroin, and synthetic opioids.[5]

Region 8 states have recently experienced increased incidence of behavioral health symptoms, according to the results from the Substance Abuse and Mental Health Services Administration's (SAMHSA) most recent National Survey on Drug Abuse and Health. For instance, among young adults (aged 18-24), the average percentage who have experienced serious suicidal ideation in the past year increased from 7.5% in the period between 2008 and 2010 to 15% in the period between 2017 and 2019. Furthermore, this trend was consistent in five of the six states in Region 8, with relative increases between these periods observed in Colorado, North Dakota, South Dakota, Utah, and Wyoming. [6] Likewise, the percent of all adults (18 and older) in Region 8 states with some form of Serious Mental Illness was 6.2% between 2017 and 2019, above the national average of 4.8%.[7]

It is in this context, that we approach the issue of access to behavioral healthcare in Region 8 before, during, and after the COVID-19 pandemic. According to the CDPHE, "behavioral health describes the continuum of one's emotional, cognitive and relational well-being and is a key factor in what behaviors people engage in."[8] For the purposes of this Deep Dive, we define behavioral health as conditions related to people's experiences of mental health distress, mental illness, substance use, and substance use disorders.

2.3.   Issue

Access to behavioral healthcare is a complex and dynamic issue, which depends upon a variety of factors, including federal, state, and local policy, funding structures, infrastructure, and equity. Due to this complexity, and the varied availability of behavioral health resources, it is unfortunately possible that individuals experiencing symptoms of behavioral health conditions may encounter gaps in the behavioral healthcare system. These gaps are particularly pronounced for individuals who lack

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[4] Kruegel, E., A grim milestone' Colorado sets record for overdose deaths in 2020. KDVR.com. Jan 22, 2021. Accessed 02/10/2020.

[5] Centers for Disease Control and Prevention. 2018 Annual Surveillance Report of Drug Related Risks and Outcomes. Surveillance Special Report. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2018. Accessed 03/15/2021.

[6] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Region 8, Volume 5. 2019. Accessed: 03/08/2021

[7] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Region 8, Volume 5. 2019. Accessed: 03/08/2021

[8] Colorado Department of Public Health and Environment. COVID-19 Vaccine Planning and Distribution: Disaster Behavioral Health Principles and Supports. Accessed: 03/22/2021

resources to pay for private services, or for those with symptomology but who have not been diagnosed with a chronic behavioral health condition.

The current state of access to behavioral healthcare in the United States is constructed through a conceptualization of behavioral health with a **chronic disease model**. In its current state, the behavioral healthcare system in the United States is largely designed to provide treatment and recovery supports for people experiencing mental illness and/ or substance use **disorders**. For this reason, the system requires that individuals meet certain criteria for a behavioral health diagnosis, to be able to gain access to public services. Although, the current system of care includes public health models for emotional health promotion and substance use prevention, the funding mechanisms are generally unstable or insufficient. Furthermore, most models are not universally implemented. While screening for behavioral health conditions is increasing across primary care, hospitals, and dentistry, it is not yet a standard practice in preventative medicine.

In other words, if a person does meet the criteria for a severe mental illness or be determined to be at risk for such an illness, and if they do not have the means to pay for private services, it will likely be more difficult for them to receive services within traditional behavioral health treatment systems.

Recently, increased recognition of the prevalence of people experiencing both mental illness and substance use has led to the development of infrastructure for integrated mental health and substance use treatment service models. In addition, especially in the context of America's opioid epidemic, infrastructure for medication-assisted treatment (MAT) support has increased, especially over the past seven to ten years.

Beyond the issue of diagnostic eligibility, access to behavioral healthcare is also limited by the physical availability of necessary resources. In many rural and low-resource communities for instance, behavioral healthcare services and resources to help individuals understand and seek these services may be limited. These limitations can be due to systemic issues such as provider shortages, and long wait times, but may also be related to logistic challenges for patients themselves, including limited transportation resources, lack of childcare, and busy schedules that preclude long travel times. For this reason, the level to which behavioral health services are integrated into primary care settings continues to be a significant variable in determining whether people access behavioral health services. Patients typically do not experience stigma when visiting their primary care provider and therefore, are more likely to access behavioral health services if they are integrated into a primary care setting.

In addition, the level to which payment systems have integrated behavioral health treatment service options, particularly behavioral health parity is another factor influencing whether people can access behavioral health services.

This Deep Dive will explore ways behavioral health, including access to behavioral healthcare, have been impacted by COVID-19 and ways in which the pandemic has exposed certain barriers to

behavioral healthcare. The analysis will also explore how shifts in policy and funding available throughout the pandemic have facilitated improvements in ways that Region 8 communities access behavioral healthcare, with a particular focus on telehealth.

3.   Accessing Behavioral Healthcare

3.1.   Accessing Behavioral Healthcare in Region 8

Access to healthcare services is defined as "the timely use of personal health services to achieve the best health outcomes."[9] Some key barriers to healthcare access include:

- Lack of comprehensive health plan coverage and in-network providers
- Access to affordable care, in the least restrictive setting and at the right time
- Lack of a robust continuum of coordinated care in many communities[10]

In the period between 2017 and 2019, only 47% of adults over the age of 18 in Region 8 with any mental illness received treatment. This regional average was slightly higher than the national average for the same period at 43.6%.[11] This section will explore how access gaps (eligibility, availability of services/infrastructure, and geographic convenience) possibly contribute to these statistics.

For the purposes of this report, we will define two types of access to behavioral healthcare, eligibility access, and physical access. Eligibility access defines whether an individual has adequate healthcare coverage to pay for the services they need. This type of coverage depends on two primary variables: an individual's health insurance (linked to socio-economic status), and an individual's diagnosis.

3.2.   Eligibility Access in Region 8 States

Table 1 below shows a general framework of options for accessing behavioral healthcare services by population, depending on the type of care needed for their diagnosis, and the type of healthcare coverage they have. Generally, if an individual is experiencing symptoms of a behavioral health condition, the first step is to seek advice from their primary care physician, which varies depending on what type of healthcare coverage they have. For individuals with no health insurance, they can seek medical care at a federally funded health center or a rural health clinic,[12] which are required by law to provide care to anyone, regardless of insurance status or ability to pay.

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[9] Office of Disease Prevention and Health Promotion. Access to Health Services. Accessed: 03/08/2021

[10] American Hospital Association. Behavioral Health. Accessed: 02/15/2021.

[11] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Region 8, Volume 5. 2019. Accessed: 03/08/2021

[12] Centers for Medicaid and Medicare. Federally Qualified Health Center. January 2021. Accessed: 03/08/2021

During a primary care visit, the providers will typically screen and assess patients for symptoms of certain behavioral health conditions or disorders. As previously discussed, behavioral healthcare is not always effectively integrated into the primary healthcare setting to the extent prescribed. Thus, it is important to mention that screenings in primary care settings are at the discretion of the provider and may be limited to a depression screening. If the patients present symptoms of a behavioral health disorder, such as major depression, bipolar disorder, schizophrenia, PTSD, substance use disorders, etc., that requires specialty care, they should be referred to a behavioral health specialty/clinic/program/clinician who can evaluate and treat those disorders. Individuals who are uninsured or underinsured are often referred to a Community Mental Health Center or at a Substance Use Disorder Treatment Facility for specialty behavioral health care.

Unfortunately, treatment gaps tend to arise for individuals who experience subclinical behavioral health conditions (e.g., do not meet the criteria for a serious behavioral health disorder), but who may require treatment. Such subclinical conditions may be treated in primary care or, if the individual has private insurance, may be referred to a behavioral health specialty/clinic/ program/clinician in their insurance network and receive care. However, for those without healthcare coverage for behavioral health services, access may be limited or delayed due to long waitlists at Community Mental Health Centers or Substance Use Disorder Facilities. Likewise, for those eligible, such care is offered in most Veterans Affairs (VA) clinics and in some Indian Health Services (IHS) facilities. State specific maps provided in Appendix C include both VA non-acute facilities as well as IHS facilities that provide behavioral health treatment in addition to the CMHCs.

Individuals with Medicaid, and Medicare coverage will have good payment coverage for both primary care services and behavioral health services. These services can be covered both through individual providers who accept Medicaid or Medicare and through federally funded health centers. However, access may be limited depending on patient location and the availability of providers, as well as provider capacity to accept additional patients under Medicaid or Medicare coverage. Furthermore, Medicaid does vary by state, therefore coverage for behavioral health services will depend on state policy.

For those without insurance, availability of services for these types of subclinical conditions is generally limited, depending on location, although they may receive treatment at federal funded health centers. These centers, which are required to provide services to anyone regardless of insurance, may however have waitlists, or fewer behavioral health provider types available at each location. The availability of these centers in remote areas is also varied. The map in Figure 1 show the percent of the population by Census Tract with No Health Insurance in relation to the locations of Community Mental Health Centers.
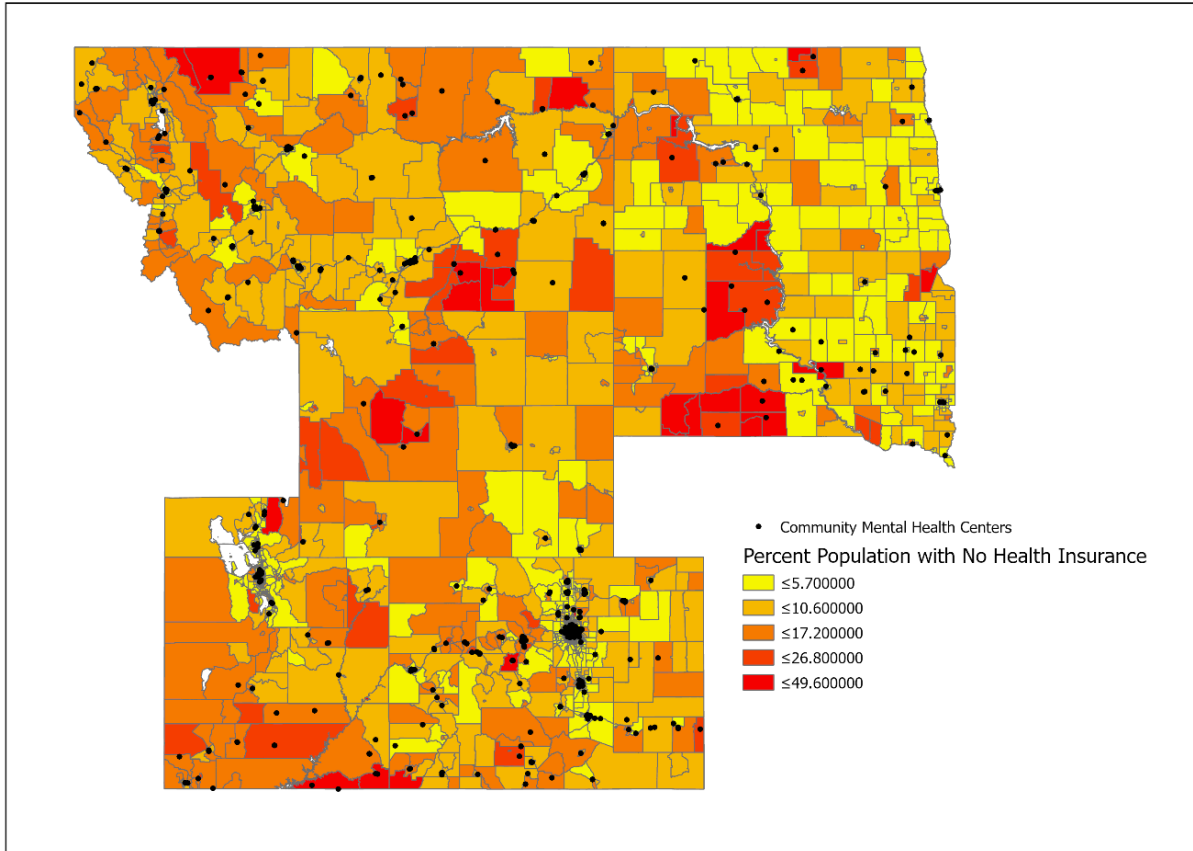
Figure 1. Percent Population with No Health Insurance Coverage in Region 8 States

Source: SAMHSA Behavioral Health Locator, ACS 2015-2019

Due to the COVID-19 pandemic, FEMA has received funding through coronavirus relief legislation to administer grant funds for disaster behavioral health services through the Crisis Counseling Program Assistance and Training (CCP). These disaster services temporarily provide outreach and psychoeducation to individuals experiencing symptoms of behavioral health conditions which may have arisen during or become exacerbated by the pandemic. While these services are currently broadly filling a population mental health promotion gap, especially for uninsured and underinsured individuals, they are temporary and will expire when the CCP funding expires.

For individuals with chronic behavioral health conditions who are experiencing acute episodes, there are a variety of healthcare options that exist, depending on severity of symptoms, which are detailed in the final row in Table 1. However, for a person experiencing subacute symptoms, such as some forms of trauma-related symptoms, resources for supports may be dependent on the person/s financial status and ability to pay for those supports.

Table 1. 'Eligibility Access' to behavioral health care services by services and healthcare coverage[13]

Type of Care	Private Insurance	Medicaid	No Insurance	Tribal (Medicare/ other insurance, IHS)	Veteran (Tricare/ Medicare)
Preventative Healthcare **Primary Care Primary Care** *(ex: prolonged and situational symptoms of stress and anxiety)*	Primary care provider/network (screen, eval, treat or refer)	Any provider that accepts Medicaid, Federally funded health centers FQHCs, rural health clinics	FQHCs, rural health clinics	IHS Facility (non-urgent), Tribal FQHCs Urban Indian Organization FQHCs	VA Facility (non-urgent)
Preventative Healthcare **Public Health/ Disaster Behavioral Health** *(ex: situational symptoms of anxiety and depression)*	FEMA Crisis Counseling Assistance and Training Program (CCP), Disaster Distress Helpline	FEMA Crisis Counseling Assistance and Training Program (CCP), Disaster Distress Helpline	FEMA Crisis Counseling Assistance and Training Program (CCP), Disaster Distress Helpline	FEMA Crisis Counseling Assistance and Training Program (CCP), Disaster Distress Helpline	FEMA Crisis Counseling Assistance and Training Program (CCP), Disaster Distress Helpline
Subclinical **Behavioral Healthcare** *(ex: mild symptoms of anxiety and depression that do not reach clinical thresholds)*	Behavioral health provider	Limited (depending on location) Any BH provider that accepts Medicaid Payment. State specific	Limited (depending on location)	IHS Facility (non-urgent), Tribal FQHCs Urban Indian Organization FQHCs (with behavioral health services)	VA Facility (non-urgent)
Specialty **Behavioral Healthcare** *(ex: symptoms of clinical mental illness or substance use disorder)*	Behavioral health provider	Any BH provider that accepts Medicaid Payment. State specific, Community Mental Health Center, Substance Use Disorder Treatment Facility	Federally funded health centers (with behavioral health services)	IHS Facility (non-urgent), Tribal FQHCs Urban Indian Organization FQHCs (with behavioral health services)	VA Facility (non-urgent)
Emergency Behavioral Healthcare *(ex: suicidal ideation/attempt, drug overdose)*	Hospital Emergency Room	Hospital Emergency Room	Hospital Emergency Room	IHS Hospital (urgent care)	VA Hospital (urgent care)

[13] This table reflects a generalization of the eligibility of access available to different populations to identify gaps. This is not meant to be understood as a comprehensive map of behavioral healthcare access. It is important to note that these considerations can vary by state and by geographic location within states.

