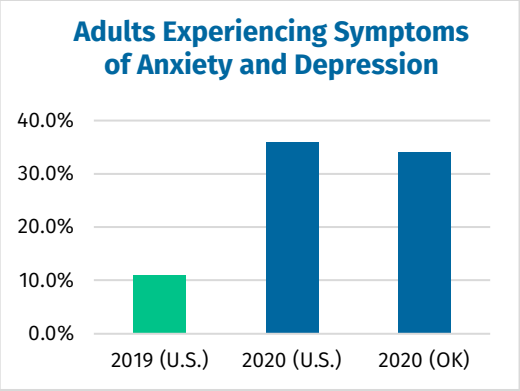
HEALTHY MINDS
POLICY INITIATIVE

OKLAHOMA'S BEHAVIORAL HEALTH WORKFORCE: COVID-19 INNOVATIONS

April 2021

INTRODUCTION

Health care providers working in emergency rooms, intensive care units, and primary care clinics have been on the front lines of the COVID-19 pandemic. However, behavioral health workers have also played a key role in responding to the pandemic. These professions have managed the stress and behavioral health challenges resulting from the social and economic fallout of the pandemic while continuing to meet ongoing behavioral health needs. The emotional toll of the pandemic has been staggering. The percentage of adults experiencing symptoms of anxiety or depression during the pandemic *more than tripled* from comparable periods in 2019,[i] and this increase continues to be apparent in the March 2021 data.[ii] The behavioral health workforce in Oklahoma has responded with innovation and creativity to the unprecedented changes and chronic uncertainty of the COVID-19 pandemic.



In our behavioral health workforce series briefs, we outline Oklahoma's behavioral health workforce shortages, offer recommendations and strategies for improving recruitment and retention of these providers and highlight how Oklahoma can best meet the behavioral health workforce needs that will arise from Medicaid expansion. In this brief, we examine the pandemic's effect on Oklahoma behavioral health providers as well as the changes and innovations they have implemented in response to the pandemic. We also identify opportunities for behavioral health workforce development funding and explore how Oklahoma can be on the leading edge of retaining behavioral health innovations that have emerged in response to the pandemic.

KEY TAKEAWAYS

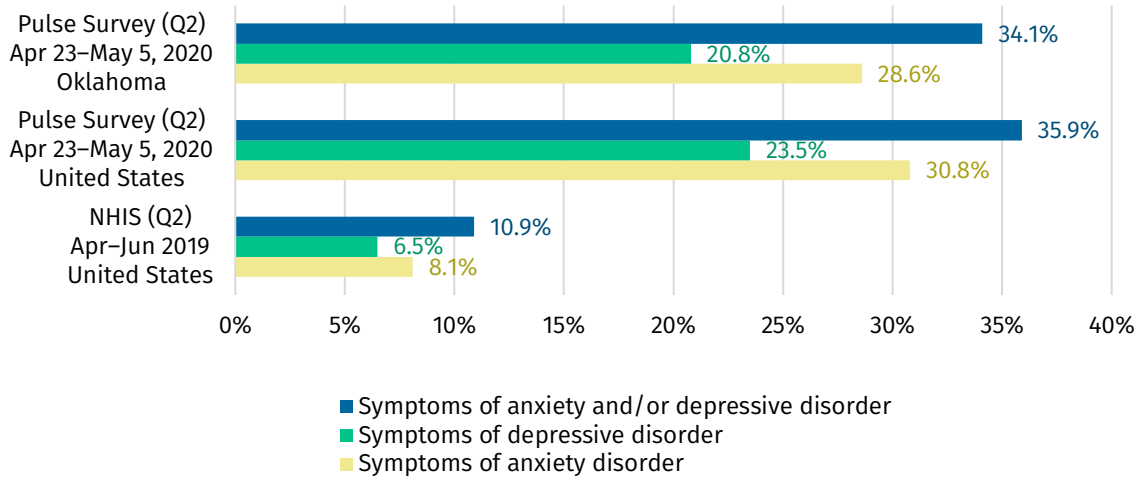
- **The COVID-19 pandemic has increased demand for behavioral health services** at a time when the workforce itself is also coping with the pandemic's effects. Supporting staff wellness is key to retention.
- **The amplification of pre-COVID-19 trends toward the use of telehealth and value-based care have provided a path forward for responding to increased demand.** Harnessing technology and better supporting and utilizing the workforce that uses it will lead to increased access to and higher quality of care, and is the number-one opportunity that has emerged from the pandemic.

