



National American Indian & Alaska Native

MHTTC

Mental Health Technology Transfer Center Network
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Mental Health

IN OUR NATIVE AMERICAN COMMUNITIES • VOL 3 ISSUE 1 SUMMER 2021

**Has COVID-19
Changed
Attitudes Toward
Telehealth for
Good?**

National American Indian & Alaska Native Mental Health Technology Transfer Center
145 North Riverside Drive, Iowa City, Iowa 52242

mhttcnetwork.org/native

DIRECTOR'S CORNER



Welcome to the summer issue of Mental Health in our Native American Communities. We have been through a very tough year; however, Native communities have shown an impressive resiliency in the handling of the pandemic and have shown an incredibly strong and positive response to the vaccination initiative. We can really learn a lot from Native Communities on how to organize the vaccination implementation process and how to keep their communities healthy and safe.

One of the ways we kept in touch with each other in 2020 was using social media like FaceTime and Zoom platforms. The use of telehealth for behavioral health services increased dramatically during the COVID-19 pandemic as well. Unfortunately, some Native communities in rural locations did not have easy access to telehealth platforms due to a lack of computer equipment, limited access to broadband connections, and being uncomfortable talking about personal issues with someone over a telehealth interface. Face-to-face interactions are always preferred in Native communities; however, because of the situation we were all in last year and the need for using different methods for behavioral health services, we hope that the telehealth hesitancy has been reduced during and after the pandemic. The National American Indian & Alaska Native MHTTC has offered several training and technical assistance opportunities using different HIPAA-approved platforms to promote the use of telehealth during the COVID-19 pandemic, with positive results. In the height of the pandemic, HIPAA requirements were also modified to make it easier to use telehealth methodology.

In this issue, we are hoping to better understand how the COVID-19 pandemic may have led to changes in attitudes towards telebehavioral health in Native communities across the country. We start with Ken Winters' and Kate Winters' article which includes an overview of promising telebehavioral health practices in Native communities,

as well as tools for implementing these practices. My colleague and dear friend, Nancy Roget, Executive Director of the Center for Application of Substance Abuse Technologies at the University of Nevada, Reno, together with Joyce Hatje, are addressing the changing attitudes and successful programming taking place in telehealth. Their group has specialized in the use of telehealth and has also provided several training opportunities for Native providers on how to plan a telebehavioral health implementation process.

We have started to dedicate a specific section of our newsletter to the MHTTC-12 Initiative, and this time the focus is on supporting telehealth in Native communities and school-based health centers. Teresa Brewington manages this program, and together with Julia Bollwitt and Kate Pruess, they have written about their initiatives in Native schools. Schools providing education for Native students in rural communities are often isolated and need support to provide culturally informed education. Use of an internet platform can be very useful for all personnel working in Native schools and can facilitate inter-tribal school-based collaborations.

Our center has also embraced offering more services on virtual platforms in the last year, and we are happy to share with you some information on our activities since January 2020 and our response to the pandemic. We are thrilled to have connected with so many of you over this time, as our need to connect has been crucial. We look forward to being able to offer programs in person again soon, but we are also grateful for the opportunities we have had in this last year to continue to connect with providers working to keep their communities safe.

Anne Helene Skinstad, PsyD, PhD

Telebehavioral Health: Changing Access to Mental Health Services in Rural Communities

KEN C. WINTERS, PhD

Contributions from
MARY K. WINTERS, MEd



Introduction

There are significant disparities in mental health and mental health care funding between Native American and Alaska Native populations and other ethnic/racial groups in the US. One contributing factor is that more than half of all Native people in the United States live in rural areas. Rural and remote areas suffer the most from these disparities. Hiring and retaining behavioral health professionals in rural or remote areas is a significant challenge, particularly concerning specialty services (e.g., such as child psychology, and addiction psychiatry).^{1,2}