Emergency Behavioral Health Care/Crisis Care Hotlines (varies by location)

- Crisis centers: Mobile crisis units
- Detox/Withdrawal Management Services (SUD only)
- Crisis Line/Warm Line (National Helpline, local crisis lines, 911).
- Veteran's Crisis Line
- National Suicide Prevention Lifeline (becoming 988 by 2022)

3.3. Physical Access in Region 8 States

The second type of access is physical access, which means that patients have access to a healthcare provider within a reasonable distance and within a reasonable time frame of their initial desire to seek care. While physical access has traditionally taken the form of face-to-face care, we intend physical access to include both face-to-face care as well as virtual care by means of telemedicine.

Physical accessibility to *face-to-face care* requires that a facility be within a reasonable distance of an individual's home community. This type of access often includes access to affordable and convenient transportation options, which depending on socio-economic and disability status may not always include drive time for personal vehicles. However, acknowledging these limitations and, for the purposes of this analysis, we have opted to use a 60-minute drive time radius from behavioral healthcare facilities as a measure of this type of physical access. Figure 2 indicates the location of Community Mental Health Centers in Region 8, which include several HRSA facilities that offer behavioral health services. The map does not include data for private practitioners, as our intent is to identify pockets of low access.

Physical accessibility to *virtual care* does not depend on physical proximity to a facility, but rather on access to technology and physical infrastructure that would allow an individual to connect virtually with a healthcare provider. To connect virtually with a healthcare provider, an individual must have a means of communication, which can include a smart phone, computer, tablet, or other device. Additionally, the individual must have some form of internet access, either through a data plan or through a broadband or dial-up internet subscription. While many different combinations of these technologies can occur in a household to provide some level of access, for this analysis we consider a computer and broadband connection to be "adequate" access for the purposes of telemedicine. Figure 2 shows the percentage of households in each county that reported having both a computer and a broadband internet subscription. Areas on the map in white indicate where virtually the entire population have these, while areas in dark blue indicate portions of Region 8 where fewer than 57% of households have both a computer and a broadband internet subscription.

Areas on the map in dark blue and blue that are not covered by the 60-minute drive time radius are geographies experiencing limited access to behavioral healthcare in both physical and virtual settings. These limitations can be related to distance, household financial limitations, a lack of adequate internet infrastructure, or a combination of the three.
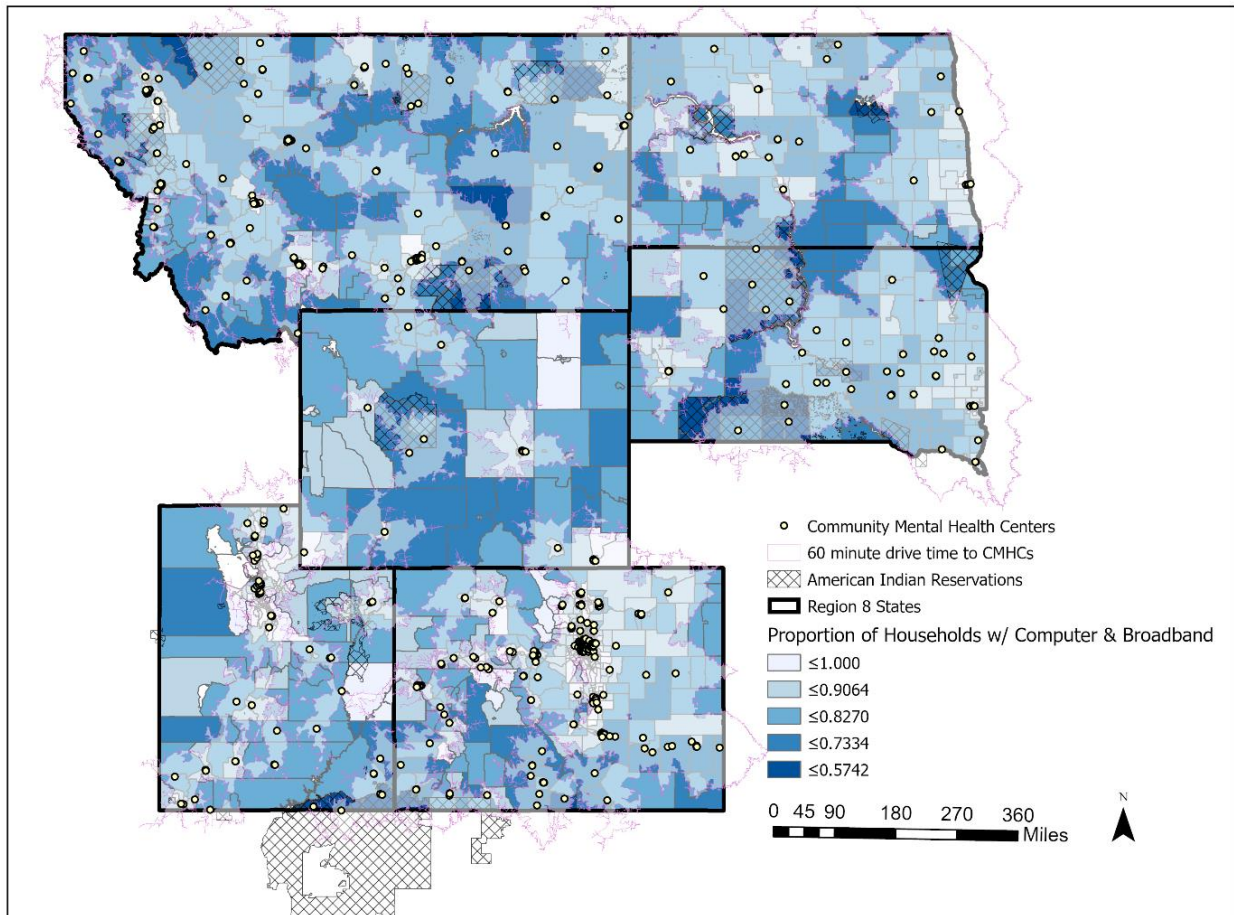

Figure 2. Drive time access to Facilities offering Specialty Behavioral Healthcare and proportion of Region 8 households with potential access to virtual care (computers and broadband)

Source: SAMHSA Behavioral Health Locator, ACS 2015-2019

4. Impacts of COVID-19 Pandemic on Behavioral Health

4.1. Social Vulnerability

Communities across the United States have experienced varied levels of impact from the COVID-19 pandemic and ensuing economic crisis. The Centers for Disease Control and Prevention (CDC) uses the term 'social vulnerability' to describe a community's susceptibility to "potential negative effects...

caused by external stresses on human health."[14] Indicators that a person, household, or community might face worse outcomes related to the COVID-19 pandemic have included:

- Lower financial income, rates of chronic health conditions (including mental illness and substance use disorders),
- Race (being from a community of color or American Indian/Alaska Native),
- Non-English-speaking status,
- Single parent household status,
- Living in a multi-generational household,
- Being in congregate or crowded housing,
- Lacking access to transportation, and
- Inadequate nutrition.

Many American communities that have experienced higher rates of exposure to COVID-19, were also most impacted by the economic downturn, and are often coincident with existing social stresses such as persistent poverty, housing insecurity, low wage jobs, and elevated unemployment rates. The pandemic is now being discussed as syndromic because of the way its economic impacts have exacerbated existing inequities that give rise to 'social vulnerability.' [15]

In recent years, several studies have investigated the relationship between social vulnerability and behavioral health outcomes. A 2011 study published in the Journal of the American Medical Association found a strong relationship between household income in the United States and behavioral health conditions. The three-year study found that as household income decreased, the risk of mood, anxiety, and substance use disorders increased.[16] Similarly, in a 2018 meta-analysis of behavioral health outcomes for depression across several countries, another group of researchers attempted to define the mechanisms that might link income inequality and incidence of behavioral health conditions. The study identified three levels of influence: [17]

1. National level (the Neo-material hypothesis): Proposes that when income inequality occurs at a national level, those at a lower income level are less likely to have access to important material things such as safe housing, good infrastructure, and healthy food.

2. Neighborhood level (Social capital and the social comparison hypotheses): Proposes that social capital, or the networks of trust and support, promotes relationship building and collaboration

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[14] Agency for Toxic Substances and Disease Registry. CDC's Social Vulnerability Index (SVI). Accessed: 03/18/2021.
[15] Taylor, S. Landry, C.A., Paluszek, M.M., et al. (2020). COVID Stress syndrome: Concept, structure, and correlates. *Depression and Anxiety*, 37(8):706-714.
[16] S. Jitender et al. (2011). Relationship Between Household Income and Mental Disorders Findings from a Population-Based Longitudinal Study. *Arch Gen Psychiatry*. 2011;68(4):419-427.
[17] V. Patel, et al. (2018). Income inequality and depression: a systematic review and meta-analysis of the association and a scoping review of mechanisms. *World Psychiatry*. 2018 Feb; 17(1): 76–89.

within a community. Income inequality in a community can reduce social capital because it promotes isolation, alienation, and stratification.

3. Individual level (psychological stress and social defeat hypotheses): Describes the feelings of defeat, worthlessness, and even shame among people living in poverty that are often associated with depression, anxiety, and suicidal ideation. [18]

This framework is useful in understanding the underlying relationships between household economics and behavioral health. It also sheds light on the mechanisms by which the pandemic has highlighted and exacerbated the existing behavioral health crisis in the United States as well as persistent social and racial inequity. For many low- and middle-income communities, the pandemic has been marked not only by health risks and stress related to contracting COVID-19, but also by extreme disruptions in access to basic needs, essential infrastructure, and social support.

The economic downturn and quarantine measures put in place to reduce the spread of the pandemic resulted in large economic disruptions leading to temporary and permanent business closures, large reductions in Gross Regional Product, reduced state and local revenues, and lasting job losses. One of the most discussed economic indicators of the impacts of the COVID-19 pandemic is job loss and unemployment. As seen in Figure 3 below, the unemployment rates in Region 8 states increased by 5-8 percentage points in 2020, relative to 2019 in all states in April and remained elevated relative to the previous year even into early 2021.
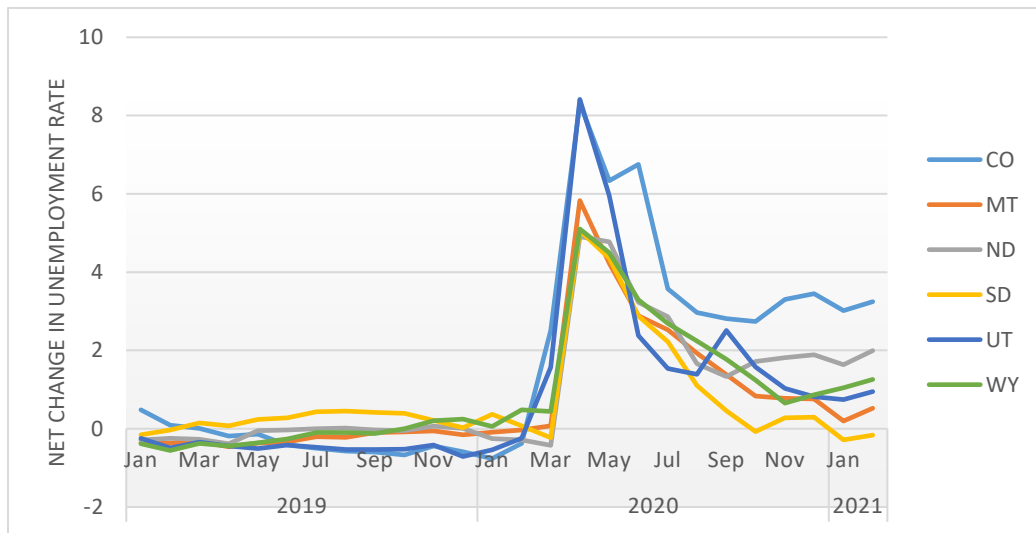

Figure 3. Year over Year Net Change in Unemployment Rate for Region 8 States

Source: BLS Local Area Unemployment Statistics

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[18] V. Patel, et al. (2018). Income inequality and depression: a systematic review and meta-analysis of the association and a scoping review of mechanisms. *World Psychiatry*. 2018 Feb; 17(1): 76–89.

It is important to note that while Figure 3 depicts a state average, the year over year increase in unemployment reached as high as 25% in certain Region 8 counties, which is well above the national average. Additionally, these figures include the entire labor force, whereas unemployment rates are much higher and more persistent for low wage workers. According to the Track the Recovery Project, national employment rates for those earning greater than $60K per year rebounded to 1.6% higher by January 2021 relative to the previous year, while employees making less than $27K per year were 28% lower than the previous year.[19]

Many of the compounding impacts of the COVID-19 pandemic are tied to increased unemployment and slow recovery among low-wage-earning labor markets. These secondary impacts include food insecurity, housing insecurity, and threat of eviction and foreclosure. According to the U.S. Department of Agriculture (USDA), food security means "access by all people at all times to enough food for an active, healthy life."[20] A report published in October 2020 by Feeding America, estimated that there was an increase from 35 to 50 million Americans experiencing food insecurity between 2019 and 2020, within the context of existent unemployment and poverty rates.[21] However, it is worth noting that there have been numerous programs funded through the USDA to provide food assistance and alleviate hunger.

Another compounding impact of the COVID-19 pandemic is social isolation. While stay-at-home orders and social distancing measures have varied by location, the pandemic has caused most people to reduce their social interactions. Additionally, pandemic conditions have restricted access to many places where communities naturally congregate, including places of worship, schools, community centers, and workplaces. While the links are still not fully understood, research has investigated links between health outcomes and social capital.[22] This is perhaps even more relevant within the context of stigma related to behavioral health disorders, which can impact social ties and social mobility. Recognizing this, behavioral health treatment systems include peer support and recovery services as part of common clinical practice.

4.2.   Disaster Behavioral Health – America is Stressed

According to HHS, the term 'disaster behavioral health' "includes the interconnected psychological, emotional, cognitive, developmental, and social influences on behavior, mental health, and substance abuse, and the effect of these influences on preparedness, response, and recovery from disasters or traumatic events."[23] In the context of disasters, behavioral health is an important factor

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[19] Opportunity Insights. Track the economic impacts of COVID-19 on people, businesses, and communities across the United States in real time. 2020. *Track the Recovery.org*. Accessed: 03/25/2021.

[20] USDA Economic Research Service. Food Security in the U. S. March 12, 2021. Accessed: 01/18/2021.

