Power on: The rapid transition of a large interdisciplinary behavioral health department to telemental health during the COVID-19 pandemic

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ARTICLE INFO

ABSTRACT

Background: The COVID-19 pandemic necessitated a rapid transition to telemental health (TMH) for behavioral health services in the behavioral health department of a large integrated primary care organization. Although the COVID-19 pandemic was the initial trigger for rapid organizational change, systems were developed with a focus on longer term scalability and sustainability.

Methods: This paper discusses the process of organizational change within our healthcare delivery system using the Strengths, Opportunities, Aspirations, and Results (SOAR) framework. Within this framework a structured mixed methods survey of 38 clinicians representing 5 different disciplines was conducted. Internal and survey data were analyzed to evaluate and guide the iterative change process.

Results: The majority of BH clinicians reported that they were as or more effective with TMH. The transition to TMH in our organization resulted in increased access to care, with a 10.3% increase in BH visit completions. The transition to TMH may benefit clinician work-life balance, but requires resources to support clinical, technological, and communication/teamwork changes.

Implications/conclusions: TMH is a feasible treatment modality for integrated care settings. It is cost-effective and well-accepted by clinicians. The SOAR framework can be used to guide rapid organizational change and ongoing QI processes.

1. Background

The use of telehealth increased significantly during the Covid-19 pandemic as healthcare organizations worked to provide care and maintain safety. Many organizations had to transition quickly, with little time for planning. While this transition presented a challenge for many organizations, integrated behavioral healthcare (BH) was well situated to adapt. This paper describes the rapid transition to telehealth from an organizational change lens. Using the Strengths, Opportunities, Aspirations, and Results (SOAR) framework, we describe how our integrated care organization leveraged existing resources to convert 98% of visits to telemental health (TMH; synchronous services delivered via video) over the course of several days. The objective of this initiative was to rapidly pivot fully in person behavioral health department to telemental health

in a scalable and sustainable way. To that end, the SOAR framework and mixed methods survey data were used to guide the organizational change process. We synthesize our findings with relevant literature to discuss implications for the future delivery of TMH within an integrated BH model.

1.1. Telemental health (TMH)

TMH has a long history of use in BH and is considered effective for a variety of conditions including anxiety and depression across populations.[1] TMH increases access to BH care within primary care and rural settings.[2–4] Because BH services rarely rely on physical measurement, they are particularly suited for telehealth. However, certain organizational factors are necessary to implement TMH effectively.[5]

Proper training, peer support, and supervision positively impact clinicians' experience delivering TMH.[5] Even when clinicians lack prior experience with TMH, institutional support can improve clinician satisfaction conducting TMH.[6] TMH is associated with more efficient use of appointment time and increased cost-effectiveness[7]; Feijt et al., 2020).

1.2. Promoting organizational change

The transition to remote work and telehealth led to a dramatic recalibration of patient and workplace communication. Although organizations make frequent changes, they are often not successful because changes create instability and are often associated with increased work-related stress.[8,9] Qualities associated with successful change include healthcare professionals' ability to influence the change, preparation for the change, and their perceived value of the change, especially in terms of patient benefit.[9]

The SOAR (Strengths, Opportunities Aspirations, Results) framework can be used to help organizations to identify and leverage existing strengths to facilitate successful organizational change.[10,11] The emphasis within SOAR is to engage in a growth-mindset, to be "the best possible"[11]; p. 12) rather than merely focusing on deficits or competing with other entities. SOAR was conceived as a transformation of the landmark SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis.[10] SOAR is congruent with the appreciative inquiry philosophy and has an emphasis on improving outcomes such as productivity, communication, and morale.[10] In SOAR, changes are reframed as opportunities to innovate and meet organizational aspirations, a valuable paradigm in times of crises.[12,13] Conducting a SOAR analysis requires consideration of each element within the context of the organization as well as engagement of stakeholders at all organizational levels.[13] This article addresses gaps in the literature by discussing the transition to TMH during the COVID-19 pandemic through an organizational change lens.