- **Oklahoma must capitalize on the large amount of funding for behavioral health care that has been included in the national response to the pandemic. This funding can help recruit and retain the well-qualified behavioral health workforce that is needed to implement innovative ways of responding to the surge in demand.** Drawing down these federal dollars can support increases in salaries, take innovative delivery models to scale and broaden the workforce by disseminating and adopting models of early detection and treatment in primary care settings.
- **Flexibility in COVID-era licensure and innovations in health care compacts** have highlighted the importance of continuing non-emergency compacts. Efforts by state boards to improve licensure reciprocity are also needed to facilitate the recruitment of behavioral health professionals.

COVID-19 HAS INCREASED DEMAND FOR BEHAVIORAL HEALTH SERVICES

As noted earlier, changes in the behavioral health needs of the people seeking treatment will have an impact on the future workforce. Like many of the changes that have accompanied the pandemic, these needs will not resolve in the near term. Since April 2020, the Household Pulse Survey, a partnership between the National Center for Health Statistics (NCHS)[iii] and the U.S. Census Bureau, has been collecting data online about U.S. adults' experiences during the pandemic, including information about their mental health. One of the topics covered by the survey is how frequently respondents experienced anxiety and depression symptoms over the seven days prior to taking the survey.[iv] The following chart demonstrates the increase in adults experiencing these symptoms from 2019 to 2020.

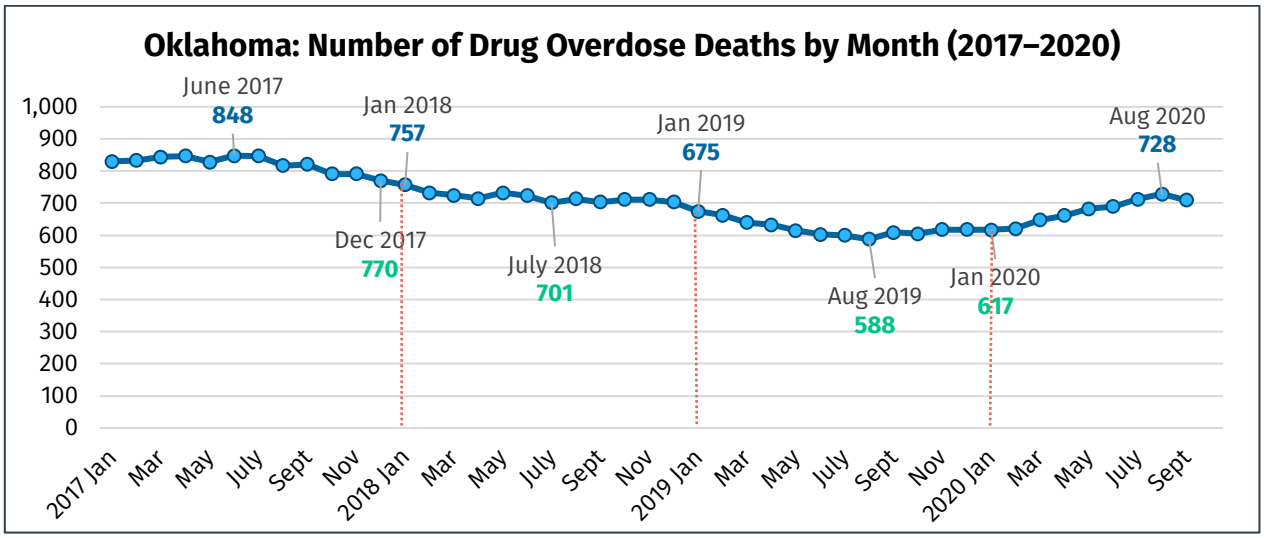
Percentage of Adults Experiencing Symptoms of Anxiety and Depression, Nationally and in Oklahoma—2019 Versus 2020



Earlier this year, the National Council for Behavioral Health surveyed 332 of its members about their workforce experiences during the pandemic.[v] Two thirds of the participating organizations reported in February 2021 that the demand for their services had increased over the previous three months.

We also heard from providers that the pandemic was particularly challenging for people who struggle with substance use issues. The CEO of one community mental health center shared, "People with addiction problems feel the stress of confinement .... [We see] more people going back to using substances."[vi] A specialty substance use provider commented that "[w]hat we are seeing is ... relapsing [in] people who have been successful for some time in the recovery process."[vii] The National Council for Behavioral Health conducted a COVID-19 workforce survey of its members and found that of the organizations who deliver substance use disorder services, over half (64%) reported in February 2021 that the demand for these services had increased over the previous three months, with a 13% increase since August 2020.[viii]

The following chart presents provisional counts of deaths caused by drug overdose by month in Oklahoma, according to the CDC.