[21] Feeding America. The Impact of the Coronavirus on Food Insecurity in 2020. October 2020. Accessed: 02/10/2021.

[22] Ehsan, A., Klaas, H.S. (2019) Social Capital and Health: a systematic review of systematic reviews. *SSM – Population Health*. 8, 100425.

[23] HHS Office of the Assistant Secretary for Preparedness and Response. Department of Health and Human Services Disaster Behavioral Health Concept of Operations. November 2016. Accessed: 02/12/2021.

because disasters inherently disturb the status quo, often challenging the worldviews and routines of both individual people and whole communities.[24] While all disasters are disruptive, the COVID-19 pandemic is uniquely challenging, as it has resulted in continuous and often unequal stressors for certain American communities, families and individuals since its global onset in March 2020.

A study conducted by the CDC attempted to measure changes in mental health and substance use indicators among American adults throughout the pandemic. Using representative panel surveys, the study found that over 40.9% of respondents reported at least one symptom of an adverse behavioral health condition, which included anxiety, trauma-and-stressor-related disorders, and stress directly related to the pandemic. Alarmingly, 13.3% of respondents reported increases in substance use to cope with the increased stress related to the pandemic."[25]

In November 2020, an article published in the American Journal of Nursing reported that Mental Health America (MHA), a national organization dedicated to mental health promotion, has seen a fourfold increase between January 2020 and May 2020, in the number of patients seeking support from an online screening tool for symptoms of anxiety, depression or other mental health related symptoms. According to the article, MHA reported that social stressors related to the pandemic such as loneliness, past trauma, and relationship problems were the primary causes of the uptick in symptoms.[26]

Many Region 8 states have seen an increase in call volume to crisis hotlines. The Utah Department of Health reported a 1.6% increase in call volume to their crisis hotline between May 2019 and May 2020.[27] In December 2020, the CDPHE reported a 55% increase in annual call volume between 2017 and 2020.[28] These increases in individuals seeking support for severe pandemic related stress illustrate the persistent impact of the pandemic on many Region 8 communities.

In April 2020, the Census Bureau initiated the Household Pulse Survey to track health related indicators in American communities throughout the pandemic. The following figures from the survey depict the rates of depression and anxiety among adults aged 18 and up in Region 8 state. As seen in Figure 4, depression and anxiety is greatest among young people in Region 8 and reduces with increased age. Figure 5 indicates that anxiety and depression have been consistently elevated among certain populations of color, particularly those who identify as Non-Hispanic Other Races or Multiple Races, Hispanic or Latino, and Non-Hispanic Black Single Rage in the region. Anxiety and

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[24] Colorado Department of Public Health and Environment. COVID-19 Vaccine Planning and Distribution: Disaster Behavioral Health Principles and Supports. Accessed 02/11/2021.

[25] Czeisler, M. et al. (2020). Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – United States, June 24-30, 2020. CDC Morbidity and Mortality Weekly Report, 69(32); 1049-1057.

[26]Roush, K. Mental Health Effects of COVDI-19, American Journal of Nursing, November 2020, Volume 120, N 11, Page 15.

[27] Simonsen, H. Utah sees fewer suicides during pandemic but calls to crisis hotline increase. KSL.com, September 12, 2020. Accessed 02/11/2021.

[28]. Newman, Z., Jojola, J. People are using Colorado Crisis Services 55% more in 2020 compared to 2017. 9 News.com, December 9, 2020. Accessed 02/11/2021

depression were lowest among Non-Hispanic Asian Single Race and Non-Hispanic White Single Race, respectively.
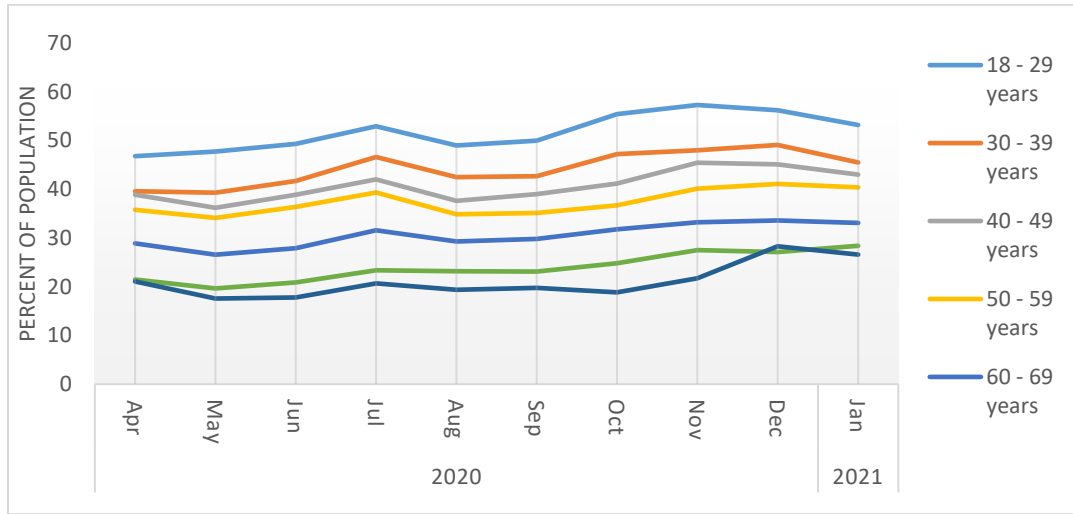

Figure 4 Percent of Region 8 Population Reporting Symptoms of Anxiety and Depression by Age
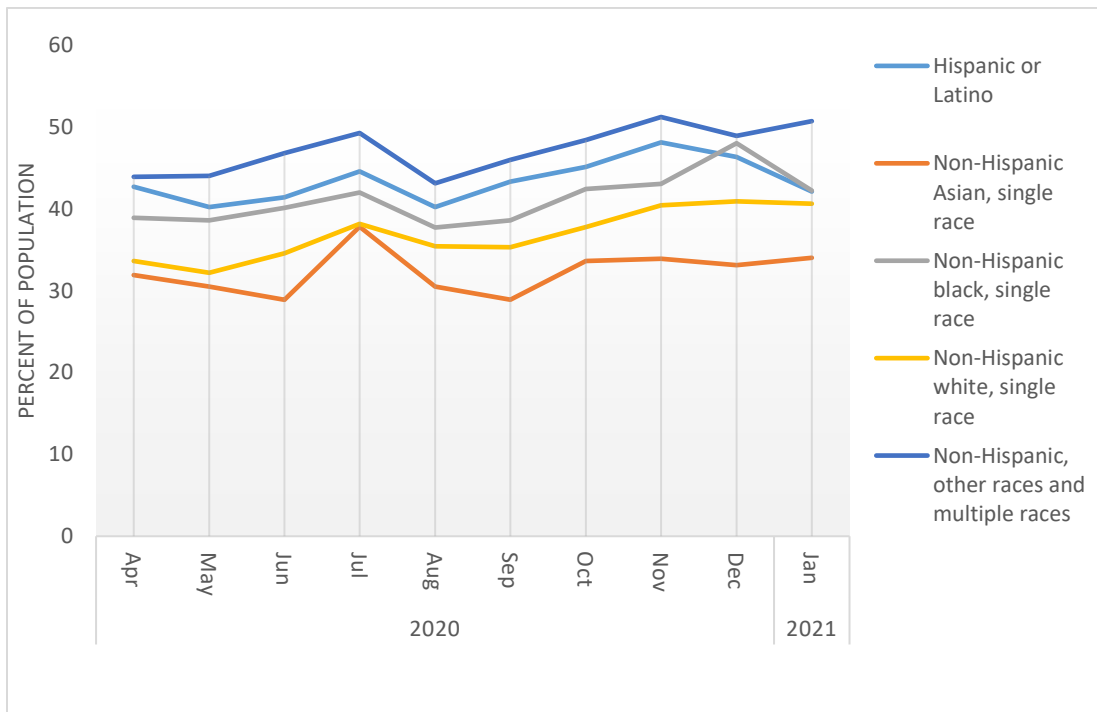
Source: CDC Pulse Survey

Figure 5 Percent of Region 8 Population Reporting Symptoms of Anxiety and Depression by Race and Ethnicity

Source: CDC Pulse Survey

4.3. Behavioral Health in Rural America

An important population characteristic to consider when evaluating access to infrastructure and resources is rural vs urban residency. When it comes to distinguishing rural from urban places, researchers and policymakers employ a dizzying array of definitions. "The use of multiple definitions reflects the reality that *rural* and *urban* are multidimensional concepts, making clear-cut distinctions between the two difficult." [29] The US Census Bureau defines rural "as any population, housing, or territory NOT in an urban area." [30] According to FEMA's *Guide to Supporting Engagement and Resiliency in Rural Communities*, 97% of the Nation's land is considered rural, in three of the six Region 8 states about 50% of the population lives in rural area, and four Region 8 states have low population densities. [31]

The pandemic has shed light on the diversity of issues facing rural areas. From greater distances travelled to healthcare facilities, to lack of access to broadband for remote work and schooling, the realities of rural life have complicated communities' ability to cope with the pandemic. Furthermore, many rural communities have experienced shifts in the industries that serve as large employers in their communities, causing economic distress. While most research investigates the impact of the pandemic and its' economic consequences on urban populations, one recent study from Utah State University surveyed individuals representing rural communities in the American west, including those in Region 8 states, to evaluate the impacts to physical, mental, and economic well-being. The study found that 52.77% of respondents reported some form of negative effect from the pandemic in their overall life, with 43.68% reporting negative impacts to their mental health.[32]

In general, a community's infrastructure informs their access to services. For instance, when it comes to healthcare, the availability of a health center in or near a community is an indicator of access. However, particularly when it comes to behavioral healthcare, this is not always an indicator that sufficient care is available, as many rural communities experience healthcare professional shortages.

According to the Health Resources and Services Administration (HRSA), a Health Professional Shortage Area (HPSA) is a population area experiencing a shortage of healthcare providers. Mental Health Professional Shortage Area Scores are calculated using seven criteria, including the Population-to-Provider Ratio, percent of population below 100% Federal Poverty Level, Elderly Ratio (percent of people over age 65), Youth Ratio (percent of people under age 18), Alcohol Abuse Prevalence, Substance Abuse Prevalence, and travel time to Nearest Source of Care outside the HPSA designation area, with a maximum score of 25 representing the highest need. The map in

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[29] USDA Economic Research Service. Defining the "Rural" in Rural America. June 01, 2008. Accessed: March 12, 2020.

[30] US Census Bureau. Rural America. 2010 Census Summary Files. Accessed: March 12, 2020.

[31] FEMA. A Guide to Supporting Engagement & Resiliency in Rural Communities. July 2020. Accessed: March 12, 2020.

[32] Mueller, T.J., McConnell, K. e al. (2020). Impacts of COVID-19 pandemic on rural America. *PNAS,* 118 (1) 2019378118.

Figure 6 shows the existing Mental Health HPSA for behavioral health providers in Region 8. Areas in blue generally represent populations with greater need.
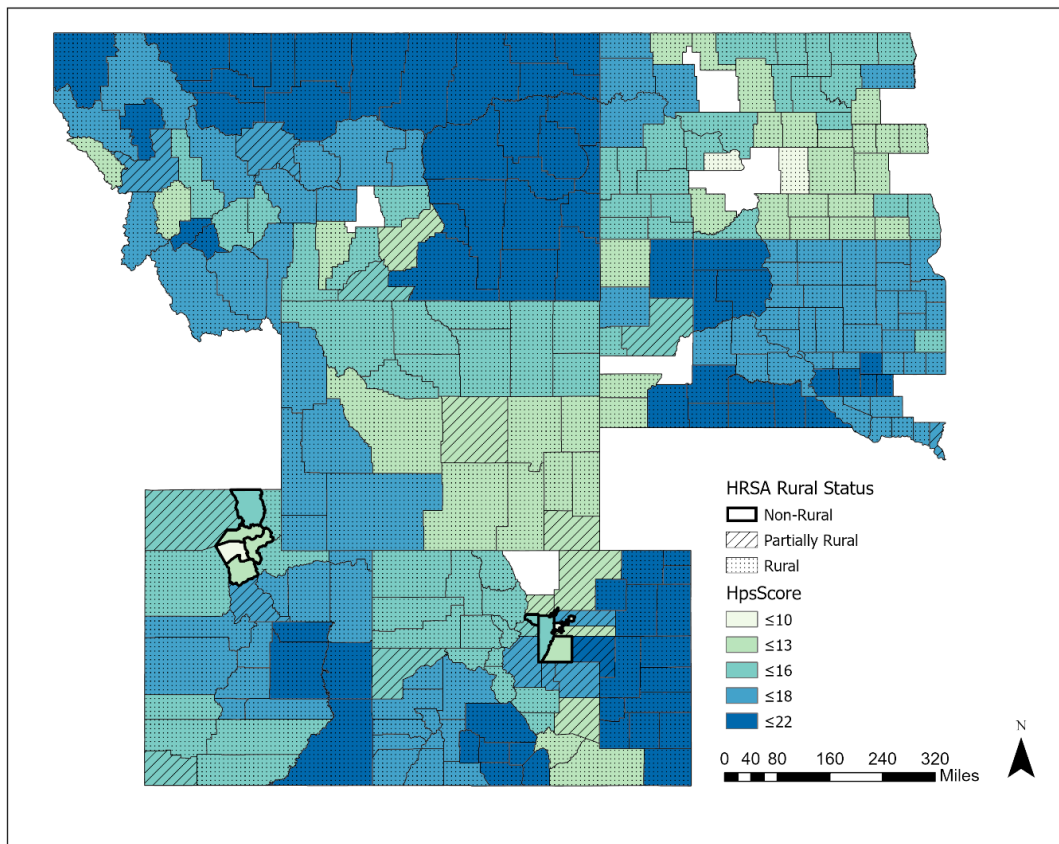

Figure 6 Mental Health Professional Shortage Areas in Region 8

Source: HRSA

4.4.   Impacts to People with Chronic Behavioral Health Needs

An important population to consider when evaluating the impact of the pandemic on behavioral healthcare is individuals diagnosed with severe mental illness and substance use disorders. These chronic behavioral health illnesses often require comprehensive clinical care, including medication and recovery support services. Many people with chronic behavioral health conditions have an elevated risk of death from suicide and/or overdose. Therefore, a good indicator to evaluate the impact of the pandemic on this population is trends in suicide and overdose mortality before and during the pandemic.