1.3. Organizational context

Reliant Medical Group is a large, multispecialty care organization in central Massachusetts with over 300,000 patients in adult and pediatric primary care. The Behavioral Health (BH) department, with about 60 licensed clinicians, is integrated within primary care. Clinicians are available for real-time consultation and intervention, tightly coordinated with primary care practices. As of early March 2020, the BH integrated care model operated with exclusively face-to-face patient visits provided by clinicians embedded in primary care sites. Services
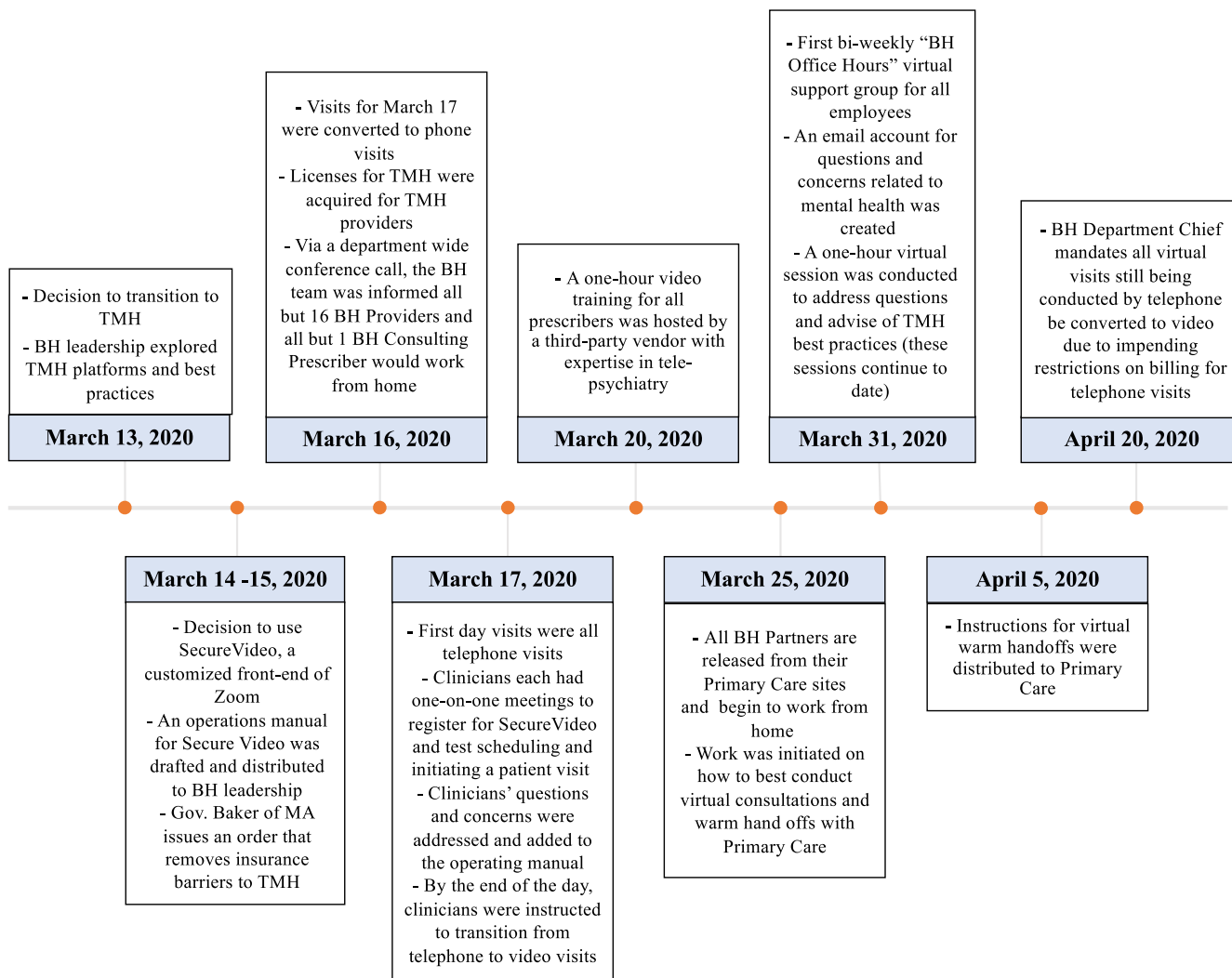

Fig. 1. Timeline of transition to TMH

provided include generalist outpatient mental health care, bariatric care, addictions counseling, Medication Assisted Treatment (MAT) for addictions, and a specialty Dialectical Behavioral Therapy (DBT) clinic. By March 13, 2020, the COVID-19 pandemic required BH clinicians to transition to virtual care. Fig. 1 provides a timeline of the changes that occurred during the transition to TMH.