Indian Health Services (IHS) and tribal health care facilities are overwhelmingly located in these rural and often very isolated settings, which is logical given the large rural Native population. Yet, too often there is limited access to mental health services. In this context, there is elevated significance on telehealth services as an essential component of health care delivery. The telehealth approach eliminates barriers of remoteness and allows a service provider to live where they prefer and still provide high-quality care. The telehealth model has the potential to close gaps in health condition recognition, diagnosis, and treatment, and to promote collaboration between health care providers, all of which can improve health outcomes in underserved rural populations.³ As noted by Mary L. Smith, IHS principal deputy director in 2016, "It is challenging to provide specialty health care in rural areas, and this is especially true in Indian Country. IHS experience shows that telemedicine is an effective way to increase access to quality health care services in remote, hard to reach areas."⁴

Telemedicine is not new to the Native health systems. Whereas the specific needs and solutions vary by location depending on population characteristics and the availability of specialty services, there are already many health specialties serving Native communities that are utilizing telehealth methods.⁵

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What is Telehealth?

Telemedicine is already widely used within many Native American and Alaska Native health systems. But what is telehealth? Experts define it as the use of electronic information and various telecommunications technologies to support and promote long-distance clinical health care and education of patients, service providers, and health administrators. Technologies include Zoom, videoconferencing, Skype, streaming media, wireless communications, and security features to ensure patient privacy (e.g., encrypted internet connection).

Telehealth can be applied in many different ways, including:

1. Live synchronous videoconferencing, which involves a two-way audiovisual link between the patient and the service provider
2. Asynchronous videoconferencing, where a patient's health information is transmitted to a health practitioner, usually a specialist
3. Remote patient monitoring, where a patient's health information is sent elsewhere for review by a provider at a different time
4. Mobile health, which uses mobile devices to provide health care and public health information (e.g., targeted texts about public health information)⁶

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What is Telebehavioral Health?

Telebehavioral health is the use of telehealth for mental health treatment. It typically takes the form of synchronous telehealth, often with videoconferencing technology. The core behavioral health services can be accommodated by this technology - intakes, assessment, therapy (individual, group, family), recovery maintenance, and medication management.

Many benefits of telebehavioral health have been cited by mental health organizations (e.g., American Psychiatric Association, American Psychological Association, and National Alliance on Mental Illness), including:

1. Improved access to mental health specialty care regardless of a patient or provider's location
2. Simplified integration of behavioral health care and primary care, continuity of care, and follow-up
3. Reduced barriers to care such as time off from work, childcare services, or transportation
4. Increased privacy, which may help reduce fears of stigma
5. Reduced delays in care, which may result in fewer emergency room visits

The role of telebehavioral health for family therapy is gaining momentum. Video chat, phone-based counseling, and the use of text messaging are examples of emerging strategies to increase access to family-based services. Telebehavioral health approaches also allow flexibility in discussing issues with individual family members and may help overcome many barriers that tend to be more prominent with traditional family therapy (e.g., coordinating schedules, insufficient time).⁷

The effects of telepsychiatry were studied in Alaska in 2020. The researcher assigned 103 cases to telepsychiatry services and compared outcomes with a matched group of 103 cases who received traditional services. Participants in the telepsychiatry group remained engaged in treatment longer, had fewer discharges against medical advice, and were more likely to complete treatment.⁸

Native American and Alaska Native Telebehavioral Programs

Telemedicine has been widely used within Native American and Alaska Native health systems for decades.⁵ Many medical health specialties serving Native communities do so using various telehealth methods, and some have created “toolkits” to support providers. Some of these efforts are described in the following pages.

Telebehavioral Health Center of Excellence (TBHCE)

In 2008, IHS established the Telebehavioral Health Center of Excellence to provide, promote, and support the delivery of high-quality, culturally sensitive telebehavioral health services to Native people. The center provides direct, ongoing care via videoconferencing to patients of all ages at 22 health care facilities across the country. Specific mental health-related clinical services include adult, child, and adolescent psychiatry, addiction psychiatry, counseling for all age groups, family and marital counseling, and therapy for trauma or post-traumatic stress disorder.⁶

The TBHCE provides a manual toolkit that details the following 7 steps to follow in setting up telebehavioral health services:

1. Identify your site’s needs
2. Select a space for telehealth contacts with clients
3. Select a telebehavioral coordinator
4. Assess your technology capacity
5. Setting up your telehealth providers
6. Pharmacy considerations
7. Adjust procedures when responding to emergencies

