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## Adaptations of an Integrated Behavioral Health Program During COVID-19

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*The coronavirus disease 2019 (COVID-19) pandemic has consistently been described as an “unprecedented” global health crisis. While the focus has been primarily on the medical and economic impact of the pandemic, psychological sequelae are anticipated. Primary care is the main point of access for mental health care in the United States, making it the ideal locale to provide psychological services for a larger proportion of the population than traditional mental health care settings. The aim of this paper is to describe how our multi-state, multi-site integrated primary care program adapted and applied cognitive behavioral therapy in the context of COVID-19. Access to mental health care was disrupted despite burgeoning mental health concerns, necessitating novel approaches to providing care. A stepped-care approach was implemented within our primary care practice, which consisted of a combination of low-intensity, high-yield stress management and resiliency building resources and cognitive behavioral therapy that were delivered flexibly based on patient preference, technological capabilities, state ordinances, insurance coverage, and institutional policies. The lessons learned from this experience can inform other integrated primary care clinics in responding to the current and future pandemics.*

SOON after the first cases were reported in China, the coronavirus disease 2019 (COVID-19) quickly spread across the globe. The incidence of COVID-19 grew exponentially in the United States, resulting in widespread “shelter-in-place” and “stay-at-home” state-wide orders and the signing of a \$2 trillion stimulus bill in March, over 100,000 documented deaths by May, and multiple states breaking single-day records for new cases in July (Taylor, 2020). Consequently, COVID-19 has been consistently described as an “unprecedented” public health crisis.

Previous public health crises involving highly transmissible respiratory infections have been associated with distress and impairments in multiple mental health domains. Past epidemics of respiratory infections, such as the 2003 severe acute respiratory syndrome (SARS) and 2012 Middle East respiratory syndrome (MERS), were associated with elevated depression, anxiety, and posttraumatic stress symptoms (Ahmed et al., 2020; Kwek et al., 2006) and reduced quality of life (Ahmed

et al., 2020; Batawi et al., 2019; Kwek et al., 2006) among patients post-hospitalization. The quarantine policies and procedures employed during these epidemics were limited to those who were potentially exposed to the virus. Those who had been quarantined reported elevated psychological distress, emotional reactivity (e.g., anger, irritability), and behavioral changes (e.g., crowd avoidance, increased handwashing), with some studies suggesting that there may be long-lasting effects (Brooks et al., 2020).

The first report on the psychological impact of COVID-19 was published in March. Increased rates of depression, anxiety, insomnia, and distress were reported among healthcare providers in China, with more pronounced symptoms observed in those providing direct and consistent care to patients in the initial epicenter (Lai et al., 2020). Subsequent reports have found that these symptoms extended beyond healthcare providers to the general population in China where strict quarantine measures were implemented (Huang & Zhao, 2020; Qiu et al., 2020; Wang et al., 2020). This led scholars to express concern about the potential psychological toll of the pandemic and necessary public health precautions (Pfefferbaum & North, 2020). While it is not yet possible to fully appreciate the mental health

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impact of COVID-19, an increase in depressive and anxiety symptoms, especially among those who were or knew someone who was directly impacted (Gallagher, Zvolensky, Long, Rogers, & Garey, 2020); trauma- or stress-related symptoms; substance use; and suicidality has been reported (Czeisler et al., 2020).

COVID-19 is unique in that its impact has extended far beyond public health, with the most notable deleterious effect on the global economic infrastructure. The World Bank reported that COVID-19 will lead to an estimated 5.2% reduction in the global economy, resulting in economic recessions in five of six world regions (The World Bank Group, 2020). Negative economic outcomes including weakening of the gross domestic product, income loss, rising debt burden, and escalating unemployment rates adversely affect individuals, especially those who are disadvantaged and underserved. There is an association between economic recessions and physical and mental health outcomes, new or worsening psychiatric conditions, and suicidality (Frasquilho et al., 2016). Scholars have speculated that this may be observed during COVID-19 due to the economic downturn, social isolation, limited availability of medical and mental health services, and increased access to lethal means (Holmes et al., 2020; Pruitt et al., 2020; Reger et al., 2020).

