September 2021

Formative Evaluation of a Technology-Based Behavioral Health Program for Victims of Crime

Final Report

Prepared for

National Institute of Justice
810 Seventh Street, NW
Washington, DC 20531

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Acronym List

COVID-19	Pandemic caused by the novel coronavirus 2019
DASS	Depression Anxiety Stress Scales
EA	Evaluability assessment
EHR	Electronic health records
HIPAA	Health Insurance Portability and Accountability Act
MNLFA	Moderated non-linear factor analysis
NIJ	National Institute of Justice
PHI	Protected health information
SAMHSA	Substance Abuse and Mental Health Services Administration
SSD	Statistically significant deterioration
VOC	Victims of crime

Executive Summary

In this report, we describe the results of the Phase 1 **Programs and Services for Victims of Crime Phased Evaluation Research** (2018-ZD-CX-0001) work (Technology-based Victim Services; [https://nij.ojp.gov/sites/g/files/xyckuh171/files/ media/document/NIJ-2018-14060.pdf]). This initial Phase 1 formative evaluation included the development of a logic model to guide telehealth programming, an evaluability assessment of existing telehealth services, and a pilot test of initial implementation to capture necessary components needed for future fidelity assessment of these telehealth services as part of a potential four-phase evaluation. The telemental health programming we focused on was the hybrid approach of service delivery by El Futuro, a community-based organization in Durham, North Carolina. Building on a solid foundation of trust it has established in the community, El Futuro's hybrid model of telemental health services combines methods of telehealth and in-person treatment with an array of service components including psychotherapy, psychiatric services, and case management for a range of victims of crime (VOCs).

Working in tandem with El Futuro leadership, our team created a new logic model that capitalized on an existing model that had been developed as a comprehensive framework of all El Futuro services. We began by identifying the existing resources El Futuro would leverage (*inputs)* and telehealth-specific activities to be enacted and their respective outputs for evaluation. From here, the team assessed the whole of the intended impact of the telehealth program and designated each outcome according to the immediacy of the effects. The logic model shown in this report (Figure 2-1) was designed to identify current practices, acknowledge existing barriers and facilitators, assess El Futuro's feasibility to implement telehealth, and integrate formative evaluation findings into the telehealth design and subsequent implementation guide.

For Phase 1, our focus was also on assessing and directly addressing several challenges around access to services faced by VOCs from marginalized populations, including Latinos and those in rural communities and urban areas. Many of the challenges to implementing telemental health treatment for these populations stemmed from a combination of three factors. Firstly, cultural factors: Not all individuals are amenable to receiving treatment via telemental health services and some are reluctant to use a videoconferencing platform, since it does not provide the sense of privacy of a clinician's office. This is especially true for older adults who do not like the technology and undocumented individuals who are concerned about the confidentiality of their session. Secondly, technical factors: El Futuro clinicians were forced to rapidly transition to telehealth during the outbreak of the COVID-19 and initially had to provide technical support for patients who struggled to use the telehealth platform. Eventually, administrative staff stepped in to provide technical assistance and troubleshooting for clients. Administrative staff and ideally a telehealth coordinator can provide necessary technological support to ensure providers can have smooth sessions uninterrupted by technology. Additionally, rural clinics face technical challenges as they require substantial internet bandwidth to support telehealth video platforms, and this may require monitoring the office use of internet to allow clients to stream telehealth. Thirdly, clinical factors: Telehealth requires consideration for the privacy and confidentiality of treatment and not all individuals have a private, secure location in their homes, which may require them to receive telehealth treatment as a rural clinic. The continued videoconferencing required of

telehealth can be exhausting for providers. This is especially true if providers are just beginning telehealth and still determining which modalities of therapy they can transition to telehealth, since not all modalities are as effective via telehealth. Lastly, telehealth can hamper the therapeutic alliance in which clinicians seek to build rapport with clients. Providers noted that an understanding of these challenges and barriers helps in finding creative solutions to attend to challenges and this enhances the telehealth service experience for themselves and their clients.

From a research perspective, there were some challenges capturing different components of fidelity. This was expected, as it is often a reported challenge in the literature. In this study, however, challenges capturing fidelity were in large part related to restrictions related to COVID-19 pandemic, which forced all participants and providers to work from home and away from our telehealth site. Fidelity and supervision were captured in individual meetings between providers and their supervisor. As part of the Phase 2 process evaluation, criteria to capture different aspects of fidelity including adherence, competence, responsiveness, and necessary adaptations.

Despite these challenges, results from our evaluability assessment showed the TeleFuturo program contained treatment components required for a successful telehealth intervention and for a range of VOCs. Overall, our results show that El Futuro's TeleFuturo achieved feasibility and evaluability. Additionally, pilot results revealed that for a wide range of different VOCs a majority noted decreases in client symptoms across diagnoses and positive results around client satisfaction with services.

1

Introduction

1.1 TeleFuturo: Telehealth for Victims of Crime

The literature consistently documents that about 20% of U.S. residents live in rural areas and report challenges accessing health services. Victims of crime (VOCs) in rural areas have more barriers to obtaining behavioral health care than do those in urban areas. Barriers can be related to treatment acceptability by VOCs, limited access to services or providers, client treatment preferences, increased travel challenges, and privacy issues. How these issues influence treatment adherence and outcome is not much addressed in the literature, but they are important nonetheless (Clarke & Yarborough, 2013). Telehealth can facilitate the provision of services by connecting clients to providers from different sites and to behavioral health specialists to whom they otherwise would not have access.

Rural areas may be mistakenly characterized as regions unaffected by violent crime. Yet studies have shown that more women in rural settings than in urban and suburban settings experience gender-based violence, namely domestic violence and sexual assault (Gray et al., 2015). In 2016, only 41% of violent crime victimizations and 47% of serious violent crime victimizations in rural areas were reported to police (Morgan & Kena, 2017). VOCs are at risk for a number of mental health problems related to crime, including anxiety, depression, posttraumatic stress disorder, and substance use problems (Robertiello, 2006; Yehuda, 1999). This risk is amplified for individuals residing in rural communities, who are considered traditionally underserved. VOCs in general underuse formal support services. Often, availability of appropriate treatment services is limited (Campbell, 2008). The situation is much worse for VOCs in rural settings. One reason is that specialized, trauma-focused training is not available to many mental health professionals in rural regions; although they recognize the importance of these trainings, providers often cannot access them because of distance challenges (Gray et al., 2015). Additionally, rural areas often have greater poverty, higher rates of unemployment, and lower rates of insurance coverage, all of which contribute to rural residents' reduced capability to pay for health services, even if the specialized services were available (Gray et al., 2015).

Another barrier to service delivery in rural settings is treatment acceptability—whether a client deems treatment to be relevant, helpful, and worthwhile; whether privacy and anonymity can be protected (Gray et al., 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2016; Werth et al., 2010); and whether the client can avoid being racially or ethnically marginalized. For example, rural communities might have only one behavioral health specialist, so regular visits in small communities might be difficult to keep private.

Although 79%–82% of residents of rural areas and small towns are non-Hispanic Whites, in the past few years rural areas have become more racially and ethnically diverse. Racial and ethnic minorities account for 83% of the population growth in rural areas (SAMHSA, 2016).

Despite the promise of telehealth models for mental health service delivery to rural VOCs, service provision challenges need careful consideration. Internet and communication access and connectivity issues

constitute a major challenge. Despite progress and contributions from the federal government around communication accessibility in rural areas, 39% of individuals living in rural areas do not have access to advanced broadband internet; as many as 19% have no access to basic broadband in their homes (SAMHSA, 2016). Insurance coverage for telehealth services is another barrier. Service providers can also be hesitant to provide telehealth services because of issues related to ensuring privacy, confidentiality, and security; initial setup costs; and other technical difficulties that can potentially compromise confidentiality. This initial phase sought to systematically assess, understand, and address many of these challenges through a formative evaluation of a behavioral health model of telehealth services for rural VOCs implemented by our local partner, El Futuro.

1.2 El Futuro

El Futuro, created in 2004, is a North Carolina nonprofit organization that provides and advances bilingual and culturally informed behavioral health treatment for underserved Spanish-speaking individuals and families, including Latinos and rural residents. El Futuro has built a strong reputation with the Latino community and allied partner organizations and treats about 1,600 Latino individuals per year (including almost 600 youth). A large percentage of treated individuals have experienced multiple, profound, or chronic traumatic events, such as abuse or neglect, or have been victims of various forms of crime. El Futuro provides outpatient individual, family, and group therapy; case management services; and individual psychiatry. In 2017, El Futuro began its telemental health program, which it now refers to as TeleFuturo. TeleFuturo is an integrated hybrid program of technology-based visits and in-person services, to meet the needs of rural clients referred from throughout North Carolina. Figure 1-1 shows the geographic areas where El Futuro is located and the rural sites originally proposed. Because of the COVID-19 pandemic stay-in-place orders imposed in the middle of the grant, the program shifted to all virtual service delivery and providers and clients implemented/received TeleFuturo programming in their homes.

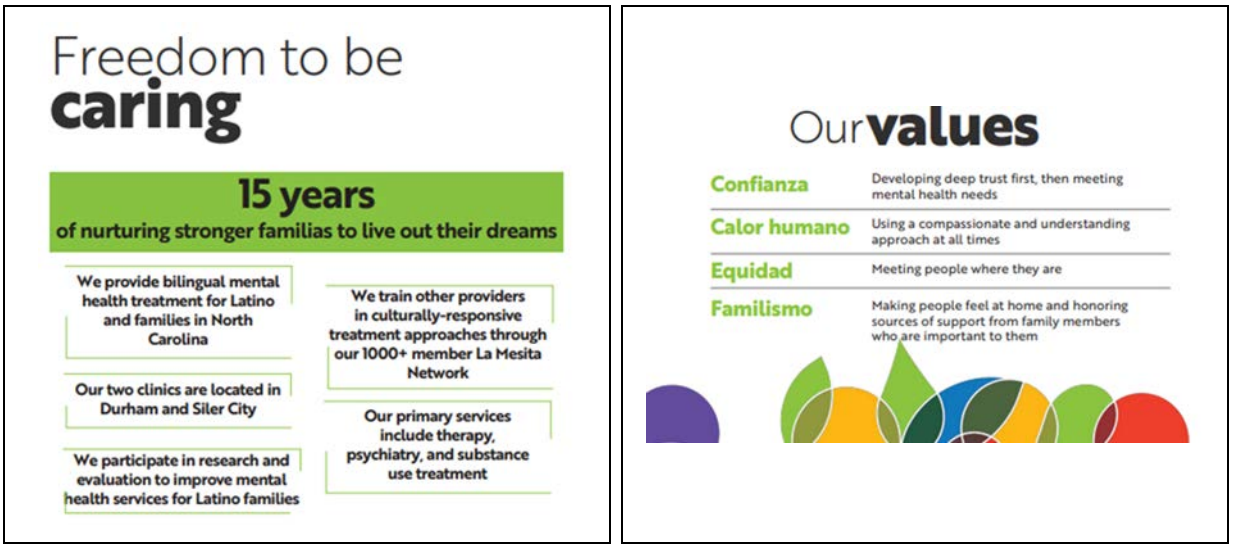
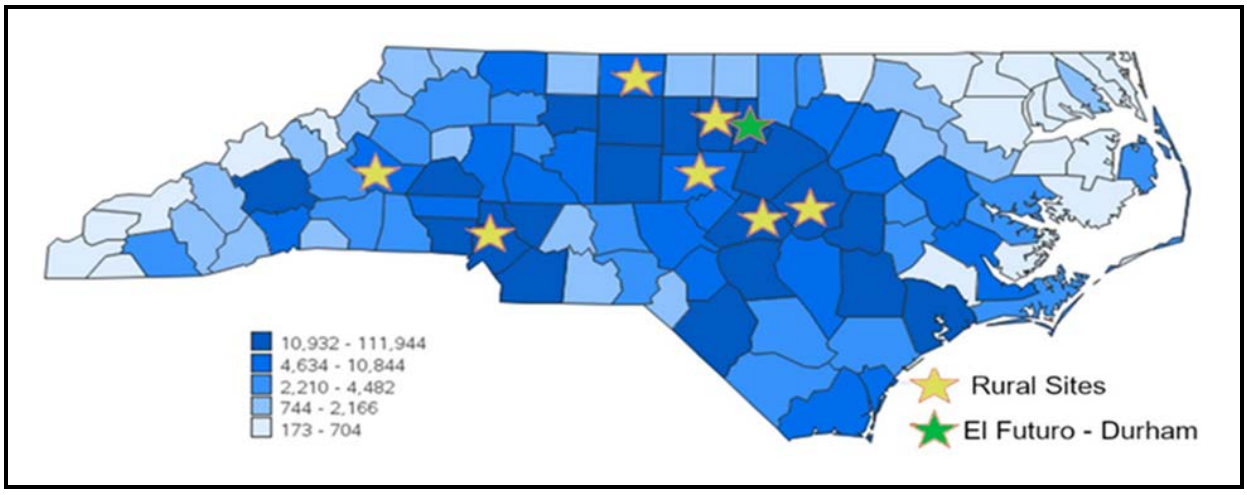


Figure 1-1. Initial Telehealth Site Locations in North Carolina



1.3 Purpose of the Formative Evaluation

This final report is divided into sections related to the study goals, design and methods, results, and discussion of results, highlighting the key issues and most important research findings in those topics. To adhere to the reporting categories required by the National Institute of Justice (NIJ), we included "Changes in Approach from Original Design and Reason for Change" within the section related to the COVID-19 pandemic in the methods section. The final chapter concludes with recommendations for key stakeholders, including implications for practice and policy. In this section we also include information about the various dissemination activities conducted under this award. Because this is part of a phased approach, considerations for Phase 2 and beyond are discussed as well. Specifically, for this formative evaluation, there were several tasks involved. These are described below within each of the Goals.

Goal 1: Formative Evaluation: Evaluability and Logic Model Development. The goal of the evaluability assessment (EA) is to examine whether El Futuro's current approach and design can answer overarching questions about its program design, implementation needs with the current design, and questions related to data being captured for adequate and informed evaluation. RTI International conducted in-depth interviews with key stakeholders, engaged in document review, and examined El Futuro's data systems and other factors to determine whether the program model and data collection procedures are implemented in a way that a credible evaluation can be performed (Peersman et al., 2015).

A critical, often overlooked, component of this initial formative work is effective engagement with key staff at El Futuro (Graham et al., 2016). Service providers are inherently overburdened and have limited time. Actively engaging El Futuro leadership and staff is critical to understand their situation and the work they do. Moreover, bringing them into the formative evaluation process is important to gain a thorough understanding of their goals and the benefits they see to participating in the evaluation, both to them and to the communities they work with. Thus, for this section, the focus was to conduct an EA to identify determinants of El Futuro's current practices by identifying barriers and facilitators, assessing feasibility of the proposed intervention, and integrating findings into intervention design, guide development, and refinement

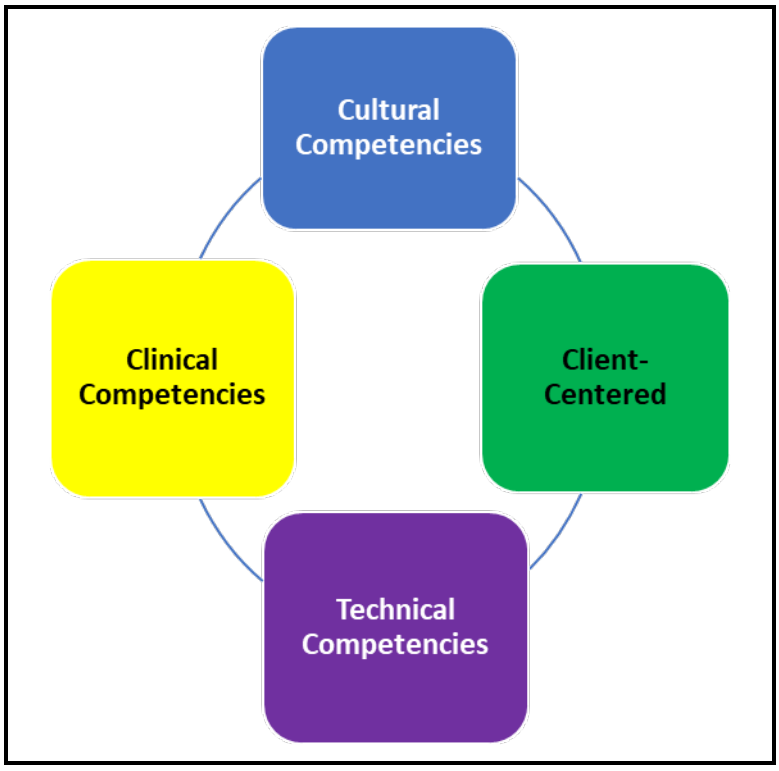
prior to implementation. We conducted a rigorous EA following the guidelines of Peersman et al. (2015). Our focus was to gather stakeholder input around key issues to determine if a program of interest is ready to be evaluated. The EA process initially included interviews, meetings, and site visits to understand program context, and review of program documents to determine how therapeutic programming context and components can be evaluated. Appendix A includes the instruments used for the in-depth interviews. As part of the EA, we also developed a program logic model and working with program staff to identify the resources and support to implement and evaluate it. Results from the EA and implications for the logic model and implementation guide are discussed below.