*[The full toolkit is available at this link.](#)*¹¹

TBHCE also supports a range of educational events. Their major goal for their tele-education program is to equip healthcare providers with the culturally sensitive education and training they need to provide excellent patient care. *[A listing of recent and upcoming workshops can be found at this link.](#)*

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Medical Specialties and Telehealth

One health-related specialty, cardiology, is an exemplary service model of telehealth benefiting Native patients. Specialists who are hundreds or thousands of miles away are able to provide cardiology consultations and services, including interpretation of echocardiograms, electrocardiograms, and other standard cardiac tests.¹

Long-term cardiac care management is also feasible, as patients’ vital signs, weight, and pulse oximetry are securely monitored via smartphones and readily available for real-time telephone consultation. Outcomes from one such program in northern Arizona, Care Beyond Walls and Wires, has reported impressive outcomes: high levels of patient satisfaction, and fewer hospitalizations and emergency department visits.⁹

Another example is the Joslin Vision Network (JVN), a teleophthalmology modality developed by the Joslin Diabetes Center. JVN provides telemedicine for diagnosing eye diseases. IHS began implementing JVN in 2000 as a pilot program at two sites in Arizona, and it has been expanded to rural and urban IHS facilities in more than 25 states.¹⁰

Telehealth in Alaska — The Alaska Federal Health Care Access Network

The Alaska Tribal Health System (ATHS) has utilized various telehealth programs to deliver medical care to some of the most remote places in the United States for decades. The largest of these programs, initiated in 2001, is the Alaska Federal Health Care Access Network (AFHCAN). This network has been installed in more than 250 sites throughout Alaska. Most of the clinic sites are staffed by community health aides or practitioners in small and low-census population villages. To overcome the problem of unavailable or unreliable broadband connectivity, AFHCAN advanced many creative telehealth strategies that allowed data to be stored and forwarded later to specialty clinics and professionals located at a distant site.¹²

Avera eCARE Behavioral Health

Another example of a provider of telebehavioral health is Avera eCARE Behavioral Health. Avera currently provides telemedicine video conferencing services to nearly 200 IHS clinics in over a dozen states. Services include assessments, psychiatric care, and behavioral counseling services.¹³

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Summary

The learning curve for telebehavioral health continues. Providers are seeing the benefits of providing guidelines to help clients prepare themselves and their space for telehealth appointments, such as finding a private and safe place to conduct their calls and testing their equipment. Tele-groups have unique challenges but the accompanying technology of Zoom and similar platforms provide chat, audio, and break-out features that can enhance the group counseling experience. Issues of responding to concerns about client safety and dealing with emergencies in this new context can require prior planning (e.g., use of apps for monitoring a client).

Experts are unanimous that telehealth offers great promise in reducing health disparities for Native clients. Between the initiatives we have seen in use thus far, along with advances in telecommunication services and improvements in bandwidth, the research indicates that telehealth's value will continue to escalate. IHS' Strategic Plan for the fiscal year 2019-2013 includes leveraging "technologies such as telemedicine and asynchronous electronic consultation systems to include a more diverse array of specialties and to expand, standardize, and increase access to health care through telemedicine."¹⁴

Also, software development, artificial intelligence, and other technological advances will enhance clinical efficiency, patient safety, regulatory compliance, and coordination with electronic health records. The use of telebehavioral services increased greatly during the COVID-19 lockdown, and providers and clients have likely become more comfortable using these programs. While reimbursement rules for telebehavioral health services still present obstacles for patients and providers, the industry continues to move forward by providing quality care to our Native communities.

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Changing Attitudes On Telehealth

Nancy Roget, MS, MFT, LADC
Joyce A. Hartje, PhD



Almost a year ago, Seema Varma, Administrator for the Centers for Medicare and Medicaid Services, stated that telehealth "will never replace the gold standard of in-person care." However, she went on to say that the swift uptake in the use of videoconferencing since the start of the public health emergency (PHE) may be transformative for the healthcare system. For example, nearly half of Medicare primary care visits were delivered virtually in April 2020, compared to just 0.1% prior to the PHE in February 2020.¹ This rapid virtualization of healthcare services may help the widespread adoption of telehealth for behavioral health services since the research base for assessing and treating mental health conditions demonstrating its effectiveness is over 60 years old. While numerous terms for delivering healthcare services exist virtually and are used interchangeably (e.g., telemedicine, telehealth, telemental health, telepsychology), a leading researcher and physician, Dr. Donald Hilty, recommended using the term telebehavioral health when referring to the delivery of behavioral health services as it includes substance use disorders (SUDs).