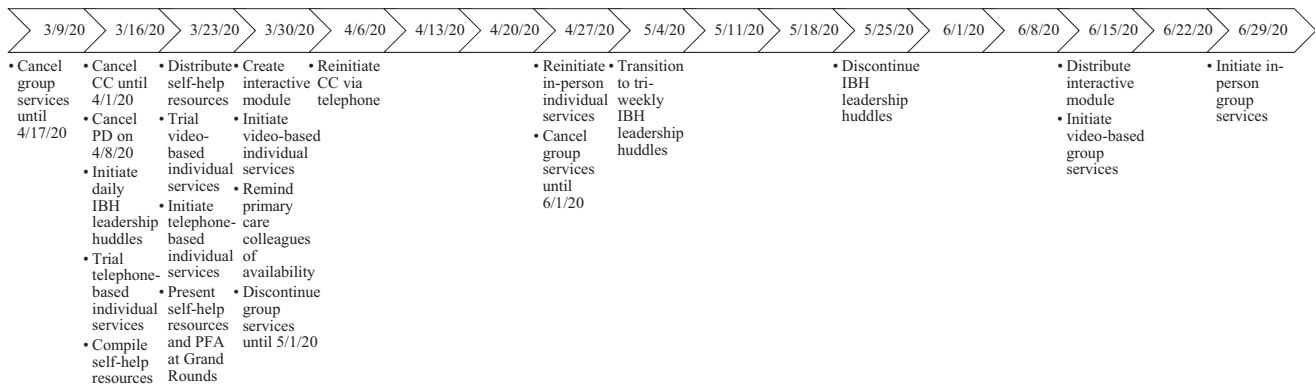
Clearly, there is evidence to suggest that concern about the psychological impact of COVID-19 is warranted. In the United States, primary care is considered to be the de facto mental health system as the majority of patients present to primary, rather than specialty, care with mental health-related concerns (Kessler & Stafford, 2008; Reiger et al., 1978). For this reason, there has been a call for increased detection of mental health symptoms within the primary care setting during the pandemic (Cullen et al., 2020). Integrated behavioral health (IBH) services are well suited to assist

primary care providers in identifying clinically significant mental health symptoms and triaging patients to the appropriate level of care. To date, there has not been a report detailing the way in which IBH clinics have responded to COVID-19.

In this paper, we focus on how our multi-state, multi-site integrated primary care program has adapted and applied cognitive behavioral therapy (CBT) in response to COVID-19. We first discuss how the pandemic disrupted access to mental health care by creating unpredictable and unprecedented obstacles. We detail the rationale for and process of creating and implementing several low-intensity, high-yield stress management and resiliency building resources that were rapidly disseminated across primary care practices and aligned with safety and social distancing requirements. We then highlight how CBT was used to assist patients in coping with COVID-19, including training staff and making adaptations to the remote delivery of specific interventions. Finally, we provide lessons learned from this experience.

### Preparing the Practice

At Mayo Clinic, the Division of IBH consists of mental health providers who are fully integrated in primary care. Psychological, psychiatric, and psychosocial services offered through IBH are short-term and targeted, the majority of which are provided in-person. IBH providers are employed across the enterprise in Minnesota, Wisconsin, Arizona, and Florida. Together, the primary care practices serve over 715,000 patients from the surrounding community. The interconnected nature of the division necessitated a coordinated response across the enterprise, which is outlined chronologically in Figure 1. Rapid changes in the delivery of individual and group psychotherapy, non-visit care activities, and workflows were necessary.



**Figure 1.** Timeline of the Division of Integrated Behavioral Health’s response to COVID-19. *Note.* CC = case consultation; PD = professional development; PFA = psychological first aid.

## Maintaining Individual Psychotherapy Services

The first step in responding to COVID-19 was to identify how to provide mental health services in a safe, patient-centered, and ethical manner while maintaining integration with the primary care teams. Patients actively engaged in their treatment plans pre-pandemic needed to be maintained, while new patients

were being referred for services given the mounting stressors and uncertainties of the pandemic. Quarantine measures issued in late March led to a drastic reduction in face-to-face patient volumes and temporary deployment of most IBH providers home. Similar to many healthcare organizations, a large-scale, technological platform solution was needed to reduce barriers to care. Telephone-delivered services were utilized for the first 10 days, but these were quickly augmented

Table 1

Service Utilization in the Division of Integrated Behavioral Health Rochester and Southeast Minnesota Regions Prior to and During the COVID-19 Pandemic