For each year, the month with the highest counts is labeled in blue, and the month with the lowest is labeled in green. After reaching a high of 848 in 2017, Oklahoma experienced a steady decline in overdose deaths in 2018 and 2019, with a flattening out in early 2020. Available data then show a steady rise in 2020 as the country entered the COVID-19 pandemic, with a large proportion of the reduction in overdose deaths from the previous two years reversed in 2020. Taken together, these national and state data suggest that the need for mental health and substance use disorder services is not subsiding even as the COVID-19 situation improves.

When asked about meeting demand during the pandemic, representatives of Oklahoma behavioral health provider organizations who were interviewed for this project shared a varied picture of work life and service delivery during the pandemic. Some clinics returned staff to their buildings relatively soon after the initial COVID-19 shutdown, whereas others still required nearly all staff to work from home a year later. Although most clinics—even those with clinicians in the building—have relied heavily on telehealth, some provider organizations have been seeing some clients in person. Pandemic-related restrictions seem to have had the most negative impact on therapy and wellness groups; many providers have shared that it has been difficult to sustain participation in virtual groups. Other providers took advantage of the warmer months in 2020 to hold groups outside under tents or in the shade of trees, but not all clinics have had those opportunities.

Supporting staff wellness during the COVID-10 pandemic has been key to staff retention

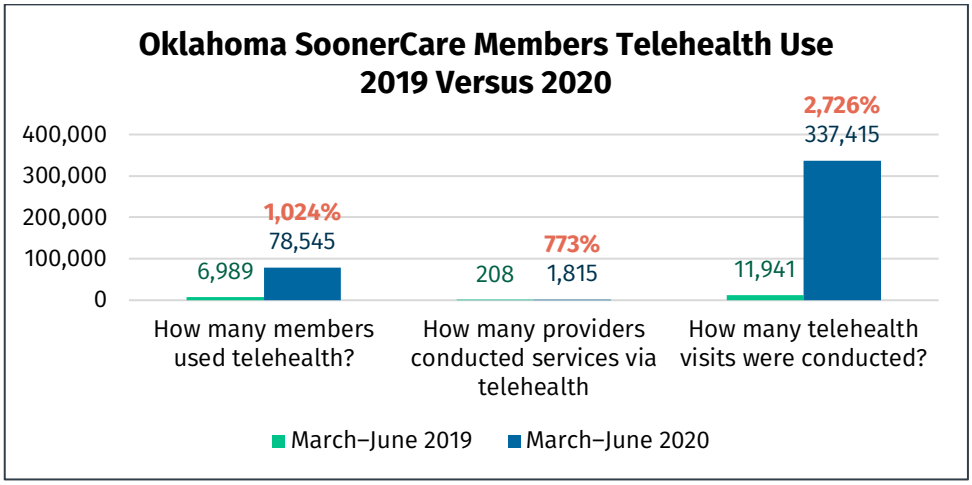
Although increased demand for behavioral health services highlights the need to recruit and retain additional behavioral health workers, the current workforce is being depleted. The pandemic has challenged behavioral health workers' own well-being, reinforcing the need to take care of the current workforce. One nurse care manager commented, "With COVID, morale and mental health are impacting team performance."[ix] Like so many people across the nation, behavioral health workers' ability to come to work on-site depends on their personal health status, risk factors and family concerns. Although behavioral health providers' need for personal protective equipment (PPE) was initially a lower priority than PPE for medical personnel, this need eventually emerged as a critical priority, especially for those working in residential and inpatient settings. One care manager shared the dilemma of balancing personal safety and client care: "I want to be safe, but I want to give [clients] a level of care that they have been used to."[x]

The CEO of one substance use treatment organization shared, "Our employees are in recovery themselves. There is high burnout, and COVID had added a layer to that."[xi] Providers have implemented wellness and retention efforts for staff, including one clinic that has a "pandemic posse" that meets regularly to assess morale, troubleshoot issues such as the availability of PPE for staff and explore programs that could provide additional resources to staff for wellness support. Examples of supportive activities include catering food for staff who come into the office, providing small stipends for staff to spend on self-care and increasing access to tele-behavioral health services for staff. Other recommendations for avoiding staff burnout include providing techniques for avoiding "Zoom fatigue" (e.g., hiding the self-view window, taking audio-only breaks)[xii] and engaging in "staff rounding" (modeled after the idea of making rounds to check on patients) in which employers/supervisors craft a process that includes

asking key questions to assess burnout, fostering an environment that honors honest responses and a developing a data-driven action plan to improve the workplace.[xiii] Another wellness benefit that employers can offer staff who are working remotely is release time for a weekly virtual "coffee chat" with colleagues. This opportunity helps make up for the loss of "water cooler" or doorway conversations when employees shifted to working remotely from home. As the pandemic resolves, employers will also have to address the looming question of whether all workers will want to come back to work in person after experiencing the flexibility and lack of commuting that has accompanied remote work, and how allowances for telecommuting factor into retention efforts.