Numerous meta-analyses have shown the benefits associated with the use of telebehavioral health services. Specifically, telebehavioral health increased patient access, medication adherence, communication, and outcomes, while showing decreases in missed appointments, wait times, readmissions, and patient travel time.² Basically, telebehavioral health is considered equivalent to in-person care according to several seminal articles that reviewed the quality and quantity of research conducted.^{3,4} While the evidence for providing mental health services virtually is much more robust than for SUD treatment services, the number and quality of studies examining the use of telebehavioral health when treating individuals with opioid use disorders and alcohol use disorders has recently expanded and demonstrates positive outcomes. When making the case for telebehavioral health, this statement provides the best summary: the use of synchronous (live) audio and video to deliver behavioral health services is considered "effective, well received by patients, and for many practitioners a standard way to deliver services."⁵

Patients report being helped by telebehavioral health services and being satisfied with service delivery, with numerous studies showing that it is not contraindicated for patients with mental health concerns or SUDs. According to Chakrabarti, all patient populations (children, adolescents, seniors, minority populations, and justice-involved individuals) report satisfaction with telebehavioral health.⁶ For some patients, services delivered via telebehavioral health provide feelings of safety and control (those with trauma or anxiety-related diagnoses), while for others the sense of "emotional or virtual distance" experienced with telebehavioral health can at times be off-putting.⁷

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A recent study found that patients participating in an online group reported feeling less connected than group members participating in in-person sessions. However, additional data confirmed that most of these online group members believed: 1) the convenience of attending group online offset any barriers or difficulties experienced; 2) they probably wouldn't have been able to attend group sessions if they did not attend the online sessions; 3) while an online group was not their first choice, it was preferred over no treatment.⁸ According to the American Telemedicine Association (ATA) and American Psychiatric Association (APA) Best Practices Guidelines, before providing telebehavioral health services clinicians should consider a patient's: cognitive capacity; history of cooperativeness with treatment professionals; history of violence or self-injurious behavior along with access to emergency medical services; support system and its efficacy; and current medical status.⁹ Finally, Shore considered it an essential practice that clinicians assess patients' comfort level with telebehavioral health on a regular basis regarding clinical issues and changes in condition and living arrangements.⁷

Some clinicians appear to show more reluctance when it comes to using telebehavioral health, citing concerns about technology negatively impacting the development of therapeutic rapport.^{2,10,11} A recent study with rural providers found similar results and also identified other concerns, including using new software programs; confidentiality issues; and questions about telebehavioral health efficacy.¹² Telebehavioral health does change how a clinician provides services, with most of the burden being on the clinician rather than the patient. For instance, the clinician will need to get training on clinical issues/interventions, learn how to use new technologies, and how to integrate the new technologies and procedures into their existing workflow, whereas the patient will only need to learn how to use the technology.¹¹

Numerous research findings, guidelines and tips, and training/technical assistance (TA) activities are now available to help clinicians adopt telebehavioral health services and increase proficiency. First, Batastini and colleagues found that rapport could be built while providing mental health services in justice settings. Specifically, clinicians were able to virtually: "project openness, interest, and inquisitiveness by expressing exaggerated postures and thoughtful inflection when speaking; introduce humor; offer therapeutic challenges with a Motivational Interviewing style."³ Next, the ATA and APA created new guidelines for delivering telebehavioral services focused on legal and regulatory issues, standard operating procedures, and technical/clinical considerations.⁹ In addition, the Center for Excellence on Privacy and Security developed tip sheets for clinicians that highlight HIPAA privacy and security issues and Federal Confidentiality 42 CFR Part 2 regarding virtual service delivery. Finally, APA published guidelines for running group counseling sessions online with helpful suggestions.