Rochester		
Variable	Pre-COVID-19	COVID-19
Number of providers, <i>n</i>	17	17
Ph.D. psychologists, <i>n</i> (%)	4 (23.5)	4 (23.5)
M.A. psychologists, <i>n</i> (%)	1 (5.9)	1 (5.9)
M.S.W. social workers, <i>n</i> (%)	12 (70.6)	12 (70.6)
Number of patients, <i>n</i>	5,241	5,503
Average fill rate, %	85.0	83.8
Number of appointments		
Completed, <i>n</i> (%)	6,551 (78.0)	6,827 (77.4)
Canceled, <i>n</i> (%)	1,180 (14.0)	1,317 (14.9)
Late canceled, <i>n</i>	552	735
Rescheduled, <i>n</i>	853	896
No showed, <i>n</i> (%)	673 (8.0)	682 (7.7)
Types of appointments		
In-person, <i>n</i> (%)	6,550 (~100.0)	3,044 (44.6)
Video, <i>n</i> (%)	0 (0.0)	2,836 (41.5)
Telephone, <i>n</i> (%)	1 (~0.0)	947 (13.9)
Southeast Minnesota		
Variable	Pre-COVID-19	COVID-19
Number of providers, <i>n</i>	6	6
Ph.D. psychologists, <i>n</i> (%)	2 (33.3)	2 (33.3)
M.A. psychologists, <i>n</i> (%)	0 (0.0)	0 (0.0)
M.S.W. social workers, <i>n</i> (%)	4 (66.7)	4 (66.7)
Number of patients, <i>n</i>	1,903	1,692
Average fill rate, %	74.4	68.1
Number of appointments		
Completed, <i>n</i> (%)	2,460 (73.7)	2,279 (74.9)
Canceled, <i>n</i> (%)	538 (16.1)	467 (15.3)
Late canceled, <i>n</i>	231	270
Rescheduled, <i>n</i>	348	239
No showed, <i>n</i> (%)	341 (10.2)	297 (9.8)
Types of appointments		
In-person, <i>n</i> (%)	2,459 (~100.0)	913 (40.1)
Video, <i>n</i> (%)	0 (0.0)	1,089 (47.8)
Telephone, <i>n</i> (%)	1 (~0.0)	277 (12.1)

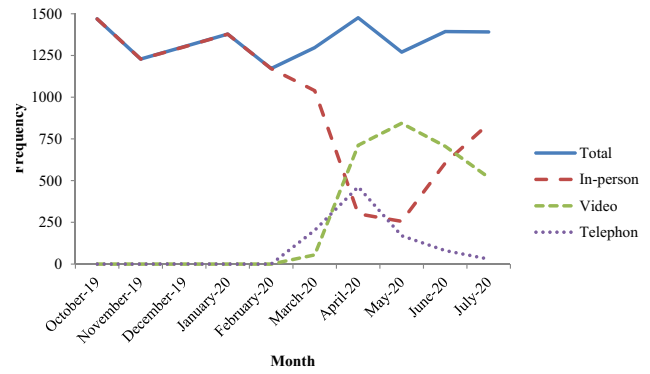
*Note.* The Rochester region encompasses 5 primary care clinics in Rochester, Minnesota. The Southeast Minnesota region encompasses 5 primary care clinics across Southeast Minnesota including Albert Lea, Austin, Faribault, Owatonna, and Red Wing, serving patients from 16 primary care clinics. Pre-COVID-19 = October 2019-February 2020; COVID-19 = March 2020-July 2020. Number of patients, number of appointments, and types of appointments were summed across providers. Average fill rate = proportion of filled and available duration across providers; Canceled = canceled more than 24-hours before scheduled visit. Late canceled and rescheduled are subcategories of canceled. Late canceled = canceled less than 24-hours before scheduled visit; No showed = failed to attend scheduled visit.

by video visits. The decision to offer video- and telephone-based services was made possible because of changes in telehealth regulations and insurance coverage in response to the COVID-19 public health crisis (The Center for Connected Health Policy, 2020).

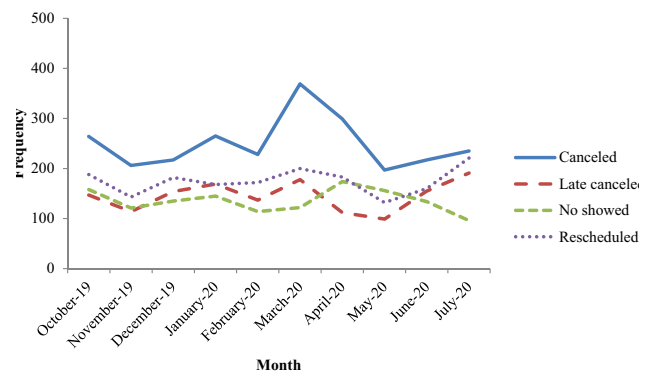
Efforts were made to assure primary care providers and allied health staff that IBH was still providing services but operating in a different way during primary care leadership meetings and through email. Likewise, primary care teams and IBH providers were trained in using the video platform to resume curbside consultations and warm handoffs, both of which are essential elements of population-based care models. In early May, in-person appointments resumed, although patients were still able to select video- or telephone-based services. To ensure safety for patients and providers, pre-visit and day-of screening, day-of temperature checks, universal patient and provider masking, provider eye shielding, hand hygiene, direct rooming after check-in, and room sanitization between patients were implemented for in-person services.