Goal 2: Implementation: Guide Development and Pilot. For this goal, the focus was to assess discrepancies between the implementation plan and execution, exploring issues of implementation of interventions for a variety of VOCs. This included what implementation components look like, as well as considerations for fidelity, intensity, and exposure. RTI assessed progress, monitored impacts and indicators of progress, and used data to inform need to modify the original strategy. This work will inform Phase 2 work. The results for this section will center on what we found were the necessary components for fidelity that should be captured in Phase 2. Components of interventions for TeleFuturo are also presented in the implementation guide (see Appendix B), which will be further developed in Phase 2.

Goal 3: Post-Implementation: Interpretation. RTI will assess the usefulness and value of telehealth from El Futuro stakeholder perspectives by eliciting stakeholder recommendations for further telehealth intervention refinements. RTI will assess victim/client satisfaction with the intervention and implementation process and identify barriers and facilitators.

From the information we have gathered as part of this formative evaluation, our El Futuro partners and team developed the TeleFuturo Conceptual Framework (Figure 1-2).

Figure 1-2. TeleFuturo Conceptual Framework



1.4 Challenges and Opportunities Related to the COVID-19 Pandemic

Challenges related to the COVID-19 pandemic unexpectedly and unprecedentedly hit every corner of our nation. The NIJ's Technology-Based initiative was prescient in its focus on the use of technology for delivering needed services to some of our most vulnerable populations via telehealth service delivery. Today, telehealth service

provision is especially relevant during the COVID-19 pandemic for rural mental health, which is a priority area of this request for proposals. Because the NIJ was already *ahead of the curve* with the 2018 release of Technology-Based Programs for Victims of Crime, we have been able to examine and attend to critical telehealth-related issues. Also, because of stay-in-place ordinances in North Carolina (and the rest of the country), we were afforded the opportunity to further expand our reach to VOCs and gather additional information about evaluability, components of the logic model, and implementation factors with a much larger sample size and provider type. Specifically, with the situation evolving daily, our partner El Futuro was able to respond quickly as it learned more about the new regulations and impacts of COVID-19 to ensure that it could expand telehealth to meet the best interest of all of its clients, but especially its most vulnerable VOCs. El Futuro was able to use this telehealth capacity to quickly expand what it was providing for VOCs to *all services* in less than 2 weeks (https://www.youtube.com/watch?v=2hWrSWv3b50&feature=youtu.be). This is critical for health service provision but also for allowing El Futuro to maintain financial solvency during these dire times. COVID-19 revealed many weaknesses in all aspects of health care, underscored the need for refined telehealth program structures, and highlighted how much more vulnerable our vulnerable populations really are. Our initial success with Phase 1 activities allowed El Futuro to greatly increase capacity (an important goal) and be prepared and generalize its VOC program to all clients.

Changes in Approach from Original Design and Reason for Change

The COVID-19 pandemic allowed our study team and El Futuro partners to enhance our recruitment and implementation of telehealth programming. However, some of the restrictions did have implications for our data collection. Modifications in our proposed approach from the original design were primarily due to the COVID-19 pandemic. These are primarily around capturing fidelity and outcome measures.

As part of the EA, we also documented the therapeutic components for TeleFuturo intervention that require continued development. As part of Phase 2 (2020-V3-GX-0073) we will expand on these concepts and adherence to the fidelity model. We found that it was premature to pilot the fidelity components because the original TeleFuturo intervention was not being delivered. Instead, we delivered an adapted/modified version because of the COVID-19 pandemic. The main difference in how we delivered the intervention had to do with the first session and the where the clients and providers were located. In the original conceptualization (and what we included in the proposal), TeleFuturo was delivered at a telehealth site where providers had more control over the telehealth equipment to help mitigate any issues related to disruptions due to technical challenges. Therefore, in our original proposal, we planned to capture a) adherence, b) competence, c) responsiveness and d) adaptation. Unfortunately, due to the COVID-19 pandemic, this study had to pivot and all interventions had to be conducted via the client's Zoom, using the client's connection and device. Similarly, the provider had to use their own connection/device. Another modification was that recruitment, and the initial session was not done face-to-face.

We were able to capture aspects about fidelity that were different from face-to-face telehealth provision. Chambers et al. (2013) encourage ongoing refinement to fidelity especially for multilevel interventions to enhance fit and appropriateness for the population of interest. Adaptation is necessary to respect the varied needs and priorities of communities to enhance ownership and relevance for those

implementing and of course to enhance local buy-in. This is important when working with culturally diverse populations but also when working within a telehealth space to ensure modifications/adaptations from face-to-face are appropriate. Therefore, some elements of each of these fidelity components were captured and discussed in supervision meetings. Many of these were used to inform the implementation guide along the way, which was part of the original intention. Unfortunately, we were not able to systematically capture with each of the clients. Instead, we focused our fidelity on ensuring that necessary therapeutic components for the client's presenting problem were being delivered in contexts compliant with the Health Insurance Portability and Accountability Act, particularly during the pandemic. This is what was captured as fidelity in this pilot study.

1.5 Study Goals, Design, and Methods

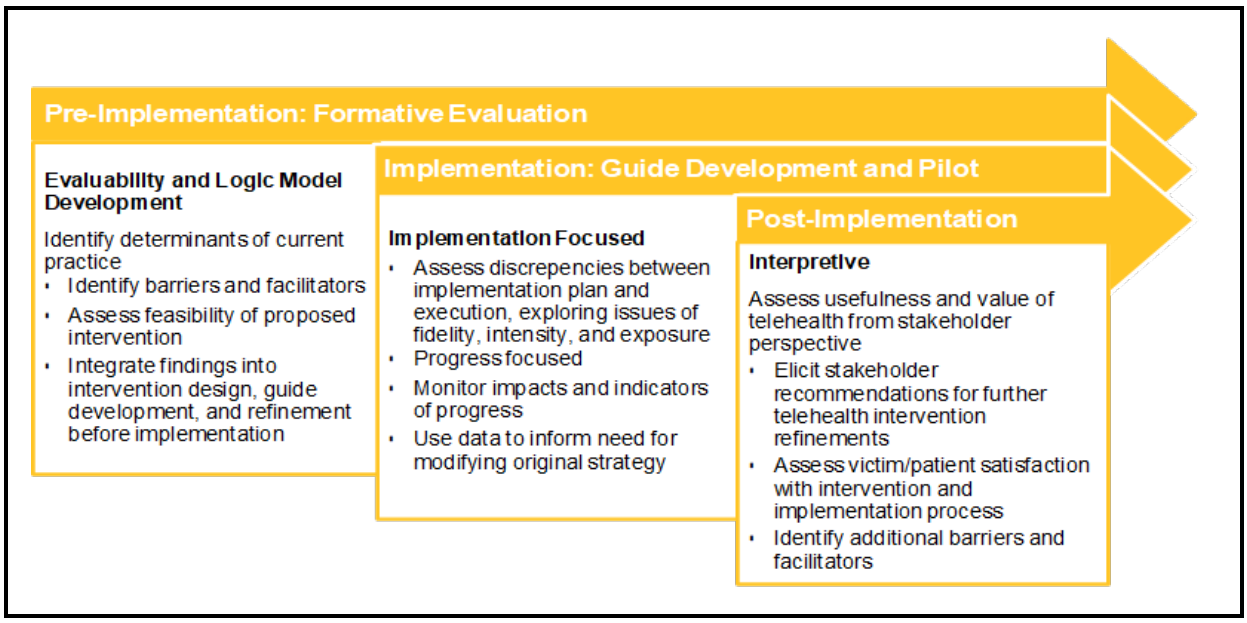
Formative Evaluation: Evaluability, Logic Model Development, and Implementation Guide Development. RTI conducted a rigorous formative evaluation of El Futuro's technology-based telemental health program for VOCs in vulnerable populations, including Latinos and those in rural settings. El Futuro named this menu of technology-based programming **TeleFuturo**. RTI formatively evaluated TeleFuturo and developed a logic model and implementation guide as part of Goals 1 and 2 of this Phase 1 award. Many community-based organizations do not formally evaluate their programs, limiting the degree to which they can measure their interventions' effectiveness. An EA is a critical first step to strengthen a program's ability to consistently measure growth and success but also to pinpoint needed programmatic improvements. Some challenges often faced in evaluation include the development of measurable indicators and replicable implementation plans. Staff training and capacity for evaluation can also represent barriers.

National Media Features of TeleFuturo

- *Civil Eats*: https://civileats.com/2020/02/04/for-farmworkers-facing-debilitating-depression-is-teletherapy-a-solution/
- *Food and Wine*: https://www.foodandwine.com/news/the-revolutionary-new-therapy-helping-depressed-farmworkers
- *USA Today*: https://www.usatoday.com/story/news/2019/07/17/lack-of-spanish-speaking-therapists/1422002001/

From an early planning stage, we captured information needed to implement and evaluate TeleFuturo services. As part of the EA, we assessed staff capacity to implement TeleFuturo services. We gathered information related to staffing availability and staff capacity, commitment and support from staff and other important stakeholders, organizational culture, and practice. In terms of organizational culture and practice, we will include information about willingness to be evaluated and to communicate outside the organization about evaluation findings, both positive and negative. We used this information to facilitate staff members' learning about program implementation and future decision making about program implementation. The results will be an appropriate foundation for a full evaluation of TeleFuturo. Formative evaluation research activities are presented in Figure 1-3 by tasks and goals.

Figure 1-3. Formative Evaluation of TeleFuturo: What Happens Before, During, and After Implementation



1.6 Formative Evaluation Guiding Questions and Overall Tasks

1.6.1 Evaluability Assessment Interviews

Formative Evaluation Tasks

- Evaluability assessment of the programs and develop a logic model for telehealth programming.
- Development of an implementation guide for TeleFuturo for VOCs.
- Pilot test implementation of telehealth services, including initial implementation, access to data and samples, and agency burden.

For the EA, we conducted in-depth interviews with El Futuro TeleFuturo staff via Zoom. Interviews were initially planned to be conducted in person with the Executive Director, Clinical Program Director (oversees service providers and implementation of services), Director of Grants and Strategic Development (oversees business development and fundraising), and Director of Operations (oversees data management) but because of the COVID-19 pandemic all the interviews were conducted on video via Zoom platform. The Executive Director and Clinical Program Director completed a 1-hour interview relating to organizational infrastructure, implementation approach, financial resources, program monitoring, and data collection procedures. We asked questions about regular data collection procedures, data management, program design and implementation, populations served, available resources, and evaluation capacity of all staff. The leadership and provider instruments can be found in Appendix A. We proposed several data collection efforts to El Futuro leadership to determine the evaluation and training and technical assistance needs for TeleFuturo based on their procedures already in place for face-to-face programming.

1.6.2 Leadership Interviews

We completed a video interview with the Director of Grants and Strategic Development to capture information about determining the needs of El Futuro in areas related to business development, grant writing, marketing, and logistics. We also interviewed the Director of Operations to understand the organization and capacity of the data collection systems within El Futuro including electronic health records (EHRs), behavioral health treatment data, and diagnostic tools and measures.

1.6.3 Service Provider Interviews

We used information from the initial leadership interviews to develop the telehealth service provider interview protocols. El Futuro's Clinical Program Director provided a list of potential respondents to RTI. Recommended respondents included the Clinical Supervisor and Clinic Manager and other service providers that represented a variety of perspectives regarding evaluation, program implementation, and data collection and the different intervention types: psychiatry, psychotherapy, case management, youth-focused, and adult-focused. The Clinical Program Director first emailed potential participants among El Futuro's staff to notify them of the purpose and timeline of the evaluability needs assessment interview. RTI sent a follow-up email to schedule one-on-one interviews. We contacted potential respondents via email and scheduled their interview. Prior to the start of each interview, RTI staff received verbal consent from each participant. The RTI interviewer noted that participation in the interview was voluntary and refusal to participate would not impact their employment. The consent form can be found in Appendix A.

Service providers completed a 30-minute to 1-hour interview about their role in the organization, responsibilities around data collection and documentation, treatment services provided, and evidence-based practices delivered. The provider instrument and survey can be found in Appendix A.

The coding team used a rapid qualitative analysis approach (Hamilton, 2013) to identify and organize themes across the seven interviews. To begin, the lead coder developed a transcript summary template containing domains addressed in the interviews. All four coders on the team used the template to independently summarize the detailed notes from one interview, sorting interview topics and notes into the various domains. The team met to compare and discuss their results, and the template was revised and annotated to ensure greater consensus across coders moving forward. The team repeated this process with a second set of notes. After this second and final test of the template, the coders' summaries were added to a matrix to facilitate an examination of the content in the domains across all coders. The remaining five interviews were then divided among the team members for individual summarizing. Once all interviews were summarized, the remaining summaries were added to the matrix. At this point we obtained transcripts for each interview. Using the matrix, the coding team engaged in an iterative ongoing process, reading through the domains, across all interviews, to identify additional, cross-cutting themes. As themes were identified, the coders returned to the transcripts to capture the direct quotations supporting them. The team exchanged their memos in a quality-checking process and established a final set of themes with supporting evidence.

2

Results

Results are divided by the goals of the study. First results from the formative evaluation are presented, which include EA and logic model development. Next is information captured monthly from stakeholders to continue to inform the EA and implementation manual, especially as the COVID-19 pandemic was evolving. All of this occurred as providers were piloting the components of the interventions. The final section presents results related to this pilot and implications for implementation and Phase 2 work.

2.1 Evaluability and Coding Results

Evaluability Questions

- Does the program have measurable objectives and the capacity for information collection, data management, and analysis?
- What training do the providers currently have on telehealth implementation? What are the current instruments used by TeleFuturo providers to measure treatment fidelity and outcomes?
- What barriers to and facilitators of implementation of TeleFuturo for VOCs have already been identified?

The COVID-19 pandemic hit globally as we were wrapping up our logic model development meetings and initial leadership interviews/meetings. We conducted most of the evaluability interviews during the early months of the spread of COVID-19 in the United States. This is in line with best practices for conducting EAs. Specifically, when EAs take place too early, key staff and stakeholders might not have sufficient knowledge about details related to program implementation to adequately comment on contextual variables and other important factors. The conversations largely focused on the rapid transition to remote work and, with it, the unanticipated, organization-wide shift to telehealth. Although many of the points raised in the interviews reflected circumstances surrounding the pandemic, within these discussions of adapting to pandemic-related needs and uncertainty we documented lessons learned that can be applied to telehealth implementation more broadly.

2.2 Initial Evaluability Results

Document review and initial interviews with leadership were guided by the Evaluability Assessment Checklist for Impact Evaluation (Peersman et al., 2015), which allowed us to define the purpose of the EA, how to define TeleFuturo programming, victim services, the hybrid model, and eligible participants/clients. In this process we captured information that allowed us to examine the following:

- Perceptions about the goal of overall TeleFuturo programming for VOCs
- Greatest impact of TeleFuturo programming for VOCs
- Unplanned/unexpected effects of greatest impact of TeleFuturo for VOCs
- Perspectives about most effective telehealth approaches for working with VOCs

Many of these components were critical for the development of the logic model (discussed below) and implementation guide (also discussed below). As recommended by Peersman et al., we also examined the following:

- TeleFuturo Intervention proposal
- Performance monitoring tools and instruments
- Face-to-face programming for VOCs that would be adapted to telehealth
- Face-to-face evaluation or progress reports
- Broader literature on relevant scientific and policy papers

2.3 Document and Data Systems Review

As part of the EA, we also reviewed El Futuro's key telehealth documents to examine its infrastructure and capacity for evaluation. We reviewed several documents that were developed for implementation of TeleFuturo services. These included versions of the following:

- Behavioral Health Emergency Policy and Procedures
- Technology Troubleshoot Document
- Policies and Procedures
- Crisis Policies
- General Emergency Policies
- Interpersonal Violence Crisis Policy

These process components were incorporated into the implementation guide found in Appendix B.

As we worked with El Futuro stakeholders to define telehealth programming, considerations about plausibility, utility, and feasibility were discussed extensively. Our discussions were focused on gathering information on (1) how telehealth programming will be implemented with specific goals and objectives specified, (2) how program success would be defined and what data are needed to assess program success, and (3) what technical assistance will be needed. This process is necessary to determine evaluation capacity needs around telehealth service provision for VOCs. El Futuro had already engaged in a previous EA for its face-to-face service provision in 2017-2018. Leadership and stakeholders were aware that this process would need to be repeated to understand the unique programming components of telehealth service provision for VOCs and how these components are connected with outcomes of interest.

Additionally, RTI staff went to El Futuro for several in-person meetings to review the data systems used by staff. We were provided with a login for the EHR system. Because El Futuro is a Health Insurance Portability and Accountability Act (HIPAA)-covered entity, RTI staff working on the data systems completed a confidentiality agreement prior to accessing any personally identifiable information. During our work, we found that some "limited data" would be more easily transferred to RTI for analysis. After consultation with RTI's privacy officer, we entered into a Data Use Agreement with El Futuro which allows for the transfer of limited Data Sets to RTI as defined by the HIPAA code. We reviewed the following EHR archival data:

- EHR system variable list
- EHR reports list
- Depression Anxiety Stress Scales (DASS) data collection interface

2.4 Logic Model Development

Logic Model Development Questions

1. What is the TeleFuturo's program for VOCs? What are the short-term, intermediate, and long-term outcomes?
2. What are TeleFuturo's inputs (the resources for implementing and operating the program provided by El Futuro)?
3. What are the current activities of TeleFuturo? What are the individual components, and how are they implemented?
4. What are TeleFuturo's measurable outputs after implementing the program?