The integrated model consists of three primary roles: the BH Partner, the BH Provider, and the BH Consulting Prescriber. BH Partners are licensed, masters-level clinicians, in psychology or social work, with low visit targets, available for real-time primary care needs – warm handoffs, crisis consultations, triage and coordination to connect patients with the right BH resources.

BH Providers are psychologists or independent social works who deliver relatively brief, goal-oriented psychotherapy (8–10 sessions) to patients triaged from the BH Partners. Providers are available for curbside consultation, crisis management, and diagnostic clarification, but not with the same real-time flexibility as the Partners.

The BH Consulting Prescriber is an advanced practice nurse or psychiatrist who supports primary care with psychopharmacological advice and brief (6–8 weeks) interventions to evaluate and adjust medications for primary care to manage. The BH model also involves referring patients to longer term community providers for patients who are too complex or challenging to be adequately served by the standard model.

2. SOAR analysis

In this section, we utilize the SOAR framework to describe how our organization was able to leverage existing strengths in order to quickly and efficiently transition to TMH.

2.1. Strengths

A number of strengths were leveraged during the pandemic to successfully transform care delivery. The most notable strength was the existing culture of innovation and flexibility. The BH integrated care model was established and continued to grow with a spirit of continuous quality improvement (QI) and stakeholder (e.g. clinicians, administrators) engagement. Specifically, all BH team members are encouraged to share successes and challenges at any time through clinical supervisions, peer groups, or even informally via email or text to the BH Chief. These topics are discussed during weekly BH meetings. The department emphasizes interprofessional practice, cross-fertilization among disciplines, and transdisciplinary meetings and trainings. Through this bottom-up approach, people closest to the delivery of services are empowered to innovate, make changes, and share results with other members of the team. Flexibility is a core component of the integrated BH model. Most patients are seen for between 6 and 10 visits, which means there is high patient turnover to allow access for new patients. Clinicians often meet several new patients each day while providing support to other team members in a fast-paced primary care setting. Pre-pandemic, a common saying among the team was "we are building the plane as we fly it", which conveys the culture of rapid plan-do-study-act (PDSA) cycles to continuously monitor and respond to changes in the healthcare delivery environment.

2.2. Opportunities

2.2.1. Legislative changes

The COVID-19 pandemic created fertile ground for expansion into TMH services. Specifically, Governor Baker of Massachusetts issued an executive order requiring payers to reimburse for TMH visits at the same rates as traditional office visits for the duration of the state of emergency, removing insurance barriers to providing BH services via TMH.[14] Pre-pandemic, TMH was discussed but not actively pursued due to reimbursement barriers.

2.2.2. Improved access and flexibility

Virtual care facilitated opportunities to put the right patient in front of the right clinician at the right time, regardless of geography. The organization operates 10 sites that are up to 50 miles apart. Some sites are significantly smaller than others and have more clinical staff relative to the size of the patient population. As a result, pre-pandemic access for patients was highly variable and site-dependent. TMH improved flexibility such that patients could be better matched to clinician expertise, patient preferences, and availability of appointment times. TMH created opportunities to see patients sooner and use BH clinician time more efficiently. In addition, we launched a BH web page to support Reliant Medical Group patients. The page featured an ongoing video series including BH topics of particular relevance during the pandemic such as an Anxiety Skills group.

2.2.3. Teamwork

Teamwork among BH and primary care clinicians was facilitated through initiatives including scheduled "huddle" meetings, web cameras for on-site clinicians to be able to meet on virtual platforms, and a branching logic, "smart" BH order within the EMR. The new "smart" order provides a single point of contact for primary care providers (PCPs) to outreach to the right BH clinicians with the right priority, depending on the urgency of a case. The order is triaged by a BH team member, ensuring efficient use of clinician time.

2.2.4. Collaboration with external stakeholders

The department strengthened relationships with external organizations providing TMH for patients who needed longer term treatment. We established a partnership with an organization that exclusively delivers telehealth, which allowed us to increase our capacity to serve our patient population.