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*"Only in the world
of man's delusions is
he in control."*

- Sean A. Bear

Most importantly, a recent study conducted by McClellan and colleagues found that "clinicians with more telehealth knowledge and experience tend to also have more favorable opinions of telehealth and vice versa."¹² The implications of this study are significant and indicate that increasing knowledge about the effectiveness of telebehavioral health and promoting skill proficiency on using telebehavioral health to deliver services through training/TA can increase clinicians' positive attitudes toward telebehavioral health, leading to more widespread adoption. Most clinicians will need specific training/TA on telebehavioral health as most academic programs do not offer courses or modules on virtual service delivery although all professional associations (e.g., ACA, NASW, AAMFT, APA) have technology practice standards for their members. As such, organizations should keep in mind the need for training/TA when planning for the implementation of telebehavioral health.

Numerous video conferencing platforms are available (e.g., Zoom, Microsoft Teams, GoTo Meeting, Skype for Business, Cisco WebEx, ezTalks Meeting, Starleaf). Other video conferencing platforms used by behavioral health clinicians include Doxy.me, Clocktree, and VSee. Zoom has become the premier video conferencing platform, largely due to its video-first engineering (i.e., the service is built from the ground up for video, engineered to be cloud-native, and optimized for video). Experts agree that the video conferencing platform should have end to end

encryption, meaning the communication is protected while it is "transferred from one end system or device to another."¹³ In addition, providers should ensure the videoconferencing vendor signs a business associate agreement (BAA) with their organization. This caveat can be a helpful reminder: equipment is not HIPAA compliant, but rather it is up to the provider to conduct assessments and determine HIPAA compliance for services delivered via telebehavioral health, including documenting actions taken to protect patient privacy and security.

Recently, Becker's 2021 Hospital Review identified sixteen key takeaways from six telehealth reports. These reports focused on healthcare services rather than behavioral health services. However, data from these reports confirmed that: almost two-thirds of healthcare providers are shifting services to include virtual service delivery; 42% of patients would prefer a hybrid model of service delivery (in-person and telehealth); small physician offices reported more negative perceptions about shifting to virtual care service delivery; and 85% of patients in the survey reported that telehealth made it easier to access services. These report findings have important implications for behavioral health practitioners regarding patient satisfaction and expectations for virtual or hybrid service delivery and how healthcare providers are expanding and shifting towards virtual care.¹⁴

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A survey conducted with behavioral health providers asked clinicians about their use of telehealth to deliver clinical services. When comparing the use of video to telephonic service delivery, clinicians perceived video services as more appealing but telephonic services more accessible, suggesting that both channels play a role in the delivery of behavioral health services.¹⁵ These survey results highlight the use of a telephone for clinical service delivery point to policy and reimbursement issues. During the PHE, all fifty states and Washington DC issued guidance to allow for a form of audio-only telehealth services. Currently, many policy-makers and legislators are advocating that audio-only or telephonic telehealth services remain reimbursable post-PHE. The Center for Connected Health Policy identified legislative trends at the federal and state levels with the re-introduction of bills to make some of the temporary changes permanent (federal), payment parity for private payers (state), use of a telephone in Medicaid (just for behavioral health-state), licensing for out of state providers (state), and requirements for regulatory boards to create regulations around telehealth (state).

In June 2021, the Substance Abuse Mental Health Services Administration (SAMHSA) released another resource guide as part of its evidence-based resource guide series. The focus of this guide is the use of telehealth (videoconferencing) to deliver treatment and recovery support services for individuals with serious mental illnesses (SMIs) and SUDs. Telehealth is considered a priority topic for SAMHSA as it helps to increase access to treatment and recovery support services for individuals with SMIs and SUDs. [The guide can be downloaded at this link.](#)

Finally, Shore recommended that lessons learned during the quick virtualization of behavioral health services due to the PHE could help create a hybrid model of service delivery that benefits patients. In this hybrid model, treatment services would be inclusive, providing a combination of in-person sessions, online sessions, telephone check-ins or consultations, and the use of apps and/or "wearables" that directly report data to the clinician.⁷ Maintenance of current virtual service delivery and/or implementation of telebehavioral health services is crucial to increasing access to treatment/recovery support services and enhancing service delivery. As such, clinicians will need assistance in honing their telebehavioral health skills, which is available through the National American Indian and Alaska Native Mental Health Technology Transfer Center (MHTTC). The future is here, with telebehavioral health serving as a vector to greater patient satisfaction and utilization of behavioral health services.