Service utilization data during COVID-19 for the Rochester and Southeast Minnesota regions is presented in Table 1. The Rochester region was selected as it is the largest region in the Division of IBH, serving over 120,000 patients across five primary care practices in Rochester, Minnesota. This serves as a larger, suburban example. The Southeast Minnesota region was selected as it is the largest region outside of Mayo Clinic's main campus, serving patients from 16 primary care practices at five primary care practices across Southeast Minnesota, including Albert Lea, Austin, Faribault, Owatonna, and Red Wing. This serves as a smaller, more rural example. The number of providers and patients and average fill rates were similar in the five months before and during COVID-19.

There was a dramatic change in the types of appointments provided prior to and during COVID-19, which is illustrated in Figure 2 for the Rochester region. The use of video appointments steadily increased from March to May, then declined with the re-introduction of in-person appointments. A similar, albeit less Gaussian, trend was observed for telephone appointments, which peaked in April and steadily declined into July. As illustrated in Figure 3, the number of appointments in the Rochester region was relatively stable during COVID-19 and comparable to service utilization rates prior to COVID-19. During COVID-19, there was a slight decrease in no-show appointments and a slight increase in rescheduled and late canceled appointments. The number of canceled appointments during COVID-19 was lower until July, which approximated the clinic's average cancellation rate before COVID-19 ( $M = 236$ ,  $SD = 27.2$ ).



**Figure 2.** Type of appointments prior to and during the COVID-19 pandemic in the Division of Integrated Behavioral Health Rochester region. *Note.* The Rochester region encompasses 5 primary care clinics in Rochester, Minnesota. Pre-COVID-19 = October 2019-February 2020; COVID-19 = March 2020-July 2020.



**Figure 3.** Number of appointments prior to and during the COVID-19 pandemic in the Division of Integrated Behavioral Health Rochester region. *Note.* The Rochester region encompasses 5 primary care clinics in Rochester, Minnesota. Pre-COVID-19 = October 2019-February 2020; COVID-19 = March 2020-July 2020. Canceled = canceled more than 24-hours before scheduled visit. Late canceled and rescheduled are subcategories of canceled. Late canceled = canceled less than 24-hours before scheduled visit; No showed = failed to attend scheduled visit.

### Suspending Group Psychotherapy Programs

IBH and primary care leadership collaborated on the decision to suspend group psychotherapy in early March to reduce the volume of primary care patients seeking in-person care. A total of eight active group therapy programs were suspended at this time, impacting 88 patients. Patients who were already scheduled to attend group psychotherapy were provided the option to wait until the group reconvened, transition to individual therapy, or utilize self-help materials. While group psychotherapy encompasses a large proportion

of the services provided in IBH, its suspension helped to ensure that providers were available to meet the acute needs of the primary care population. Group psychotherapy was re-initiated in mid-June with new workflows in place, such as limiting the size of in-person groups to allow for social distancing and implementing the same precautions as in-person services. Of note, the delivery platform used for video appointments was not initially equipped to provide services to multiple patients concurrently. A technical solution was later developed so that virtual group therapy programs could be conducted.

### **Repurposing Non-Visit Care Activities**

Given the importance of interdisciplinary collaboration between primary care and behavioral health providers (Vogel et al., 2017), time has been intentionally carved out of providers' schedules to facilitate consistent communication within care teams. IBH providers attend relevant huddles, meetings, and trainings based on their scope of practice. In March, some of these activities were temporarily suspended while others were transitioned to video or telephone to maintain operations while encouraging social distancing. A daily IBH leadership telephone meeting was established to problem solve new or ongoing clinical and administrative challenges. This meeting decreased in frequency over time and was disbanded by the end of May once more emergent workflows had been implemented.

### **Developing and Disseminating New Workflows**

The aforementioned changes greatly impacted the IBH practice policies and procedures. For example, video visit orders needed to be created to support proper scheduling, documentation, and billing within the electronic health record (EHR). In an effort to rapidly develop and disseminate an order for video visits, the institution opted to create a more generic scheduling order. An unintended consequence of the generic order was that self-report measures were no longer auto-triggered. Given that tracking patient reported outcomes at every session is an essential feature of the IBH model (Sawchuk et al., 2020), providers needed to be trained in a new workflow to either manually initiate the pre-visit self-report measure distribution process or administer them verbally at the start of session.