Over the past few years leading up to the pandemic, the United States was already experiencing a rise in both suicide and overdose mortality rates on a national scale, as well as among Region 8 states. Figure 7 and Figure 8 demonstrate these trends respectively for Region 8 states using data from the National Center for Health Statistics.
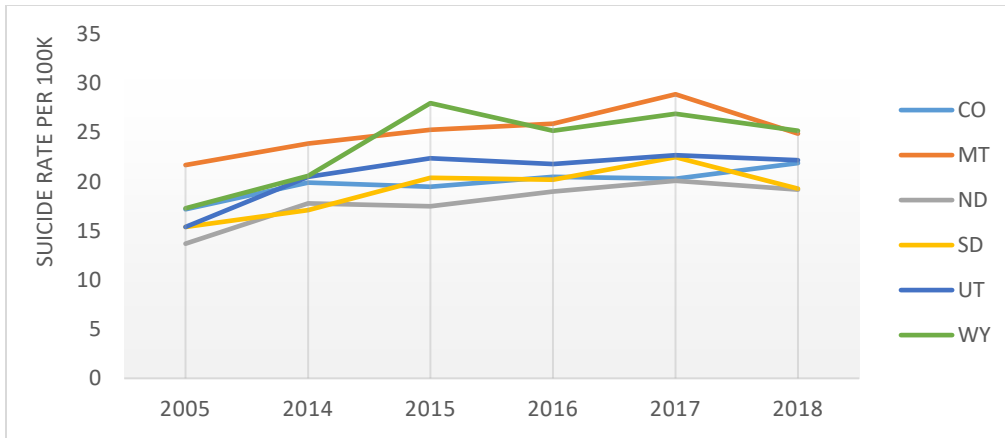
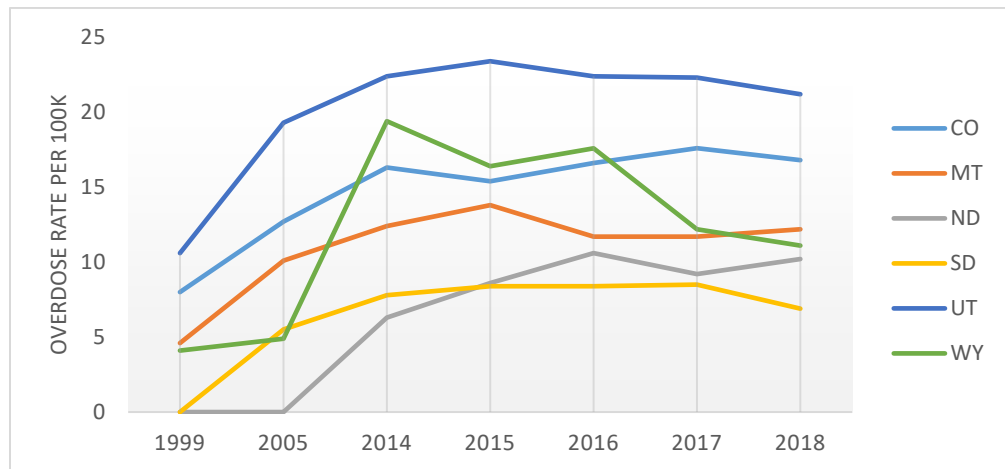**Figure 7 Change in suicide mortality rate in Region 8 states over time**

Figure 8 Change in Drug Overdose Death Rate in Region 8 States over time

Source: National Center for Health Statistics, CDC 2020

Both nationally, and in Region 8 states, rates of overdose and suicide deaths increased dramatically in 2020. In anticipation of such a rise, an analysis published in May 2020 projected the potential impact of the COVID-19 pandemic on "deaths of despair" from either suicide or overdose, calling these deaths "the epidemic within the pandemic."[33] The analysis projected that the US would see an increase of approximately 75,000 additional deaths from suicide or alcohol or drug use, particularly in places without "healthy community conditions, good healthcare coverage, and inclusive policies," according to Benjamin Miller, the Chief Strategy Officer at the Well Being Trust.[34]

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[33] Petterson, Steve et al. Projected Deaths of Despair During the Coronavirus Recession, Well Being Trust, May 8, 2020. Accessed: March 8, 2020.
[34] The Well Being Trust. The COVID Pandemic Could Lead to 75,000 Additional Death from Alcohol and Drug Misuse and Suicide. 2021. Accessed: 02/10/2021

In December 2020, the CDC released a Health Advisory for the dramatic increase in fatal drug overdose deaths that occurred before and during the COVID-19 pandemic. The report attributes most of the increase to synthetic opioid use, but a rise in cocaine and methamphetamine related deaths also occurred.[35] While much of the overdose data is still preliminary, the same report included a geographic breakdown of the rate of increased deaths in the 50 states. Figure 9 illustrates the percent change in overdose deaths over the 12-month period ending in May 2020. As seen in the figure, all Region 8 states, except for Utah, had a greater than 20% increase in overdose deaths during this period. However, as seen in Figure 8 above, Utah had already sustained the highest rate of overdose deaths in the region from 1999 to 2018, exceeding 20 deaths per 100K people between 2005 and 2018.
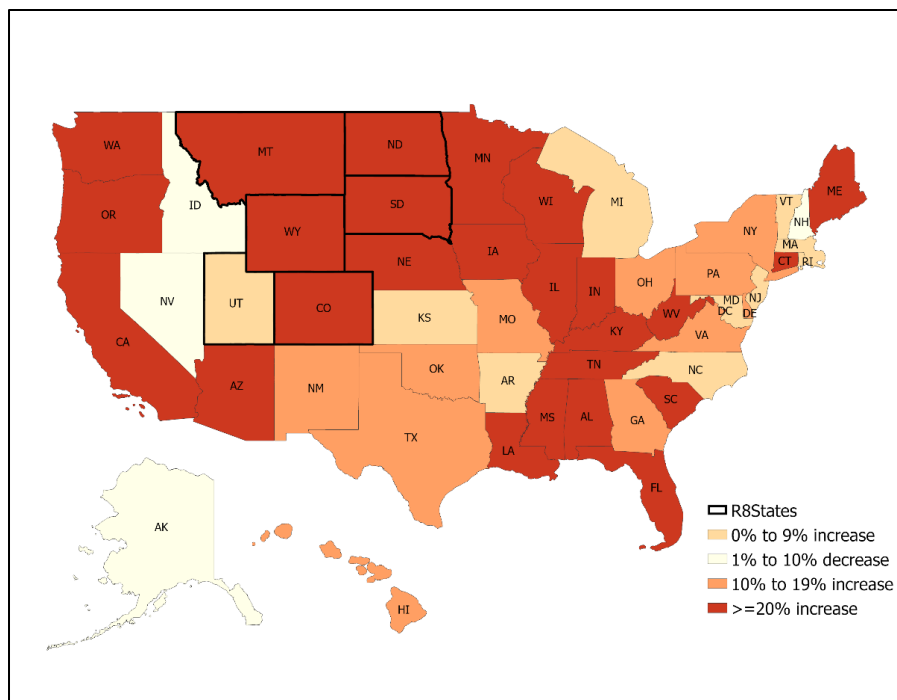
Figure 9. Percent increase in drug overdose deaths across the US in 12 months leading to May 2020

Source: CDC Health Advisory

4.5.   Trauma and Grief Associated with COVID-19

In addition to stress among the general population, there are additional manifestations of a pandemic that accompany the trauma of surviving the event. These types of psychological effects

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[35] CDC Health Advisory. Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic. December 17, 2020. Accessed: 02/11/2021.

are often seen following epidemics or other disaster events among survivors and their families as well as healthcare workers.

Some examples of psychological effects that health professionals often expect following close personal experiences with the COVID-19 virus can include complicated grief and a variety of trauma related conditions including emergence of Posttraumatic Stress Disorder (PTSD). Complicated grief, a form of prolonged grieving, is often observed among survivors following natural disasters, in which individuals suddenly experience multiple types of life-altering loss.[36] One example includes the effects observed on communities in many African countries following the Ebola epidemic, which resulted in lasting community level grief and anxiety.[37] Research indicates that a person's experience of severe illnesses caused by an epidemic or pandemic can result in post-recovery psychological effects. For example, one recent study investigated the psychological repercussions of Ebola and Zika virus outbreaks and found that one-third of survivors experienced feelings of rejection from their social networks, one-half experienced survivor's guilt, and all respondents felt greater connection to religion.[38] This study reflects an increasingly studied phenomena in which people experiencing high rates of posttraumatic stress may also experience high levels of post traumatic growth.

There has also been concern about the development of trauma-related conditions for hospitalized patients with severe illnesses, such as COVID-19. Numerous studies have found that many patients following admittance to a hospital Intensive Care Unit (ICU) develop PTSD, [39] particularly those who were intubated[40] and underwent prolonged mechanical ventilation.[41]

In addition to the risk of trauma related conditions among COVID-19 survivors and their families, there is also concern over the psychological effects that a prolonged pandemic event could have on the healthcare workforce. Healthcare workers, particularly those working in disaster or emergency settings, can develop trauma-related conditions as a result of prolonged exposure to stressful or under-resourced environments. [42] One such condition, PTSD, can result in a number of behavioral

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[36] Gesi C, Carmassi C, Cerveri G, Carpita B, Cremone IM and Dell'Osso L (2020). Complicated Grief: What to Expect After the Coronavirus Pandemic. *Frontiers of. Psychiatry,* 11:489.

[37] Reardon S. (2015). Ebola's mental-health wounds linger in Africa. *Nature,* 519:13–4.

[38] Tucci, V., Moukaddam, N. (2017). The Forgotten Plague: Psychiatric Manifestations of Ebola, Zika, and Emerging Infectious Diseases. *Journal of Global Infectious Diseases,* 9(4):151-156.

39 Battle, C. E., James, K., Bromfield, T., & Temblett, P. (2017). Predictors of post-traumatic stress disorder following critical illness: A mixed methods study. *Journal of the Intensive Care Society*, 18(4), 289–293. 3

40 Girard, T. D., Shintani, A. K., Jackson, J. C., Gordon, S. M., Pun, B. T., Henderson, M. S., Dittus, R. S., Bernard, G. R., & Ely, E. W. (2007). Risk factors for post-traumatic stress disorder symptoms following critical illness requiring mechanical ventilation: a prospective cohort study. *Critical care* (London, England), 11(1), R28.

41 Jubran, A., Lawm, G., Duffner, L. A., Collins, E. G., Lanuza, D. M., Hoffman, L. A., & Tobin, M. J. (2010). Post-traumatic stress disorder after weaning from prolonged mechanical ventilation. *Intensive care medicine*, 36(12), 2030–2037.

[42] Dutheil.F., Aubert, C. et al. (2019). Suicide among physicians and health-care workers: A systematic review and meta-analysis. *PloS ONE,* 14(12): e0226361.

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[36] Gesi C, Carmassi C, Cerveri G, Carpita B, Cremone IM and Dell'Osso L (2020). Complicated Grief: What to Expect After the Coronavirus Pandemic. *Frontiers of. Psychiatry,* 11:489.

[37] Reardon S. (2015). Ebola's mental-health wounds linger in Africa. *Nature,* 519:13–4.

[38] Tucci, V., Moukaddam, N. (2017). The Forgotten Plague: Psychiatric Manifestations of Ebola, Zika, and Emerging Infectious Diseases. *Journal of Global Infectious Diseases,* 9(4):151-156.

39 Battle, C. E., James, K., Bromfield, T., & Temblett, P. (2017). Predictors of post-traumatic stress disorder following critical illness: A mixed methods study. *Journal of the Intensive Care Society*, 18(4), 289–293. 3

40 Girard, T. D., Shintani, A. K., Jackson, J. C., Gordon, S. M., Pun, B. T., Henderson, M. S., Dittus, R. S., Bernard, G. R., & Ely, E. W. (2007). Risk factors for post-traumatic stress disorder symptoms following critical illness requiring mechanical ventilation: a prospective cohort study. *Critical care* (London, England), 11(1), R28.

41 Jubran, A., Lawm, G., Duffner, L. A., Collins, E. G., Lanuza, D. M., Hoffman, L. A., & Tobin, M. J. (2010). Post-traumatic stress disorder after weaning from prolonged mechanical ventilation. *Intensive care medicine*, 36(12), 2030–2037.

[42] Dutheil.F., Aubert, C. et al. (2019). Suicide among physicians and health-care workers: A systematic review and meta-analysis. *PloS ONE,* 14(12): e0226361.

health presentations including reduced sociability, flashbacks, and anxiety, as well as heightened risk for suicidal ideation and attempts.[43]

Many in the behavioral health field have expressed concern over burnout and moral injury experienced by healthcare professionals. According to the Moral Injury Project at Syracuse University, "moral injury is the damage done to one's conscience or moral compass when that person perpetrates, witnesses, or fails to prevent acts that transgress one's own moral beliefs, values, or ethical codes of conduct."[44] Distinct from PTSD, moral injury is a particular risk during large surges of infections when hospital beds, ventilators, and medications become scarce and healthcare workers are forced to make decisions that contend with their values as healthcare professionals. While these impacts are concerning, there is evidence that these types of distress can be mitigated by supportive work environments and stress reduction activities within the healthcare workforce.[45]

5.   Telehealth and Behavioral Health Policy

5.1.   Technology and Infrastructure - Access to Broadband

Over the past several decades, the internet has become a critical tool for households to access information and services, learn, connect with family and friends, shop, and work. Having access to affordable and reliable broadband has become one of the most critical infrastructure challenges of our time, just as electrification, railways, and roadways were in the 19th and early 20th centuries. As a result of stay-at-home orders, social distancing measures, and school and business closures, many Americans have been increasingly reliant on the internet. Likewise, the internet has become increasingly essential for most sectors of the American economy.[46]. In addition to changing the way we work, attend school, shop, and socialize, this shift has caused large changes in the way we access healthcare.

The shift to the virtual world, accelerated by the COVID-19 pandemic, shed light on the fact that many American households do not have internet connections that are reliable and fast enough to do things like attend class or work virtually. This reality creates what is being called a "digital divide," which often delineates differences in access between urban and rural areas.[47] Often, this divide is due to infrastructure limitations in areas of the country which are physically isolated from population centers and sparsely populated.

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[43] Dutheil F., Mondillon L., Navel V. (2020). PTSD as the second tsunami of the SARS-Cov-2 pandemic. *Psychological Medicine,* 1–2.

[44] The Moral Injury Project, Syracuse University. What is Moral Injury, Accessed: 03/08/2021.

[45] Hines SE, Chin KH, Glick DR, Wickwire EM. (2021) Trends in Moral Injury, Distress, and Resilience Factors among Healthcare Workers at the Beginning of the COVID-19 Pandemic. *Int J Environ Res Public Health*, 18(2):488.

[46] Education First. Making the Most of "Going Virtual" in Response to COVID-19. March 13, 2020. Accessed: 02/18/2021.

[47] American Bar Association. Expanding Broadband Access to Rural Communities. March 21, 2020. Accessed: 02/15/2021.

According to the Federal Communications Commission, as of year-end 2018, 94.4% of the overall population had coverage of such service providing 25/3 Mbps, which is their benchmark for fixed advanced telecommunications capability. This was an increase from 93.5% in 2017. [48]Nonetheless, the gap in rural and Tribal America remains notable: 22.3% of Americans in rural areas and 27.7% of Americans in Tribal lands lack coverage from fixed terrestrial 25/3 Mbps broadband, as compared to only 1.5% of Americans in urban areas.[49] While the gap between urban and rural areas has shrunk in recent years, it remains a challenge for rural communities, particularly during the pandemic when Americans have become more reliant on broadband.