2.2.5. Professional growth

BH clinicians identified personal learning opportunities with TMH, and the department coordinated additional trainings to meet identified needs. For example, each clinician had the opportunity to engage in a one-to-one TMH practice session with the Chief of BH to practice using the new platform while attending to TMH communication skills. The BH consulting prescribers received additional training with an experienced telepsychiatry vendor. BH clinicians shared educational materials from professional organizations via the department email list, supporting self-selection into additional trainings.

2.2.6. Employee support

Several initiatives were developed to address clinicians' personal needs and work-life balance, including twice weekly BH "office hours" call. BH employee office hours were implemented early in the pandemic to offer a venue for evidence-based clinical support for all organization employees and their families. Interested parties were able to write questions and concerns to a secure email address. These were reviewed and addressed by the Chief of BH during 30-min webinars, which occurred twice-weekly.

2.3. Aspirations

The BH department aspirations included evolving to accommodate TMH within our model even post-pandemic. Beyond offering TMH services, we aspired to ensure to develop the department's capacity to serve the patient population while ensuring productivity and teamwork with primary care colleagues and other key stakeholders. The department also aspired to retain the department's identity as an employer of choice focused on professional growth and work-life balance.

2.4. Results

In the SOAR framework, results include outcomes indicative of

success as well as an iterative process of continuous QI.[11] Results were gathered through analysis of internal visit and referral data, and through the development and implementation of a structured survey of clinicians.

2.4.1. Internal visit data

We used visit data from the Electronic Medical Record (EMR) to characterize visits across the transition to TMH. In the 14 months prior to the start of the COVID-19 pandemic (January 2019 to February 2020), 61.9% of scheduled BH visits were completed (M scheduled = 3931; M completed = 2435). In the 11 months after the transition to TMH (April 2020 to February 2021), 72.2% of scheduled BH visits were completed (M scheduled = 5476; M completed = 3956), resulting in a 10.3% increase in BH visit completions after the transition to TMH. In the 14 months prior to the transition to TMH, the BH department conducted 100% of visits in person. Following the full transition to TMH (from April 2020 to February 2021) an average of 85.6% of visits were conducted with video and 12.9% were conducted via telephone per month. Approximately 1.5% of visits per month remained in-person, primarily within the substance-use services clinic.

2.4.2. Referrals to telehealth partner organization

We leveraged an existing partnership with a local telehealth provider, substantially increasing the number of referrals to this organization to accommodate the increased demand for services in our patient population. Prior to the transition to TMH, we referred an average of 3.3 primary care patients per week to this provider between August 2019 and March 21, 2020, with an average of 10 patients engaged in care per week. Following the transition to TMH, an average of 17 new patients were referred to this provider each week, with an average of 140.2 engaged in care each week between March 21, 2020 and December 31, 2020.

2.4.3. Acceptability among clinicians

A cross-sectional survey of BH clinicians about the transition to telehealth was developed by a working group of clinicians and administered in December 2020. The survey was administered electronically and utilized a mixed methods convergent design, simultaneously collecting quantitative and qualitative data. The survey included 22 Likert scale items about clinicians' experiences conducting TMH visits compared to face-to-face (FTF) visits. Topics were aligned with identified opportunities and aspirations, including clinical and technological efficacy, communication, and work-life balance. Open-ended questions asked clinicians to identify clinical presentations that are difficult to assess or treat via TMH and barriers to practicing TMH long term. The survey was determined to be exempt by the Reliant Medical Group Institutional Office of Human Research. All 58 integrated BH clinicians received the survey.

Quantitative data were analyzed descriptively. Thirty-eight of 58 clinicians completed the survey, resulting in a 66% response rate. Survey results indicated high acceptability among clinicians. Nearly two-thirds of clinicians preferred to continue telehealth in the future. Ninety percent felt they were as or more effective at establishing therapeutic alliances with patients using TMH, while 87% felt they were as or more effective at assessing patients' mental status. However, a sizable minority (35%) of clinicians reported difficulty conducting warm handoffs (passing a patient between primary care and behavioral health). Forty-percent of clinicians felt they were more effective at accommodating patients with disabilities. Average treatment duration remained relatively constant, but the frequency of visits increased according to 44.4% of participants.

The transition to TMH also impacted clinicians' wellbeing and work-life balance. Sixty-eight percent felt they were as effective or more effective at balancing work and personal life. Decreased job-related stress was reported by 44.7% of participants. When asked about effective team communication, most participants felt they were as effective.

Full survey results are displayed in Table 1.

