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## Telebehavioral Health Program Needs Assessment Conducted at Aurora Mental Health Center

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# Telebehavioral Health Program Needs Assessment Conducted at Aurora Mental Health Center

## Abstract

The purpose of this project was to conduct a needs assessment for a Telebehavioral Health Program at Aurora Mental Health Center (AuMHC) to determine how telebehavioral health aligns with the organization's interests, needs, services, target population, and readiness for telebehavioral health services. This investigator used survey and content analysis methods to conduct this investigation. Findings of this assessment showed that both literature and existing programs at AuMHC were supportive of moving forward with telebehavioral health services. Considerations of AuMHC's contextual conditions and recommendations for successful implementation are provided.

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TELEBEHAVIORAL HEALTH PROGRAM NEEDS ASSESSMENT

TELEBEHAVIORAL HEALTH PROGRAM NEEDS ASSESSMENT CONDUCTED AT  
AURORA MENTAL HEALTH CENTER

A DOCTORAL PAPER  
PRESENTED TO THE FACULTY OF THE GRADUATE SCHOOL OF PROFESSIONAL  
PSYCHOLOGY OFFICE OF GRADUATE STUDIES UNIVERSITY OF DENVER

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE DOCTOR OF  
PSYCHOLOGY

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### Abstract

The purpose of this project was to conduct a needs assessment for a Telebehavioral Health Program at Aurora Mental Health Center (AuMHC) to determine how telebehavioral health aligns with the organization's interests, needs, services, target population, and readiness for telebehavioral health services. This investigator used survey and content analysis methods to conduct this investigation. Findings of this assessment showed that both literature and existing programs at AuMHC were supportive of moving forward with telebehavioral health services. Considerations of AuMHC's contextual conditions and recommendations for successful implementation are provided.

*Keywords:* Telemental health, telebehavioral health, telehealth, telepsychiatric, behavioral health services, needs assessment

### **Context of the Study**

The Aurora Mental Health Center (AuMHC) has encountered several significant changes and challenges in the past two years. The changes include new leadership, a new RAE contract, and a new medical system SmartCare. As the CEO, Dr. Kelly Phillips-Henry, mentioned in her weekly Friday announcement, “This is the new world we live in and is the only way for us to sustain the programs and services we provide. The 25 billable hours per week requirement is a national standard used in behavioral health field to align AuMHC’s service provision with Medicaid payment (Phillips-Henry, 2019).” The center also faces several challenges, including achieving the 25 billable hours per week in priority contracts (Regional Accountable Entity, Medicaid, Colorado State Office of Behavioral Health, and grant funding), sustaining valuable skilled employees, improving cash flow and financial performance, and providing consistent, evidence-based quality services for patients. Telebehavioral health programs have been recognized as a cost-effective delivery method, a fit for the target population, a way to improve efficacy of services and save costs, and a means of expanding the reach of services (HRSA, 2013). Hence, the objective of this needs assessment was to provide meaningful and practical information to assess how a telebehavioral health program might align with AuMHC’s interests, needs, services, target population, and readiness for telebehavioral health services.

### **Vision**

The vision of the Telebehavioral Health Program of AuMHC is to provide accessible, affordable, and high-quality mental healthcare services via telehealth care and to improve mental healthcare services to underserved and disadvantaged communities to ensure that all individuals have access to comprehensive, affordable, high-quality mental healthcare.

### **Mission**

The mission of this needs assessment was to improve access to quality psychotherapy and consultation for underserved populations by linking psychiatrists, counselors, psychologists, peer specialists, and case managers to these populations. Therefore, the objective of the needs assessment was two-fold: First, it was to provide meaningful and practical information to assess how telebehavioral health aligns with AuMHC's interests, needs, services, target population, and readiness for telebehavioral health services. Second, it was to investigate whether or not the AuMHC can implement a Telebehavioral Health Program effectively for a greater number of clients, while continuing to provide quality mental health services on site.