References can be found on page 13.

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MHTTC Activities and Process Evaluation

from Jan. 2020- June 15th, 2021

Noah Segal, MPH

As the rest of the country transitioned to virtual programming as a result of the COVID-19 pandemic, so was true for the National American Indian & Alaska Native MHTTC. In 2019, a majority of the activities conducted by the MHTTC were done in-person at different sites around the country. During that year, the MHTTC conducted 24 events with a total of 963 participants. So, in March of 2020, when it was clear that COVID-19 would be a serious issue, the NCBH team came together and planned to shift the format of events to a virtual setting. In addition to challenges from shifting formats, it was clear that there was also an increase in the need for the training and TA provided by the center. Public health professionals warned that Native communities would likely be hit the hardest by the virus. According to data pulled from the CDC, confirmed cases of COVID-19 in Native American and Alaska Native individuals increased by over 10-times from March to April of 2020. Over the same period of time, the MHTTC tripled the number of events it was offering and had nearly a 9-times increase in participants (86 to 771). The graph at the bottom of the page depicts the number of participants reached and the number of events held by the MHTTC, along with the monthly count of positive COVID-19 tests for Native American and Alaska Native individuals. The height of this activity was during the summer of 2020, when more participants joined our events in each of the months of June and July than the total number from 2019.

Though the number of activities and the reach increased significantly as a result of COVID-19, the quality of events never faltered. Over 98% of the individuals (n=2,145) who completed a post-event survey from Jan. 2020 to June 15th, 2021, indicated they would recommend the MHTTC event they just attended to a friend or colleague. Additionally, over 94% of participants agreed or strongly agreed that they expected the event to benefit them professionally. Only less than 1% disagreed or strongly disagreed with the statement. Similarly, 88% of individuals agreed or strongly agreed that they would use the information gained to change their current practice.

These process and outcome data show that the MHTTC has responded to the challenges caused by the pandemic with a substantial increase in quality, culturally informed, and professionally valuable programming to the Native providers that rely on our services. We are committed to meeting the needs of mental and behavioral health providers serving Native communities for the rest of the pandemic and after.