The current version of the logic model (see Figure 2-1) was developed by RTI and El Futuro staff using a team approach to collaboratively create a graphic representation that would guide the telehealth program and serve as a roadmap to connect El Futuro's activities with the intended goals of its telehealth services. The team capitalized on an existing logic model that had been developed as a comprehensive framework of all El Futuro services to develop a new model that focused on the implementation of the telehealth program. The process began by assessing the resources that would be leveraged to implement the telehealth program and the individual activities that would be used to enact the program. The initial draft of the logic model was used to identify data to be evaluated, and new measures were added that were pertinent to telehealth. Each activity was mapped to a specific measurable output for evaluation.

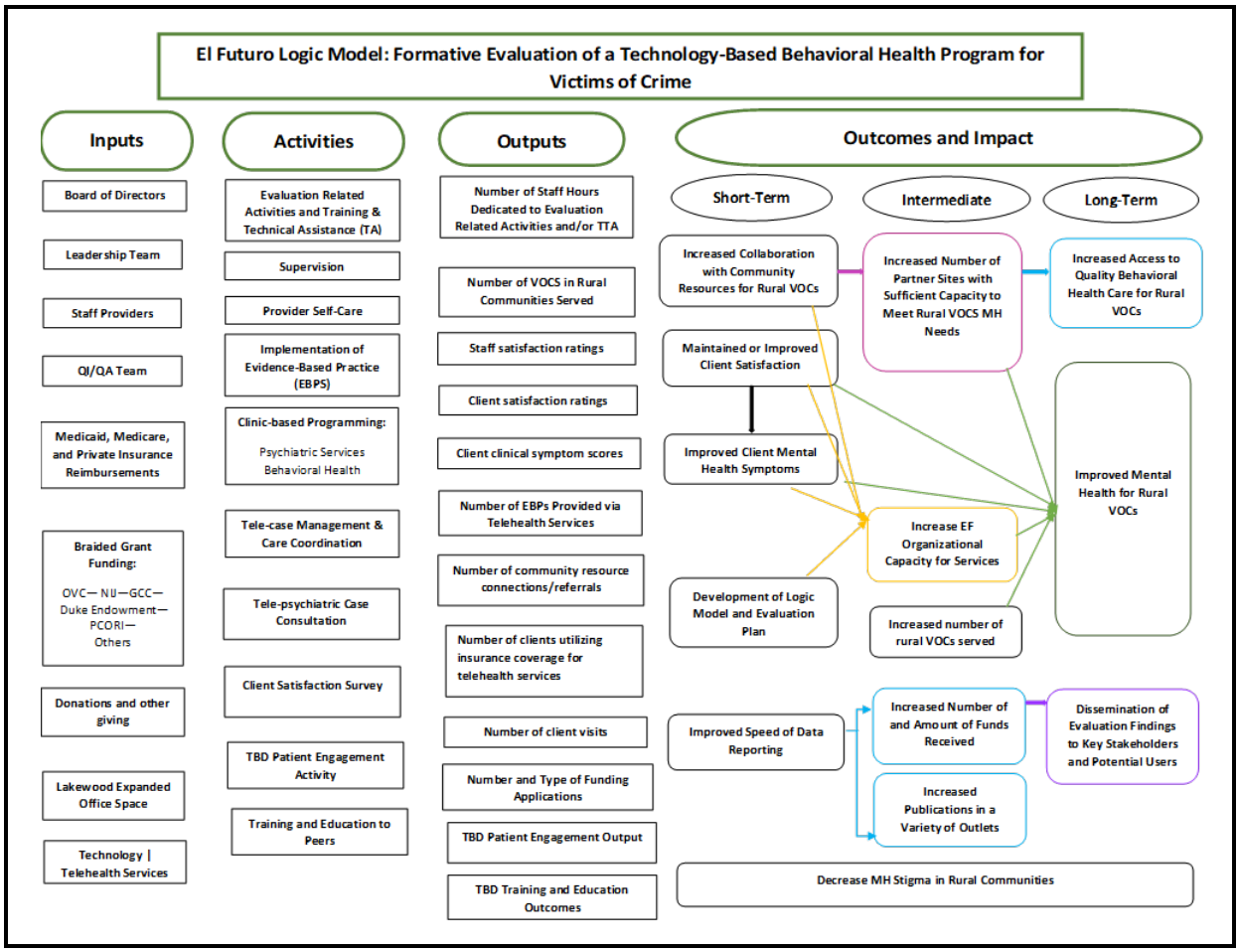
The logic model was used to identify current practices, acknowledge existing barriers and facilitators, assess the agency's feasibility to implement telehealth, and integrate formative evaluation findings into the telehealth design and subsequent implementation guide. The team evaluated the whole of the intended impact of the telehealth program and designated each outcome according to the immediacy of the effects.

Ultimately, the logic model served to enhance El Futuro's capacity to provide services through careful consideration of the resources being used by the organization (inputs), the efforts being made by El Futuro (activities), and how those two elements contributed to the goal of the telehealth program (outcomes and impact). This logic model can be leveraged to demonstrate El Futuro's model of change when the agency pursues additional, future funding to support their telehealth work.

2.5 Post-COVID-19 Modifications

The logic model framework was made in multiple iterations and updated as the COVID-19 pandemic impacted the activities that El Futuro was able to implement and the method of providing services. The initial iteration of the logic model was created in early 2020 and was modified in 2021 to reflect the modifications and additions that El Futuro enacted in response to the pandemic. COVID-19 and the subsequent stay-at-home orders forced El Futuro to conduct a rapid transition to telehealth service-only provision. El Futuro benefited from the existing telehealth funding grant and infrastructure to support telehealth, but additional changes were necessary to implement teletherapy and telepsychiatry agency wide. El Futuro sought to assess client satisfaction throughout the telehealth transition, and the Executive Director implemented a client satisfaction survey to assess how the clients felt about the adjustment. These results are presented within the pilot study sections below (see Table 2-7). El Futuro psychiatrists adapted to providing telepsychiatric care for the first time and administrative staff transitioned to provide case management and care coordination while completely remote.

Figure 2-1. TeleFuturo Logic Model for Provisions of Telehealth With Victims of Crime



2.6 Additional Implementation Learnings From the Evaluability Assessment: Informing Implementation Guide

2.6.1 Coordination of Telemental Health Services

> "A dedicated team to just help with the logistics, to just help the client be able to connect so that you don't put that stress on the clinician," adding, "The clinician is already stressed enough with the clinical visit."
>
> *—Clinician*

Beyond evaluability, the first set of findings from the interviews relates to the critical role played by administrative staff to technology-based programming. To ensure the success of a telehealth initiative, participants stressed that a clinical practice must have adequate administrative staff. These staff should be trained in the use of the selected telehealth technology and able to support clients and providers in using the technology. When asked for their advice on establishing a telehealth program, one participant insisted on the need to have "a dedicated team to just help with the logistics, to just help the client be able to connect so that you don't put that stress on the clinician," adding, "The clinician is already stressed enough with the clinical

visit." This advice extended to satellite offices, where clients may come into the office to connect with a remote clinician. According to one therapist, "It would be really nice to have somebody, and someone that's just there and available and accessible if there's an emergency, and not somebody that's kind of running around doing another job with this like tacked on to their other responsibilities." In addition to helping to troubleshoot or respond to emergent issues, administrative staff were viewed as essential to orient clients to the telehealth process and the technology prior to their joining a session with a therapist. At satellite offices, "They're kind of providing that warm handoff to the therapist, but also providing some education about what the session is going to be like… It's just so, so important that someone is there, and a warm body, to… help with that bridge to the therapist," one therapist said. In providing this pre-session education, the administrative staff person helps to ensure that the therapist and client can "get right to the session," without having to spend as much time orienting to the technology. As with in-person service delivery, administrative staff continued to be instrumental in ensuring that clients were scheduled and attended telehealth appointments and that the practice was reimbursed for telehealth visits. The organization had to adjust its billing process multiple times over the course of the pandemic to reflect changes to federal and state reimbursement policies. With the broadening of what was considered reimbursable, telehealth became much more widely available to clients and providers. During our interviews, participants wondered aloud about the future of telehealth reimbursement policy and the effects on the organization's services.

Using telehealth has multiple impacts on providers. Trying to engage clients over video is often difficult and can be exhausting. It can be difficult to establish a therapeutic alliance with new clients with no in-person interaction. Providers have concerns about missing nonverbal cues that would be more easily noticed during in-person visits. Telehealth limits the types of modalities providers can use and they would benefit from a better understanding of which modalities work best for telehealth and which modalities are not appropriate for use in telehealth. Some aspects of treatment, such as medication checks, are easier with telehealth since it allows clients easy access to their medications when they are home. However, other aspects are more difficult, such as speaking with parents, and unless clients have specific equipment at home, providers are not able to check vital signs. Telehealth requires providers to develop new skills, new techniques, and safety protocols. It may help to have a dedicated workspace at home that mimics the therapeutic environment. Providers also need to increase their technical troubleshooting skills to assist clients when needed. Extra work is required of providers outside of sessions to prepare materials in advance and communicate more frequently with clients. To mitigate some of the issues associated with these new challenges, providers need support including new training, appropriate policy updates, support staff to assist with scheduling and technology issues, and sufficient technological skills and equipment to successfully conduct telehealth from various locations.

The interviews also produced findings and recommendations related to providers. Most of the providers interviewed were relatively new to teletherapy. They were compelled by the pandemic to quickly transition to seeing their clients online or over the phone. Providers identified both benefits and challenges associated with teletherapy, although the focus tended to be on the latter. Presumably, as

> "You have to observe quite a bit more because you're not in there picking up the physical cues," noted one.
>
> Another found this challenging during assessments, adding, "I think about assessing, there is a lot of information missed when you're not seeing like a full person, like their whole body, because you think about body language and nonverbal communication and all of that gets missed via video."
>
> —Clinicians

therapists and clients grow more accustomed to teletherapy many of these challenges will diminish. The interviews revealed that conducting therapy via video or phone requires providers to develop new technological skills, therapeutic techniques, and protocols, particularly for gaining trust and ensuring remote clients' privacy and safety. One unique stressor of the pandemic was the lack of time therapists were given to build these skills and processes before being thrust into teletherapy delivery. One provider observed, "We are basically getting certified in telehealth while we're doing it," adding, "We are overhauling our entire skill set to become a different kind of clinician because we have to."

Some of the challenges cited by providers during these early months of teletherapy included the occasional struggle of establishing rapport with new clients over video, having to adapt therapeutic techniques to a virtual environment (or consider abandoning techniques, like creative arts or eye movement desensitization and reprocessing, that did not translate well), and having to cope with the difficulty of not being able to make eye contact with clients or monitor subtle, nonverbal cues. According to one provider, "If I talk to the camera then I also can't—I want to maintain that eye contact and not look over at my screen and start typing on the notes." Another added, "It's an artificial focus, and so we're looking at people's faces the entire session…. It's tough, it's exhausting for the clinician to be that focused for that long for that many clients in a row." Providers also had to adjust to not being able to easily see the small movements of clients on which they routinely rely for additional information. Some of the providers we interviewed shared that teletherapy was more time-consuming for them because of the additional preparation required for each session and the additional communication with clients between sessions to share resources electronically. Others who prescribed medicine for their clients had a harder time collecting vital signs. One provider expressed concerns about being able to adequately address the safety needs of clients who were remote, saying,

> Whereas we have protocols for managing suicidality in the clinic and that involves involuntary commitment and doing safety planning and all those things, it's a little bit precarious to have your client out in the world and you know they're having these thoughts…. It's just a different sensation of, I can't maintain the same level of safety of my clients as I could when I was seeing them regularly in the clinic.

Despite these challenges, therapists remarked that some clients responded better to or preferred telehealth, and, for all clients, teletherapy during the pandemic was better than the alternative of no therapy. As one therapist reflected, "Our office is closed, we have to do it over video, so best quality of care is video versus nothing, of course.... But, if there were all the options available, I still think that for some clients best quality of care might be video." For some clients, teletherapy helped them to overcome regular barriers to care, such as transportation, work and school conflicts, and lack of childcare. Another therapist with more telehealth experience observed, "There are some challenges with telehealth, but once we get past the kind of initial—like just getting comfortable with the technology and get to know each other, I don't think it makes a difference in the rapport or in the treatment." Some of the approaches the providers used to address the challenges they encountered with telehealth included making an additional effort to build rapport with clients who are VOCs (e.g., talking to people about projects they may be working on around their house or meeting their pets), taking time in advance of sessions to prepare materials and activities suitable for virtual use, and pinpointing the key components of different therapeutic models that can be delivered via telehealth, even if

some elements are not possible. The providers we interviewed further recommended that therapists should have a dedicated workspace at home and should have plans in place with clients for any issues that arise with connectivity during a session, a common barrier. This point is specific to working during the COVID-19 pandemic. Initially, we proposed telehealth service provision in a designated telehealth space within the clinic. In light of the capacity that has been built by therapists providing TeleFuturo and those across the nation responding to the pandemic, this is still strongly recommended to ensure the privacy needed by VOCs specifically but also all telehealth clients in general.

Providers noted that teletherapy was advantageous for providers when it came to collecting information from other adults in the household. One therapist shared that "One plus, I would say, for older adults is that it's been easier for me to get collateral information from family members that are in the house." Also, this therapist noted telehealth allows providers to ask their clients if medications were handy for example, to get dosing and other information.

2.6.2 Pandemic-Specific Implementation Considerations: Looking Beyond the Pandemic

Using telehealth has multiple impacts on providers. Trying to engage clients over video is often difficult and can be taxing on the provider, especially after back-to-back sessions. It can be difficult to establish therapeutic alliance with new clients with no in-person interaction. Providers have concerns about missing nonverbal cues that would be more easily noticed during in-person visits. Telehealth limits the types of modalities providers can use, and they would benefit from a better understanding of which modalities work best for telehealth and which are not appropriate for use in telehealth. Some aspects of treatment, such as medication checks, are easier with telehealth since it allows clients easy access to their medications when they are home. However, other aspects are more difficult, such as ensuring privacy when others family members are home, and unless clients have specific equipment at home, providers are not able to check vital signs. Telehealth requires providers to develop new skills, new techniques, and safety protocols. It may help to have a dedicated workspace at home that mimics the therapeutic environment. Providers also need to increase their technical troubleshooting skills to assist clients when needed. Extra work is required of providers outside of sessions to prepare materials in advance and communicate more frequently with clients. To mitigate some of the issues associated with these new challenges, providers need support including new training, appropriate policy updates, support staff to assist with scheduling and technology issues, and sufficient technological skills and equipment to successfully conduct telehealth from various locations.

Providers also shared their perspectives on clients' receptivity to telehealth. Some clients responded better to or preferred telehealth, while others found it less desirable or unworkable. According to one provider, survey data in the early months of the pandemic (April 2020) showed that most people preferred to be seen in person, but about 15% to 20% preferred video appointments. These differences appeared related to multiple factors, including the client's access to technology, age, diagnosis, and privacy concerns.

Consistent with the literature on telehealth, one of the most common barriers for clients and providers was limited internet connectivity and access to technology (Gray et al., 2015). Issues with internet connectivity presented challenges not only with clients being able to access appointments but also with providers and clients being able to complete a therapy session uninterrupted. As one therapist described it,

"The technological interactions can really impact the treatment because if the technology goes down and you just can't get reconnected, that's a disruption in the treatment…. And that always, it will happen, it happens to every client and it happens to every clinician at least once." Although the pandemic amplified connectivity issues as multiple household members competed for internet bandwidth, internet connectivity has historically been an issue in many rural areas like those served by El Futuro (Gray et al., 2015; Hirko et al., 2020). As the COVID-19 pandemic wore on, the organization attempted to address some client connectivity issues by offering clients the option to park their cars near the El Futuro office and connect to El Futuro's wireless internet for their teletherapy sessions.

Age seemed to affect the quality and accessibility of sessions conducted by video, at both ends of the client age spectrum. Multiple therapists described the additional work required to engage children and adolescents in teletherapy. Therapists had to adapt to children's shorter attention spans, limits on which therapeutic techniques and materials (e.g., games, drawings) could easily be used in a virtual appointment, the challenge of trying to engage parents/guardians in virtual sessions, and children's general lack of familiarity with the medium.

More than one therapist commented that children and youth also seemed particularly distracted by their own image during video calls. At the other end of the age spectrum, therapists struggled at times to help older clients connect to teletherapy and feel confident and comfortable using the technology. One therapist observed that for older clients, teletherapy seemed like a "much more isolating experience as opposed to kind of like a cathartic experience." This therapist found the lack of physical connection (e.g., passing a tissue box or holding the client's hand) particularly difficult with older clients and took extra care to build rapport with them in other ways, like asking about their interests.

> Working with adolescent VOCs: "Kids don't know where to put the camera. I mean, I can't tell you the number of foreheads I'm doing therapy to… They're just moving around and it just, it's harder to get to the meat of the trauma treatment; I think it takes longer for kids."
>
> Although adolescents tended to be more comfortable using video for appointments, competing demands on adolescents' attention and perhaps too much comfort on video also affected treatment: "To them it makes it feel like this is just another call from a friend… They're not as engaged…. It is different when you're in an office with them because like the whole setting gives the message this is an appointment."
>
> *—Clinician*

Another factor that contributed to telehealth use and outcomes was client diagnosis. Therapists found that for some clients, like those with autism, teletherapy was preferable. For others, like clients with attention deficit/hyperactivity disorder or those who were paranoid, telehealth was more difficult. "Clients with psychosis that might be paranoid or like not open to do a video appointment and they might be more evasive, so you spend a lot more time like, not even assessing, but trying to engage," commented one therapist.