### **Literature Review**

Prior to the investigation, a careful review of existing reported evidence in the research literature and funding reports regarding the feasibility, trends, and acceptance of telebehavioral health was conducted. This review specifically focused on reports and literature obtained in the State of Colorado, where AuMHC is situated.

Telehealth resource centers use both the terms *telemental health* and *telebehavioral health* (Ostrowski & Collins, 2016). Nickelson (1998) defined telehealth as “the use of telecommunication and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, education and information across distance” (p. 527). The National Center for Telehealth and Technology uses the term *telemental health* in the Department of Defense Telemental Health Guidebook (National Center for Telehealth & Technology, 2015). In the current study, the terms “telebehavioral health” and “telemental health” will be used throughout the study.

Traditionally, clinical activities in psychology take place in person, between a “provider” and a “patient”. The patient may be an individual, a couple, a family, or even a community. Given recent innovations in communication and healthcare technology, various options have expanded the traditional face-to-face mental health care that offers healthcare providers potentially better avenues through which to meet the public’s needs. Telebehavioral health can reduce cost, enhance efficiency, offer more language options, and increase access for clients from lower socioeconomic backgrounds for whom time and travel may be a significant barrier to treatment. In addition, the contemporary digital-savvy generations already prefer to communicate via social media and texting. Therefore it seems reasonable to question whether in-person treatment will remain the primary mode of intervention.

Telehealth aims to provide the same quality service to existing client populations, and to expand both provider and patient access to timely quality health care. As technology has improved over the past decade, the structure of health service institutions has been profoundly reshaped. In a recent report to Congress about telehealth, 60% of health care institutions report currently using some form of telehealth (Khemlanie, 2016).

Mental health services are experiencing some of the most significant effects of the telehealth movement. According to the U.S Department of Commerce, mental health was ranked as the fifth most common telehealth service in the beginning of 1997. Yet, by the end of 1997, it was ranked as the most common telehealth service (Grigsby, 1997 as cited in Stamm, 1998). Additionally, a twenty-eight percent increase in Medicare payments for telehealth services in 2016 according to the Centers for Medicare and Medicaid Services (<http://www.ebglaw.com>). The American Psychiatric Association (“APA”) also indicated that the telepsychiatry “has become a core tool of daily clinical practice” (Shore, 2017).

A growing number of literature reviews and studies on the topics of telebehavioral health indicate their growing use in the American healthcare system. In addition to the needs of the public and advancing technology, a variety of reasons have been suggested for the recent shift towards adopting telehealth care strategies. For example, telepsychiatry services started due to a shortage of psychiatrists and other mental health workers.

Two basic forms of telebehavioral health were outlined in a March 2012 daylong meeting convened by the U.S. Department of Health and Human Services (HHS) and its Health Resources and Services Administration's (HRSA) Office of Special Health Affairs (HRSA, 2013). These are: (i) a distance-based consultation between a non-behavioral care provider and a behavioral health specialist, or (ii) an encounter between a patient in a videoconference session with a behavioral health specialist. The second form is most common in the published reports or literature. For instance, an elderly man in a rural nursing home is having disruptive behaviors and appears paranoid. The elderly man is not able to participate in the group activities and interacts with the nursing staff. With the telebehavioral service, the elderly man is now able to receive a video consultation and treatment recommendations from a psychologist located elsewhere. Another example: A child with autism who is in foster care, lives in a rural community with a population of 500 people, and is suffering from emotional distress due to the recent loss of his primary caregiver, can now receive a teleconsultation at the local primary school and benefit from timely expert diagnosis, support, and treatment (Myers, Myers, & Turvey, 2013).

These documented success stories not only add to the statistics regarding mental health needs across Colorado, but also highlight the needs of the disadvantaged and how telehealth addresses those needs. Empirical research on telemental health revealed significant and



consistent evidence of telemental health efficacy, accessibility, and capability to provide positive outcomes, including medication adherence, accessibility, and efficiency of treatment (Bashur, Shannon, Bashur, & Yellowless, 2016).