TELEHEALTH IS THE NUMBER ONE HEALTH ACCESS OPPORTUNITY EMERGING FROM THE PANDEMIC

Telehealth offers an opportunity to increase access to services, reduce demand on facilities and expand the reach of the existing behavioral health workforce. The Centers for Disease Control and Prevention reported that the number of telehealth visits increased by 50% during the first quarter of 2020, compared with the same period in 2019, with a 154% increase in telehealth visits during the last week of March 2020.[xiv] The figure below demonstrates the dramatic increase in telehealth use among Oklahoma Medicaid enrollees that is attributable to the pandemic.[xv]



The Centers for Medicare and Medicaid Services made virtual visits with physicians more accessible by broadening access to telehealth services, including permitting physicians licensed in one state to provide telehealth services to patients in a different state and allowing the delivery of audio-only (telephone-only visits) services. The Oklahoma Health Care Authority initiated expanded use of telehealth on March 16, 2020—which was most recently extended on April 19, 2021 for an additional 90 days—for services that could be provided safely via secure telehealth communication devices for all SoonerCare members.[xvi] The use of

telephone services may be used when a member does not have access to telehealth equipment with video capability, the health and safety of the member is at stake and the service can be provided safely and effectively over the telephone.[xvii]

For the most part, providers reported that telehealth improved access and that both staff and clients have had a positive response to this service: "[Clients] love it. Transportation is a huge barrier. I don't think we will ever go back."[xviii] Multiple providers noted improvement in no-show rates: "Between March and May [2020], we had a significant decrease in no-show rates. [Therapists] saw 97–99% of people on their caseloads since transportation wasn't a challenge. This has opened a lot of access."[xix] Another provider reported that a 30% to 40% no-show rate was reduced to less than 15% once the agency transitioned to telehealth and stated that they would continue to use telehealth to reduce transportation barriers even after the pandemic resolves. Still, the transition to remote work and telehealth has not been successful for all staff and clients. As one staff member reported, "Within a week and a half, we converted to 100% telehealth and curbside pharmacy pickups. That was a challenge for some staff. They are too distracted working from home."

Additional training is needed on how best to deliver telehealth, as is research on the efficacy of delivering behavioral health services virtually. One social work professor commented that "virtual delivery will continue as a trend. COVID has forced this hand, but I think more training in best practices and the ethical delivery of online services is needed. How do you make sure [clients] are safe and data is protected?"[xx] A professor of psychiatry acknowledged the benefits of increased access, but cautioned that "we need to look at outcomes. Are people really getting better? We're all just winging it. We definitely need more training."[xxi]

Payment parity will be needed to sustain telehealth

Healthy Minds Policy Institute outlined several telehealth recommendations in *Oklahoma Mental Telehealth Expansion: Policy Considerations for 2021 Legislative Session*. Among these recommendations are:

- Pass *Oklahoma Senate Bill (SB) 674,* which was introduced in the 2021 legislative session. This bill provides game-changing legislation that aims to expand and sustain telehealth by ensuring that service recipients will have no greater costs or limitations for care and that providers will have equal reimbursement for these services. SB 674 will provide continued support for payment/reimbursement parity for telehealth, mandating that provider payments for in-person behavioral health and tele-behavioral health are equivalent when telehealth is medically appropriate. This bill would apply parity for telehealth provided by any licensed medical professional, not just physicians.
- Retain the federal changes in telehealth policy for Medicaid and Medicare in response to the COVID-19 pandemic that help support competitive wages by paying physicians

the same rate for telehealth/tele-psychiatry services as they receive for in-person visits, for all diagnoses, and allow physicians to waive or reduce cost-sharing for telehealth visits.