160

of Events

9180

of Participants

Figure 1: Total Events and Participants from January, 2020 - June 15, 2021

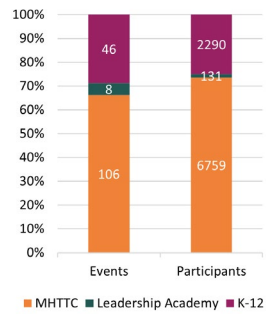


Figure 2: MHTTC Post Event Responses

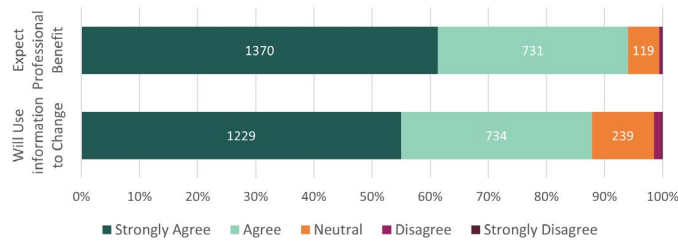


Figure 3: Would Recommend Event

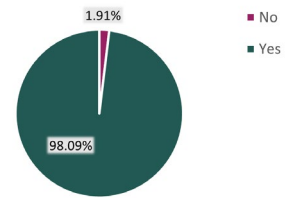
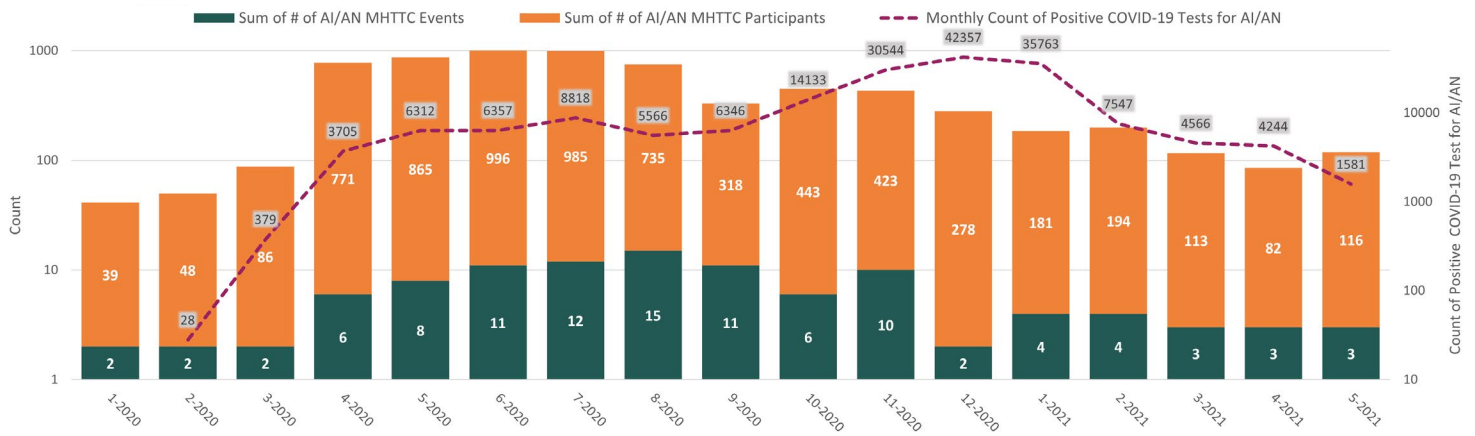


Figure 4: Event and Participant Numbers Compared with Positive COVID-19 Tests for Native Americans and Alaska Natives



Source: CDC COVID-19 Case Surveillance Public Use Data Set June 21, 2021, <https://data.cdc.gov/Case-Surveillance/COVID-19-Case-Surveillance-Public-Use-Data/vbim-akaf>

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Supporting Telehealth in Native Communities and School-based Health Centers



**Teresa Brewington, MBA MEd, Coharie Enrolled Lumbee Descendant;
Julia Bollwitt, MA; Kate Pruess, BA**

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When discussing the importance of access to healthcare, one of our most vulnerable demographics is often overlooked: school-age children. Telehealth is a must-have for schools when you consider the access it provides to students who might otherwise experience multiple barriers to health care. To help address this need, thousands of schools across our nation are implementing school-based health centers (SBHCs).

The Native Center for Behavioral Health has carefully considered the evidence behind telehealth, and we have partnered with Solutions of Substance to provide access and training in the use of a telehealth platform for practitioners serving Native American and Alaska Native clients. We have seen successful outcomes for clients and providers alike, and are committed to bringing this service to those who deliver mental health services in schools and SBHCs.

To learn more about telehealth in schools, we talked with Beau Boryca, LMHP/LADC, Director of Behavioral Health at the Nebraska Urban Indian Health Coalition. Mr. Boryca has been with the coalition for over nine years and is a licensed mental health practitioner and licensed drug and alcohol counselor. He also serves on the Nebraska Joint State Advisory Committee for Mental Health and Substance Abuse and fills the position of President of the Great Plains Behavioral Health Directors Association. Since last year, he has participated in the MHTTC K-12 telehealth initiative and continues to use telehealth to deliver services to clients in Nebraska.