A Denver-based mHealth app focusing on behavioral health, named myStrength, is intended to serve as an online behavioral health company delivering evidence-based and scalable solutions for healthcare payers, providers, and consumers. myStrength claims it can help to bridge the gap between providers' direct care sessions and the daily lives of their patients, to serve as a critical treatment extension to traditional behavioral health care models, and to provide a better continuum of care for consumers (<http://www.myStrength.com>). With more than 10 million consumers currently accessing myStrength.com and the myStrength mobile app, myStrength could possibly complement traditional face-to-face therapy at a fraction of the cost and with proven significant clinical outcomes. The company has reported that 74% of consumers experience improvement in depression scores, and that 70% of clinical improvement happens within the first 14 days. These improvements reduce annually healthcare claims by \$382 per myStrength user, thus demonstrating a direct link between telehealth services and reduced healthcare expenditures (<http://www.myStrength.com>).

As health systems worldwide are under increasing pressure to deliver quality services in a cost-effective manner, there are many recognized barriers to behavioral health care, including a shortage of mental health practitioners, poor access to specialty care, and financial barriers. In addition, with the previous expansion of Medicaid in the state of Colorado and the subsequent increased patient load, rural communities are in need of additional ways to recruit providers to their communities.

According to Colorado Rural Health Center's Michelle Mills, CEO's update reports (2017), there are 12 counties that do not have a licensed psychologist or a licensed social worker. Access to mental health providers is significantly limited among rural residents with only one provider per 6,008 residents. Furthermore, 17% of rural adults lack sufficient mental and emotional support. Telehealth offers a way to overcome some of these barriers. For example, according to a 2014 Colorado Department of Transportation report from Colorado Health Institute (2016), more than half (52%) of seniors and adults with disabilities depend on family, friends, aides, or volunteers for some of their transportation needs. More than one in 10 (16%) are completely dependent upon others for all of their trips and under half (47%) have trouble finding transportation when they need it (Colorado Health Institute, 2016). Having access to quality and timely mental health services via video conferencing technologies could greatly improve outcomes for these clients.

Many communities and health facilities are already providing telemental health services. For example, between 1997 and 2011, the Veteran Health Administration's (VHA) National Telemental Health Program provided more than 5000 telemental health services for issues such as behavioral pain management, bipolar disorder, and post-traumatic stress disorder, as well as compensation and pension examinations to Veterans in the United States and overseas (Department of Veteran Affairs, 2012).

Telebehavioral health is one way to provide services for the increasing number of patients with limited providers. For example, Bashshur et al. (2016) reviewed literature reviews published between 2005 and 2015 to assess the empirical evidence on the effect of telemental health interventions on access, quality, and cost of care. Nearly all the research findings affirmed

the positive outcomes of telemental health, including providing effective approaches to the long-term management of mental illness, making care accessible by providing a useful link for individuals with special needs, increasing cost-effectiveness with a large volume of patients and increasing overall usage of services (Bashshur et al., 2016). Furthermore, most of the studies also found that telemental health demonstrates effective treatment (particularly CBT) for depression and anxiety disorders, as well as improving medication compliance (Bashshur et al., 2016).

Several empirical studies have supported the efficacy of telebehavioral health substance use disorder treatment. As rates of substance use disorder, and particularly opioid use disorder, continue to increase nationally, telebehavioral health fills the gap to increase access for medication-assisted treatment (MAT) and behavioral therapies (Trica & Bradford, 2019). An e-therapy program for problem drinkers was evaluated in a population of 527 Dutch-speaking patients. Weekly alcohol consumption, alcohol-consumption-related health problems, and motivation were assessed in a pre-post study. Although the dropout rate was high, patients showed a significant decrease of alcohol consumption and alcohol consumption-related health complaints (Postel, De Haan, & De Jong, 2012). Congress also introduced three bills related to growing substance use disorder telehealth services in 2018.