One community mental health provider agreed that the financial aspects of telehealth have been positive: "Overall, the reimbursement for telehealth has gone well for [us]. Any decrease was insignificant. What helped was the codes being opened up."[xxii] The Oklahoma Department of Mental Health and Substance Abuse Services reported a 900% increase in the utilization of technology for mental health service delivery during the course of the pandemic. This increase included telehealth services as well as use of iPads to connect with police to better serve the community, for example.[xxiii]

Behind the iPad: A case study of workforce infrastructure and the strategy behind the technology

Grand Lake Mental Health Center (GLMHC) is a Certified Community Behavioral Health Center that serves 12 counties in northeastern and northcentral Oklahoma. When the pandemic began, GLMHC shifted to having two thirds of its staff work from home in an effort to limit the number of people in its clinics. However, echoing the information noted above, GLMHC leadership commented that some people needed to be seen in person: "We never closed one clinic. Our business model never changed, just shifted."[xxiv] GLMHC reported that it never saw a drop in appointments.

Even before the pandemic began, GLMHC had embarked on the use of iPads to increase access to services. With the onset of the COVID-19 pandemic, GLMHC accelerated its use of technology (in addition to continuing to serve people in person), ordering 5,000 additional iPads at the beginning of the pandemic to ramp up access to both urgent and routine services. A conversation with GLMHC's chief executive officer and chief operating officer shed light on the details behind the technology. They reported, "We already had the methodology; [the] pandemic forced our hand to move faster." But GLMHC leadership said that beyond dealing with a pandemic, they wanted to open up access in a way that could prevail under any difficult condition: "You could substitute any mass barrier to services for COVID-19. We want to serve clients whenever and wherever they are."

The system efficiently transfers data directly to the agency's electronic health record. Clinicians are able to send documents for signature via this platform and clients can use the iPads to complete assessments such as the Patient Health Questionnaire-9 (PHQ-9). GLMHC conceded that there were large upfront costs to have software written and to purchase iPads and data plans. The platform GLMHC uses for its iPads—MyCare—did not exist until the agency contracted with a firm to have it designed. In addition to the iPads and software, GLMHC has to

maintain a specific and reliable data plan to support this service. GLMHC also has several programmers who fulfill the critical role of maintaining the technology infrastructure. As the CEO stated, "It's not something you just develop and can walk away from."

The outcomes and innovative strategies developed through this effort include:

- *An impressive return on GLMHC's investment in technology, with an 80% decrease in inpatient admissions and an increase in client satisfaction rates*. GLMHC's CEO shared that people ask, "How can you afford all those iPads?" In response, he asks them, "How can you afford *not* to have them?"
- *A "call hunt" process, which supports 24-hour virtual access in addition to an in-person walk-in clinic and regular therapy appointments*. The call hunt directs incoming calls to the first staff member in line. If that staff member is not available, the call goes to the next clinician or support provider and so on until the client is connected. Even the CEO and COO, though further down the call list, are included.
- *A choice of two buttons on the iPad for requesting services: crisis, for clients who are willing to see anyone, and non-crisis, which puts clients into a virtual waiting room to see their requested clinician*. In non-crisis situations, people call in and are placed in a queue until their therapist is available. Clients are able to see whether their therapist is available so they can decide to wait or request a call back.
- *Only scheduling clients with therapists four hours a day, leaving the other four hours for therapists to be available to clients in the queue*. GLMHC reports that its no-show rate has decreased significantly and that it has been billing six to seven hours per day for therapists' services because they have been providing these "on-demand" services rather than having unbillable time when clients do not show for appointments.
- *A team leader who supervises two other staff, such as a peer family support specialist.* "We are not hiring therapists, we are hiring team leaders and paying them very competitively." Agency leadership noted that there was an adjustment for staff at first, but now the employment satisfaction rate is higher than it has been in years.

When tele-behavioral health is not sufficient: Serving clients with complex behavioral health needs

Although many clients with behavioral health needs can be served via tele-behavioral health, clients with serious mental illnesses and complex needs—such as homelessness and involvement with the criminal justice system—may not be in a position to have their needs addressed virtually. A study conducted by Nemani et al. (2021) that involved several thousand people who tested positive for COVID-19 found that people with a history of schizophrenia spectrum disorder were more than twice as likely to die within 45 days of a COVID-19 diagnosis, even after controlling for demographic and other medical risk factors: "In a comparison with other risk factors, a diagnosis of schizophrenia ranked behind only age in

strength of association with mortality."[xxv]

Assertive Community Treatment (ACT), an intensive evidence-based model that is delivered in the community for people living with serious mental illnesses, is a high-touch treatment that cannot be provided with fidelity via telehealth. During the pandemic, home visits have been replaced by lawn and porch visits, and PPE has become essential equipment for ACT teams who provide in-person services, with fidelity to the community-based model. "ACT within the COVID Pandemic" is a website that was developed to share discussion posts, forum recordings and presentation notes that address ideas, challenges and encouragement to support ACT team staff and service recipients.[xxvi]

Inpatient or residential services such as supportive housing also require workers to be on site. One inpatient provider organization reported that most of its behavioral health professionals were providing telehealth services from home to their patients in the hospital, but direct care and nursing staff were not able to work remotely. Many people who need inpatient care experience serious acute cognitive symptoms that make it challenging to maintain personal protective measures, such as wearing a mask, in these settings.