While access to broadband infrastructure can often be a major reason for the gap, access and availability of broadband also depends on household's ability to pay for broadband services. According to American Community Survey (ACS) estimates from 2019, seen in the Table 2, 15.8% of households in Region 8 do not have an internet subscription. As the pandemic continues, understanding where internet is accessible, and at what speed, will play a role in the wellbeing of citizens, the economy, and communities[50].

Table 2. Household Access to Communications Technology Across Region 8 States

State	Total Households	% with 1 or more types of computing devices	% w/ no computer	% w/ internet subscription	% W/O an internet subscription
Colorado	2,113,387	92.8	7.2	86.2	13.8
Montana	423,240	87.3	12.7	79	21
North Dakota	314,903	88.5	11.5	79.4	20.6
South Dakota	341,565	86.8	13.2	78.6	21.4
Utah	957,619	94.4	5.6	86.1	13.9
Wyoming	230,630	90.8%	9.2	81.7	18.3
Region 8 Total	4,381,344	91.8%	8.2%	84.2%	15.8%

Source: US Census ACS 2019, 5Y Table S280

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[48] Federal Communications Commission. 2020 Broadband Deployment Report. April 24, 2020. Accessed: 02/15/2021.
[49] Federal Communications Commission. 2020 Broadband Deployment Report. April 24, 2020. Accessed: 02/15/2021.
[50] Argonne Internet Access Index Whitepaper

5.2. Telehealth and Telebehavioral Health

Along with the shift to the virtual world, the U.S. has seen a large shift towards the use of telehealth during the pandemic. HRSA defines telehealth as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, and public health and health administration. Telehealth technologies include videoconferencing, the internet, store and-forward imaging, streaming media, and landline and wireless communications."[51]

While telehealth adoption has been relatively slow over the past decade, it has accelerated dramatically following the onset of the pandemic and has recently been endorsed by the American Medical Association[52], American Academy of Pediatrics[53] and the American Association of Nurse Practitioners[54], along with the CDC[55]. A survey conducted in April 2020 by McKinsey & Company found that 46% of Americans used telehealth to replace cancelled healthcare visits, which was up from 11% of consumers that reported using telehealth in 2019. [56]

Telebehavioral health is the application of telehealth for the purpose of providing behavioral healthcare. It can involve screening, diagnostic evaluations, therapy (individual, group, family), patient education, chronic disease management, recovery support services, and medication management. The American Psychiatric Association notes several benefits of telebehavioral health including:[57]

- Improve access to mental health specialty care that might not otherwise be available
- Bring care to the patient's location
- Help integrate behavioral health care and primary care, leading to better outcomes
- Reducing the need for trips to the emergency room
- Reducing delays in care
- Improving continuity of care and follow-up
- Reducing the need for time off work, childcare services, etc.
- Reducing transportation barriers, such as lack of transportation or the need for long drives
- Reducing the barrier of stigma[58]

The US has also seen a dramatic increase in adoption of telebehavioral health during the pandemic. In October 2020, the State Mental Health Program Directors National Research Institute (NRI)

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[51] Health Resources & Services Administration. Telehealth Programs. January 2021. Accessed: 03/10/2021.
[52] American Medical Association. COVID-19. AMA's recent and ongoing advocacy efforts. 2021. Accessed: 03/05/2021.
[53] Committee on Pediatric Workforce, (2015). The use of telemedicine to address access ad physician workforce shortages. *Pediatrics*. 136(1) 202-209.
[54] American Association of Nurse Practitioners. Telehealth. September 2019. Accessed: 03/10/2021.
[55] Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic | CDC
[56] McKinsey & Company. Telehealth: A quarter-trillion-dollar post-COVID-19 reality. May 29, 2020. Accessed: 03/10/2021.
[57] Indian Health Service. About TeleHealth and Telebehavioral Health. Accessed: 02/25/2021.
[58] Indian Health Service. About TeleHealth and Telebehavioral Health. Accessed: 02/25/2021.

released a report, which includes data from a survey conducted of State Mental Health Authorities (SMHAs) on the use of telebehavioral health since the beginning of the pandemic. It included the following findings:

- Telephone encounters increased by 365%, video-conferencing encounters increased by 137% from January to June 2020.
- State telehealth claims increased from 1,500 to 4,500 per month, half for mental health.
- 88% of SMHAs reported their community providers experienced a decrease in in-person, face-to-face encounters since March 2020 three SMHAs reported no decrease, and two had insufficient data to respond.
- 71% of SMHAs reported the decrease has been significantly offset by an increase in telehealth visits, while 15% (6) of SMHAs reported that telehealth has not significantly replaced face-to-face visits.
- As community providers experienced a reduction in clients coming in for services in response to COVID-19, 71% of SMHAs reported providing supportive funds to providers.[59]

This increase may be most readily seen in the numbers of Veterans seen for mental health by the Veterans Health Administration:

- Individual tele-mental health (TMH) visits to Veterans' homes/preferred locations averaged 27K per month pre-COVID. In FY21 February, there were over 452,000 such visits – the highest monthly volume to date.
- TMH-to-home group therapy averaged 150 group visits per month pre-COVID and increased to over 116,500 visits in FY21 February—the highest TMH-to-home group utilization to date.
- Mental health care and consultation over the telephone grew to a maximum of more than 979,500 visits in FY20 April, a 6-fold increase over pre-COVID levels. Phone has gradually decreased as telehealth and in-person visits have increased.
- The greatest volume of TMH-to-home visits has been in general mental health, substance use disorders and PTSD clinics.[60]

The progression in the application of telemedicine over the past year, particularly in the context of behavioral health, constitutes a major opportunity for the healthcare system to extend access to communities that traditionally have had limited access to healthcare services. These communities include, but are not limited to, those with limited mobility, rural communities, and tribal communities.

However, this opportunity is not without its challenges. Access to internet connection, either through a phone data plan, broadband connection or ethernet is required to access these services, which can often be a financial barrier. Additionally, technology support afforded to both patient and provider, as well as real and perceived safety are important considerations. Video visits require

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[59] National Association of State Mental Health Programs Directors Research Institute. NRI: Impacts of COVID-19 on State Mental Health Services. November 12, 2020.
[60] Data provided by the Veterans Health Administration.

patients and providers to have the knowledge and capacity to access an online platform, operate and troubleshoot audiovisual equipment, and communicate without the cues available in person. Many older adults may be unable to do this because of disabilities or inexperience with technology.[61] In a report on the impact of COVID-19 on state mental health services, released by the National Association of State Mental Health Program Directors Research Institute (NASMHPD), one SMHA noted that while "some providers have reported a decrease in no-shows due to telehealth, some have reported difficulties in connecting with clients via telehealth due to clients' difficulty accessing and using technology." [62]

A recent article by the Brooking's Institute illuminated limitations of equity when it comes to broadband. "According to the Pew Research Center's most recent report on Digital Readiness Gaps, the slight majority (52%) of U.S. adults are still relatively hesitant when it comes to new technologies and digital skills. This means that they have low levels of digital skills, limited trust in the internet, or don't often turn to it as a source. The report's national numbers further illustrate the depth of the challenge: 60% of adults find it difficult to know whether the information they find online is trustworthy, and 40% usually need help setting up or navigating new devices." [63]

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[61] Lam, K., Lu, A.D., Shi, Y. et al. (2020). Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic. JAMA Intern Med: 180(10): 1389-1391.
[62] National Association of State Mental Health Programs Directors Research Institute. NRI: Impacts of COVID-19 on State Mental Health Services. November 12, 2020. Accessed: 02/15/2021.
[63] The Brookings Institute; How broadband can deliver health and equity to all communities. February 27, 2020. Accessed: 02/15/2021.

5.3.   Telehealth in Tribal Nations
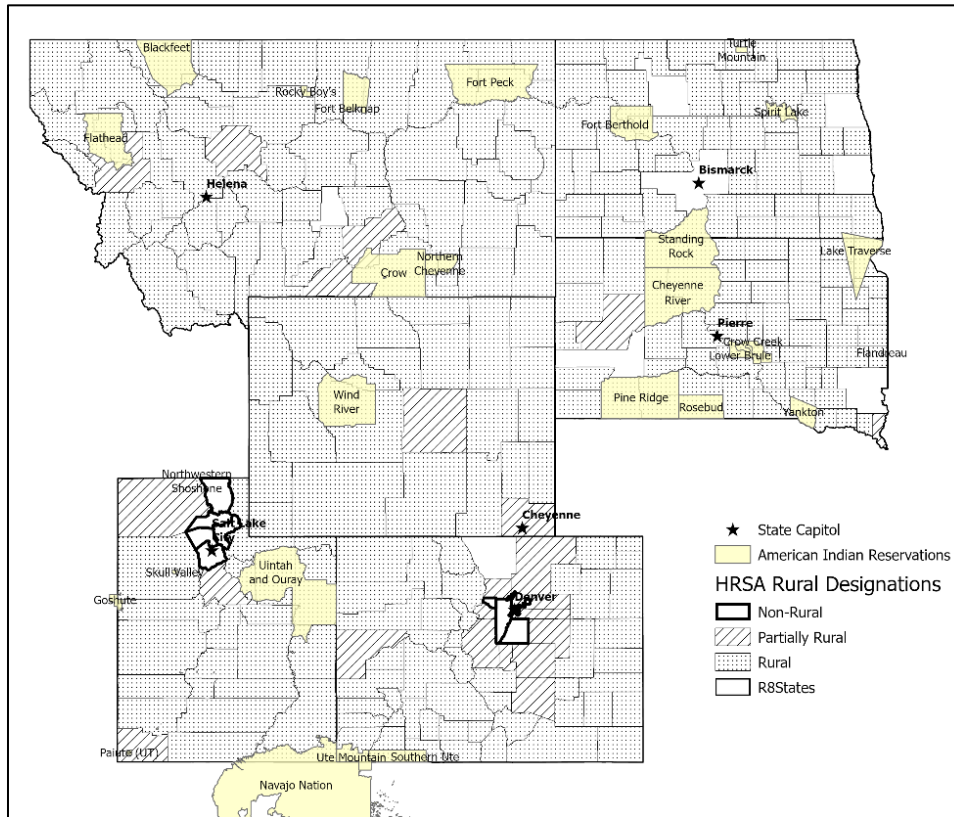
Figure 10. Location of Region 8 American Indian Reservations in Relation to HRSA Rural Designations

Source: HRSA, DOI

Many tribal nations in Region 8 states and throughout the United States exist in geographically isolated settings with limited infrastructure and different barriers to accessing services, particularly in comparison to more densely populated settings. In the context of healthcare, this can lead to a lack of access to specialty services, such as behavioral healthcare, as specialists are often not available in these locations and travel costs can be prohibitive.

Some tribal nations have been at the forefront of telemedicine to alleviate these challenges, even before the COVID-19 pandemic. For example, healthcare systems operated in partnership between the U.S. Department of Health and Human Services- Indian Health Services (IHS) and/or operated independently by a Tribal Nation, have seen some major successes in implementing video teleconferencing and telebehavioral health care, such as in rural Native Alaskan communities.[64]

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[64] Hays, H., Carroll, M. (2014). The Success of Telehealth Care in the Indian Health Service. *AMA Journal of Ethics*, 16(12):986-996.

However, while Tribal Nations may be open to implementing greater telehealth programs, access to infrastructure still presents a challenge. In the 2020 Broadband Deployment Report, the Federal Communications Commission (FCC) acknowledged that broadband deployment is slow to reach tribal lands because the "isolated nature of these areas combined with challenging terrain and lower incomes increase the cost of network deployment and entry, thereby reducing the profitability of providing service." [65]

5.4. Federal and State Policies during the COVID-19 Pandemic

Soon after the Public Health Emergency declaration in March 2020, communities issued stay-at-home orders, businesses closed, and many services were halted. For continued access to essential medical care however, many states across the US adopted temporary changes to policies to accommodate greater flexibility for both patients and healthcare providers during the pandemic.

One of the major changes to federal policy was the HHS Office for Civil Rights' release of *Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*. [66] Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that the Office for Civil Rights might seek to impose a penalty for HIPAA noncompliance related to the good faith provision of telehealth. The Notice also clarifies that similar video communication applications that are public facing, such as Facebook Live, Twitch, TikTok, should not be used in the provision of telehealth by health care providers.

Similarly, in response to the COVID-19 pandemic, SAMHSA issued emergency guidance to states, territories, tribal nations, and local communities to ensure that substance use disorder treatment services were uninterrupted.[67] SAMHSA temporarily waived the prohibitions on use and disclosure of patient identifying information under 42 C.F.R. Part 2 to the extent that, as determined by the addiction treatment provider, a medical emergency exists. Under 42 U.S.C. §290dd-2(b)(2)(A) and 42 C.F.R. §2.51, patient identifying information was permitted to be disclosed by a Part-2 program (substance use disorder treatment provider or agency) or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained. Information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed by such personnel for treatment purposes as needed. This flexibility allowed for many behavioral health providers, who would have otherwise not been able to provide virtual care due to the requirement for written patient consent, to provide uninterrupted care. Due to many substance use disorder treatment provider offices closing

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[65] Federal Communications Commission. 2020 Broadband Deployment Report. April 24, 2020. Accessed: 02/15/2021.
[66] HHS. Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. January 20, 2021. Accessed: 02/18/2021.
[67] SAMHSA. Coronavirus (COVID-19). April 09, 2021. Accessed: 04/14/2021

or patients being unable to attend treatment, telebehavioral health services (video and telephone) quickly filled the gap.

SAMHSA, also under the public health emergency, provided specific flexibilities for the use of telebehavioral health for the initiation and on-going treatment of individuals with opioid use disorders. For new patients with an opioid use disorder treated with buprenorphine, SAMHSA exempted Opioid Treatment Programs (OTP) from the requirement to perform an in-person physical evaluation (under 42 C.F.R. § 8.12(f)(2)) prior to initiation of buprenorphine, providing that the treating physician determines that an adequate evaluation of the patient can be accomplished via telehealth. Likewise, SAMHSA extended privileges to licensed substance use disorder medical providers to use telebehavioral health (including telephone) to treat existing patients assuming patient safety and standard of care is maintained.[68]

SAMHSA also permitted Opioid Treatment Programs (OTPs) to receive blanket exceptions for take home medications. This allowed OTP Medical Directors to authorize a stable patient receiving treatment in an OTP more take-home medications than was allowed pre-pandemic. While this was not directly related to telehealth, it did allow less in person contact for many patients in OTPs.