The objective of this investigation is to conduct a needs assessment of AuMHC to understand whether its existing infrastructure will support telebehavioral health services and whether they can implement this telebehavioral health program effectively. This investigation will also identify any barriers to introducing telebehavioral health, and how these might be addressed. The findings of this investigation can be used to assist AuMHC leadership in considering critical aspects of development and to support decision making, strategic planning, and partnering with community members to enhance and expand their behavioral health services.

### **Methodology**

The investigator used mixed qualitative and quantitative methods to conduct the needs assessment. She developed a data collections tool, a checklist survey which was completed by interview subjects involved in this needs-assessment study (Appendix A). She then applied content analysis techniques to review regulations, qualification, and capacity standards. Specifically, there were four data sources: data gathered using the developed checklist on staff perceptions of their services, needs, and concerns toward telebehavioral health program, data from the Western Interstate Commission for Higher Education (WICHE), AuMHC's internal database, and released data gathered from AuMHC's executive office and newsletters. The Colorado State Telehealth Laws and Reimbursement Policies were also reviewed for relevant information.

The method of evaluation is adapted from the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) Increasing Access to Behavioral Health Care Through Technology program evaluation method and the California Telehealth Resource Center (CTRC) Telehealth Program Developer Kit (CTRC, 2014). Two primary questions guide this investigation:

*Question 1: Can the persons who are in need of but not utilizing behavioral health services benefit from telebehavioral health services?*

*Question 2: Who are the individuals currently receiving AuMHC services who could possibly also benefit from telebehavioral health services?*

### **Survey Instrument**

The checklist survey (see appendix A) was created and sent out via AuMHC's daily

announcement to explore AuMHC staff's experience, interest, and willingness to engage in telebehavioral health services. The list of statements was intended to explore the staff's experiences with telebehavioral health therapy and potential barriers, and the staff's perceptions of what issues AuMHC clients may face when attending therapy. The questions were validated and piloted.

### **Data Analysis**

The investigator used the *Sequential Explanatory* mix methods (Caffery, Martin-Khan, & Wade, 2017) for the telebehavioral health program needs assessment. The investigator first analyzed the quantitative data from the Western Interstate Commission for Higher Education (WICHE), Colorado Health Institute, literature, and AuMHC's database to describe the extent of individuals' unmet needs and whether the clients and the center can benefit from providing telebehavioral health services. The qualitative component gathered from the survey, interviews, and literature provided insights and unpacked issues impacting the validity of the quantitative data, as well as identify the center's readiness for establishing a telebehavioral health services program.

### **Outcome Measures**

In considering the outcomes which may be of interest to the executive leadership team of the AuMHC, the key areas were identified as: (i) clinical outcomes (representing the provider and professional perspective); (ii) impact on mental health-related or general quality of services (reflecting the quantitative outcomes such as the individual unmet needs among communities); and (iii) resources utilization and gap analysis (reflecting on the cost-effectiveness studies and determining the current services).

## Findings

### Findings for Investigation Question 1:

*Can the persons who are in need of but not utilizing behavioral health services benefit from telebehavioral health services?*

The prevalence of mental health disorders was estimated at about 43.7 million adults in the United States in 2012, excluding alcohol and substance use disorders (Bashshur et al., 2016). An estimated 100,316 individuals with a serious behavioral health disorder were not served in FY2014-15. In 2015, 9.9% of Coloradoans reported having poor mental health (Colorado Health Institute, 2017). According to the Colorado Health Access Survey (CHAS) data (2017), the barriers to receiving specialty care in 2015 included being unable to get an appointment (18.7%), being unable to make an appointment because of a work schedule conflict (12.2%), being unable to schedule an appointment because of a child care issue (7.9%), and being unable to find transportation to the doctor’s office, or the office being too far away (4.7%). Among these reported barriers, “unable to get an appointment” was the top barrier, which was also revealed in the CHAS Regional survey data collected between 2013 and 2017 (Colorado Health Institute, 2017). This report also revealed that the barriers of getting an appointment for those who did not receive needed mental health care and that the reasons for not getting needed mental health care (see table below).