Finally, clients had varying levels of privacy-related concerns. Particularly during the pandemic, when clients were frequently sharing space with family members, finding a private space to attend appointments and keeping the nature of the appointment confidential could be tricky. Therapists occasionally had to encourage clients to find a private place in which to conduct their appointment. This was a more pressing concern for clients with who already felt unsafe at home. Privacy was also a particular concern for a portion of El Futuro's clients who were uninsured or undocumented. "They might be a little concerned about using the phone for a video appointment and, like, who knows where my information is going or am I being recorded," said one therapist. For this reason, therapists suspect some clients preferred phone-only

appointments. When these concerns surfaced, therapists took extra care to reassure clients about the steps being taken to protect their confidentiality. During the later stages of the pandemic, the organization also began opening their building one day per week to allow interested clients to join telehealth appointments with remote therapists from inside the El Futuro offices. One participant shared, "They can come in and we connect them to their clinician that's still at home…because, especially for victims of crime, we've noticed that they—it's not comfortable or even safe for them to be at home having these conversations." This in-clinic option presumably helped to address some of the clients' concerns with privacy and issues with connectivity.

Teletherapy allowed some clients to overcome regular barriers to care, such as transportation issues, work and school conflicts, lack of childcare, and even confidentiality concerns. For clients without a driver's license, for example, or for those who lived at a great distance or were nervous about receiving therapy from a provider in their own close-knit, rural community, telehealth was preferable. One provider we interviewed expressed how impressed they were by "how disclosing and seemingly honest people are with their symptoms."

With COVID-19 forcing the rapid, organization-wide shift to telehealth, more providers, administrators, and clients than anticipated were required to quickly adjust to a new way of delivering and receiving care. This offered many opportunities to uncover lessons for the longer-term implementation of telehealth. In addition to those already listed, participants stressed that, ideally, telehealth programs should be developed intentionally, with input from clinicians, careful consideration of the needed infrastructure, and with the client population's specific needs and capacity in mind. One provider advised,

> People think telehealth is you put a therapist in front of the screen, you put a client in front of the screen and, bam, magic happens, and that is definitely not the case. So just really over, over-reiterating the importance of knowing the scope of what it takes to do telehealth. I think people go in a little blind, thinking, 'It's just going to be this and it's going to be that,' and then, you know, everybody's going to be great and amazing therapy is going to happen for all the millions of people who don't have access to treatment, and it's just, it's not that. So the, the true awareness of what it takes to implement good-quality telehealth—that's actually therapeutic, I think—is a really important consideration as we're thinking about helping folks, especially people who have been victimized and who don't have all the resources at the ready.

All staff, providers, administrators, and technology support staff should receive thorough training in the organization's systems and protocols so that, as one participant asserted, "All your team is following the same, so the client is getting the same experience no matter who they talk to." Providers stressed that the client experience must mimic the in-person experience to the extent possible, and clients should be provided a thorough introduction to teletherapy and planful aftercare. Clinicians should be provided with high-quality equipment, training on videoconferencing and various therapeutic models that are more effective for telehealth, and guidance on how to adapt their workflows and toolkits for virtual appointments. And although clinicians might not share physical space with each other when delivering telehealth, there is still a strong need for clinical meetings and consultation, like the ones El Futuro has continued to provide its staff. These meetings serve as opportunities for clinicians to share ideas with each other and for the organization to examine what is working well with the telehealth program and what may need adjusting. As one provider

observed, "Working with victims of crime can be draining emotionally and now you're working alone, you're at home solo all the time." The provider continued, "Operational and clinical discussions, that's key to me, not only to feel like you have the support but that you are like not isolated, no working alone... and also so changes can be implemented in a timely manner."

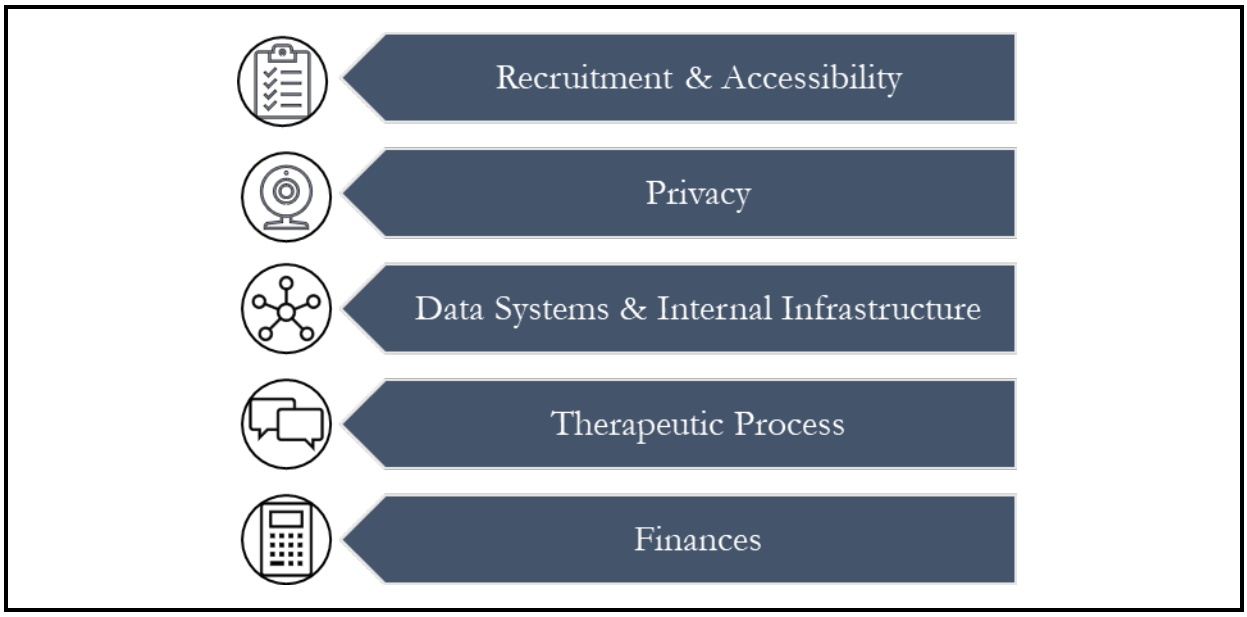
2.7 TeleFuturo: Implementation Peaks and Valleys

El Futuro program staff completed **the Implementation Peaks and Valleys** form to provide qualitative information on challenges encountered, and strategies enacted, in relation to different categories of implementation (Figure 2-2). Forms were completed monthly from September 2019 to February 2021. Below, we present a high-level summary of findings for each of these areas, separated into categories of general implementation and COVID-19.

Implementation Guide and Fidelity Measurement Development

1. What are the hybrid delivery methods of the TeleFuturo (i.e., video conference, telephone call, in-person contact) and when are they implemented?
2. How is the appropriate TeleFuturo service selected for each victim of crime?
3. What are the recommendations of experts and community members in the creation of the TeleFuturo for this population?
4. What cultural adaptations are necessary for addressing the behavioral health needs of Latino and rural VOCs?
5. What are the guidelines to service providers to mitigate potential harm using technology-based services (e.g., breaches in confidentiality, suicidality, and lethality concerns) for VOCs?

Figure 2-2. Implementation Categories in Peaks and Valleys Form



2.8 Recruitment and Accessibility

General implementation challenges included establishing recruitment processes at new partner sites through staff buy-in, culture shifts, and necessary updates to relevant policies and protocols. These efforts to increase client numbers were facilitated by hiring staff to go out to the community and client homes, adapting flyers for outreach, engagement in local activities, and direct engagement with new primary care providers to encourage referrals. In general, recruitment processes were developed over time at each partner site, although disruptions were occasionally experienced considering competing priorities (e.g., end-of-year reports). In these instances, El Futuro incorporated gentle reminders to outreach staff to keep up communications.

COVID-19 Peaks & Valleys

- Shift to virtual outreach
  - Offered support to partner sites in promoting the service, messaging clients, and using adapted telehealth workflows
- Clients opting to wait for in-person therapy
  - Contacted at regular intervals to provide telehealth status updates and assess whether preferences had changed
- Impact on site operations
  - Reached out to closed sites to offer direct services to clients
- Competing staff priorities in response to COVID-19
  - Highlighted impacts on client mental health in messaging to staff

As time went on and client caseload increased, select sites experienced capacity issues; this prompted additional management of client titration and creation of additional mental health support programming for group settings. Other partner site-specific obstacles were encountered in rural communities, where lack of bilingual psychiatry services and the transition from agricultural season to seasonal workers posed issues to client accessibility. In response to these issues, flyers were adapted for Spanish speakers and evening clinical hours were extended into the off-season to accommodate more clients.

2.8.1 Privacy

Implementation of TeleFuturo sparked initial HIPAA concerns around cross-site communications and online scheduling. For example, staff recognized that sending clinical notes to nonclinical sites or including protected health information (PHI) in emails could betray client confidentiality. EHR reports were generated by request rather than sending any PHI. Moreover, a HIPAA-secure online scheduler was obtained for use at El Futuro and partner sites. Additional privacy challenges included those inherent to working with multiple sites with different levels of integration and communications around clinical care, which resulted in visiting and training partners as needed.

COVID-19 Peaks & Valleys

- Lack of privacy for clients and clinicians at home
  - Worked to find times and locations that work best to support unique needs
  - Created a video for clients on preparing for telehealth visits at home
  - Assessed client comfort levels at start of each visit
- Privacy concerns with Zoom
  - Identified alternative platforms if needed
  - External security settings were strengthened

2.8.2 Data Systems and Internal Infrastructure

TeleFuturo implementation included adoption or customization of data systems and infrastructure to support virtual scheduling and appointments. Although the new, HIPAA-secure online scheduler addressed privacy concerns outlined above, it also brought issues to be addressed in and across sites, such as double-booking and technological issues. El Futuro responded to these challenges with one-on-one trainings and a video tutorial for sites and troubleshooting specific issues with the software's support team as needed. File sharing also posed a challenge, as not all partner sites had e-fax capabilities. Instead, several file-sharing services were tested to find a suitable replacement. Finally, EHR updates were required to develop electronic forms and records management to supplant hard copies of enrollment paperwork and client signatures.

COVID-19 Peaks & Valleys

- Limited capacity to host digital networks for remote workers
- Fundraised to support purchase and installation of more powerful server
- Technological issues with Zoom, connectivity
  - Set up accounts on alternative virtual platforms to use as backup
  - Handed out mobile hotspots to clients with connectivity issues or no access to broadband

2.8.3 Therapeutic Process

During early implementation stages, clinicians observed and mitigated a range of barriers to the therapeutic process. For example, it was originally not always clear to a clinician why a client was being referred, nor what the client was told about the TeleFuturo service. This limited communication prior to the first appointment was resolved by requesting detailed referral notes from the primary care provider in the EHR and training telepresenters to have consistent messaging when describing the service. Other challenges were created by the change in setting (e.g., the client's home), which omitted the rapport-building walk with the client to the room; removed a layer of formality that is desired by some clients; and, at times, was accompanied by cell reception/WiFi issues. Strategies to address these problems included the creation of pictographic material to educate clients about ways to prepare for a successful therapy session and—when necessary—changing to a different location to address technological issues.

COVID-19 Peaks & Valleys

- Distractions and increased stress related to quarantining
  - Conducted interviews to collect information about client perceptions of the service and therapeutic relationship
- Children in online school at home
  - Involved kids in family therapy at times if client was interested

2.8.4 Finances

A key financial consideration raised during TeleFuturo implementation was that of reimbursement, which plays an important role in determining long-term program sustainability. Partners noted the challenge of keeping up with changes to Medicaid and telehealth reimbursement and the people power needed to research and test Current Procedural Terminology (CPT) codes. At times, superbills/CPT codes

COVID-19 Peaks & Valleys

- Uncertainty around how long telemental health codes would remain billable and whether some could be available long-term
  - Planned multiple reentry paths to span possible extension of billing codes or return to pre-pandemic functioning
- Inconsistent processes from MCOs around billing for phone-based sessions
  - Worked diligently to transition clients to Zoom or other video platforms

were denied because of inconsistencies between managed care organizations' (MCOs') internal processes and Department of Health and Human Services regulations, which required multiple phone calls to MCO representatives to resolve any issues. TeleFuturo also underwent a staffing change to the Financial Director position in the first few months of implementation. As some grant periods came to an end, program staff had to prioritize time to write new grants to continue services for VOCs and other communities served by El Futuro. This grant-writing process was facilitated by coordination and teamwork. Finally, the cost of site-based telehealth remained as expensive as cost per client service, and so staff worked to add efficiencies, including optimizing division of labor and clarification of roles to allow clinical staff to focus on clinical duties, rather than working on recruitment and engagement strategies. The program director also attended a conference with the aim to learn more around financial sustainability in telehealth. Many of these challenges were not present as the project transitioned into the COVID-19 pandemic. Many of these restrictions were lifted to attend to stay-in-place ordinances across the state and the country. Many of the regulations and challenges discussed int this section will resume post-pandemic.

2.9 Measurement Development: DASS-6 for Telehealth

As part of the EA, one of the challenges that providers and El Futuro leadership noted early on was related to measuring outcomes in constrained time periods and context of the telehealth modality. The development of reliable brief instruments that allow providers and clients to maximize their in-session time while still capturing psychometrically sound and clinically useful information is critical for in-person and telehealth service provision. As part of the pilot, RTI used data from 949 clients at El Futuro with primary anxiety and depressive disorders.

DASS-6

- Developed shortened form of DASS-21 in both English and Spanish for screening.
- Shortened form of DASS-6 is useful for discriminating between primary anxiety and affective disorders.
- This study is an important step in the validation of a screening tool that could be an efficient way to identify individuals affective disorders where time restrictions are present.

Using data from El Futuro's larger client population, we developed the DASS face-to-face and telehealth using graded response item response theory that was designed to maintain maximum reliability across the clinical range of mental health treatment-seekers. Results indicated minimal loss in reliability in reducing the DASS to six items, with reliability exceeding .85. The DASS-6 was useful for distinguishing clients with single disorders (e.g., anxiety alone, depression alone) from those with comorbid disorders. The DASS-6 is an efficient tool for assessing depression, anxiety, and stress in both English and Spanish in telehealth settings. DASS-21 and DASS-6 were used for pilot results with the intention of using the DASS for telehealth (six-item version) in Phase 2 and beyond.

2.10 Pilot Test Evaluation Questions

Pilot study guiding questions were focused on issues around implementation. For our pilot study evaluation questions for Phase 1, El Futuro providers drew on clinical encounters of 2,623 clients since October 2019, and 1,017 of those clients were VOCs who received telehealth services. The Farmworkers and Episcopal Ministry programs accounted for 118 of those clients (Table 2-1). The complete program participation is listed below. The pilot group is majority female VOCs (Table 2-2), and the primary mental

Pilot Study Guiding Questions

1. What are the barriers to and facilitators of engaging the targeted population in TeleFuturo, including each method of service delivery? Are the VOCs who need TeleFuturo accessing it? Why or why not?
2. During implementation of each TeleFuturo component, what are the barriers and facilitators experienced by providers?
3. How does the use of technology-based methods to implement evidence-based practice affect implementation in comparison to traditional service implementation for VOCs?
4. What are the hours and burden on providers associated with implementing TeleFuturo for VOCs? Is it sustainable without outside funding?
5. Were potential harms of using technology-based services with VOCs (e.g., breaches in confidentiality, suicidality, and lethality concerns) mitigated?

health diagnoses are listed on Table 2-3, with posttraumatic stress disorder and depression being the main psychiatric diagnoses. After the sites closed because of the COVID-19 pandemic, all clients including VOCs in the rural sites and the main El Futuro site began receiving therapy using telehealth, including clients who had previously participated in face-to-face services. In our overall pilot there were 12,413 clinical encounters, the majority of which were teletherapy (Table 2-4). In-person services (hybrid TeleFuturo) for returning clients before the COVID-19 protocols account for 18% of visits, the second most common type of encounter. Telepsychiatry, phone services, and client intakes compose the remainder of the top five visit types. The majority of clients (87.26%) had at least two therapeutic visits during the time frame. We report information on Tables 2-4 and 2-5 as these sessions for VOCs informed the various tasks including evaluability, development and refinements of the logic model, and the components for the implementation guide. Pilot information from Tables 2-1, 2-6, and 2-7 shows initial outcome results in terms of improvement and satisfaction. The majority of the clients reported improvements and high satisfaction with El Futuro services.

Table 2-1. Telehealth Site Breakdown

Telehealth Sites*	Frequency	Percentage
GCC Episcopal Ministry	69	6.76
NC Farmworker Program—Good Samaritan	29	2.84
NC Farmworker Health Program—La Casita	18	1.76
NC Farmworker Health Program—Benson Area	2	0.02
El Futuro Telemental Mental Health Services	899*	88.4

Note. *These clients were VOCs who received Telemental programming that was covered by private insurance or Medicaid.