Another example was navigating hospitalization if a patient was suicidal, homicidal, or gravely disabled. Risk assessment, safety planning, and hospitalization procedures needed to be adapted to ensure that provi-

ders were able to maintain patient safety even if the patient was not physically present (Pruitt et al., 2020). EHR documentation templates were created and disseminated so a more standardized approach could be adopted across providers, including the allowance for safety plans to be sent to patients. A centralized emergency preparedness team helped create the updated hospitalization procedures. Primary care providers were educated in new ways of involving IBH staff in crisis situations and agreed-upon workflows were developed.

These changes were communicated to the entire IBH team. Weekly practice updates were disseminated via email to facilitate clear and consistent communication across all sites. Quick reference guides detailing step-by-step instructions for the standardized implementation of new workflows were created and regularly updated. These materials were stored on the Division's intranet website to increase accessibility across the enterprise.

### **Compiling and Creating Low-Intensity, High-Yield Mental Health Resources**

The compilation and creation of low-intensity, high-yield mental health resources were deemed imperative given the high volume of projected service needs that would outstrip available resources (Pfefferbaum & North, 2020). Initially, individuals were discouraged from seeking medical and mental health services unless they were experiencing an urgent issue. As the number of COVID-19 cases decreased, quarantine measures were relaxed and phased re-opening plans were implemented, which varied greatly across our clinics operating in different states. Self-guided stress management and resiliency building resources were prioritized as it allowed evidence-based information to be easily disseminated to a larger swath of the population within the parameters outlined by state decrees.

### **Creating and Centralizing Patient Education and Self-Help Materials**

Previously created patient education forms focused on stress, sleep, and anxiety and mood management for adults and adolescents, children, and their caregivers were compiled. These topics were selected based on the anticipated areas of distress and disruption due to COVID-19, which aligned with preliminary reports from China (Huang & Zhao, 2020; Lai et al., 2020; Qiu et al., 2020; Wang et al., 2020). Lists of external resources were compiled for patients and providers, which included evidence-based books, apps, and websites focused on stress, sleep, and anxiety and mood management. A novel patient education form tailored

to COVID-19 (*Tips to Help You Manage Stress Related to Novel Coronavirus, COVID-19*) was also created. This document detailed the cause of and symptoms associated with stress and focused on four core components of stress management and resiliency building: behavioral activation, social connection, cognitive challenging, and relaxation training. These skills were selected based on their use in evidence-based treatments for stress and resiliency (e.g., cognitive-behavioral stress management, [Antoni et al., 2007](#); resiliency training, [Meichenbaum, 2007](#)) and the nature of this particular stressor. All of these resources were created in electronic, rather than print, form to facilitate dissemination to patients. They were stored on a centralized intranet website to increase accessibility for all providers, even those operating outside of primary care. Information about these materials was disseminated through multiple communication channels. The material for children, adolescents, and their caregivers was shared with local school districts to increase access to evidence-based information for pediatric populations.

### Shifting to Interactive Learning Platforms

The content from this patient education form was expanded into an interactive e-Learning module (*Building Resiliency During the COVID-19 Pandemic*) with the assistance of Mayo Clinic Office of Patient Education. This platform allowed the information to be presented in a multimodal format. Pre-recorded videos were embedded into each module to provide an in-depth explanation of complicated topics or lead participants through an interactive skill. Knowledge prompts were placed throughout the module to provide participants with the opportunity to test their understanding of the information. Feedback was provided and participants had the ability to recomplete knowledge prompts. Importantly, knowledge prompts were not required to advance to the next module due to concerns that this could have dissuaded engagement, completion, or re-engagement. Goal setting prompts were placed at the end of each module to encourage participants to set personally relevant goals. To increase the ease of dissemination for providers, standardized language outlining the purpose, content, and use of the interactive e-Learning module was crafted and distributed along with the external-facing link.