Another area that underwent policy shifts throughout the pandemic is regulation and access to prescription medications. Beginning March 31, 2020, The Drug Enforcement Administration (DEA) implemented two important temporary policy exceptions for the remainder of the public health crisis. These are: 1) a practitioner can prescribe controlled substances to a patient using telemedicine, even if the patient is not at a hospital or clinic registered with the DEA and 2) qualifying practitioners can prescribe buprenorphine to new and existing patients with opioid use disorders based on a telephone evaluation. [69]

In March 2020, the Centers for Medicare, and Medicaid Services (CMS) announced several temporary changes to policy related to the developing situation around the COVID-19 pandemic. These short-term changes temporarily expanded access to telehealth services by ensuring that healthcare providers would be compensated at commensurate rates for the same service regardless of the format (in-person or remotely). The policy updates include:

- Ensuring that providers would be reimbursed for Medicare and Medicaid services offered via telehealth at the same rate as in-person appointments
- Providing a waiver for health care providers to practice telehealth across state lines, if it corresponded with state policies
- Allowing health care providers to establish new patient relationships via telehealth communication in addition to seeing existing patients using telehealth platforms.

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[68] SAMHSA. Opioid Treatment Program (OTP) Guidance. March 19, 2020. Accessed: 01/24/2021.
[69] DEA. How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency. March 31, 2020. Accessed: 02/21/2021.

- Allowing for not only physicians, but any type of healthcare provider to bill for Medicare or Medicaid services provided via telehealth.
- Allowing providers to offer supervised services (real-time audio or video communication

CMS also added certain services permanently to the Category 1 telehealth list of the CY 2021 Medicare Physician Fee Schedule. These services include:

- Group Psychotherapy (CPT code 90853)
- Psychological and Neuropsychological Testing (CPT code 96121)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99334-99335)
- Home Visits, Established Patient (CPT codes 99347-99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M) (HCPCS code G2211)
- Prolonged Services (HCPCS code G2212)

The final important policy change is related to licensing and telehealth allowances at the state level. Prior to the pandemic, certain states participated in interstate compacts to allow physicians to obtain licensing in other states. However, at the onset of the pandemic, many states expanded their state legislation to allow greater access to licensing for qualified healthcare providers. Many states also allowed healthcare providers to provide interstate care with new or existing patients via telemedicine. See table 3 below for a detailed summary of each Region 8 state's temporary changes.

Table 3 Temporary Changes to State Telehealth and Licensing Policy During the Public Health Crisis

State	Telehealth[70]	Licensing[71]
Colorado	-Suspended requirement that patient be in Colorado -Permanently prohibit insurers from requiring an established in-person patient-practitioner relationship -Existing law allowed for physicians licensed in other states to practice for free in CO or provide occasional services in CO if they do not have a regular practice in the state	-Expand existing statute to allow training physicians to temporarily practice without a license -Physicians with expired license may practice under a 60-day grace period Expires Feb 24, 2021

70FSMB, U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19, Accessed 01/28/21
71 FSMB, U.S. States and Territories Modifying Licensure Requirements for Physicians in Response to COVID-19, Accessed 01/28/21

	Expires: Feb 24, 2021	
Montana	Existing legislation allows DOL&I to expand the scope of services for providers in the case of emergencies to include secure portals, messaging, phone conversations, audio-visual conversations -Providers must ensure that patient rights to confidentiality and security are same as with traditional office visits -Payment coverage parity is required for telemedicine Expires: End of Montana State of Emergency	-Existing legislation allows DOL&I to provide interstate licensure in the case of an emergency or disaster -DOL&I implemented a COVID-19 Emergency Healthcare Registration allowing out of state professionals to register Expires: End of Montana State of Emergency
North Dakota	-Insurers are required to cover virtual check-ins and e-visits for established patients Expires: End of North Dakota State of Emergency	-licensure requirements suspended allowing for providers in good standing in other states to provide health care and behavioral health services, including telehealth to citizens Expires: End of North Dakota State of Emergency
South Dakota	-Per SD code, the Governor may grant license expansion to member state practitioners in the Uniform Emergency Management Assistance Compact to provide support if needed to SD facilities by in-person or remote means. This authority was exercised March 23, 2020 by Gov. Noem. -Regulations restricting providers from using telehealth or tele-medicine were suspended. Expires End of South Dakota State of Emergency	Per SD code, the Governor may grant license expansion to member state practitioners in the Uniform Emergency Management Assistance Compact to provide support if needed to SD facilities by in-person or remote means. This authority was exercised March 23, 2020 by Gov. Noem. Expires End of South Dakota State of Emergency
Wyoming	-Temporary voluntary license may be acquired through the Wyoming Medical Board (allowance of out-of-state telemedicine is implied) -Out of state providers with existing patient relationships may provide services via telemedicine to patients in the state without a Wyoming license. Care may not be provided for a new diagnosis without a Wyoming license. Expires: End of Wyoming State of Emergency	-Physicians licensed in other states may apply for "consultation exemption" during a public health crisis to provide services in the state of Wyoming. Once approved physicians or physician assistants may initiate a new patient relationship. This exemption extends 45 days after end of state of emergency -Current licenses in the state have been extended from current expiration date of June 30,2020 o September 30, 2020 Expires: End of Wyoming State of Emergency

Utah	Providers may offer telehealth services that do not comply with HIPAA so long as they inform the patient that services are not HIPAA compliant, provide the opportunity for the patient to decline service, and ensure the security and privacy of the telehealth services. Expires: end of Utah State of Emergency	Physicians from out of state may practice in Utah without a Utah state license if 1) they have an out of state license and at least 10 years of experience 2) services are provided as a non-commercial service or 3) services are provided for free (with the exception of cost of care and malpractice insurance). Expires: End of Utah State of Emergency

5.5. CARES Act Funding for Behavioral Health & Disaster Behavioral Health

In addition to changes in policy that have facilitated a rise in telehealth during the pandemic, both behavioral health and broadband have been priority areas in much of the COVID-19 related legislation and supplemental funding packages. To aid the nation's recovery from the COVID-19 pandemic, the U.S. Congress passed four special appropriations laws in 2020 for the federal government to use in relief efforts. All but around $15 billion of COVID relief come from four pieces of legislation. The largest of these was the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which provides approximately $2.09 trillion and is the largest supplemental appropriation in American history

Funding to support steady state behavioral healthcare systems was primarily oriented through SAMHSA. In FY 2020, SAMHSA awarded $424,244,671 in discretionary grants funded through CARES Act legislation, which were largely broken into five grant categories: [72]

- TBH COVID – Tribal Behavioral Health
- Emergency Response COVID-19
- COVID-19 ERSP: COVID-19 Emergency Response for Suicide Prevention
- CCF-COVID: Suicide Prevention Lifeline Crisis Center Follow-Up (Expansion Grants)
- CCBHC COVID: Certified Community Behavioral Health Clinics (Expansion Grants)

Funding for Disaster Behavioral Health was directed through the FEMA Crisis Counseling Program to provide two types of programming: Immediate Services Program (1-5 months) and Regular Services Program (9 months), in Partnership with SAMHSA. Table 4 below demonstrates the funding for these programs in Region 8 states.

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[72] SAMHSA. FY 2020 SAMHSA COVID-19 Funded Grants. February 3, 2021. Accessed 02/25/2021.

Table 4. Cumulative Funding for the Crisis Counseling Program in Region 8 States

	Immediate Services Program (ISP)	Regular Services Program (RSP)
Colorado	$1,780,587	$8,688,454
Montana	$251,053	$1,642,155
North Dakota	-	$835,629
South Dakota	$210,723	$681,872
Utah	$1,419,476	$3,277,676
Wyoming	-	-
Totals	$3,661,839	$15,125,786

Source: FEMA ExSumm

SAMHSA received another $4.25 billion in funding from the Consolidated Appropriations Act, 2021 and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260]. As of early March, SAMHSA had awarded $685,755,492 in supplement to the CCBHC-COVID, and the Emergency Response COVID-19 grant programs.
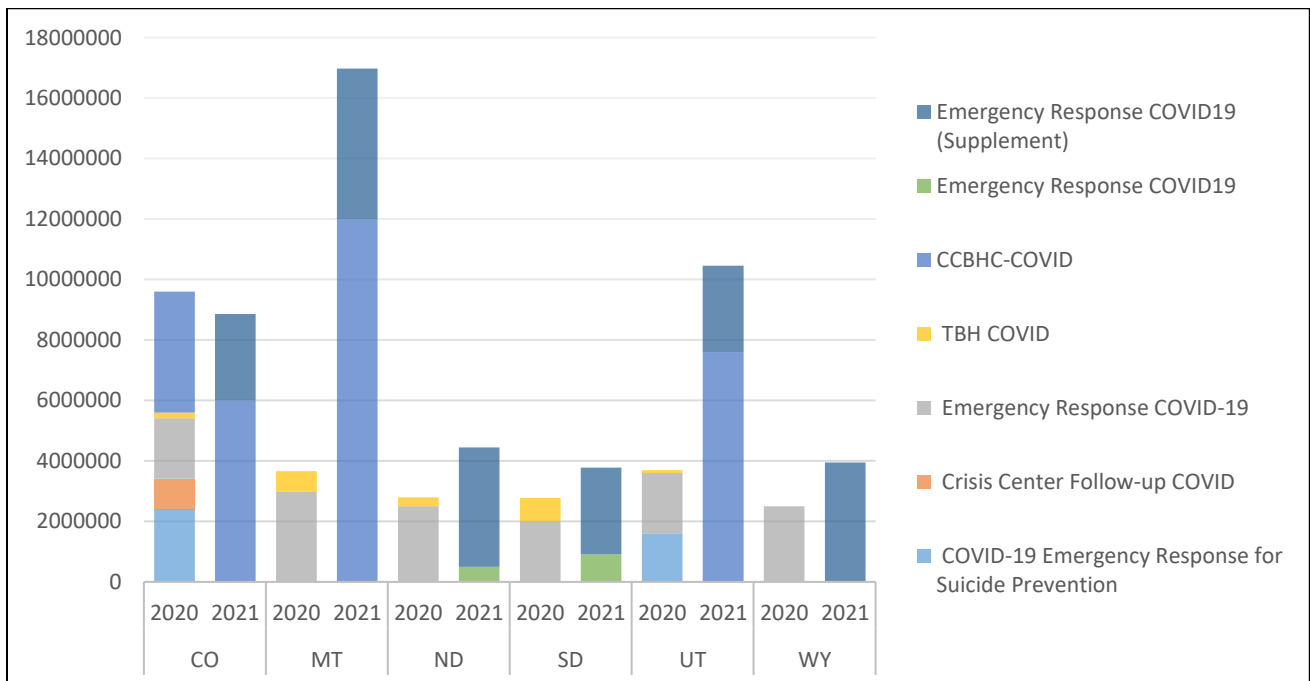
Figure 11. Breakdown of SAMHSA CARES Act Funding in Region 8 States

Source: SAMHSA (2021, 2020)

Of the funds allocated, $24.8M went to programs in Region 8 states in 2020, and $48.5M has gone to programs in Region 8 states thus far, in 2021. Figure 11 provides a breakdown of the grants allocated in Region 8.

5.6.   CARES Act Funding for Broadband Expansion and Telemedicine

In addition to funding that has been directed to behavioral healthcare, the CARES Act and supplemental funding packages passed in 2020 and 2021 have provided additional funding directed to the expansion of broadband access for the purpose of remote education and telemedicine. Much of this funding is directed toward expanding access in rural areas that may be considered vulnerable. Table 5 below lists various grant programs through multiple agencies aimed at expanding access to broadband infrastructure for education, healthcare, and equity.

Even prior to the COVID-19 pandemic, internet access was a growing national priority, specifically in rural areas. Certain programs meant to serve rural areas, such as the USDA Distance Learning and Telemedicine Grants and ReConnect Programs existed prior to the COVID-19 pandemic. A summary of USDA spending between 2010 and 2020 can be found in Appendix B. However, during the Pandemic, several agencies received funding to implement broadband programs through the CARES Act and other supplemental legislation.

Table 5. Existing and new programs for the expansion of access to broadband infrastructure

Agency	Grant Program
HHS/HRSA	Area Health Education Centers Program – COVID-19 Telehealth Awards
	Centers of Excellence Program – COVD-19 Telehealth Awards
	Geriatrics Workforce Enhancement Program – COVID-19 Telehealth Awards
	Registered Nurses in Primary Care Training Program – COVID-19 Telehealth Awards
	Veteran Nurses in Primary Care training Program – COVID-19 Telehealth Awards
	Maternal and Child Health Telehealth Program
	Rural Telehealth Resource Centers
	Rural Tribal COVID-19 Response Programs
	Rural Telehealth – Licensure Portability Grant Program
USDA	Distance Learning and Telemedicine Grants
	Telecommunications Infrastructure Program
	Broadband Initiative Program
	Community Connect Grant Program
	ReConnect Grants
FCC	COVID-19 Telehealth Program
	Emergency Broadband Benefit Program
	Digital Opportunity Data Collection
	Connecting Minority Communities Fund
NTIA	Grants for Broadband Connectivity

6.   Conclusion

Behavioral health continues to be one of the greatest challenges for Americans throughout the COVID-19 pandemic. There have been several behavioral health implications of COVID-19, including a rise in general stress, substance use, anxiety, depression, and suicidality, and overdose deaths. As discussed, these increases are more apparent and severe in populations and geographic areas with greater pre-existing social vulnerabilities, as defined by the CDC, which have been exacerbated by the economic crisis.

To mitigate impacts to behavioral health, Federal and many state and tribal governments have established programs, and instituted policy changes to increase access to behavioral healthcare in this time of crisis. Programs that have arisen because of the Public Health Crisis, such as the FEMA CCP and the CMS Medicare waivers, extended behavioral healthcare access to individuals and

populations that would not have otherwise had them. However, gaps still exist for access to continued care, especially for individuals without symptoms meeting certain diagnostic criteria or lacking healthcare coverage.

Additionally, the pandemic emphasized the need for increased equity to both behavioral health services and access to internet connection. Broadband internet connection has become an increasingly important form of infrastructure throughout the pandemic, allowing many Americans to work, attend school, socialize, attend religious services, and access medical care in a virtual environment, safe from exposure to COVID-19. Because of this shift to a virtual environment, access to affordable and high-quality internet service has become a question of social equity and public health, particularly in rural communities.

Through many grant programs supported through Economic Development Administration (EDA), USDA, FCC, and National Telecommunication and Information Administration (NTIA), broadband internet access has been funded and expanded in numerous rural communities that previously had substandard access. These improvements will pave the way for the expansion of telemedicine and greater access to healthcare in general.