Table 2-2. Gender Breakdown

Self-Reported Gender	Frequencies	Percentage
Female	706	69.2
Male	311	30.5
Not reported	3	0.03

Table 2-3. Psychiatric Diagnosis for Telemental Health Visit

Diagnosis	Frequencies	Percentage
Trauma	410	42.27
Depression	339	34.95
Other	103	10.62
Anxiety	89	9.18
Substance use	29	2.99

Table 2-4. Session Types

Session Types	Session Counts	Percentage
Face-to-face psychotherapy	2082	16.8
Teletherapy	6631	53.4
Telepsychiatry	1334	10.7
Phone visit	746	6.0
Evaluation and Management	377	3.0
Intake-only visits	479	3.9
Other	764	6.1

Table 2-5. Reported Trauma for Telemental Health Visit

Diagnosis	Frequencies	Percentage
Domestic violence	405	58.36
Sexual abuse/assault	265	38.18
Assault/physical abuse	185	26.66
Substance use	154	22.19
Arson	90	12.97
Violence in home country (political violence, death threats, etc.)	88	12.68
Robbery	71	10.23
Bullying (verbal, cyber, physical)	58	8.36
Legal involvement	54	7.78
Survivor of homicide victim	39	5.62
Accident/injury	36	5.19
Mass violence/violence in home country (e.g., community/school shooting, war atrocities)	31	4.47
Stalking/harassment	25	3.6
DUI/DWI crash survivor	20	2.88
Abuse during migration	20	2.88
Other	115	16.57

Table 2-6. Client Improvement After TeleFuturo, Using the Depression Anxiety and Stress Scale-6

Significant Change	Frequency	Percentage
Improved	96	50
Same	67	34.8%
Worsened	29	15
Total	192	

Table 2-7. Client Satisfaction With TeleMental Health Sessions

Client Rating	Frequency	Percentage
High satisfaction	121	99%
Not satisfied	1	0.01%
Total	122	

2.10.1 Implementation Guide Considerations and Implications for Phase 2

Our work in Phase 1 will directly inform the expansion of the implementation guide, to be finalized in the Phase 2 process evaluation. Modifications will be made if there are needed changes related to telehealth regulations around implementation. At the time the guide was put together, El Futuro was still working under COVID-19 pandemic reimbursement regulations. This guide leveraged findings from the EA to present key components of interventions for TeleFuturo, to be tailored based on site and population needs (e.g., site-based vs. direct-to-consumer settings). As we gathered information from our EA and in our regular meetings with El Futuro, our partners began putting together the components needed for successful implementation. These were started before the COVID-19 pandemic and revised along the way. Throughout this process we assisted El Futuro Telehealth Programming leadership, but they ultimately led the development of this guide. Contributions were made from El Futuro leadership and providers from each of the types of services offered at El Futuro for VOCs and patients in general (psychiatry, therapy, case management). Below, we present a high-level overview the types of TeleFuturo telemental health sessions that informed this formative evaluation including the EA and the contents of the implementation guide.

2.10.2 Implementation Model and Competencies

The implementation guide will begin an introduction to telehealth more broadly aimed at providing telehealth for VOCs, framed by growing availability and access of technological capabilities, before providing information specific to the TeleFuturo program. This will include the following:

- Definitions of telemental health and other key terminology
- Description of the population to be served, including VOC and victim-centered approaches

- Overview of evidence in support of TeleFuturo, telehealth in general
- Summary of benefits, including specific needs that it can attend to

The guide will draw from the Implementation Model, described in Appendix C to present key competencies needed to support TeleFuturo implementation—namely, **technological, cultural, clinical, and victim-centered competence**. These competencies will be contextualized with examples of their application in practice and steps to identify training needs and enhance capacity when working with VOCs. The implementation guide is described below and included in Appendix C.

2.10.3 Key Components

The components to be highlighted in the implementation guide signify an incremental process, spanning from early adoption to ongoing implementation:

- Determine **key internal leadership** staff/program champions within the organization to advance the implementation program.
- Determine **a goal/vision/target community** for the new service delivery model.
- (For direct-to-consumer implementation) Evaluate and determine **scope** of need for telemental and in-person services via survey.
- Evaluate and assess relevant **regulatory practices** impacting service provision and implementation, including state and local laws, provider and client requirements and limitations, and documentation and other regulatory requirements.
- Assess **feasibility** of implementation within the organization, particularly regarding service needs, provider capacity, and financial impacts.
- (For direct-to-consumer implementation) Establish **criteria** for telehealth services, taking into account client preferences, clinical considerations, payer source, and best practice standards.
- Pick **technology** that matches the need, balancing streamlined access, clinical tools, and PHI protections.
- Establish **standard workflows and communication protocols** for administrative, logistical/technological, and clinical areas.
- (For site-based implementation) Develop **ideal criteria for partner sites** in relation to the target audience.
- **Conduct Request for Proposals and Requests for Applications to identify interested and appropriate partners.**
- **Assess/evaluate** interested sites in terms of the criteria relevant to the target audience/program structure (e.g., location, accessibility, internal capacity).
- (For site-based implementation) **Select site(s) and launch.**
  - Identify and cheerlead key staff, both leadership and on the ground.
  - Conduct initial assessments of needs/goals/capacity/scope of the program.

  - Set training dates.
  - Implement initial training with follow-up consultations and check-in meetings.
  - Work collaboratively to review existing workflows to adapt for site-specific needs.

- **Train site staff on workflows—retrain staff frequently** to address changes to arise with any part of the people, process, and product cycle.
- **Provide consultation** regarding client recruitment and engagement, as needed.
- **Pilot** the service.
- Implement **circular evaluation** of effectiveness regarding service utilization uptake, clinical outcomes, client and staff feedback, and financial considerations.
- Make **small changes** as needed based on feedback and evaluation outcomes.
- **Continuously monitor** utilization, staff and client feedback, policy changes impacting service delivery, clinical recommendations and training needs, and technology updates.

2.11. Dissemination Activities

From this project we developed several products for dissemination. Some are completed, others under review and we have one manuscript in preparation. Our two submitted manuscripts are focused on measurement issues we encountered when working in a telehealth space and with VOCs who were either bilingual or monolingual Spanish speakers. Data from our provider interviews related to barriers, opportunities and challenges providing telehealth was useful for our partners to disseminate to other providers across the state of North Carolina. Our work on this project was also featured in blogs, a podcast, and other outlets. These are all described below.

2.11.1. Peer-Reviewed Articles

Saavedra, L. M., Morgan-López, A. A., Smith, L. M., & Yaros, A.C. Graded response item response theory in the development of a shortened DASS-21 for use in telehealth settings for clients with primary affective disorders. Submitted to *Journal of Clinical Psychology*.

One of the main barriers in provision of telemental health is proper assessment of victim's mental health status. The need for brief instruments that can quickly and accurately assess symptoms of depression, anxiety, and stress in ways that can inform treatment decisions is critical in most settings but especially in urban and rural primary care and community-based organizations that provide mental health treatment, especially telehealth. The development of reliable brief instruments that allow providers and clients to maximize their in-session time while still capturing psychometrically sound and clinically useful information is critical for in-person and telehealth service provision. As discussed previously, using data form 949 clients with primary anxiety and depressive disorders who were VOCs, we developed a shortened form of the English and Spanish versions of the 21-item DASS for face-to-face and telehealth using graded response item response theory. This approach allowed maximum reliability across the clinical range of mental health treatment-seekers. Results indicated minimal loss in reliability in reducing the DASS-21 to 6 items, with reliability exceeding .85. The DASS-6 was useful for distinguishing clients with single disorders (e.g., anxiety alone, depression alone) from those with comorbid disorders. The DASS-6 is an efficient tool for assessing

depression, anxiety, and stress in both English and Spanish in telehealth settings. This manuscript received a favorable review from the *Journal of Clinical Psychology* and was invited for resubmission.

Morgan-López, A. A., Saavedra, L. M., Ramirez, D., Smith, L. M., & Yaros, A.C. moderated non-linear factor analysis of the English and Spanish versions of the DASS-21: Implications for group- versus client-level outcomes monitoring. Submitted to the *International Journal of Methods in Psychiatric Research.*

The need to increase access to mental health service delivery to Latinx populations raises parallel concerns regarding comparability in the assessment and monitoring of treatment progress among mixed populations of bilingual and monolingual Spanish speakers. Using data from El Futuro (N = 379), we propose the use of Moderated Non-Linear Factor Analysis (MNLFA) for estimating item parameters and negative affectivity scale scores from the English and Spanish versions of the DASS-21, accounting for differential item functioning (DIF) across language, gender, age, and assessment wave. Two-thirds of the DASS-21 items showed DIF across language use, yet differences in effect sizes between MNLFA scores (d = -.92) and sum scores (d = -.85) were negligible, likely owing to extremely high local and global reliabilities. However, even with overall effect sizes larger than d of |.8|, 25% of individual clients in the sample had worsening of their negative affectivity scores, with the proportion of clients rated with statistically significant deterioration (SSD) dependent on whether individual-level Reliable Change Indices were estimated using MNLFA scores (8% SSD) or sum scores (16% SSD). The present study demonstrates the mitigation of cross-language measurement bias in the DASS-21, illustrates how individual-level assessment is particularly sensitive to the scale score estimation approach and further highlights the disconnect between group-level effect sizes and individual client outcomes. This manuscript is under second Revise and Resubmit at the *International Journal of Methods in Psychiatric Research.*

2.11.2. Dissemination to Other Providers via El Futuro's La Mesita Network of Providers

One of El Futuro's La Mesita Network's founding goals is to connect providers across the state with resources and referrals to decrease provider burnout and increase the quality of services provided to the Latinx community. The La Mesita Network has served as an effective platform to connect providers not only to El Futuro training resources but to services across the state. Perhaps one of the most rewarding outcomes of our programming is the ability to see connections being forged between agencies, institutions, and private providers across the state. As the coronavirus pandemic began taking hold in the United States, it became clear that the Latinx community would be disproportionately impacted and would require a significant response from our community of providers. Thus, beginning in March of 2020, La Mesita began holding "COVID-19 Info Sessions," bringing together providers across North Carolina to share resources and updates, strategize for how to best serve the Latinx community, and to connect and support one another throughout the changing COVID-19 landscape. As part of dissemination activities for this study, the team continuously put together information that were a result of learnings from this telehealth project for VOCs. Our partners at El Futuro disseminated information from this study to over 185 providers throughout the state of North Carolina. Topics covered included:

- Ensuring privacy
- Telehealth engagement strategies

- Decreasing clinician burnout
- Working from home and work-life balance
- Connecting/ADVOCATING within schools and other services
- Case management

2.11.3. Blogs and Podcasts

Because the NIJ was prescient in funding studies for telehealth, our project allowed us to comment and share our learnings early in the pandemic with other providers working with VOCs and in mental health in general, including the addictions. One of the principal investigators (Saavedra) contributed to the *Medical Care Blog,* the blog for the peer-reviewed journal *Medical Care* (American Public Health Association). Dr. Saavedra discussed privacy issues when working in a telehealth space and offered recommendations for providers and clients: https://www.themedicalcareblog.com/addiction-telehealth-part-2/

The principal investigators of this project (Saavedra and Yaros) were invited to discuss issues concerning mental health services provision during the COVID-19 pandemic, especially about challenges reaching rural populations with limited access. The resulting podcast and blog (https://measureradio.net/2020/11/20/discussing-mental-health-during-a-pandemic/) include a discussion of learnings from our pilot study.

2.11.4. Other Outlets Where the Project Was Featured

Civil Eats featured some initial findings of our telehealth program which housed some of our farmworker sites: "The new [North Carolina Farmworker Health Program] farmworker teletherapy program, which provides mental health treatment to agricultural workers in rural reaches of North Carolina, is one of the first of its kind in the U.S.—and its creators are hoping it can become a model for others" (https://civileats.com/2020/02/04/for-farmworkers-facing-debilitating-depression-is-teletherapy-a-solution/). *Food and Wine* magazine reprinted the article (https://www.foodandwine.com/news/the-revolutionary-new-therapy-helping-depressed-farmworkers).

3

Summary and Conclusions

In this report we document several important accomplishments for Phase 1 that will prepare us to launch a Phase 2 Process Evaluation of TeleFuturo Programming for VOCs (2020-V3-GX-0073). Our results show that TeleFuturo is an evaluable program for a range of mental health problems experienced by VOCs. Without a doubt the COVID-19 pandemic accelerated the pace of our work. Although we were able to gather necessary data to address each of our evaluation questions, there are several unanswered questions for the field when working with VOCs. The main areas have to do with best components to capture fidelity for the varying types of telehealth programming (psychological, psychiatric, case management).

In this report we describe a formative evaluation of implementation of telemental health programming for a range of victim mental health services. It is essential to continue this line of research by (1) conducting randomized clinical trials to compare the efficacy of providing evidence-based therapy to VOCs via telemedicine and (2) developing a practice guideline for delivering psychotherapy via telemedicine to VOCs. Rigorous investigation and practice guidelines could help ensure that the safety of the client is the highest priority while also providing evidence-based care to those most in need: for example, suicidal clients who live in rural areas or who cannot access treatment otherwise. The COVID-19 pandemic forced our team to quickly build capacity and use the information we had already gathered for the implementation guide to expand all services to telehealth programming. It also accelerated our pace to test/implement these components for each type of mental health service for VOCs and other clients in general. The work in this initial phase revealed what is still needed to protect the privacy of VOCs. But it allowed us to develop a solid blueprint to continue to explore these options for rural VOCs and the challenges that providers and clients will face as the country transitions back to face-to-face care.

Our plan is to expand on these in our Phase 2 work (2020-V3-GX-0073) to address the utility of the telehealth approaches being examined and get a better understanding of the types of interventions that work with different VOC populations. As the country transitions back to face-to-face care, many rural populations of VOCs specifically, but individuals in general, will continue to have issues accessing a range of services. Many of our findings and their implications for next steps will begin to map the needs providers of technology-based services for VOCs should consider, what options they have to keep their clients safe while ensuring their privacy and promoting positive change in their lives.

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Appendix A. Telehealth Leadership Interview Protocols

Formative Evaluation of TeleFuturo at El Futuro

Telehealth Interview Guide – Leadership Questions

Discussion Lead:
Note Taker:
Participant(s) (Name and role):
Date/Time of Discussion:

Purpose: The purpose of this interview discussion is to gain insight into the key issues related to telehealth service delivery at El Futuro for victims of crime from the perspective of different stakeholders at a provider organization. These individual discussions will provide each stakeholder an opportunity to describe (1) what they believe are the factors associated with successful clinical and service delivery models and (2) ways to overcome some of the implementation barriers commonly encountered when the program is implemented. For this interview, we also are interested in issues related to leadership around telehealth service provision.

Introduction and Consent to Audio Record

Thank you for making time to speak with us today. As we explained in our email, we are independent researchers from RTI International who working with El Futuro and the National Institute of Justice on a formative evaluation to better understand factors influencing use of telehealth for victims of crime. To understand this further, we are conducting discussions with providers to gather different perspectives on the issues related to telehealth use. Given your position and expertise we are interested in learning from your experience. There are no right or wrong answers. Also, we recognize that there is currently limited research and work to date on telehealth specifically for mental health and substance use disorder treatment with victims of crime, which is why your opinion is so valuable. Moreover, many organizations conducting this work cite several barriers and challenges conducting this work. With that in mind, we welcome your perspectives whether they are based on your current involvement in the delivery of telehealth services or based on your general expertise and understanding of the broader landscape of telehealth.

(Introduce team members and briefly describe qualifications/background and roles during the discussion.)

We expect that our conversation will take less than 1 hour. Participation in this interview discussion is voluntary. If you do not wish to participate or answer any specific questions, please let us know. Similarly, if you decide at any time to end participation, you can let us know and we will stop the discussion.

Finally, we would like to audio-record our conversation to ensure that our notes from today are complete. Although we are taking detailed notes, the audio recording will help verify our discussion notes. We will not share the recording outside of this team and it will be deleted when the project is complete. If you agree to the audio-recording, you may ask us to stop recording at any time.

Do we have your permission to record this discussion?

(Obtain permission from each participant in the interview.)

Do you have any questions about what I have explained?

Note to RTI staff:

- *If yes, start audio recording.*
- *Begin discussion.*

Overarching Questions

1. Thanks again taking the time to speak with us today. Just to start, could you please introduce yourself and tell us about how you use telehealth (and/or other specific domains as appropriate: overseeing mental health or substance use disorder treatment, case management, special populations, policy, financing, mental health etc.)?
    a. If you are a clinician, how long have you been using telehealth in your practice?
    b. How did you get started with it?
    c. If you are a clinician, how long have you been supervising other practitioners in telehealth service delivery?
2. How does your organization use telehealth for *identifying* or *treating* mental health problems and disorders among victims of crime? (e.g., direct delivery, service support or enhancement, telephone/video asynchronous video, mobile technology, etc.)
    a. What populations are you typically serving using telehealth?
        i. Have the populations served changed since introducing the use of telehealth? If so, how?
        ii. What are the primary mental health problems or disorder service needs of your clients?
        iii. How do clients get referred to you/linked to your program?
        iv. Do you also provide similar services face-to-face?
    b. What types of telehealth are in use?
        i. Provider to provider?
        ii. Provider to client?
        iii. Are these services synchronous or asynchronous, meaning the provider and the client talk together in real-time or share messages back and forth?
        iv. Are they direct-to-consumer?
3. What barriers do you see/have you seen in implementing and using telehealth for mental and substance use disorders/conditions when working with victims of crime? What strategies/solutions have been used to overcome those barriers?
    a. Service delivery?
    b. Policy barriers?
    c. Credentialing?
    d. Reimbursement?

   e. Operational considerations?
   f. Client/caregiver engagement?
   g. Provider/staff engagement?
   h. Privacy considerations?