The interactive e-Learning module content expanded upon the patient education form. The nature of stress generally and in response to COVID-19 was described, which included the uncertain and uncontrollable nature of this stressor, consistent yet unclear information, and significant impact on daily

life. The cognitive, behavioral, affective, and physiological symptoms associated with stress were detailed to provide a rationale for the four core components of stress management and resiliency building. Behavioral activation focused on typical behavioral tasks that were likely to be disrupted during quarantine and throughout the pandemic. Social connection discussed the importance of and strategies for maintaining social connection despite social distancing recommendations, setting boundaries with social contacts, selecting reputable sources of information, and limiting news and social media consumption. Cognitive challenging discussed negative automatic thoughts and their connection to negative affect, emphasizing the goal of promoting accurate and flexible thinking. Common cognitive distortions in response to unpredictable and uncontrollable situations like COVID-19 were detailed. A list of Socratic questions was provided to help participants evaluate and challenge their negative thought patterns. Relaxation training focused on mindfulness, grounding, deep breathing, passive and progressive muscle relaxation, and guided imagery. Participants were encouraged to trial these different techniques and incorporate those that worked best for them into their daily routines.

### Providing Stress Management and Resiliency Building Interventions

A significant proportion of the services provided through IBH consist of individual psychotherapy. As previously detailed, a psychotherapy tracking database has been developed and implemented to evaluate psychotherapy outcomes ([Craner et al., 2017](#)). Our reports indicated that our patient population was predominantly White, middle aged, female identified, and insured. Patients commonly sought services for anxiety and mood concerns, which were most frequently addressed through psychoeducation, cognitive interventions, and behavioral strategies ([Bogucki et al., 2021](#); [Sawchuk & Craner et al., 2018](#)).

The content of the aforementioned resources was used to guide individual-level interventions. CBT is the primary theoretical orientation used within our practice as its short-term structure, skill-based approach, and goal-oriented focus is well suited to the primary care setting ([Sawchuk & Craner, 2017](#)). Additional complementary skills, such as motivational interviewing and mindfulness, are frequently implemented when indicated. The application of psychological interventions in primary care is best accomplished through on-demand consults, time-limited psychotherapy, stepped-care options, measurement-based care, and maintenance of treatment fidelity ([Sawchuk et al., 2020](#)).

Table 2  
Negative Automatic Thought Themes Reported During the COVID-19 Pandemic

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Transmission of and susceptibility to COVID-19, both for themselves and loved ones
Uncertainty about the future
Disruptions in daily life and coping strategies
Increased amount or lack of contact with others
Voluntary quarantine from family as an essential employee or due to vulnerability
Difficulty accessing food, shelter, and medical or sanitizing supplies
Economic and employment concerns
Challenges accessing childcare or caregiving
Questioning the nature or severity of the pandemic, especially in a rural location
Civil unrest following the killing of George Floyd

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### Adaptations to Cognitive Interventions

CBT focuses on the interplay between cognitions, emotions, behaviors, and physiological reactions. Therapeutic techniques target maladaptive cognitions, avoidant behaviors, and/or uncomfortable physical sensations to impact emotional experiences (Beck, 2011). Cognitive techniques employed in response to COVID-19 included identifying and evaluating negative automatic thoughts. There were identifiable themes of patients' negative automatic thoughts related to COVID-19, which are detailed in Table 2. Often, these negative automatic thoughts were more extreme and influenced by various information processing biases. Typical cognitive distortions related to COVID-19 included all-or-nothing thinking, catastrophizing about its course and outcomes, personalization about the associated consequences, and imperatives related to the pandemic response. At times, negative automatic thoughts about COVID-19 were true. In these circumstances, negative automatic thoughts were evaluated based on whether they were helpful or compassionate, rather than accurate. Additional cognitive strategies utilized included tolerance of uncertainty and identifying reasonable precautions to mitigate their risk of infection.

Some factors appeared to contribute to the sense of unpredictability and uncontrollability associated with COVID-19. First, the 24-hour news cycle and continually updating social media feeds provided an incessant stream of emotionally charged information. This information was often speculative rather than demonstrably true due to the uncertainty about the novel coronavirus and its transmission, at least initially. This resulted in a sense of unpredictability as the messaging rapidly, and at times drastically, changed when new information was discovered. Unfortunately, this sometimes led to uncertainty about and questioning of the accuracy of this information. Second, the dramatic change in daily routines during quarantine and, to a lesser extent while socially distancing, disrupted indi-

viduals' sense of normalcy. This led to a perceived lack of control or purpose and limited access to wanted coping strategies. These factors can be challenging to target through cognitive techniques and may be more effectually addressed through behavioral strategies.

### Adaptations to Behavioral Activation Strategies

Behavioral activation was the primary behavioral technique employed in response to COVID-19. A large focus was on re-establishing a quasi-normal routine through behavioral scheduling, sleep hygiene, diet, physical activity, and socializing as these domains were significantly disrupted by COVID-19. Metaphors such as "refilling your gas tank" were used to illustrate the importance of engaging in these health promotion behaviors as a way to maintain physical and mental well-being in the face of stressful life events.