Qualitative data were gathered from open-ended survey questions. Thematic analysis was conducted, with cross validation completed via a representative sample of BH clinicians. When asked about clinical presentations that were more challenging to assess or treat using TMH, participants identified attention deficit hyperactivity disorder, schizophrenia, social anxiety/shyness, and neurocognitive concerns such as dementia. Additionally, clinicians believed pediatric patients were more difficult to treat virtually. Participants also noted that behaviors such as psychomotor changes or abnormal movements were more challenging to assess with TMH. Thematic analysis is summarized in Table 2. The three main themes were *Technology Needs, Personal Needs,* and *Presence/ Teamwork.* Technology needs primarily concerned patients' needs, for example clinicians shared that "technical glitches (lack of audio) and patient user error are intermittent", and "the client's inability to access technology". Personal needs were focused on the clinicians' own adaptation to working from home and TMH, exemplified with statements such as "we no longer have a buffer between patients (patients arriving late, etc.)", and "I also have more distractions at home that interfere with accomplishing all tasks". Presence/teamwork included statements indicating positive, negative, and neutral changes with TMH including "our roles were developed to be integrated in the office ... we had primary care and staff immediately accessible", "I miss the team-based work that comes with being in the office, but virtual work has allowed me to access new populations who had many barriers to in-person visits", and "good connection with PCP team".

3. Discussion

We used the SOAR framework to examine the transition of a large integrated BH department to TMH during COVID-19. We examined how specific strengths such as the organizational culture of flexibility, continuous QI, and clinician engagement were leveraged to facilitate this transition. Consistent with extant literature, institutional support and structures facilitated the successful transition to TMH[6,7]; Feijt et al., 2020). Internal visit data and survey data were analyzed to guide QI initiatives during the transition to TMH. Survey data were consistent with previous studies on TMH, with benefits including flexibility, increased access, clinician satisfaction, and barriers including technology problems and some clients (e.g. pediatric, cognitively impaired) not being as well suited to TMH (Feijt et al., 2020.[4,15,16]; Overall, BH clinicians in our setting reported that they felt they were as effective or more effective when using TMH.

Consistent with the literature, BH clinicians identified both benefits and challenges associated with work-life balance in the remote environment.[5,16] Notably, nearly half of respondents reported decreased work-related stress. This may have resulted from improved flexibility with staffing, scheduling, and site coverage to better meet employee and patient needs. The department worked actively to support employees' needs during the transition, providing office hours and continuously monitoring feedback and improving workflows. Nonetheless, it is important to note that nearly twenty-five percent of clinicians still reported difficulties adapting to remote work. One explanation is that the large decrease in patient cancellations in the remote environment removed "buffer" periods between visits. Additionally, as one participant described, the boundaries between home time and work time were blurred without a commute or separate workspaces.

Developing the new technological infrastructure and helping patients and clinicians adapt to the technology was also critical to the success of the transition. Technology needs were identified early in the transition to TMH. Outreach was conducted to community organizations to assist patients in obtaining devices or internet connectivity to engage in TMH. BH clinicians also became adept at providing coaching, troubleshooting, or switching to telephone visits to meet patients' needs and workflows were adapted as needed throughout the transition. For example, the department also later transitioned to a virtual platform

Table 1
Telehealth survey results (n = 38).

How do you compare your effectiveness in a variety of clinical activities using the virtual platform to in-person visits?

	More effective		About as Effective		Less effective	
	n	%	n	%	n	%
Clinical work	8	21.1%	25	65.8%	5	13.2%
Assessing patients' mental status	2	5.3%	28	73.7%	8	21.1%
Establishing therapeutic alliance	5	13.2%	29	76.3%	4	10.5%
Conveying empathy	3	7.9%	30	78.9%	5	13.2%
Managing patients' risk	2	5.4%	26	70.3%	9	24.3%
Engaging patients	11	28.9%	23	60.5%	4	10.5%
Accommodating patients with disabilities	15	39.5%	16	42.1%	7	18.4%
Completing warm handoffs	3	8.1%	21	56.8%	13	35.1%

How do you compare your experiences working remotely with working in the office?

	More effective		About as Effective		Less effective	
	n	%	n	%	n	%
Communicating effectively with team members	3	7.9%	25	65.8%	10	26.3%
Balancing work and personal life effectively	16	42.1%	10	26.3%	12	31.6%

How do you compare your stress working remotely with working in the office?