4. Pharmacotherapy is an increasingly important treatment for mental and substance use disorders. What barriers are there for prescribing practices for treating substance use disorders via telehealth?
   a. Medications for anxiety and depression?
   b. Alcohol use disorders?
   c. Other mental health?
   d. Drug use disorders?
   e. Co-occurring disorders?
5. What do hybrid approaches look like at El Futuro? By hybrid we mean combinations of face-to-face and telehealth services with the same client.
6. What is the program design?
   a. What are the program's goals and objectives?
7. Does the program serve the population for whom it was designed?
8. Does the program have the resources discussed in the program design?
   a. What resources are in place for implementing and operating the program?
   b. What is the maximum capacity of the program?
   c. What is the duration of the program (i.e., how long can clients stay)?
9. Are the program activities being implemented as designed?
   a. How are clients' needs assessed?
10. How are staff trained for program implementation and operation?
11. Is there an implementation plan for the program?
12. What problems, if any, have been encountered in implementing the program?
13. Does the program have the capacity to provide data for an evaluation?
14. What data are collected? How are they entered/stored? Are they qualitative, quantitative, or both?
15. How well are data collected? Are they reliable?
16. Will the evaluation require additional data collection?
17. Is the program capable of collecting and managing the data needed for an evaluation?

Best Practices

18. What works well when using telehealth to identify and manage mental and substance use disorders in victims of crime? What doesn't work so well?

Financing Questions

19. Beyond this grant, how are your telehealth services for other clients financed?
    a. Are these clients primarily covered by commercial payers or Medicaid?
    b. Is this a fee-for-service model, a Managed Care model or other model?
    c. Are there any payer-based incentives for using telehealth?
    d. Is telehealth part of a payment bundle?
    e. Are you aware of any incentives to incorporate telehealth into current care models?
    f. Are your services supported by any other sources, e.g., foundation grants, federal discretionary grants, etc.?
20. Does the way in which services are financed change how you deliver telehealth services for the treatment of mental and substance use disorders with pediatric clients?
    a. Billing and procedure codes
    b. Interactions with other providers, e.g., operating under other providers' licenses
    c. Service location considerations
    d. Others?
21. Does reimbursement for telehealth for mental and substance use disorders differ from reimbursement available for medical/surgical services? If so, how?
22. Are there any other special considerations with reimbursement for telehealth? If so, please explain.

Wrap up and Future Directions

23. When thinking of the future of telehealth service delivery for mental and substance use disorders among victims of crime, are there any things you think would need to be changed in order to improve service delivery? If so, what would you change?
24. If you could give advice to another organization implementing telehealth what would it be?
25. Is there anything else you think we should know about the use of telehealth for mental and substance use disorder treatment and related services with victims of crime that we have not asked about today?

Formative Evaluation of TeleFuturo at El Futuro

Telehealth Interview Guide - Provider

Discussion Lead:
Note Taker:
Participant(s) (Name and role):
Date/Time of Discussion:

Purpose: The purpose of this interview discussion is to gain insight into the key issues related to telehealth service delivery at El Futuro for victims of crime from the perspective of different stakeholders at a provider organization. These individual discussions will provide each stakeholder an opportunity to describe (1) what they believe are the factors associated with successful clinical and service delivery models and (2) ways to overcome some of the implementation barriers commonly encountered when the program is implemented.

Introduction and Consent to Audio Record

Thank you for making time to speak with us today. As we explained in our email, we are independent researchers from RTI International who working with El Futuro and the National Institute of Justice on a formative evaluation to better understand factors influencing use of telehealth for victims of crime. To understand this further, we are conducting discussions with providers to gather different perspectives on the issues related to telehealth use. Given your position and expertise we are interested in learning from your experience. There are no right or wrong answers. Also, we recognize that there is currently limited research and work to date on telehealth specifically for mental health and substance use disorder treatment with victims of crime, which is why your opinion is so valuable. Moreover, many organizations conducting this work cite several barriers and challenges conducting this work. With that in mind, we welcome your perspectives whether they are based on your current involvement in the delivery of telehealth services or based on your general expertise and understanding of the broader landscape of telehealth.

(Introduce team members and briefly describe qualifications/background and roles during the discussion.)

We expect that our conversation will take less than 1 hour. Participation in this interview discussion is voluntary. If you do not wish to participate or answer any specific questions, please let us know. Similarly, if you decide at any time to end participation, you can let us know and we will stop the discussion.

Finally, we would like to audio-record our conversation to ensure that our notes from today are complete. Although we are taking detailed notes, the audio recording will help verify our discussion notes. We will not share the recording outside of this team and it will be deleted when the project is complete. If you agree to the audio-recording, you may ask us to stop recording at any time.

Do we have your permission to record this discussion?

(Obtain permission from each participant in the interview.)

Do you have any questions about what I have explained?

Note to RTI staff:

- *If yes, start audio recording.*
- *Begin discussion.*

Overarching Questions

1. Thanks again taking the time to speak with us today. Just to start, could you please introduce yourself and tell us about how you use telehealth (and/or other specific domains as appropriate: mental health or substance use disorder treatment, case management, special populations, policy, financing, mental health etc.)?
    a. If you are a clinician, how long have you been using telehealth in your practice?
    b. How did you get started with it?
2. How does your organization use telehealth for *identifying* or *treating* mental health problems and disorders among victims of crime? (e.g., direct delivery, service support or enhancement, telephone/video asynchronous video, mobile technology, etc.)
    a. What populations are you typically serving using telehealth?
        i. Have the populations served changed since introducing the use of telehealth? If so, how?
        ii. What are the primary mental health problems or disorder service needs of your clients?
        iii. How do clients get referred to you/linked to your program?
        iv. Do you also provide similar services face-to-face?
    b. What types of telehealth are in use?
        i. Provider to provider?
        ii. Provider to client?
        iii. Are these services synchronous or asynchronous, meaning the provider and the client talk together in real-time or share messages back and forth?
        iv. Are they direct-to-consumer?
3. How would you describe any differences in telehealth services for youth versus adults who are victims of crime?
    a. Service delivery model (e.g., type of technology, setting, provider staff types, etc.)
    b. Clinical model/content (e.g., community reinforcement, family involved, MOUD, etc.)
    c. Accessibility (e.g., logistic, financial, etc.)

4. What are your thoughts on differences between face-to-face and telehealth services for mental and substance use disorder treatment with victims of crime in terms of service delivery or clinical approach?
    a. Rapport?
    b. Engagement?
    c. Compliance?
    d. Quality of care?
    e. Client, family, and provider satisfaction?
5. What barriers do you see/have you seen in implementing and using telehealth for mental and substance use disorders/conditions when working with victims of crime? What strategies/solutions have been used to overcome those barriers?
    a. Service delivery?
    b. Policy barriers?
    c. Credentialing?
    d. Reimbursement?
    e. Operational considerations?
    f. Client/caregiver engagement?
    g. Provider/staff engagement?
    h. Privacy considerations?
6. Are there special considerations in treating victims of crime with co-occurring mental and substance use disorders via telehealth? If so, please explain?
7. Pharmacotherapy is an increasingly important treatment for mental and substance use disorders. What barriers are there for prescribing practices for treating substance use disorders via telehealth?
    a. Medications for anxiety and depression?
    b. Alcohol use disorders?
    c. Other mental health?
    d. Drug use disorders?
    e. Co-occurring disorders?
8. What do hybrid approaches look like at El Futuro? By hybrid we mean combinations of face-to-face and telehealth services with the same client.

Best Practices

9. What works well when using telehealth to identify and manage mental and substance use disorders in victims of crime? What doesn't work so well?

Financing Questions

10. Beyond this grant, how are your telehealth services for other clients financed?
    a. Are these clients primarily covered by commercial payers or Medicaid?
    b. Is this a fee-for-service model, a Managed Care model or other model?
    c. Are there any payer-based incentives for using telehealth?
    d. Is telehealth part of a payment bundle?
    e. Are you aware of any incentives to incorporate telehealth into current care models?
    f. Are your services supported by any other sources, e.g., foundation grants, federal discretionary grants, etc.?
11. Does the way in which services are financed change how you deliver telehealth services for the treatment of mental and substance use disorders with pediatric clients?
    a. Billing and procedure codes
    b. Interactions with other providers, e.g., operating under other providers' licenses
    c. Service location considerations
    d. Others?
12. What are your thoughts on differences between face-to-face and telehealth services for mental and substance use disorder treatment in terms of financing, utilization and cost?
    a. Reimbursement amounts?
    b. Different requirements for coverage (e.g., provider credentials, technology etc.)?
    c. Utilization rates?
    d. Costs?
    e. Reductions in other avoidable healthcare use?
13. Does reimbursement for telehealth for mental and substance use disorders differ from reimbursement available for medical/surgical services? If so, how?
14. Are there any other special considerations with reimbursement for telehealth? If so, please explain.

Wrap up and Future Directions

15. When thinking of the future of telehealth service delivery for mental and substance use disorders among victims of crime, are there any things you think would need to be changed in order to improve service delivery? If so, what would you change?
16. If you could give advice to another organization implementing telehealth what would it be?
17. Is there anything else you think we should know about the use of telehealth for mental and substance use disorder treatment and related services with victims of crime that we have not asked about today?

Appendix B. Phase 1 Pilot Study Materials, Consents, and Instruments

Formative Evaluation of TeleFuturo at El Futuro: Leadership Interview Consent Form

Introduction and Consent to Participate and Audio Record

Introduction and Purpose: The purpose of this interview discussion is to gain insight into the key issues related to telehealth service delivery at El Futuro for victims of crime from the perspectives of different stakeholders. These individual discussions will provide each stakeholder an opportunity to describe (1) what they believe are the factors associated with successful clinical and service delivery models and (2) ways to overcome some of the implementation barriers commonly encountered when the program is implemented. For this interview, we also are interested in issues related to leadership around telehealth service provision.

Thank you for making time to speak with us today. As we explained in our email, we are independent researchers from RTI International who are working with El Futuro and the National Institute of Justice on a formative evaluation to better understand factors influencing the use of telehealth for victims of crime. To understand this further, we are conducting discussions with providers to gather different perspectives on the issues related to telehealth use. Given your position and expertise, we are interested in learning from your experience. There are no right or wrong answers. Also, we recognize that there is currently limited research on telehealth specifically for mental health and substance use disorder treatment with victims of crime, which is why your opinion is so valuable. Moreover, many organizations conducting this work cite several barriers and challenges to its implementation. With that in mind, we welcome your perspectives whether they are based on your current involvement in the delivery of telehealth services or based on your general expertise and understanding of the broader landscape of telehealth.

We expect that our conversation will take less than 1 hour. Participation in this interview discussion is voluntary. If you do not wish to participate or answer any specific questions, please let us know. Similarly, if you decide at any time to end participation, you can let us know and we will stop the discussion.

Finally, we would like to audio-record our conversation to ensure that our notes from today are complete. Although we are taking detailed notes, the audio recording will help verify our discussion notes. We will not share the recording outside of this team and it will be deleted when the project is complete. If you agree to the audio-recording, you may ask us to stop recording at any time.

Do we have your permission to record this discussion?

(Obtain permission from each participant in the interview.)

Do you have any questions about what I have explained?

Formative Evaluation of TeleFuturo at El Futuro: Provider Interview Consent Form

Introduction and Consent to Participate and Audio Record

Introduction and Purpose: The purpose of this interview discussion is to gain insight into the key issues related to telehealth service delivery at El Futuro for victims of crime from the perspectives of different stakeholders at a provider organization. These individual discussions will provide each stakeholder an opportunity to describe (1) what they believe are the factors associated with successful clinical and service delivery models and (2) ways to overcome some of the implementation barriers commonly encountered when the program is implemented.

Thank you for making time to speak with us today. As we explained in our email, we are independent researchers from RTI International who are working with El Futuro and the National Institute of Justice on a formative evaluation to better understand factors influencing the use of telehealth for victims of crime. To understand this further, we are conducting discussions with providers to gather different perspectives on the issues related to telehealth use. Given your position and expertise, we are interested in learning from your experience. There are no right or wrong answers. Also, we recognize that there is currently limited research on telehealth specifically for mental health and substance use disorder treatment with victims of crime, which is why your opinion is so valuable. Moreover, many organizations conducting this work cite several barriers and challenges to its implementation. With that in mind, we welcome your perspectives whether they are based on your current involvement in the delivery of telehealth services or based on your general expertise and understanding of the broader landscape of telehealth.

(Introduce team members and briefly describe qualifications/background and roles during the discussion.)

We expect that our conversation will take less than 1 hour. Participation in this interview discussion is voluntary. If you do not wish to participate or answer any specific questions, please let us know. Similarly, if you decide at any time to end participation, you can let us know and we will stop the discussion.

Finally, we would like to audio-record our conversation to ensure that our notes from today are complete. Although we are taking detailed notes, the audio recording will help verify our discussion notes. We will not share the recording outside of this team and it will be deleted when the project is complete. If you agree to the audio-recording, you may ask us to stop recording at any time.

Do we have your permission to record this discussion?

(Obtain permission from each participant in the interview.)

Do you have any questions about what I have explained?

El Futuro is a part of a research study that evaluates and measures the impact of their telebehavioral health services and its impact on clients. The research is being conducted by RTI International, a non-profit research organization in Durham, NC and is being funded by the National Institute of Justice (NIJ).

You are being asked to participate in this research study because you are a client of El Futuro's telebehavioral health services. Your experience as a recipient of telehealth services is important to this evaluation. You may benefit by knowing that the answers you provide will help determine how to improve the intervention to benefit El Futuro clients. There are no foreseen, substantial risks to participating in this research study. Your participation in this research study is voluntary, and your information will be kept confidential and de-identified. You have the right to refuse to provide any information, and you may withdraw from the study at any time. Your decision to participate or not to participate in the research study will not have any impact on the services you receive from El Futuro.

I, _____ , understand that I have been selected to participate in a research study of El Futuro's telebehavioral health services.

_____ I understand that I am being asked to participate in this research because I am an El Futuro client who is receiving telebehavioral health services.

_____ I understand that the information that will be collected and shared with RTI International will be kept confidential and de-identified.

_____I understand that I have the right I have the right to withdraw from the research study at any time without it impacting the service I am receiving from El Futuro.

_____	_____	_____
Client Signature	Print Name	Date

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the client fully understands what I have explained and answered.

_____	_____
Provider's Signature	Date

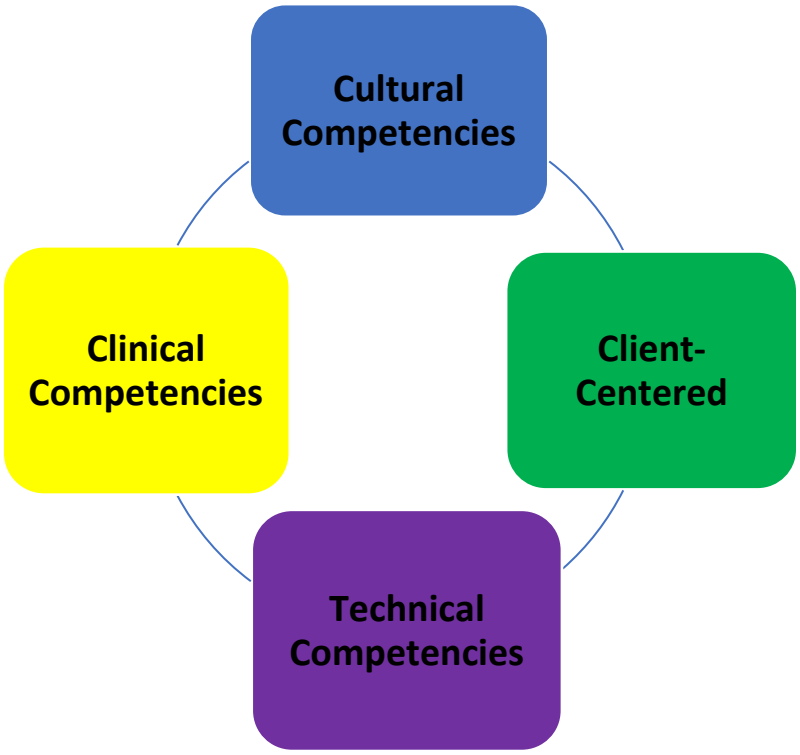
Appendix C. Implementation Model

Phase 1 Implementation Guide

Overarching Conceptual Frameworks for Telebehavioral Health Implementation

1) **People-process-product (**or who-how-what**)**
   People: Who will receive the service, who will offer the service?
   Process: How will the service be offered and received?
   Product: What is being offered/received and how to manage quality over time?