Barriers to Receiving Care for Both Mental Health and Substance Use	2013		2015	
	Number	Percentage	Number	Percentage
People were concerned about the cost of treatment	285,164	75.60%	252,018	57.30%

People did not feel comfortable talking with a health professional about their personal problems	116,023	31.00%	177,286	40.20%
People were concerned about what would happen if someone found out you had a problem	74,124	19.80%	120,433	27.60%
People had a hard time getting an appointment	114,515	30.50%	150,006	34.00%
People did not seek an appointment because they were uninsured	96,522	77.50%	40,869	65.20%

A new model for identifying unmet demand found that one in four unmet specialty visits could be handled through e-consults. This finding suggested that new care delivery approaches such as e-consults can be an important part of improving access to specialty care visits (Colorado Health Institute, 2018). Currently, the Mental Health Center of Denver and Denver Health Medical Center are providing telecounseling services for Medicaid and/or uninsured clients who cannot participate in traditional outpatient treatment.

According to the Denver Health Telephonic Counseling Program treatment team, the telecounseling service program provides services to anyone regardless of whether or not the client is insured. Primary care providers are their typical referral source. The program started in 2010 with funding resource from the Robert Wood Johnson grants. The grants covered primary care patients experiencing depression or anxiety to access assessment and short-term intervention. Such a successful approach of telecounseling services program may be a useful

model for AuMHC to consider. This may also help AuMHC address the needs of those who are in need of but not utilizing behavioral health services due to some of the previously identified barriers.

**Findings for Investigation Question 2:**

*Who are the individuals currently receiving AuMHC services could possibly also benefit from telebehavioral health services?*

**Culture for change – 3-year key thrust (FY2023).** AuMHC has grown and transformed into a full-service community mental health center over more than 40 years. With the recent opioid crisis, AuMHC has updated its mission: “Deeply rooted in our diverse community, we deliver state-of-the-art care impacting emotional wellbeing and addiction recovery” (Kelly Phillips-Henry, email message to staff newsletter, July 5<sup>th</sup>, 2019). AuMHC also has encountered many significant changes including new leadership as of January 2019, a new Regional Accountable Entity (RAE) contract with Colorado Access, a new crisis sub-contract (crisis services) partnership with Signal Behavioral Health, and a new electronic health records system SmartCare. All the internal changes aim to strengthen the foundation of AuMHC, while the external changes have significantly impacted financial and strategic planning for AuMHC.

The executive leadership team and the Board have laid out a 3-year key thrust (FY2023) to “Dominate the market by being the provider of choice (access, client experience, and comprehensive continuum of care)” (Kelly Phillips-Henry, email message to staff newsletter, July 5<sup>th</sup>, 2019). With the on-going changes and challenges, the CEO, Dr. Phillips-Henry, has indicated the need to expand services including telebehavioral services during the most recent Spring Town Hall meeting. One of AuMHC strategic anchors is “access.” The move to providing more telebehavioral health services will fit well with these changes and with AuMHC’s



established priorities of providing high-quality and accessible care. With organizational management change, new financial savings measures to adjust to the new RAE contract, and service expansion to provide better quality care for clients, telebehavioral health services will expand access to quality, evidenced-based behavioral health and care management such as the telebehavioral health program.

The State of Behavioral Health Care in Colorado (TriWest Group, 2011) updated the status of behavioral health care in Colorado in 2011. The number of patients increased by 58% between FY 2001-2002 and FY2009-2010 at AuMHC. In light of the growing number of patients, the AuMHC executive leadership team and the Board have committed to focusing on strategic business development and growth. The telebehavioral health program can be one of the potential program expansions, according to the CEO Dr. Philips-Henry in a town hall meeting in May 2019. While AuMHC has been securing new partnerships with Colorado Access (Medicaid capitation funding primary resource) and Signal Behavioral Health (CCC funding resource), the center still encounters many tensions when integrating the various funding streams involved in the care, particularly in a time of budget freezes and reductions. Therefore, expanding services, increasing revenue and productivity, and providing effective quality care become imperative.