Many experts believe that, despite the challenges presented by the pandemic, the innovations that resulted from logistical limitations have created and expedited improvements to telehealth infrastructure and access. Todd Askew, the AMA's Senior Vice President of Advocacy, said during a recent AMA COVID-19 Update video, "we have moved forward a decade in the use of telemedicine in this country and it's going to become, and will remain, an increasingly important part of physician practices going forward."[73] An October 2020 Blog Post in Health Affairs stated: "The United States Congress, Centers for Medicare & Medicaid Services (CMS), and other policymakers need to consider long-term telehealth solutions that build on progress achieved during the pandemic and ensure access to high-quality, patient-centered care while simultaneously reducing unnecessary spending and health disparities."[74]

In July 2020, the Telehealth Modernization Act[75] was introduced in Congress. Congress is beginning to examine what needs to be done from the regulatory, legislative, and private-sector perspectives to sustain this momentum. A recent hearing before the U.S. Senate Health, Education, Labor and Pensions (HELP) Committee was a first step in this process. [76]

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[73] Robeznieks, A. How to maintain momentum on telehealth after COVID-19 crisis ends. American Medical Association. June 30, 2020. Accessed: 02/25/2021.
[74] Cutter, C. "Establishing A Value-Based 'New Normal' For Telehealth" Health Affairs October 8, 2020. Accessed: 03/15/2021.
[75] S.4375 – Telehealth Modernization Act. Congress.gov. Introduced 07/30/2020. Accessed: 03/25/2021.
[76] Robeznieks, A. Senate bill would nix geographic, site restrictions on telehealth, American Medical Association, September 18, 2020. Accessed: 03/21/2021.

Appendix A

Telebehavioral Health Resources

SAMHSA National Treatment Locators

Substance Use Treatment Locator. FindTreatment.gov.

Behavioral Health Treatment Services Locator. findtreatment.samhsa.gov.

Buprenorphine Practitioner & Treatment Program Locator. www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator.

Early Serious Mental Illness Treatment Locator. www.samhsa.gov/esmi-treatment-locator.

Opioid Treatment Program Directory

SAMHSA National Crisis Lines

Suicide Prevention Lifeline

1-800-273-TALK (8255) | TTY: 1-800-799-4889 | www.suicidepreventionlifeline.org

SAMHSA's National Helpline

1-800-662-HELP (4357) | TTY: 1-800-487-4889 | www.samhsa.gov/find-help/national-helpline

Disaster Distress Helpline

1-800-985-5990 | www.samhsa.gov/find-help/disaster-distress-helpline

Veteran's Crisis Line

1-800-273-TALK (8255) | TTY: 1-800-799-4889 | www.veteranscrisisline.net

Drug-Free Workplace

1-800-WORKPLACE (967-5752) | www.samhsa.gov/workplace/resources/drug-free-helpline

SAMHSA Publications

SAMHSA In Brief: Rural Behavioral Health: Telehealth Challenges and Opportunities (2016).

SAMHSA Advisory: Using Technology-Based Therapeutic Tools in Behavioral Health Services (2021).

SAMHSA TIP 60: Using Technology-Based Therapeutic Tools in Behavioral Health Services (2015).

ASPR Behavioral Health Resources

ASPR TRACIE COVID-19 Behavioral Health Resources

ASPR TRACIE Behavioral Health Compendium

ASPR TRACIE Telehealth Resources

SAMHSA Training and Technical Assistance Centers

Mountain Plains Prevention Technology Transfer Center (University of Utah).

Mountain Plains Addiction Technology Transfer Center (University of North Dakota and University of Nevada-Reno).

Mountain Plains Mental Health Technology Transfer Center (University of North Dakota and Western Interstate Commission on Higher Education).
Southeast Mental Health Data: Tele-health and Mental Health Care Access (2021).

Additional Telebehavioral Health Resources

Center for Connected Health Policy
American Telehealth Association

U.S. Department of Health and Human Services:
Agency for Healthcare Research and Quality (AHRQ). The evidence base for telehealth: Reassurance in the face of rapid expansion during the covid-19 pandemic

Health Resources and Services Administration (HRSA), National Consortium of Telehealth Resource Centers
Office of National Coordinator for Health Information Technology

Centers for Medicare and Medicaid Services (CMS). MLS-Telehealth Services.
From Coverage to Care (C2C) virtual resources to support providers and patients.
- Telehealth for Providers: What You Need to Know
- Telehealth: What to Know for Your Family (also available in Spanish)

Great Plains Telehealth Resource and Assistance Center. Telehealth Start-Up and Resource Guide Version 1.1

National Council for Behavioral Health. Resources and Tools for Addressing Coronavirus (COVID-19).
Rural Health Information Hub (University of North Dakota). Rural Prevention and Treatment of Substance Use Disorders Toolkit

To view more resources, please access the Disaster Resource Library via the FEMA MAX-TRAX platform. To request access to this database, please contact R8-FEMA-NDRF@fema.dhs.gov. For information on specific behavioral health resources in Region 8, contact the SAMHSA regional administrator: Charles.Smith@samhsa.hhs.gov.

Appendix B

Table 6: USDA Rural Utilities Service Telecommunications Program Investments FY 2010 – 2020

State	Program	Projects Approved	Funds Awarded
CO	Telecommunications Infrastructure Program	3	$27,130,864
CO	ReConnect Program	3	$15,066,668
CO	Distance Learning and Telemedicine Program	20	$6,009,657
CO	Broadband Initiatives Program	7	$25,259,161
	Colorado Total	33	$73,466,350
MT	Telecommunications Infrastructure Program	13	$266,568,000
MT	ReConnect Program	3	$19,468,366
MT	Distance Learning and Telemedicine Program	20	$5,463,902
MT	Broadband Initiatives Program	4	$87,907,488
	Montana Total	40	$379,407,756
ND	Telecommunications Infrastructure Program	16	$291,365,867
ND	ReConnect Program	3	$24,797,489
ND	Distance Learning and Telemedicine Program	24	$3,430,425
ND	Community Connect Grant Program	6	$14,178,969
ND	Broadband Program	1	$68,897,967
ND	Broadband Initiatives Program	10	$74,101,254
	North Dakota Total	60	$476,771,971
SD	Telecommunications Infrastructure Program	10	$224,760,482
SD	ReConnect Program	7	$29,317,196
SD	Distance Learning and Telemedicine Program	25	$5,281,687
SD	Broadband Initiatives Program	3	$26,235,671
	South Dakota Total	45	$285,595,036
UT	Telecommunications Infrastructure Program	3	$23,949,500

UT	ReConnect Program	4	$29,975,399
UT	Distance Learning and Telemedicine Program	22	$4,629,853
UT	Community Connect Grant Program	4	$4,500,065
UT	Broadband Initiatives Program	1	$1,839,017
	Utah Total	34	$64,893,834
WY	Telecommunications Infrastructure Program	3	$54,666,500
WY	ReConnect Program	4	$8,747,756
WY	Distance Learning and Telemedicine Program	8	$1,471,977
WY	Community Connect Grant Program	1	$1,309,394
	Wyoming Total	16	$66,195,627