2) **Implementation Model Framework**



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Site Based Telebehavioral Health Program Implementation Process

- Determine **key internal leadership** staff/ program champions w/in your organization to advance the implementation program

- Determine **a goal/vision/target community** for the new service delivery model

- Evaluate and assess relevant **regulatory practices** impacting service provision and implementation
    - State and local laws
    - Provider requirements/limitations
    - Client requirements/limitations
    - Documentation and other regulatory requirements

- Assess **feasibility** of implementation w/in your organization
    - Service needs
    - Provider capacity
    - Financial impacts- short and long term

- Pick **technology** that matches the need
    - Prioritize client streamlined access to the service for clients
    - Find a resource that offers clinical tools necessary to meet the needs of your client population
    - Ensure protection of PHI and ePHI
    - Think about paperwork demands/needs (virtual signatures, confirming consent for treatment and release of information are properly shared, signed etc, and that meet payer sources requirements)
    - Include the following team members when picking a technology: Clinical Team, Administrative Team, Technological Team

- Establish **standard workflows**
    - Administrative
        - Registration and enrollment
        - Informed consent/ policies and procedures
            - Answer the questions:
                - *How does the client get enrolled in the service*
                - *How does client provide informed consent for treatment*
                - *How does client pay for the service, if needed*
    - Logistical/Technological
        - Technology training for clients on the front end
        - Multiple methods of teaching and problem solving with clients
            - Meet needs both regarding the technology and how to prepare for a successful visit (privacy, limit distractions etc.)
        - **Dedicated staff and resources are crucial for this to succeed**

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        - Answer the questions
            - *How will the client know where to go for their appointment, and what happens if they have questions, or have trouble w/ accessing their clinician?*
    - Clinical
        - Clinical assessment and treatment planning
        - Service Provision and follow up
        - Safety planning and considerations
            - Answer the questions:
                - What will the provider do in case of the following:
                    - *The client is disconnected from the session*
                    - *The client is expressing safety concerns*
                    - *The clinician has concerns about client or other safety needs*
                    - *The client cannot be contacted for the session*
                    - *Who is responsible for follow up care/scheduling?*
                    - *Where will the client go if they no longer want to participate in virtual care?*
    - Communication
        - Establish how team members will communicate about both individual client needs and the overall functioning of the program
            - Set expectations for periodic/as needed communication
            - Set expectations for regular check-ins across levels (director to director, provider to site-based coordinator etc.)
        - Establish how clients will get questions answered and needs met
            - Clear contact information at all stages of the interaction

- Develop **ideal criteria for partner sites** in relation to the target audience

- **Conduct RFP/RFA to identify interested and appropriate partners**

- **Assess/evaluation** interested sites in terms of the criteria relevant to your target audience/program structure. Examples include:
    - Existing relationships with the target community
    - Location of sites/access to the community
    - Previous work or demonstrated interest in mental health services
    - Is there an existing need for the service in the community
    - Does the site have internal capacity to support the project
        - Dedicated staff
            - Leadership/Management
            - Telebehavioral Health Coordinator role
        - Time to invest in uptake of the service
        - Time to invest in the ongoing needs of the program
        - Time and capacity to recruit and engage clients to the service

- **Select site(s) and launch**
    - Identify and cheerlead key staff, both leadership and on the ground
    - Conduct Initial assessments of needs/goals/capacity/scope of the program
    - Set training dates
    - Implement initial training w/ follow up consultation/check in meetings
    - Work collaboratively to review existing workflows to adapt for site specific needs

- **Train site staff on workflows- retrain staff frequently** to address changes to arise with any part of the people, process, product cycle

- **Provide consultation** re: client recruitment and engagement, as needed
    - Embed in current service provision encounters (ie- offer at intake, f/u appts. etc.)
    - Standard/traditional marketing
    - Social media marketing
    - Direct marketing to referral sources

- **Pilot** the service

- **360 Comprehensive Evaluation** of effectiveness
    - Service utilization uptake (including no-show rates)
    - Client clinical outcomes
    - Client feedback
    - Staff feedback
    - Financial/funder considerations
    - Answer the questions:
        - *Who and how are people being served?*
        - *Does the service meet the needs of the community?*
        - *Who is being left out of our service offerings?*
        - *Is the staff appropriately trained to meet the need?*
        - *Does the selected technology work to meet the needs of staff and clients?*
        - *Is this a sustainable model in the short, medium and long term?*

- Implement **small changes** as needed based on feedback and evaluation outcomes

- **Continuously monitor**
    - Utilization of the service
    - Buy-in of site based staff at all levels
    - Client feedback about the service
    - Policy changes impacting service delivery
    - Clinical recommendations and training needs of clinical staff
    - Technology updates/changes/requirements for service delivery

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Direct to Consumer Telebehavioral Health Program Implementation Process

- Determine **key leadership** staff/ program champions w/in the organization to advance the implementation process

- Determine **shared goal/vision** for the new service delivery model

- Evaluate and determine **scope** of need for tele and in-person services via survey
    - Multiple modes of information gathering
        - Current clients
        - Waitlist clients
        - Clients who have been difficult to engage via video/phone
        - Staff
        - Clinical Staff
        - Community members

- Evaluate and assess relevant **regulatory practices** impacting service provision and implementation
    - State and local laws
    - Provider requirements/limitations
    - Client requirements/limitations
    - Documentation and other regulatory requirements

- Assess **feasibility** of implementation
    - Service needs
    - Provider capacity
    - Financial impacts- short and long term

- Establish **criteria** for telehealth services
        - Client preference
        - Clinical considerations
        - Payer Source (i.e. if some payers reimburse telehealth and others don't)
        - Best practice standards for the industry/area of practice

- Pick **technology** that matches the need
    - Prioritize client streamlined access to the service
    - Find a resource that offers clinical tools necessary to meet the needs of your client population
    - Ensure protection of PHI and ePHI
    - Think about paperwork demands/needs (virtual signatures, confirming consent for treatment and release of information are properly shared, signed etc, and that meet payer sources requirements)

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- Include the following team members when picking a technology: Clinical Team, Administrative Team, Technological Team

- Establish **workflows** that mirror in-person as much as possible
  - Administrative
    - Registration and enrollment
    - Informed consent/ policies and procedures
      - Answer the questions:
        - How does the client get enrolled in the service
        - How does client provide informed consent for treatment
        - How does client pay for the service, if needed
  - Logistical/Technological
    - Technology training for clients on the front end
    - Multiple methods of teaching and problem solving with clients
      - Meet needs both regarding the technology and how to prepare for a successful visit (privacy, limit distractions etc.)
    - **Dedicated staff and resources are required for this to succeed**
    - Answer the questions
      - How will the client know where to go for their appointment, and what happens if they have questions, or have trouble w/ accessing their clinician?
  - Clinical
    - Clinical assessment and treatment planning
    - Service Provision and follow up
    - Safety planning and considerations
      - Answer the questions:
        - What will the provider do in case of the following:
          - The client is disconnected from the session
          - The client is expressing safety concerns
          - The clinician has concerns about client or other safety needs
          - The client cannot be contacted for the session
          - Who is responsible for follow up care/scheduling
          - Where will the client go if they no longer want to participate in virtual care?
  - Communication
    - Establish how team members will communicate about both individual client needs and the overall functioning of the program
    - Establish how clients will get questions answered and needs met
      - Clear contact information at all stages of the interaction

- **Identify Key staff**
  - Administrative
  - Clinical

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    - Management/Leadership

- **Train internal and site based staff on workflows- retrain staff frequently** to address changes to arise with any part of the people, process, product cycle

- **Advertise/market the service**
    - Embed in current service provision encounters (ie- offer at intake, f/u appts. etc.)
    - Standard/traditional marketing
    - Social media marketing
    - Direct marketing to referral sources

- **Pilot** the service

- **Circular evaluation** of effectiveness
    - Service utilization uptake (including no-show rates)
    - Client clinical outcomes
    - Client feedback
    - Staff feedback
    - Financial impacts
    - Answer the questions:
        - Who and how are people being served?
        - Does the service meet the needs of the community?
        - Who is being left out of our service offerings?
        - Is the staff appropriately trained to meet the need?
        - Does the selected technology work to meet the needs of staff and clients?
        - Is this a sustainable model in the short, medium and long term?

- Implement **small changes** as needed based on feedback and evaluation outcomes

- **Continuously monitor**
    - Client feedback about the service
    - Policy changes impacting service delivery
    - Clinical recommendations and training needs of clinical staff
    - Technology updates/changes/requirements for service delivery

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Additional Policy and Procedure Documents (PDFs)

Tele-Behavioral Health Program Overview
TeleFuturo Community Information Session
Teletherapy Partnership Implementation
EFWM Crisis Policies Introduction
EFWM Emergency Policy
Behavioral Health Emergency Policy and Procedures
EFWM Technology Troubleshoot Draft
EFWM and EF Policies and Procedures
EFWM Interpersonal Violence (IPV) Crisis Policy

Project Management & Administration

Select tools (Gantt, Basecamp) Select collaboration platform (SharePoint, Google Drive) Identify HIPAA-secure space(s) for service provision Create admin meeting schedule Create clinical service schedule Review Tele-behavioral Health Policies and Procedures (revise as needed) Develop and distribute marketing materials (i.e.electronic/paper flyers)

Training & Capacity Building *On-boarding training for all direct service providers (i.e. Outreach Workers, Clinicians) Clinical training (i.e.Targeted Treatment, Motivational Interviewing)*

Technology *Select video platform (i.e. Zoom) Purchase or obtain iPad Test internet speed and connectivity*

Clinical Support Services *Outreach Making referrals Provide private space for tele-behavioral health sessions Support scheduling & coordinating appointments(check-in & check-out, session setup) Provide case management and crisis support Transportation (if applicable) Program evaluation support (Patient Satisfaction Survey, 1-item)*

Clinical Services *Diagnostic assessment & evaluation Targeted treatment (MH/SU) Care Coordination Psychoeducation Psychiatric consults*

Documentation *Select EHR platforms (i.e. IMS, Athena) Therapist completes visit note in selected EHR for each encounter Therapist enters diagnosis and CPT code in selected EHR Therapist enters encounter data in Telehealth Caseload Spreadsheet*

Billing *(if applicable)*

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Program Data *Develop evaluation and satisfaction survey protocols Design and implement evaluation process Select evaluation data storage (application or platform) Monthly data review and analysis (iterative program design) Quarterly data reporting for NCFHP*

TeleFuturo Partnership

El Futuro is currently seeking partnerships to deliver culturally sensitive trauma-informed and bilingual video-based therapy services to the Latinx community in our state.

Services would be provided by El Futuro therapists and offered at select community partner sites.

OUR GOALS

To improve access to and provide bilingual mental health services to historically undeserved Latinx communities in North Carolina using video conferencing technology.

JOIN US!

Learn more about TeleFuturo and how to become a partner at one of our Community Information Sessions!

APRIL 1 12:00 1:00PM
DURHAM CLINIC

APRIL 4 5:30 6:30PM
SILER CITY CLINIC

** Sessions will take place virtually and in-person**
Click here to sign up for a session.

ABOUT EL FUTURO

El Futuro is a nonprofit outpatient clinic that provides comprehensive mental health services for Latinx families in a bilingual environment of healing and hope.

Visit our website for more information:
https://elfuturo-nc.org/

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El Futuro

TeleTherapy Partnership Implementation Domains

Partnership Development

- MOU
- BAA
- Establishment of regular communication routine and platform
- Goal setting (# of clients for deliverables, possible scheduling options for clients)
- Definition of roles (partner-site team and El Futuro team)

Protocols Development

- General Policies and Procedures
    - Enrollment and Referral Procedure
    - Video Behavioral Health Visit Procedure
    - Data Collection
    - Data Reporting

- Crisis Policies
    - Technology Troubleshooting Policy
    - Emergency Policy
    - Involuntary Commitment Policy
    - Interpersonal Violence Crisis (IPV) Policy

- Workflow Chart

Infrastructure and Training

- Scheduling Platform and Training
- Telehealth Technology Setup and Training
- Client Engagement Support:
    - Sample Scripts
    - Program brochures for clients and referral sources
    - Promotional and instructional videos
- Procedures Training (Policies, Procedures, Best-Practices, and Clinical Quality Standards)
- Clinical Training
    - Telehealth model training and supervision
    - Telemental Health Certification and continuing education

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Introduction to Tele-Behavioral Health Crisis Policies and Procedures

The following policies have been created to protect the safety and well-being of staff and clients participating in tele-behavioral health services provided by El Futuro clinicians, and can be found in the operations manual:

1. Technology Troubleshooting Policy
2. Emergency Policy
3. Behavioral Health Emergency Policy and Procedures
4. Interpersonal Violence Crisis Policy

Terms & Definitions

The **distance site** (DS) is defined here as the location of the tele-behavioral health (TBH) clinician which might include any partner clinic sites (**El Futuro Clinic**).

Tele-behavioral health clinician (TBH clinician) is defined here as the employee providing the remote, live, tele-based synchronous behavioral health service (**El Futuro Therapist)**.

The **originating site** (OS) is defined here as the location where the client is located which includes the partner clinic site (**Episcopal Farmworker Ministry/EFWM**).

The **EFWM support staff** refers to the staff member(s) assisting the client **onsite** with:

1. Orienting the client to services
2. Verifying the client's identity and demographic information
3. Completing and signing the following paperwork:
   - ✓ Referral form
   - ✓ Informed consent
   - ✓ Partner Release of Information (ROI) Forms including "Patient Support Person" contact information
4. Establishing live, synchronous tele-connection with the assigned TBH Clinician
5. Serving as the point of contact for TBH clinician in cases of **emergency** or **technological failure**
6. Initiating or responding to **code red, if needed**.

An **emergency** is defined here as a situation in which there is an immediate safety concern to TBH clinician, and/or EFWM clients/staff. **Emergencies** include, but are not limited to, weather events, active shooters, health crises or client aggression/threats.

Technological failure is defined here as barriers to a successful TBH session due to technology problems (e.g. loss of internet access at originating or distance site, poor internet connection resulting in insufficient audio/visual connectivity to conduct session, faulty equipment or dead battery that is unable to be re-charged during session).

Code Red is defined here as a crisis situation/**emergency** **requiring immediate action** to ensure the safety of clients and staff. The term should be used to **alert team members during**

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a crisis situation. Code red applies to events or situations not included in the Behavioral Health Emergency policy. Examples of code red include weather-related crises (natural disasters), presence of an active shooter, or a physical health emergency.

It is important for the **TBH clinician** to implement increased safety protocols that will help to prevent and prepare for crisis situations. These safety protocols include, but are not limited to:

- ✓ Confirm the client's identity at enrollment session.
- ✓ Confirm the client's physical location at the start of each session.
- ✓ Review safety, privacy and security measures for which client is responsible (e.g. ensuring that they are in a private, secure location).
- ✓ Ensure that local emergency contact number for client's location is on-hand.
- ✓ Identify a "Patient Support Person" (i.e. reliable and trustworthy emergency contact) at first session and have a signed Release of Information on file to permit communication with this support person in the case of an emergency.

The TBH clinician will reference the below definitions to determine risk levels for involuntary commitment and best indicated crisis response.

Danger to self, defined as:

1. He/she would be unable without care, supervision, and the continued assistance of others not to exercise appropriate self-control, judgment, and discretion in the conduct of his/her daily responsibilities or to satisfy his/her need for nourishment, personal, or medical care, shelter, self-protection and safety

AND

A. there is a reasonable probability of suffering serious physical debilitation within the near future unless adequate treatment is given (e.g. grossly irrational or uncontrollable behaviors, impaired insight/judgment).

OR

B. Individual has attempted/threatened suicide and there is a reasonable risk of suicide unless treatment

OR

C. Individual has mutilated/attempted to mutilate self and there is a reasonable probability that client will seriously mutilate self without treatment.

Danger to others, defined as:

1. Client has inflicted/attempted to/or threatened serious bodily harm to others. This has been done in a way that indicates substantial risk for serious bodily harm to others or client has engaged in extreme destruction of property

AND

2. There is a reasonable risk that conduct will be repeated.

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Emergency Policy

Policy Title: Emergency Policy for Tele-Behavioral Health (TBH) Services
Effective Date: July 1, 2019
Policy Scope: Defines emergency policies and procedures for all TBH services provided at Episcopal Farmworker Ministry (EFWM) (in-session only).
Reason for policy: To ensure client safety for all EFWM TBH clients by outlining emergency procedures.

El Futuro and EFWM staff will work collaboratively to ensure the well-being of TBH clients. In the event that an emergency occurs while a EFWM TBH client is in-session, El Futuro and EFWM staff will initiate crisis management services by following the policies and procedures outlined below.

El Futuro TBH clinicians and EFWM staff must be prepared for emergency situations that may occur at the distance site (DS) or at the originating site (OS).

TBH clinician is responsible for:

1. conducting a safety assessment of the situation and immediately reporting an emergency situation to 911 (or emergency number at location of the emergency) and alerting EFWM staff working directly with client.
2. supporting EFWM staff with initiating/responding to **code red** if there is imminent danger on-site at EFWM (in-session only).

EFWM staff is responsible for:

1. initiating/responding to **code red**
2. enacting safety measures, in collaboration with designated EFWM staff, TBH clinician, and client, as appropriate

Procedure:

If emergency occurs at originating site (EFWM):

1. TBH clinician or EFWM staff assesses the nature of the emergency and contacts 911 (or emergency number at location of the emergency) immediately for all medical emergencies, client aggression/threatening behaviors, etc.
2. TBH clinician or EFWM staff activates **code red**, simultaneously if possible, or immediately following.
    a. EFWM staff will remain available to enter the room upon invitation and prompting by TBH clinician.

If emergency occurs at distance site (El Futuro):

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1. TBH clinician may disconnect from TBH session immediately if necessary.
    a. If possible, TBH clinician will communicate emergency to client and notify EFWM regarding the emergency before disconnecting from TBH session.
2. Post-emergency, TBH clinician will debrief the incident with EFWM staff, client, and all affected parties and document the incident in client record.

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Behavioral Health Emergency Policy and Procedures

Policy Title:Behavioral Health Emergency Policy and Procedures for Tele-behavioral Health (TBH)
Effective Date: July 01, 2019
Policy Scope: Describes procedures for responding to behavioral health crises during the provision of TBH services at Episcopal Farmworker Ministry (in- session only).
Reason for policy: To ensure client safety for all EFWM TBH clients. El Futuro and EFWM staff will work collaboratively to ensure the well-being of EFWM TBH clients. In the event that a EFWM TBH client presents in crisis, El Futuro and EFWM staff will initiate crisis management services by following the policies and procedures outlined below.