OKLAHOMA MUST CAPITALIZE ON THE LARGE AMOUNT OF FEDERAL FUNDING FOR ADDRESSING THE PANDEMIC

The behavioral health issues that have accompanied the pandemic have highlighted the need for increased capacity to deliver treatment for mental health and substance use issues. This heightened attention has generated funding opportunities, the most recent of which are included in the American Rescue Plan Act.[xxvii] This act contains resources for funding behavioral health service delivery innovations and treatment programs, workforce development opportunities—including some that may support the implementation of our recommendations included in *Oklahoma's Behavioral Health Workforce: Action Areas*—and the following initiatives:

- $100 million for the National Health Service Corps State Loan Repayment Programs, an opportunity for funding Oklahoma's Mental Health Loan Repayment program, created in 2019 by Senate Bill 773.
- $80 million through the Health Resources & Services Administration (HRSA) for mental health and substance use disorder training for health care professionals, paraprofessionals and public safety officers—a potential funding source for expanding the behavioral health workforce by taking to scale current programs that train primary care providers to detect and treat mild-to-moderate behavioral health conditions.
- $100 million for behavioral health workforce education and training that could help increase the number of psychiatry residencies in Oklahoma, expand fellowship opportunities in child and adolescent psychiatry and addiction medicine and increase

the numbers of advanced practice registered nurse–psychiatric mental health nurse practitioners (APRN-PMHNPs) in the state.

- $80 million through the Substance Abuse and Mental Health Services Administration (SAMHSA) to fund pediatric mental health care access, which could help establish a psychiatry access network that offers pediatricians virtual "curbside consultation" to support the initial prescribing and ongoing management of psychotropic medications.
- $40 million through HRSA to promote mental health among health care professionals, reflecting the point made earlier that supporting staff wellness is key to retention and to providing the resources for Oklahoma to invest in the wellness of its behavioral health workforce.

Drawing down these federal dollars can support taking value-based and outcome-oriented models to scale and broaden the workforce by disseminating and adopting models of early detection and treatment

The COVID-19 pandemic, which appears to be causing an increased need for behavioral health treatment that will not likely go away anytime soon, and Medicaid expansion are creating a perfect storm of increased future demand on the behavioral health system. By drawing down federal dollars, we have an opportunity to support and expand the behavioral health workforce during a time when we need it most.

Statewide expansion of Oklahoma's existing network of Certified Community Behavioral Health Clinics (CCBHCs) provides an important opportunity to develop the programmatic and financial infrastructure to recruit and retain a qualified behavioral health workforce. CCBHCs provide a broad array of behavioral health services, including evidence-based practices, care coordination and integration of mental health, substance use and physical health services at one location. CCBHCs are paid a monthly prospective payment system (PPS) rate based on the agency's average cost of providing services.[xxviii] This payment approach promotes more financial stability than other methods and puts provider organizations in a better position to pay competitive wages.

In addition to sustaining innovative specialty behavioral health care models such as CCBHCs, it is critical that primary care settings expand capacity to treat the increased incidence of anxiety, depression and substance abuse in the general population brought on by the COVID-19 pandemic. As highlighted in each of the workforce series briefs, people with more complex behavioral health conditions need the comprehensive services offered by CCBHCs, yet many others who have mild to moderate conditions and are otherwise relatively healthy can best be served in integrated primary care settings. This model incorporates screening for behavioral health conditions and the use of proven tools to monitor the effectiveness of care.

HEALTH CARE COMPACTS FOR NON-EMERGENCY HEALTH CARE PROFESSIONS AND IMPROVED LICENSURE RECIPROCITY MAY FACILITATE RECRUITMENT EFFORTS

Even before the pandemic, licensing reciprocity—sometimes called "license mobility" or "licensing portability"—was seen as a way to address workforce shortages and uneven geographical distributions of mental health professionals. In response to the pandemic, government agencies quickly modified the licensure requirements for physicians and other health care professionals in order to address these workforce needs.