In our interview, Mr. Boryca emphasized that telehealth was a crucial part of healthcare during a time of social distancing and mandatory COVID-19 lockdowns. As Medicare and Medicaid services permitted patients to be seen through videoconferencing in their homes, he and his colleagues adapted telehealth to the emergency. Their priority was to ease the burden on healthcare facilities in outbreak areas, especially with Native communities' ongoing struggle with healthcare access. Disparities in access stem from relative isolation from cell phone services, access roads, and the internet, along with exacerbating issues like lack of clean running water. With social distancing mandates in place, some miss out on their only sources of healthcare, food, water, and community. Mr. Boryca also reports it is crucial to understand the unique framework of Native populations. Seeing the underserved community made him realize how major misconceptions of Native communities affected care, and that recognizing cultural factors was vital to their telehealth operation. The first step was addressing skepticism towards telehealth. He reflected on a quote from Professor James R. Alleman: "People meet and fall in love online and have done so through ordinary love letters for as long as there has been written language. My conclusion is that a mental health care professional working with a client to effect change is doing psychotherapy--even if it is over the Internet?"¹

Mr. Boryca found his introductory process especially helpful for patients, using picture diagrams and step-by-step instructions for accessing services. Using a simple, straightforward platform reduced stress levels for those who had little experience using telehealth. During implementation, they also faced staff challenges like resistance to change, technical knowledge, and the novelty of telehealth. Ultimately, Mr. Boryca found his program resulted in cost reductions, expanded access for chronic diseases, fewer gaps in treatment planning and implementation, and care management improvements. He also noted that the overtime needed to set up and secure staff buy-in was well worth the results.

Currently, COVID-19 vaccines continue to reopen many parts of our country. As we transition services to hybrid and in-person models, many are questioning telehealth yet again. Even with fewer lockdown mandates, many patients still lack the time or transportation necessary for attending in-person appointments. For Native communities, telehealth will continue to be an important resource for patients who cannot present at the clinic.

Thus far, our MHTTC K-12 initiative has connected several mental health professionals to this training cohort. However, given its continued growth and the emerging need for telehealth, we would like to expand this opportunity to other Native American and Alaska Native community providers and school-based health centers to engage in this training. For more information about this initiative, you can contact Teresa Brewington, MHTTC K-12 Program Manager at teresa-brewington@uiowa.edu.

Please check out our previously recorded webinars about Telehealth:

May 22, 2020, Native Youth Telehealth Initiative Webinar: featuring Dr. George Bason, MHRD, EdD CTE, and Natasha Peterson, BS. [View the recording.](#)

September 10, 2020, Special Weekly Series for Tribal Schools as they Reopen Amidst COVID-19: Native Youth Telehealth. [View the recording.](#)

February 11, 2021, Overcoming the Storm: Special Bi-Monthly Training for AI/AN School Comm. in the COVID-19 Pandemic Telehealth: The Benefits and Challenges in Tribal and Rural Communities. [View the recording.](#)

Resource:

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"The true mettle of a man is not forged in the fires of life, but tempered throughout his trials within life."

- Sean A. Bear

ACTIVITIES & EVENTS

For all of our upcoming events, publications, and announcements, [please visit our website.](#)

Date	Event
2nd Wednesday of the month	Trauma-Informed Therapy webinar series - This six-part series is presented by Avis Garcia, PhD, LAT, LPC, NCC, Northern Arapaho. See the links below to view previous sessions, and register for upcoming sessions. Part 1 - View the recording Part 2 - View the recording Part 3 - View the recording Part 4 - View the recording Part 5 - View the recording Part 6: July 14 - Register
Twice monthly	Overcoming the Storm: Special Bi-Monthly Training for Native American School Communities in the COVID-19 Pandemic - Our MHTTC K-12 program offers support, resiliency tools, and connections that are relevant and supportive for members of the whole K-12 education community. Register. View recordings of previous sessions.
6/21-24 6/28-29 8/9-11 8/12-14 10/13-16 10/24-27	Recent and upcoming conferences our staff will be presenting workshops or posters: The College on Problems of Drug Dependence (CPDD) Annual Scientific Virtual Meeting Society of Indian Psychologists Convention Southwest Schools Conference American Psychological Association (APA) Convention National Indian Education Association Annual Convention American Public Health Association (APHA) Annual Meeting
July 22	Engaging American Indian/Alaska Native (AI/AN) Relatives In Psychotherapy This webinar is offered in collaboration with South Southwest MHTTC, and features John Jewett, MA, Oglala Lakota Nation, a member of the National AI & AN MHTTC Advisory Council, and graduate of our Leadership Academy. Register.



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