EFWM staff may not touch or restrain the patient in an effort to keep client on the premises. In the event that a client chooses to leave the premises, EFWM staff should provide any information available to assist law enforcement with locating the client.

TBH Clinician is responsible for:

1. conducting a risk assessment of their client and immediately reporting an emergency situation to EFWM staff working directly with client, and contacting local authorities in the case of imminent danger.

2. supporting EFWM with following procedures based on the scenario, including the completion of forms/templates related to safety planning, voluntary and involuntary commitment, OR supporting EFWM with initiating **code red**.

3. following-up with client post-commitment evaluation and/or hospitalization, scheduling in coordination w/ EFWM.

EFWM staff is responsible for:

1. assisting client with completing documentation, or completing documentation on the client's behalf as directed by TBH clinician, OR initiating/responding to **code red**.

2. following-up with TBH clinician to ensure continuity of care.

Procedures for Responding to Behavioral Health Emergencies (in-Session)

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If at any time the TBH Clinician or EFWM staff determines that there is **imminent danger, code red** will be initiated (911 emergency will be called). The primary goal is to ensure immediate safety of both clients and staff.

Scenario #1: Safety Planning with the Client

If risk for self-harm is determined and client agrees to a safety plan, TBH Clinician will notify the onsite EFWM staff and initiate a written plan with client (with EFWM staff present).

- TBH clinician emails the safety plan to EFWM staff to print; the client and EFWM staff as witness will sign the paper copy.
- EFWM scans signed document and emails back to TBH for inclusion in IMS record.
- Client identifies a support person (friend, family member etc) who TBH Clinician calls during video session with client present to confirm their support.
- TBH Clinician calls client within 48 hours to ensure compliance with safety plan.

Scenario #2: Voluntary Commitment

If client is at risk but does not complete a safety plan the TBH Clinician notifies onsite EFWM staff and initiates a voluntary commitment procedure for the client.

- TBH Clinician writes a statement of the client's condition and agreement to emergency psychiatric evaluation/care, and includes the clinician's contact information on El Futuro letterhead.
- The client identifies a support person (friend, family member etc) to transport them to the nearest crisis center.
- TBH Clinician calls the support person and confirms they are able to transport the client.
- EFWM staff prints statement from TBH Clinician and remains with client until transportation arrives.
- Client's support person transports client to the hospital/crisis center and delivers TBH Clinician's statement to the psychiatric care team.
- TBH Clinician calls the identified contact person and the crisis facility in 2 hours to confirm the client arrived safely.
- In the event the client did not arrive at the facility, TBH Clinicians calls client and/or support person.
- If the call is not answered or the procedure is not completed, TBH Clinician calls 911 (initiates Scenario #4).

Scenario #3: Involuntary Commitment

If client is at risk but cannot comply with the aforementioned options, TBH Clinician notifies onsite EFWM staff and initiates involuntary commitment (IVC) procedure.

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- With the assistance of the TBH Clinician, EFWM staff completes, signs, and submits the **Affidavit and Petition for Involuntary Commitment Form** to local magistrate's office (contact information below). If available, an additional EFWM staff member can assist with administrative tasks (i.e. faxing, calling magistrate's office).
- EFWM staff remains with client throughout the entire IVC procedure until police or mobile crisis unit arrives.
- EFWM staff notifies all previously scheduled clients for that day about any delays, rescheduling or cancellations necessary in order to equitably attend to the service needs of all EFWM clients.
- EFWM will prioritize TBH clinician seeing the next client whenever possible.

Scenario #4: Behavioral Health Emergency Out-of-Session

If TBH Clinician or EFWM are notified of a risk for the client or others outside of the session time, then the following procedure will take place.

- **Call 911 directly** (or emergency number local to the client) if the client shares information that indicates they are a danger to self or others, as defined above in this policy.
- Tips for managing crisis situations when client is out-of-session:
    - If possible, ALWAYS ask the client where they are calling from and work to obtain specific address and phone number.
    - If client is in imminent danger and you are able to alert a colleague through another medium of communication, ask your colleague to call the police of the jurisdiction where the patient is physically located while remaining on the line with your client to attempt to de-escalate the situation while help arrives.
    - Provide colleague or dispatcher key information about the emergency. Such as, but not limited to:
        - degree of urgency
        - details about how they intend to harm self (suicidal ideations with intent)
        - details about how they intend to harm others (homicidal ideations with intent)
        - access to weapons
    - If client location is unknown, because the client is either unable/unwilling to provide contact information, TBH clinician or EFWM staff member must still alert the police and provide client's home address on client file or any other tips for how they might locate patient.

As a reminder: Code Red examples include weather-related crises (natural disasters), presence of an active shooter, or a physical health emergency.

1. Assess for safety and secure the environment.

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2. Call emergency dispatch:

- If EFWM staff is calling: **Call 911 immediately**
- If TBH Clinician is calling: Call **910-592-1151** (Sampson Co. Emergency Communications Center)
- Inform emergency dispatch contact that the situation involves a behavioral health client. Can ask for a CIT (Crisis Intervention Team) officer. They receive extra training on handling behavioral health crisis situations.

3. Notify **EFWM Executive Director** and notify them of **code red** situation.

- Lariza Garzon **919-805-1607**, lariza@efwm.org

4. **Seek safety** for all clients and staff while waiting for police to arrive (such as, evacuating waiting room, or identifying a safe room and directing everyone to stay there until it's safe to exit).

Sampson County Local Crisis Center

Many counties have a specialized crisis center where a patient can walk in for a crisis assessment and referrals to additional services. Appointments are not needed.

The crisis center in your county is provided by:
Tri County-CommWell Health
306 Beamon St. Clinton, NC

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910-567-7107

Monday – Friday: 8:00am-5:00pm

Magistrate Contact Information

Sampson County

Magistrate Office: 112 Fontana St. Clinton, NC 28328

Magistrate Phone: 910-596-6619 (select option '4' for involuntary commitments from main menu)

Magistrate Fax: (910) 592-8641

Emergency Communications Center [Dispatch]: **(910-592-1151)**

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Technology Troubleshooting Policy

Policy Title: Technology Troubleshooting Policy for Tele-Behavioral Health Services (TBH)
Effective Date: July 01, 2019
Policy Scope: Defines policies and procedures in case of technological failure during TBH (teletherapy) session.

Reason for policy: To ensure the highest quality behavioral health care for clients through session interruptions related to technological failure.

Episcopal Farmworker Ministry (EFWM) and El Futuro will work collaboratively to ensure the well-being of TBH clients. In the event that a technological failure occurs while a TBH client is in session, EFWM staff and the El Futuro TBH clinician will initiate troubleshooting procedures by following the policies and procedures outlined below.

TBH Clinician is responsible for:

1. Informing TeleFuturo team, as necessary
2. Following-up with client as soon as connectivity is restored

EFWM is responsible for:

1. Posting Technology Troubleshooting Protocol (below) in area easily visible to EFWM staff assisting client with connection
2. Posting technology instructions for client (below) in client room
3. Remaining available throughout teletherapy sessions
4. Supporting client, in collaboration with El Futuro staff during technology failures
5. Facilitating restoration of internet/video connection between El Futuro and client
6. Following-up with client post-session

Procedure:

1. TBH Clinician and EFWM Staff connecting client, as applicable should identify a technological failure and assess the nature of the failure.
2. TBH Clinician and EFWM Staff will inform one another regarding the technological failure and communicate to make a troubleshooting plan.
3. If initial troubleshooting is successful, EFWM should ensure a stable, working connection before exiting client room.
4. If initial troubleshooting is unsuccessful **(troubleshooting is not to exceed 5 mins)**, TBH Clinician and EFWM will implement Technology Troubleshooting Protocol.
5. If session cannot be restored, EFWM will assist with connecting client by phone to TBH Clinician, and the session should be completed by phone if possible. If, for whatever reason, the session cannot continue by phone, EFWM will work to reschedule the appointment.

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Technology Troubleshooting Protocol (for use by EFWM and TBH Clinician):

1. If video is blurry/poor video/audio connection...
    a. Close all other programs on the computer
    b. Turn on and off the video/audio option in Zoom
    c. Test video/audio options (if any)
    d. End meeting and return to Zoom link
    e. Unplug and reconnect hardware (headphones, cameras, microphones)

2. If connection appears slow...
    a. Close all other programs on the computer
    b. Be aware of other internet users at your site. If they are streaming internet content inappropriately, ask them to stop streaming at least until session is complete
    c. Conduct an internet speed test*
    d. Restart computer/device
    e. Reset the modem/router/hotspot/wifi connection if possible
    f. Contact IT support (via EF Director of Operations)

*Google “test internet speed” and click “run test,” or visit site http://www.speedtest.net/and clicking “Go.”
*ATA ***minimum*** speed recommendation:

- 384 kilobits per second (mental encounters)
- 512 kilobits per second (skin details)
- ATA Optimal Speed Recommendation:
- 768 kilobits per second or higher (mental health encounters)*

Instrucciones Para el Cliente

Instructions for the Client

En caso de fallos tecnológicos:
En cualquier momento puede ir a la recepción y pedir ayuda

In case of technological failure:
At any moment, you can go to the reception and ask for help.

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Tele-Behavioral Health General Policy & Procedures

Policy Name: Tele-Behavioral Health at Episcopal Farmworker Ministry
Effective Date: July 01, 2019
Policy Scope: Defines guidelines for tele-behavioral health (TBH) services at Episcopal Farmworker Ministry (EFWM)
Reason for Policy: To provide excellent tele-behavioral health (teletherapy) services and meet the unique behavioral health needs of Latinxs in rural counties in North Carolina.

I. Definitions[1]

Tele-behavioral Health
Tele-behavioral health (teletherapy) is the use of two-way real-time interactive audio and video between places of lesser and greater clinical capability or expertise to provide and support behavioral health care when distance separates participants who are in different geographical locations. A beneficiary is referred by one provider to receive the services of another provider via tele-behavioral health (TBH).

Service Sites
The originating site (EFWM) is the facility in which the beneficiary is located.

The distant site (El Futuro) is the facility from which the provider furnishes the tele-behavioral health service.

Providers
The referring partner from EFWM determines the need for a consultation for a beneficiary and arranges the services of a consulting tele-behavioral health provider from the distant site for the purpose of the diagnosis and treatment.

The consulting provider, throughout this policy referred to as the **TBH clinician**, evaluates the beneficiary via tele-behavioral health upon the recommendation of the referring partner. Treatment is initiated as needed.

II. Procedures

A. Enrollment Procedure

1. **EFWM** sends client's complete referral paperwork via e-fax to **TBH clinician**.
    a. EFWM submits the following forms to TBH clinician:
        i. Referral Form
        ii. Consent for Treatment
        iii. Release of Information
        iv. Therapist Disclosure Form (if applicable)
2. **EFWM** notifies **TBH clinician** via email (with NO PHI) that paperwork has been faxed

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and adds client to partner google calendar for appointment request
    a. Information to include in the google calendar: name of client, client phone number, and EFWM staff that will be facilitating that appointment
3. **TBH clinician** locates faxed paperwork in IMS incoming faxes folder
4. **TBH clinician** reviews paperwork
    a. If paperwork is not complete or incorrect, TBH clinician calls EFWM and requests correction
5. **TBH clinician** confirms appointment time via email
6. **TBH clinician** creates chart in IMS
    a. **TBH clinician** enters biographic information for client
    b. **TBH clinician** enters EFWM as 'insurance' for new EFWM client
    c. **TBH clinician** links faxed registration paperwork to corresponding client chart in IMS
7. **TBH Clinician** schedules appointment in IMS calendar.
8. **EFWM** calls client for reminder of appointment ___ day(s) before appointment

B. Tele-behavioral Health Visit Procedure

1. **Client** arrives for appointment at EFWM
2. **EFWM** connects client to video call in telehealth room
3. **EFWM** notifies TBH clinician that client is ready through email
4. **TBH clinician** follows walk-in procedure
5. **TBH clinician** provides behavioral health service
6. **TBH clinician** documents encounter in IMS
7. **TBH clinician** walks client out in IMS by clicking "Check Out"
8. **TBH clinician** instructs client to find EFWM staff person while TBH Clinician remains in the session
9. **EFWM staff** joins the session to assist with scheduling follow-up if needed
10. **TBH clinician** schedules any follow up appointment in the google calendar and IMS

III. No Show Policy

- **No-Show:** the client either misses the appointment without notifying us, or notifies us less than 24 hours before their appointment, making it difficult for the provider to arrange another productive use of the appointment time.
    - Appointments cancelled on the same day will be considered "Missed Appointment":
    - If client calls to cancel same day, appointment will be marked as "Missed".EFWM will notify client of No-Show Policy and will reschedule them.
    - *If client misses more than 2 appointments, TBH clinician has the discretion of discharging or following up with client*.

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- **Cancellation**: the client notifies us at least 24 hours in advance that they will miss their appointment.

III. Data Collection

1. **El Futuro** collects demographic information from referral forms and assessments.
    - Data that will be tracked includes: number of visits, agencies referred to, number of victims of crimes served, and counties served
2. **El Futuro** de-identifies any data for analysis.

IV. Data Reporting

1. *Forthcoming*

1 Definitions Source: *NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 1H, Telemedicine and Telepsychiatry, p. 1, Dec. 1, 2018. (Accessed January 2019).*

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Interpersonal Violence (IPV) Crisis Policy

Policy Title: Interpersonal Violence (IPV) Crisis Policy for Tele-Behavioral Health Services
Effective Date: July 01, 2019
Policy Scope: Defines IPV Crisis policies and procedures for all tele-behavioral health (TBH) services provided at Episcopal Farmworker Ministry (EFWM) (in- session only).
Reason for policy: To ensure client safety for all EFWM TBH clients experiencing an IPV crisis. El Futuro and EFWM staff will work collaboratively to ensure the well-being of TBH clients. In the event that a EFWM TBH client presents with an Interpersonal Violence (IPV) crisis, El Futuro and EFWM staff will initiate crisis management services by following the policies and procedures outlined below.

EFWM staff may not touch or restrain the client in an effort to keep client on the premises. In the event that a client chooses to leave the premises, EFWM staff should provide any information available to assist law enforcement with locating the client.

TBH clinician is responsible for:

1. conducting a risk assessment of her/his client and immediately reporting an emergency situation to EFWM staff working directly with client
2. assisting client and family members with seeking safety
3. develop a written safety plan with emergency resources listed
4. supporting EFWM staff with initiating **code red** if there is imminent danger on-site at EFWM.

EFWM staff is responsible for:

1. coordinating client care to facilitate safety planning, in collaboration with TBH clinician
2. initiating/responding to **code red**
3. following-up with client post-crisis
4. following-up with TBH clinician to ensure continuity of care

Procedure:

1. TBH clinician will conduct a risk assessment and will further assess safety concerns, including but not limited to: nature of the threat, IPV perpetrator's history of violence, perpetrator current location, perpetrator access to weapons, intensity, frequency and duration of past violent episodes, history of client hospitalizations due to past violence (if any).
    a. If the TBH clinician determines that there is **imminent danger**, TBH clinician first notifies 911 (via the client's local emergency number) and initiates **code red** by immediately notifying EFWM staff of the situation. The primary goal is to

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ensure immediate safety of both clients and staff.

b. When EFWM determines that it is safe to proceed, EFWM staff may proceed with step two of this procedure.

2. TBH clinician will collaborate with client and EFWM staff (if available) to create a written safety plan consistent with the level of risk.
    a. If applicable, discuss the legal obligation to report child abuse--***this includes knowledge that a child has witnessed domestic violence.***
    b. TBH clinician makes copy and scans written safety plan in client record.
    c. EFWM staff will support client in connecting with the following local resources:
        i. Law Enforcement/Police Department
        ii. Department of Social Services/Child Protective Services
        iii. Housing/Emergency Shelter
    d. EFWM staff will follow-up with client as outlined in written safety plan to assist client with any concerns she/he may have after leaving the clinic.

Interpersonal Violence Resource Sheet

Sampson County

UCare Domestic Violence & Sexual Assault Program. Bilingual Spanish/English 24- Hour Crisis Hotline 910-596-0931. Domestic Violence shelter and assistance. Business number 910-596-0931.

Johnston County

Harbor Bilingual Spanish/English 24/7 hotline 919-631-5478. Sexual Assault and Rape Crisis Program, Domestic Violence/ Crisis Intervention, 24-Hour Emergency Shelter, Families in Transition Program, and Court Advocacy. Business Hours Monday-Friday 8:00-5:00pm. Business number: 919-938-3566. https://www.thehotline.org/

Harnett County

SAFE of Harnett County 24/7 hotline 910-893-7233. Crisis Counseling & Support, Emergency Hospital Response, Courtroom Companionship, Restraining Order Assistance, Emergency Shelter, and Support Groups. Services for persons affected by: domestic violence, sexual assault, stalking, elder abuse, human trafficking, child abuse, dating violence, and unhealthy relationships. Address: 1210 South Main St. Lillington, NC 27546. https://safeofhc.org/

National & State Resources

National Domestic Violence Hotline available 24/7 at 1-800-799-7233
The National Suicide Prevention Lifeline available at 800-273-TALK (8255)
Trans Lifeline available 10am-4am EST at 877-565-8860

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