AuMHC provides services within Colorado Denver Region 3, which consists of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Gilpin, and Jefferson Counties (WICHE, 2015). Roughly 75% of the clients served by AuMHC live at or below the federal poverty level. Additionally, there was a 47% increase in services for underinsured populations from 2011 to 2015 (WICHE, 2016). The number of people with a Serious Behavioral Health Disorder (SBHD) who were not served was calculated by subtracting the estimated number of persons served from the estimated prevalence of SBHDs within AuMHC catchment area. An

estimated 41.3% of age group, SBHD, and CMHC (community Mental Health Center) in FY 2014-FY2015 suggested 10.1% of the need is unmet across the state. The Substance Use Disorder (SUD) had the highest unmet need percentage, at 67.7% of the total unmet need percentage (WICHE, 2016). Therefore, obtaining grants such as a federal or state funding including Screening, Brief Intervention, and Referral to Treatment (SBIRT) grants can potentially expend the current substance services and close the gap of unmet need at AuMHC.

AuMHC currently provides the following telepsychiatric services:

**Program addressed identified gaps in current mental health services of inmates.**

The former chief psychiatrist, Dr. Leslie Winter, initiated telepsychiatric services in 2016. Dr. Winter helped establish telepsychiatric services in prisons (L. Winter, personal communication, May 27<sup>th</sup>, 2019). Initially, the treatment team felt a need to provide service for inmates being discharged from prison. AuMHC treatment team also provides therapy for inmates in the prison setting. At the time of release from prison, there is a concern that the inmates may not follow up with the mental health treatment and medication with AuMHC treatment team. Consequently, without follow-up, the inmates would decompensate and often ended up returning to prison for various reasons. Dr. Winter and the treatment team decided to bridge the treatment gap using telehealth. Prior to the individual's release from prison, the psychiatrist will perform the initial screen and assessment via a telehealth port. Once the inmates are discharged, they are already connected to mental health services with AuMHC for the follow-up appointment.

**Program addressed identified gaps in current mental health services of residential clients.** AuMHC recognizes the importance of basic needs for some clients who are in the process of recovery from mental health and/or substance abuse disorders. AuMHC provides a range of six residential services for active clients, depending on need and eligibility. For

example, John Thomas House is a hospital step-down and diversion program, providing short-term residential care to help adults stabilize and recover from debilitating mental health crises. Aurora Veterans Home is a 15-bed facility serving honorably discharged veterans struggling with homelessness, substance use disorder, and mental health issues (AuMHC, n.d.). The Department of Veterans Affairs (VA) provides Home Telehealth (HT), which can be a potential service model for AuMHC residential clients. The VA Home Telehealth program provides care and case management to enrolled Veterans. This program was intended to coordinate care to improve clinical outcomes and access to care, while reducing hospitalizations and clinic or emergency room visits for veterans in post-acute care settings or veterans at risk for placement in long-term care. Telebehavioral health can fill the gap in providing care and case management to the hospital step-down psychiatric clients before and between their visits with their psychiatrist and therapist (Department of Veterans Affairs, 2012).

**Program to increase access in geographically remote or challenging areas.** According to Dr. Winter, the psychiatric treatment team also provides a few existing outpatient opportunities via telehealth. Some of the adults or minors who have established care with the AuMHC may use telehealth to continue working with their psychiatrist for medication follow-up services after transitioning to college.