In addition, more traditional behavioral activation strategies were used for patients experiencing significant avoidance of or disengagement from pleasurable activities. Daily activity monitoring logs of activities and the level of pleasure and mastery associated with these activities were used to establish a connection between activity level and mood. Patients then identified and scheduled pleasant activities that they were engaging in at a low frequency, previously engaged in, or interested in trying. Patients continued to complete a daily activity monitoring log to track their activities and stay accountable to their goals.

The nature of COVID-19 made it more challenging to implement behavioral activation. First, many pleasant activities were difficult to engage in while quarantined or social distancing. Flexibility and creativity was required, which the examples in Table 3 demonstrate. Second, many of the regular (e.g., social activities, religious services) and periodic (e.g., vacations, events) pleasurable activities that we build into our schedules were no longer present or had to be celebrated in unconventional ways (e.g., birthdays, holi-



Table 3  
Behavioral Activation Adaptations During the COVID-19 Pandemic

Activity	Pre-COVID-19	COVID-19
Socializing	In-person	Telephone calls Video chats
Reading	Purchasing in-person Borrow from a local library	Purchase online Borrow through a library app
Exercising	Gym Recreation center Yoga studio	Outdoor activities Online exercise classes At-home exercise equipment

days). These scheduled bursts of pleasurable activities that were reflexively removed from our schedules had to be intentionally replaced in a purposeful and planful way. Finally, there is still a lack of certainty related to when the pandemic will be over. While a preliminary report found promising results for the first of many vaccination trials (Jackson et al., 2020), there is still uncertainty about when effective vaccinations will be available for the general public, let alone the global population. This has made it nearly impossible to anticipate a “light at the end of the tunnel,” which can make it more challenging for individuals to think positively about the future.

### Lessons Learned

Through this experience, we have identified several key lessons learned that may be informative for other integrated care programs. We hope that this information can help other practices swiftly, thoughtfully, and tactfully respond to the current and future pandemics.

#### Communicate

First, clear and consistent communication is imperative and one of the most important lessons learned during this experience. Communication was important for a multitude of reasons. First, communication ensured that all members of the IBH team were informed about updated policies and procedures, provided with an outlet to ask questions and receive assistance during the transitional period, and commended for their service during this chaotic and uncertain time. Second, communication helped to facilitate a coordinated response across the enterprise. This was a challenging task as our integrated primary care program includes multiple sites in multiple states. Third, communication with our primary care colleagues increased awareness about the availability of IBH services. This was important as the mental health needs of their patients were still present, if not amplified, in the context of COVID-19. Finally, communication with colleagues in other inpatient and

outpatient service lines allowed us share resources that were universally applicable and could be easily disseminated to patients.

Clear and consistent communication has been recommended within the medical literature discussing the ways in which practices and providers should respond to COVID-19 (Chopra et al., 2020; Dewey et al., 2020). We strongly believe this sentiment also applies to the integrated care setting and includes communication within the IBH team as well as with primary care providers and colleagues in other practice locations. We recommend using a combination of previously established formal (e.g., email listserves and distribution lists, departmental and division meetings) and informal communication channels.

#### Establish an Interdisciplinary Team

Second, assemble a small and representative team as soon as possible to respond to emerging and ongoing clinical or administrative challenges. The selection of an interdisciplinary, rather than intradisciplinary, team is helpful for identifying the wide range of challenges in a timelier manner. Leveraging the different knowledge and skill sets of team members allowed for collaborative decisions to be made and implemented in real time. Consistent communication between team members can be facilitated through regularly (e.g., daily or weekly) scheduled yet brief (e.g., 15 to 30 minutes) meetings. We believe that consistent communication between the interdisciplinary team allowed us to problem solve clinical and administrative challenges efficiently and effectively. Establishing this interdisciplinary team ensured the larger IBH team that concerns would be immediately and routinely reviewed and responded to.

#### Prioritize When Problem-Solving

Third, respond to the most pressing issues first and foremost. While this point may seem intuitive, we acknowledge that it is difficult to prioritize the differ-

ent clinical and administrative challenges as all matters are pressing during a public health crisis. In line with the Mayo Clinic primary value that “the needs of the patient come first,” problem-solving the provision of clinical services was most important for our practice. However, the most pressing issue may differ based on the practice, institution, population served, or nature and impact of the public health crisis.