In Oklahoma, Amended Executive Order 2020-07 allowed any licensed medical professional to be deemed licensed in Oklahoma if their credentials had been issued by any state that is party to the Emergency Management Compact. This order was extended to May 11, 2021.[xxix] Any medical professional who intends to practice in Oklahoma must first receive approval from their appropriate professional board; each board is responsible for verifying the license or other credentials of applicants.[xxx, xxxi] However, the order did not include most behavioral health providers; it covered psychiatrists, who are medical doctors, as well as health professionals such as physical and occupational therapists, but not behavioral health professionals such as social workers and licensed professional counselors, who most often provide behavioral health services.

The state should explore health care compacts for non-emergency professions and other efforts that improve licensure portability and reciprocity to address ongoing behavioral health workforce shortages and enhance providers' readiness to respond to emergency situations. Oklahoma has made some headway in this area by participating in some health care compacts for non-emergency professions, including the Enhanced Nurse Licensure Compact (eNLC), which allows registered nurses or licensed practical nurses in good standing in one of the compact member states to automatically practice in any member state. Thirty-four states, including Oklahoma, are currently members of the eNLC compact.[xxxii]

Oklahoma also participates in the Psychology Interjurisdictional Compact (PSYPACT), an interstate compact designed to facilitate the practice of telepsychology and temporary in-person, face-to-face psychological services across state lines. PSYPACT has been enacted in 14 states.[xxxiii,xxxiv] Oklahoma—along with Arkansas, Missouri, Nebraska and Texas—has also signed on to the Association of State and Provincial Psychology Boards Agreement of Reciprocity, which encourages states to enter into a cooperative agreement that allows any psychologist holding a license in one participating jurisdiction to obtain a license to practice in another participating jurisdiction. To qualify under this agreement, candidates must have practiced for five years and no disciplinary history. Psychologists seeking reciprocity will still have to submit

application materials, but the process is less involved than applying as a new applicant.

Despite Oklahoma's participation in these efforts, there is still work to be done in this area:

- Future executive orders issued during health emergencies and other disasters should include behavioral health providers such as social workers and licensed professional counselors, in addition to psychiatrists.
- The eNLC does not apply to advanced practice registered nurses, so it is not a vehicle for bringing in more psychiatric nurse practitioners, a consideration outlined in *Oklahoma's Behavioral Health Workforce: Action Areas*. In cooperation with Oklahoma's Board of Nursing, policy makers could work to include advanced practice registered nurses in workforce expansion efforts.
- Oklahoma's State Board of Behavioral Health should be monitoring the progress and implementation of the Interstate Compact for Portability that is being advanced by the American Counseling Association, which would smooth the process for licensed professional counselors to move their credentials from one state to another. The compact development effort is now in Phase II, which is focused on developing an online resource kit, a legislative strategy and other legislative processes to move the compact forward.[xxxv] Phase III, projected to take place in 2023, will focus on establishing the commission that will provide ongoing coordination for the compact.