**Program to provide services in special allocated areas.** According to the former chief psychiatrist, Dr. Winter Leslie, initially the reason to provide telepsychiatric services was due to staffing shortage and the need to find a good fit for specific populations served by AuMHC, such as refugees and correctional populations. Some of the psychiatrists have left the center due to moving out of the state, and it has been difficult to recruit new psychiatrists who will be a good fit for special populations, such as refugee or pediatric populations. In order to provide the

continued care services, the psychiatrists provide remote services for their patients. For example, AuMHC's partner program, Asian Pacific Developmental Center (APDC), is one of the locations, which has begun to provide telepsychiatric services. Asian Pacific Development Center (APDC) was founded in 1980 to serve refugees resettling in Colorado after the Vietnam War. APDC is a provider of, and advocate for, whole community health of Asian American, Native Hawaiian, Pacific Islander, immigrant, and refugee communities. APDC predominantly serves members of these communities through its main office in Aurora and satellite offices throughout the Metro Denver area to ensure access to services (Asian Pacific Development Center, n.d.).

According to Dr. Winter, the psychiatrist at APDC moved out of the state and they were not able to find an immediate replacement. To ensure no gap in services for existing patients, the psychiatrist continues to provide medication management via internet video teleconferencing. The patients will still come to the clinic and utilize a conference room to meet with the psychiatrist for medication management with a live interpreter in session if needed. The outcomes are well received by the patients and the treatment team according to Dr. Tien, a psychologist provider at APDC.

**Program to increase efficiency in places where travel time can be optimized.** Travel time for AuMHC providers significantly diminishes their clinical time. Dr. Winter foresees the potential future expansion of telehealth services in addition to the current telepsychiatric services to address this concern. Dr. Winter states that the mobile crisis services (MCT) and group therapy will be appropriate for telebehavioral health. Patients who are in different locations can participate in group therapy on Zoom, which integrates technology and health by using high quality video, and low-bandwidth environments (see: <https://zoom.us/healthcare>). The mobile

crisis team can expand their services by sending intern students or unlicensed therapists to the residential home to provide service while the licensed therapist can be online for consultation and other services.

**Program to expand services to meet demand and increase productivity.** Two vulnerable populations, the incarcerated and the homeless, are either ineligible or unlikely to enroll in Medicaid but will still need behavioral health treatment. For these reasons, SAMHSA's block grants will still be important as safety net (state funded services) funding for specialty behavioral health treatment (Woodward, 2015 cited in WICHE, 2016). In 2015, the AuMHC provided services to 7.1% of the total uninsured population and 17.6% of the total underinsured population (WICHE, 2016). In addition, substance use treatment is one of the fastest-growing treatment services at the AuMHC according to the division director of the Substance Treatment Services, Eugene Medina. In addition, 67,000 Coloradans needed but did not get services for alcohol and drug use (Colorado Health Institute, 2018). A significant number of individuals with serious behavioral health disorders have not received services; particularly those individuals with a substance use disorder (WICHE, 2016).

Stigma is still the primary factor that prevents many from receiving needed mental health/substance use treatment (Colorado Health Institute, 2017). One of the most promising contributions of telehealth is its potential to eliminate the stigma. Telehealth service can potentially provide a way for individuals to access treatment and services without inadvertent disclosure to their communities (especially in the rural areas or underserved populations) (Substance Abuse and Mental Health Services Administration, 2016). For instance, one prevention intervention group offered via telebehavioral health treated subthreshold alcohol use before it became dependence.

### **Survey Findings**

Thirty-two people responded to the survey. The results show that 93% of staff have previously conducted an intervention via phone. Thirty-three percent of staff have personally used a telehealth service. Seventy-three percent of staff feel comfortable conducting real time mental health counseling services with their clients via video conferencing equipment. Lastly, 90% of staff are interested in receiving telebehavioral health service training.

The survey also revealed that 77% of AuMHC clients have problems finding transportation for attending therapy. This aspect needs to be considered and can be the prime reason for the center to expand its telebehavioral service programs. Similar to the literature, the reasons that AuMHC clients could not make it to an appointment included transportation, childcare issues, etc.