Source: USDA Rural Utilities Service

Appendix C
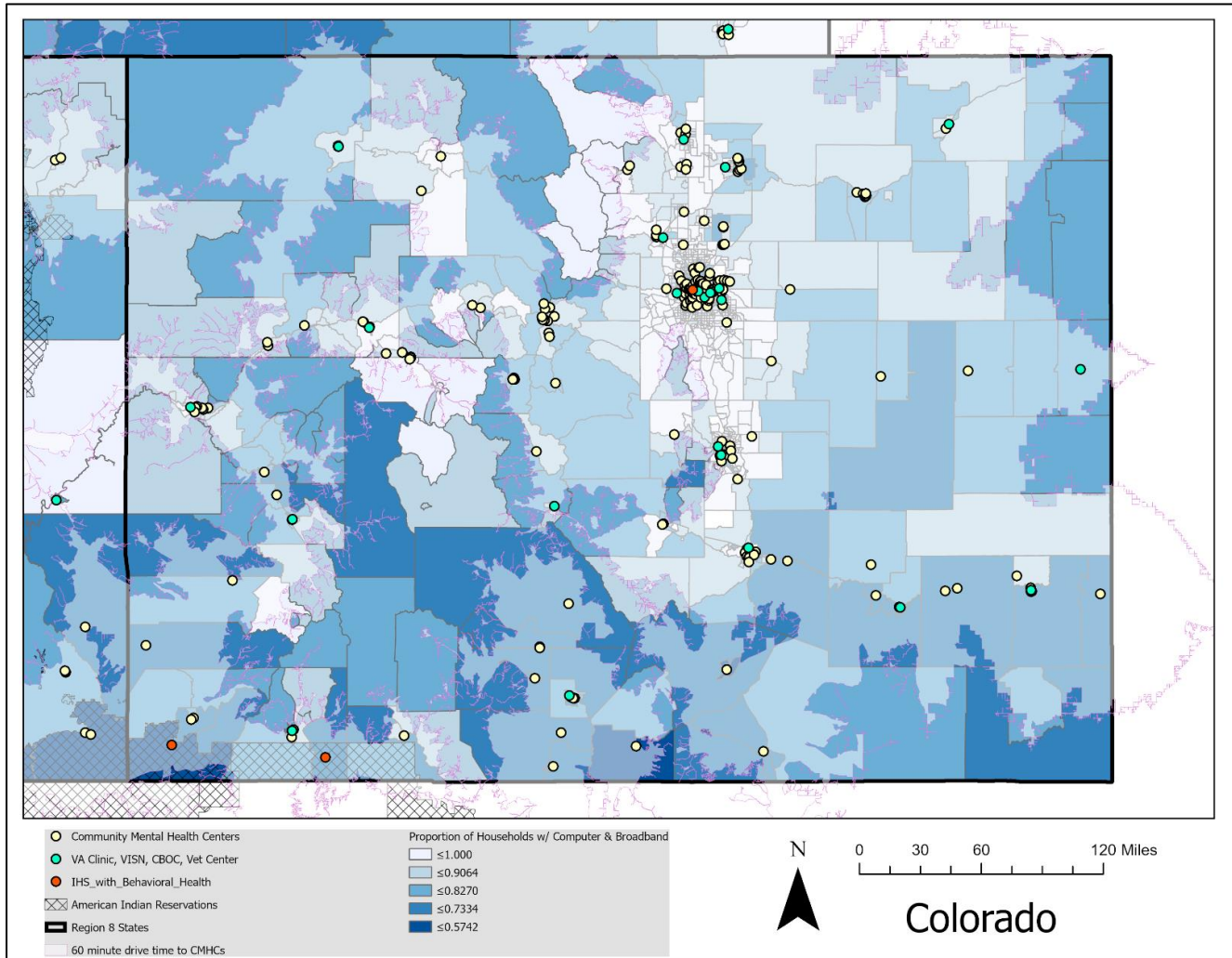
Figure 12. Drive time access to Facilities offering Specialty Behavioral Healthcare and proportion of Colorado households with potential access to virtual care (computers and broadband)
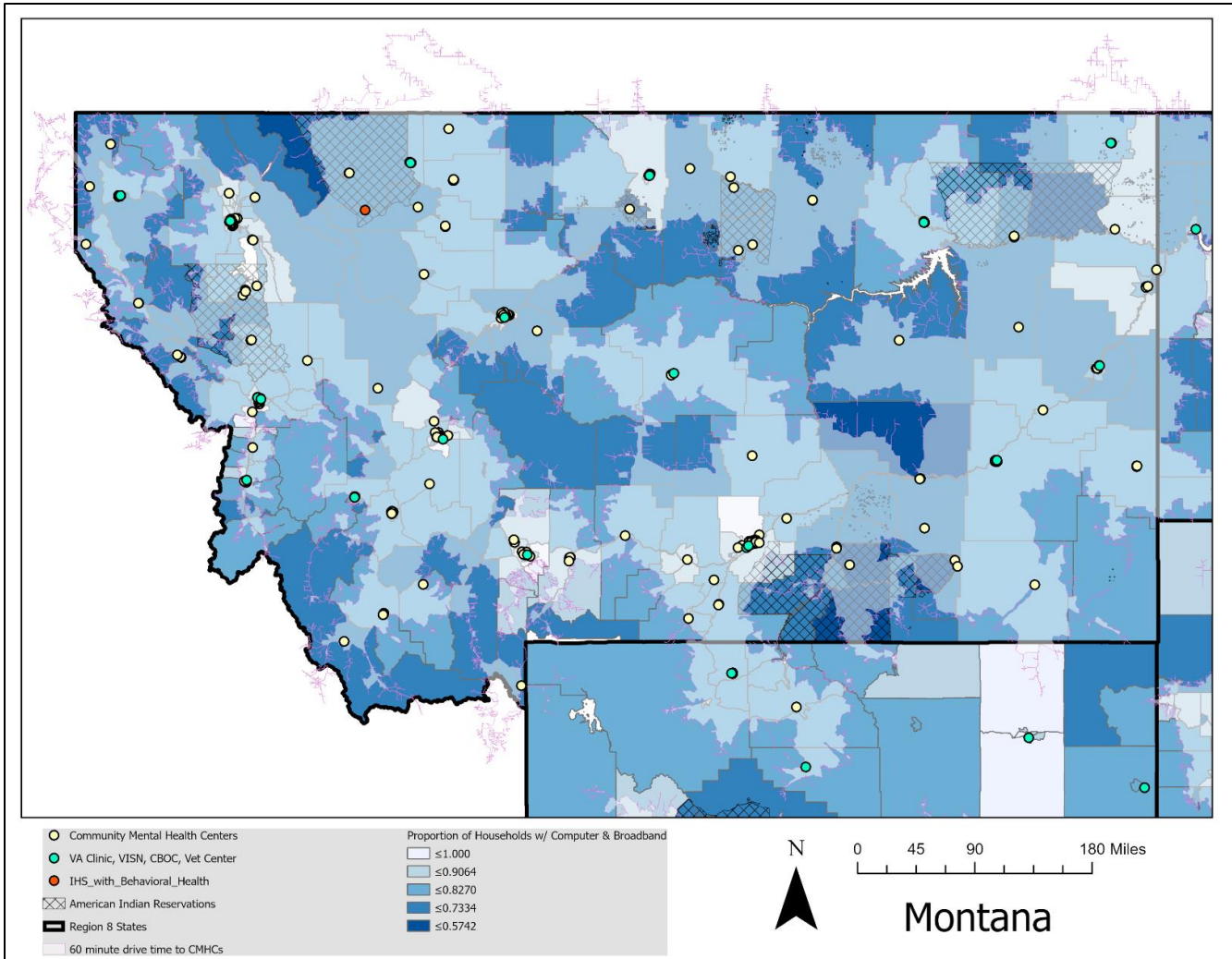
Figure 13. Drive time access to Facilities offering Specialty Behavioral Healthcare and proportion of Montana households with potential access to virtual care (computers and broadband)
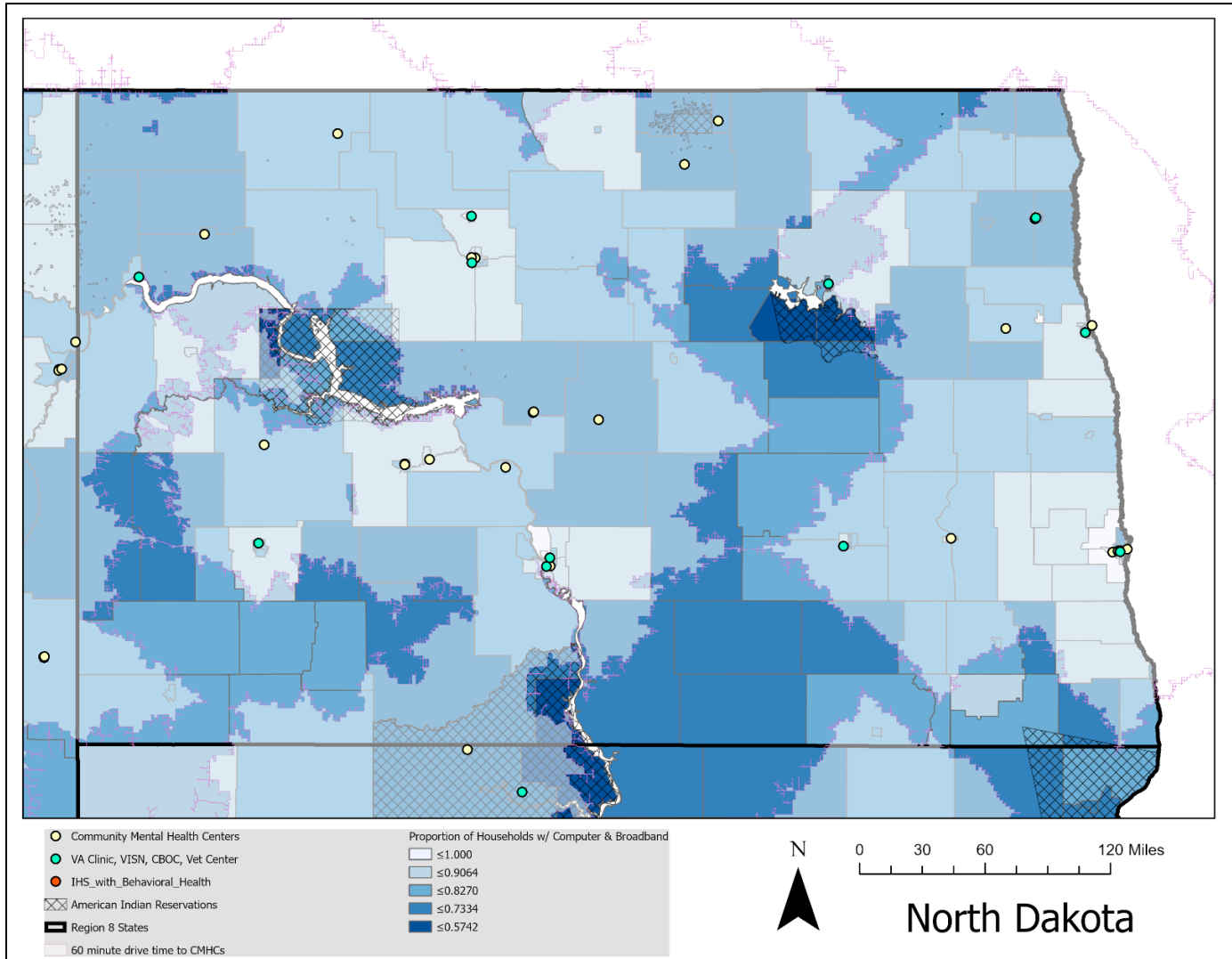
Figure 14. Drive time access to Facilities offering Specialty Behavioral Healthcare and proportion of North Dakota households with potential access to virtual care (computers and broadband)
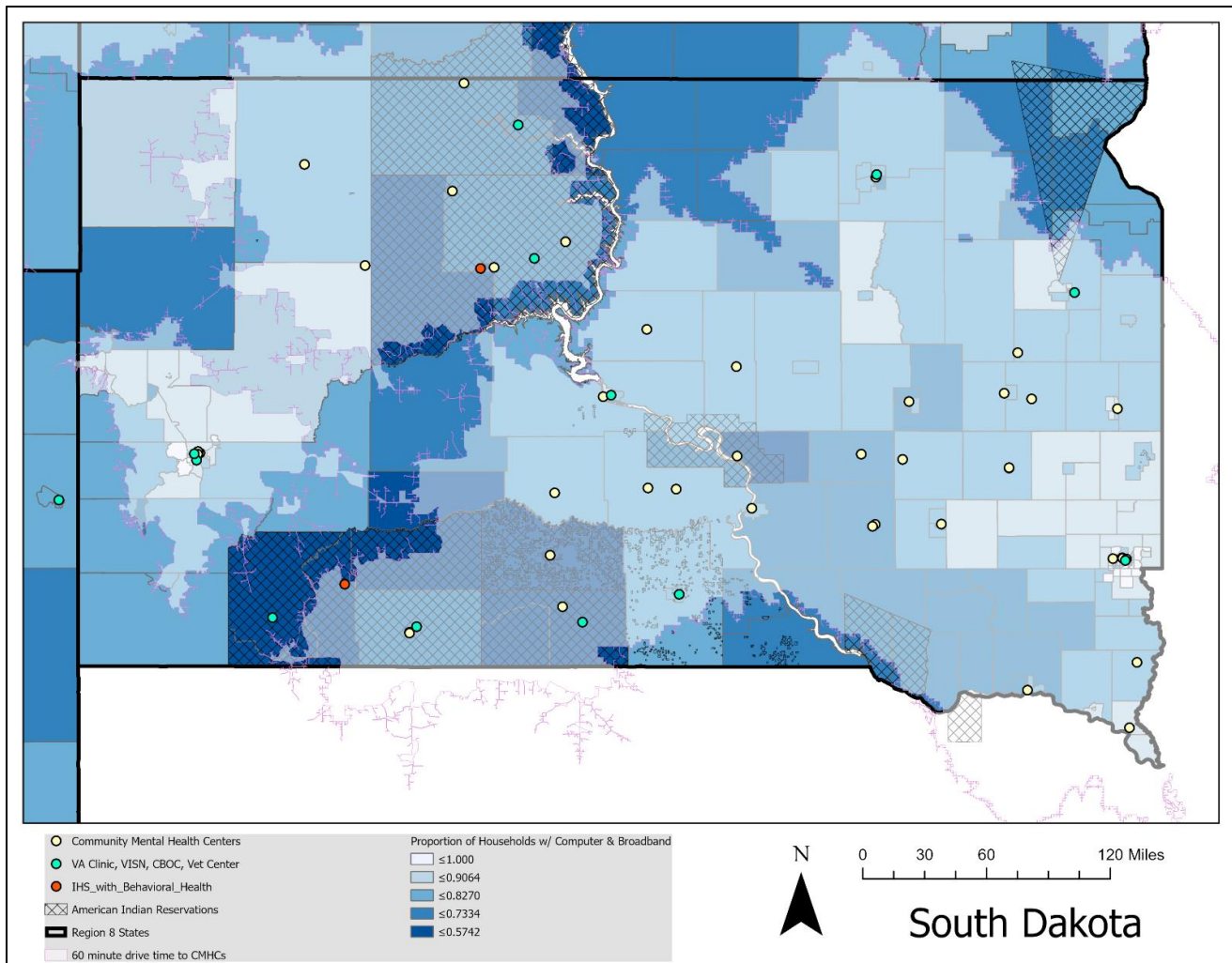
Figure 15. Drive time access to Facilities offering Specialty Behavioral Healthcare and proportion of South Dakota households with potential access to virtual care (computers and broadband)
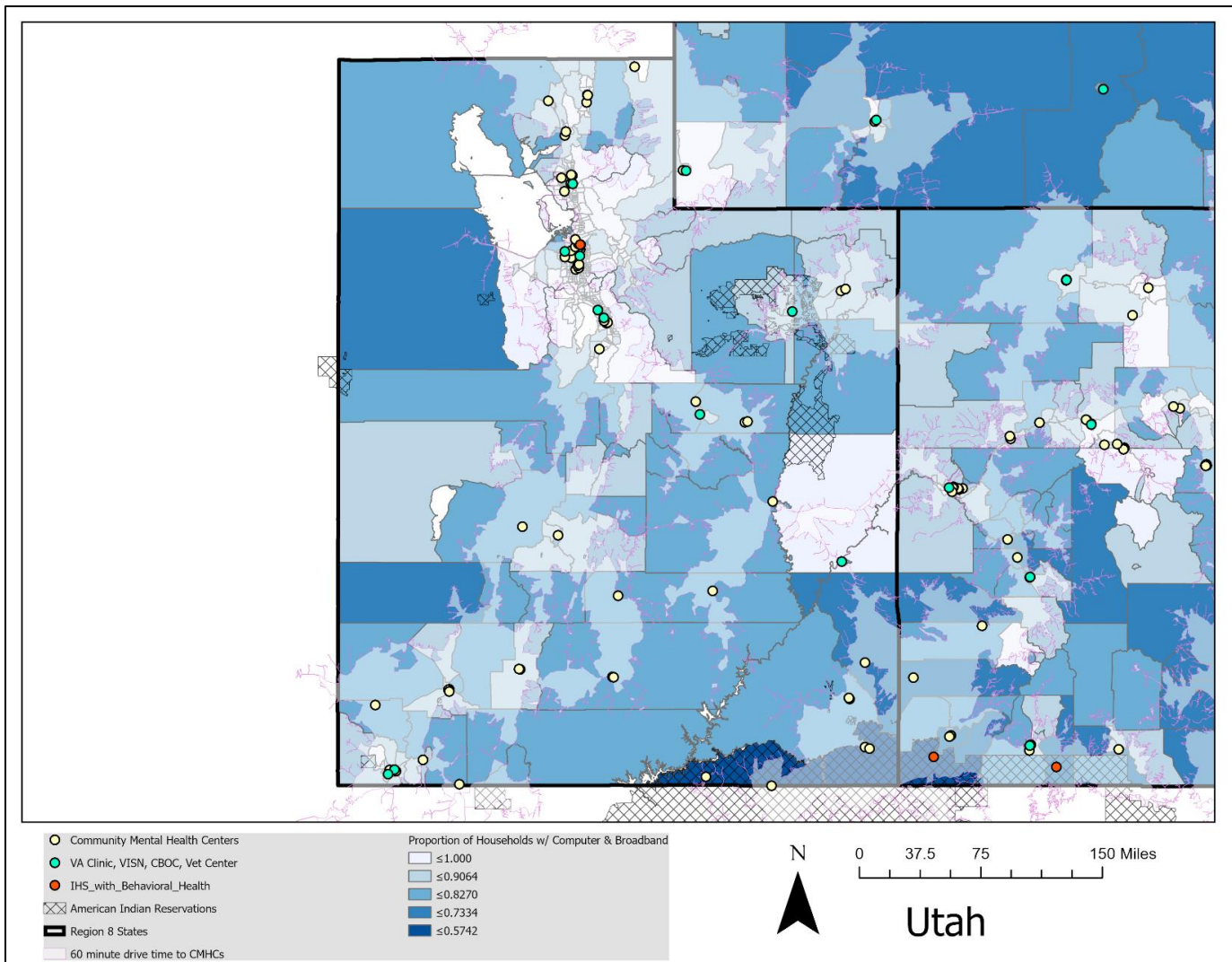
Figure 16. Drive time access to Facilities offering Specialty Behavioral Healthcare and proportion of Utah households with potential access to virtual care (computers and broadband)
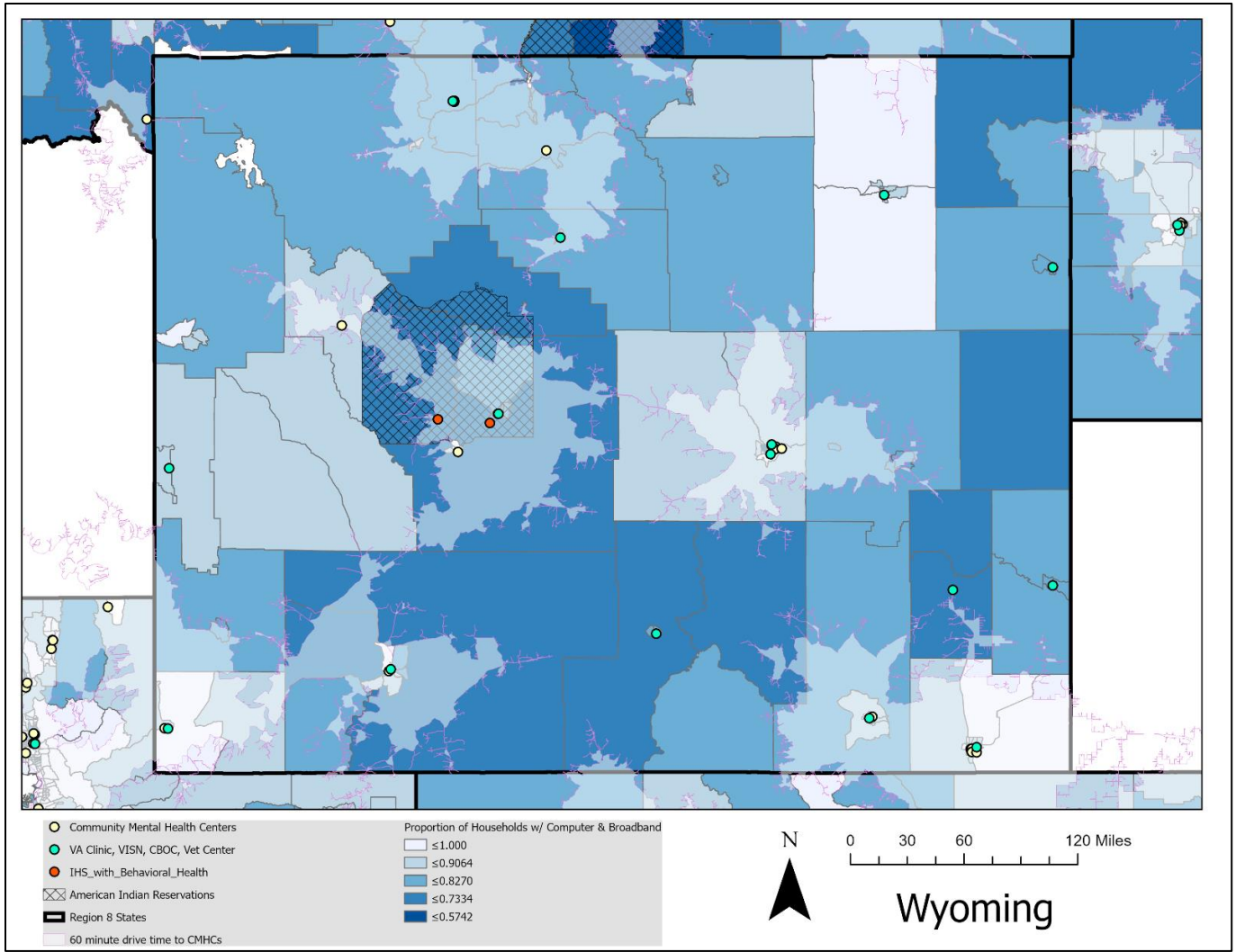
Figure 17. Drive time access to Facilities offering Specialty Behavioral Healthcare and proportion of Wyoming households with potential access to virtual care (computers and broadband)