NOTES

[i] National Center for Health Statistics. (2020, May). *Early release of selected mental health estimates based on data from the January–June 2019 National Health Interview Survey.* National Health Interview Survey Early Release Program. https://www.cdc.gov/nchs/data/nhis/earlyrelease/ERmentalhealth-508.pdf
[ii] National Center for Health Statistics. (n.d.). *Mental health care. Household Pulse Survey.* Retrieved on February 10, 2021, from https://www.cdc.gov/nchs/covid19/pulse/mental-health-care.htm
[iii] National Center for Health Statistics. (2020, May).
[iv] National Center for Health Statistics. (n.d.). *Mental health care. Household Pulse Survey.* Retrieved on February 10, 2021, from https://www.cdc.gov/nchs/covid19/pulse/mental-health-care.htm
[v] National Council for Behavioral Health. (2021, February). Member Survey. National Council for Behavioral Health Polling Presentation. *Morning Consult.* https://www.thenationalcouncil.org/wp-content/uploads/2021/03/NCBH-Member-Survey-Feb-2021.pdf?daf=375ateTbd56
[vi] G. Lapidus, Family & Children's Services (personal communication, July 7, 2020).
[vii] C. Hodges, Resource Center for Women (personal communication, June 30, 2020).
[viii] National Council for Behavioral Health. (2021, February).
[ix] C. Flanagan, CREOKS Health Services (personal communication, October 26, 2020).
[x] K. Stricker, CREOKS Health Services (personal communication, October 27, 2020).
[xi] J. Cizek, The Center for Therapeutic Interventions (personal communication, July 9, 2020).
[xii] Bailenson, J. N. (2021, February 23). Nonverbal overload: A theoretical argument for the causes of Zoom fatigue. *Technology, Mind, and Behavior*, *2*(1). https://doi.org/10.1037/tmb0000030
[xiii] Romano, L. (2021, January 4). *Considering the quieter crisis: Addressing staff burnout and strain*. Addiction Professional. https://www.psychcongress.com/article/countering-quieter-crisis-addressing-staff-burnout-and-strain
[xiv] Koonin, L. M., Hoots, B., Tsang, C. A., et al. (2020, October 30). Trends in the use of telehealth during the emergence of the COVID-19 pandemic—United States, January–March 2020. *Morbidity And Mortality Weekly Report (MMWR), 69*(43). http://dx.doi.org/10.15585/mmwr.mm6943a3
[xv] Oklahoma Health Care Authority. (2020, August). *2020 Telehealth Summary*. https://taoklahoma.org/wp-content/uploads/2020/09/Telehealth-Summary-OHCA-June-2020-1.pdf
[xvi] Oklahoma Health Care Authority. (2021, January 15). *Public health emergency.* Global Messages. https://oklahoma.gov/ohca/providers/updates/global-messages/global-messages.html
[xvii] Oklahoma Health Care Authority. (n.d.). *Expanded use of telehealth and telephonic services during COVID-19 national/state emergency for COVID-19*. https://www.okhca.org/providers.aspx?id=24604
[xviii] J. Cizek, The Center for Therapeutic Interventions (personal communication, July 9, 2020).
[xix] S, Bowman, B. Smith, J. Pierce, & B. Black, CREOKS Health Services (personal communication, July 1, 2020).
[xx] J. Miller Cribbs, Center for Social Work in Healthcare, University of Oklahoma (personal communication, July 31, 2020).
[xxi] S. Coffey, Child and Adolescent Psychiatry, Oklahoma State University (personal communication, July 8, 2020).
[xxii] B. Black, CREOKS Health Services (personal communication, July 1, 2020).
[xxiii] Slatton-Hodges, C. (2021, April 5). *Presentation to Oklahoma 988 Crisis Services Advisory Group.* Oklahoma Department of Mental Health and Substance Abuse Services.
[xxiv] L. Smith and J. Cantwell, Grand Lake Mental Health Center (personal communication, February 4, 2021).
[xxv] Nemani, K., et al. (2021, January). Association of psychiatric disorders with mortality among patients with COVID-19. *JAMA Psychiatry*. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2775179
[xxvi] The ACT within the COVID-19 Pandemic website can be accessed through this link: https://forum-19.freeforums.net/
[xxvii] Congress.Gov. (n.d.). *H.R. 1319-American Rescue Plan Act of 2021.* Retrieved on March 29, 2021, from *https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc-*

HC69E0A965EAF4E8A868DB96813C3B9B1

[xxviii] Oklahoma Department of Mental Health and Substance Abuse Services. (2020, July). *Oklahoma Certified Community Behavioral Health Clinics CCBHC provider manual* (page 31). http://www.odmhsas.org/picis/Documents/CCBHC%20Manuals/CCBHC%20Manual%20Final%20SPA.pdf

[xxix] Office of the Governor State of Oklahoma. (2021, April 11). *Executive Department Amended Executive Order 2021-07*. https://www.sos.ok.gov/documents/executive/1996.pdf

[xxx] Federation of State Medical Boards. (2020, March 30). *States waiving licensure requirements/renewals in response to COVID-19*. http://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensures-requirementscovid-19.pdf

[xxxi] Office of the Governor State of Oklahoma. (2020, March 17). *Executive Department Amended Executive Order 2020-07*. https://www.sos.ok.gov/documents/executive/1914.pdf

[xxxii] Hentze, I. (2020, August 3). *COVID-19: Occupational licensing during public emergencies*. National Conference of State Legislatures. https://www.ncsl.org/research/labor-and-employment/covid-19-occupational-licensing-in-public-emergencies.aspx

[xxxiii] Association of State and Provincial Psychology Boards. (n.d.) *Psychology Interjurisdictional Compact (PSYPACT).* https://www.asppb.net/page/PSYPACT

[xxxiv] Psychology Interjurisdictional Compact. (n.d.). *Map.* https://psypact.org/page/psypactmap

[xxxv] American Counseling Association. (n.d.). *The Interstate Compact for Portability, update as of October 2020*. https://www.counseling.org/docs/default-source/licensure/interstate-compact-licensure-portability.pdf?sfvrsn=6f7a242c_4