Overall, the survey results suggest that most of the staff (77%) is interested in providing telebehavioral health services to their clients. Although the survey revealed the health care staff's interest in using the telecommunications technologies to support and promote long-distance behavioral health care services, the managerial team has mixed responses to promoting the telebehavioral health program. For example, one of the program directors revealed her positive personal experience in utilizing telehealth service with her primary care physician. However, she prefers to provide in person counseling to her clients. Some of the concerns or hesitation the managers and providers raised included: the timing of making more changes to ways of providing services, the limited providers, individuals' skepticism about the efficacy of telebehavioral health, or viewing telehealth technologies as inconvenient.

### **Discussion and Conclusion**

In summary, this investigation has shown telebehavioral health services can benefit those who are in need of but currently not utilizing behavioral health service programs. The context and readiness for change at AuMHC and its current existing programs have also led to evidence that AuMHC can benefit from expanding its telebehavioral health service programs.

While considering telebehavioral health's potential fit for the AuMHC, the new EHR system (SmartCare) and telehealth equipment will need to be further assessed. Integrating with existing technology by using current SmartCare systems to set the groundwork for use of technology in the clinic, and using the initial work to prepare staff to adopt new technologies (HRSA, 2013) can be the next step for AuMHC.

According to Telehealth Resource Centers (2018), four main categories of telecommunications technologies are used for telehealth including synchronous, asynchronous, Remote Patient Monitoring (RMP), and mHealth. The virtual visit is the video visit between provider and patient. This investigator recommends that only basic technology is needed, including a desktop/laptop computer, tablet or smartphone, fast internet connection with at least 384 kpbs, and a good quality camera and microphone. AuMHC also should consider some existing mental health apps, such as the mobile health (mHealth) technology for psychiatric and counseling services. Specifically, an example would be the smartphone app developed by the Department of Defense (DoD). The DoD's National Center for Telehealth and Technology (T2) is an app designed to make it easier for service members, veterans, and their families to monitor their emotional health as they deal with the psychological aftermath of a deployment. The application helps users track how they're feeling in real time. The user then shares that information with their psychiatrist or doctor who uses it to monitor their behavior throughout

their treatment plan. Available for smart phones using the Android® operating system or the iPhone®, psychologists and developers say the app simply helps the user rank and rate how they are feeling on a variety of behavioral health areas that are associated with deployment and post-deployment (Bush, Quellele, & Kinn, 2014).

The second recommendation is that AuMHC staff's interest and willingness to engage in telebehavioral health, as revealed in the survey findings, should be taken into consideration. Some factors may need further exploration in the future. For example, the potential questions or challenges regarding use of telebehavioral health services versus other care services.

In conclusion, the literature review and needs assessment of this study have shown the promise of telebehavioral services and potential benefits to both AuMHC and the target population that AuMHC serves. Moving forward, the implementers need to consider how to implement the telebehavioral health in a less disruptive manner to AuMHC's clinic operations. Is the volume for telebehavioral health services at AuMHC justifiable for scaling up existing programs? What are the funding options and revenue sources? What mechanisms can be constructed to track clients' acceptance rates for telebehavioral health?



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### Appendix A

Date:

(*Research Use Only Participant #*):

Below is a list of statements describing experiences with telebehavioral health therapy and potential barriers that your clients may face when attending therapy. Some of these statements you may not have considered previously; however we would like you to think about them now. Read each statement carefully and circle **True** if you believe the statement applies to you and **False** if it does not.

- |  |      |       |
|--|------|-------|
| 1. Have you ever conducted an intervention via phone?  | True | False |
| 2. Have you provided case consultation with other providers via phone?   | True | False |
| 3. Have you heard about telebehavioral health service in general?  | True | False |
| 4. Have you ever used a telehealth service?  | True | False |
| 5. I will feel comfortable conducting real time mental health counseling service with my client(s) via video conferencing equipment. | True | False |
| 6. Problems with transportation will make it difficult for my client(s) to attend therapy.   | True | False |
| 7. Have you encountered clients who could not make it to an appointment due to transportation, childcare issues, or other barriers?  | True | False |
| 8. Would you consider using a telebehavioral health service if you were a client?  | True | False |
| 9. Are you interested in receiving telebehavioral health service training?   | True | False |