### **Adopt a Flexible Approach**

Fourth, adopt a flexible approach when creating new policies and procedures. As previously stated, the majority of IBH services were provided in-person before COVID-19. In problem-solving how to provide clinical services during the pandemic, it was important to balance patient preference, the available technology, state ordinances, insurance coverage, and institutional policies. Our collective understanding of COVID-19 changed rapidly as new information was obtained and disseminated. It was imperative to be able to flexibly respond when updated national and state decrees, institutional mandates, and public health recommendations were made available. We adopted the idiom of “building the plane while in flight” to acknowledge that we were simultaneously providing mental health care while determining the best way for it to be packaged and delivered to patients.

### **Assume a Population-Based Approach**

Fifth, assume a population-based approach for a population-level problem. This can be achieved by implementing a stepped-care approach, which offers different treatment options of varying intensities. In our practice, this is discussed during the initial consultation session. Providers present an overview of the low-, middle-, and high-intensity interventions that are available at Mayo Clinic and in the community, discuss the pros and cons of each option, inquire about and answer patient questions, and provide recommendations about which level of care may be most appropriate for the patient given the frequency, intensity, and duration of symptoms and level of distress and impairment associated with their presenting problem (s). In line with the patient-centered medical home (PCMH) model (Baird et al., 2014), patients are directly involved in the decision-making process. Patients, rather than providers, are encouraged to select the level of care that best meets their needs. Providers then assist patients in coordinating whichever level of care they choose.

When implementing a stepped-care approach, attention should initially focus on low-intensity, high-yield

resources that focus on domains that are likely to be impacted by the public health crisis. In the case of COVID-19, this included stress, daily life activities, and social connection that were addressed through behavioral activation, cognitive challenging, and relaxation training. If possible and applicable, repurpose previously developed material that can be efficiently distributed to providers. It is important to ensure that these resources can be easily dispersed to patients and any barriers to dissemination are removed. Attention should then shift to the delivery and implementation of evidence-based practices such as CBT, cognitive-behavioral stress management, or resiliency training for patients that require a higher-step level of care. This approach enables a large proportion of the population to access evidence-based information while also ensuring that patients with greater distress or impairment are able to access the appropriate level of care in a timely manner.

### **Practice Self-Care**

Finally, use the strategies and skills that you recommend to your patients. COVID-19 has had a significant impact on providers’ personal lives. Further, studies have shown that providers have also experienced challenges coping with COVID-19 (Lai et al., 2020). It is an ethical imperative for psychologists to maintain their physical, psychological, and emotional well-being (Barnett et al., 2007). The *American Psychological Association (2017) Ethical Principles of Psychologists and Code of Conduct* states that psychologists must be aware of and address personal problems in Ethical Standard 2.06 Personal Problems and Conflict:

- (a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
- (b) When psychologists become aware of personal problems that may interfere with their performing work related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties.

A similar sentiment is also present in the ethical codes of other mental health providers such as physicians, nurses, and social workers (American Medical Association, 2016; American Nurses Association, 2015; National Association of Social Workers, 2017). Altogether, these statutes indicate that providers must take care of themselves so they are able to competently and

ethically care for their patients. Behavioral activation, cognitive challenging, and relaxation training, all of which we recommended to patients during COVID-19, can be used by providers to combat stress, uncertainty, disruptions in daily life activities, and lack of social connection. These strategies and skills can also help in coping with the challenges that many mental health providers have experienced during COVID-19, such as the stress of abruptly transitioning to telehealth, loss of the *je ne sais quoi* of in-person psychotherapy, reduction in patient panels, concerns about their patients' health and safety, employment insecurity, and economic downturn at the personal and/or societal level. As providers, we must remember to "walk the talk."

## Conclusions

COVID-19 has presented unpredictable and unprecedented obstacles for mental health providers. Our multi-site, multi-state integrated primary care program responded to these challenges by maintaining individual psychotherapy services; suspending group psychotherapy programs; repurposing non-visit care activities; developing and disseminating new workflows; compiling and creating low-intensity, high-yield mental health resources; and providing stress management and resiliency building interventions. In particular, we found that CBT could be adapted to assist patients in coping with COVID-19 and its associated challenges, especially through the development of CBT-based resources that could be easily disseminated across a wide population. Overall, this experience has resulted in multiple lessons learned, including the need for communication, teamwork, prioritization, flexibility, adoption of a population-based approach, and self-care. We hope that these lessons can assist other integrated primary care clinics to swiftly, thoughtfully, and tactfully respond to the current and future pandemics.

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