	Increased		Remained the Same		Decreased	
	n	%	n	%	n	%
Job-related stress	10	26.3%	11	28.9%	17	44.7%

How do you rate your resources for conducting telehealth visits?

	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
Possess technological needed	16	42.1%	15	39.5%	7	18.4%	–	–	–	–
Possess Equipment needed	12	31.6%	20	52.6%	2	5.3%	4	10.5%		
Possess resources needed	9	23.7%	12	31.6%	12	31.6%	4	10.5%	1	2.6%

Compared to in-person visits, how do you rate the length of treatment and frequency of visits?

	Increased		Remained the Same		Decreased	
	n	%	n	%	n	%
Average treatment length	5	13.5%	29	78.4%	3	8.1%
Frequency of visits	16	44.4%	19	52.8%	1	2.8%

Percent encountering clinical presentations that are difficult to …

	n	%
Assess	16	43.2%
Treat	13	35.1%

Percent who would prefer to practice telehealth in the long-term

	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
Prefer telehealth long-term	13	35.1%	10	27.0%	8	21.6%	2	5.4%	3	10.8%

Table 2
Qualitative themes.

Theme:	Participant Comments:
Technology Needs	"The client's inability to access technology"
	"Technical glitches (lack of audio) and patient user error are intermittent"
	"Lack of ability to print or save things to a device"
Personal Needs	"We no longer have a buffer between patients (patients arriving late, etc.)"
	"I also have more distractions at home that interfere with accomplishing all tasks"
	"I miss the mental break during the commute"
	"Zoom fatigue is real"
Presence/ Teamwork	"Our roles were developed to be integrated in the office … we had primary care and staff immediately accessible"
	"I miss the team-based work that comes with being in the office, but virtual work has allowed me to access new populations who had many barriers to in-person visits"
	"Good connection with PCP team"

within the EMR which allowed patients to connect to visits and communicate with clinicians within one application.

This study has several limitations. Survey data collected are cross-sectional and from one integrated BH department in the Northeastern region of the United State and findings may have limited generalizability to other settings. However, we had a relatively high survey response rate of 66% among BH clinicians and representatives from five different disciplines. Additionally, the use of the SOAR framework to organize the change process, along with the use of a structured survey, are strengths that are replicable across settings.

Future directions include evaluating feedback from other key stakeholders (e.g. primary care providers and patients), continuing to improve processes around technology and teamwork, and supporting clinicians' adaptation to remote work. Future work should also include identifying ways to improve TMH or alternative options for patient populations that are difficult to treat via TMH (e.g. pediatric or cognitively impaired). Critically, the use of TMH during the COVID-19 pandemic has created an opportunity for the widespread examination of this modality and consideration of the long-term advantages of TMH care delivery. In January 2021, Massachusetts passed legislation ensuring permanent coverage of BH services via TMH, supporting long

term viability of TMH within our model (MGL Chapter 260). Our experiences with TMH have led the organization to consider a long-term switch to TMH as the de facto mental health service modality within our organization.

4. Implications/conclusion

Rapid and successful organizational change is possible, even in times of crisis such as the COVID-19 pandemic. TMH within an integrated primary care setting is feasible, sustainable, and cost-effective. It may improve work-life balance, but some employees may also benefit from additional support around remote work. TMH offers additional opportunities to address the triple aim of healthcare cost, quality, and access by breaking barriers that existed in the office visit setting.

In our setting, strengths including the existing culture of participatory innovation and interdisciplinary collaboration were leveraged to adapt to TMH swiftly. Other healthcare delivery systems undergoing significant organizational changes may benefit from application of the SOAR framework to guide the process. Identifying and developing organizational strengths in advance of significant changes may also increase success. Strengths such as empowering clinicians to participate in the change process and establishing a culture of continuous quality improvement can facilitate successful change. Feedback from key stakeholders should be elicited early and often in the change process, using both informal and structured methods. This aids in engagement and identifies issues and areas for improvement. Organizational changes, even those made rapidly to adapt to crises, should include robust planning and engagement of key stakeholders as the foundation.

Funding

CRediT authorship contribution statement

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original draft, Writing – review & editing. **S. Nordberg:** Conceptualization, Methodology, survey design, Formal analysis, Interpretation, Writing – original draft, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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