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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Ramona Singletary-Robertson

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2023

Abstract

Behavioral Health Leadership Strategies to Increase Telehealth Engagement

by

Ramona Singletary-Robertson

MS, National-Louis University, 2002

BS, Aurora University, 1990

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Psychology in Behavioral Health Leadership

Walden University

June 2023

Abstract

One of the challenges brought on by the recent COVID-19 pandemic has been the promotion and use of telehealth services. While recent data from Medicare has depicted an increase in this new service delivery modality (over 4,000%), there has been a stark disparity in the use of telehealth services in lower socioeconomic demographics, such as rural and underrepresented communities, and among Medicare recipients. Equitable, consistent, and optimal service expansion of the telehealth modality requires therapists and leaders of behavioral health organizations to develop and deploy creative tactics to remedy this disparity. In this case study, leaders of Miss Emma's Behavioral Health Center (MEBHC; pseudonym) explored the challenges mentioned above in availing this innovative pathway to behavioral health wellness in low-use and socioeconomic communities in their locus of control. In addition to validating the overall efficacy of behavioral telehealth solutions, this study uncovered the barriers to increased engagement of members in low socioeconomic and underserved demographics in the mid-Atlantic region of the east coast. A critical outcome of the study was the development of MEBHC strategies to create and increase access to existing and new clients, thus potentially reducing the disparities and inequities in providing behavioral health services to clients with mental health challenges. These validated strategies and tactics can then be replicated and availed to clients and potential clients in other demographics and markets in various U.S. regions leading to positive social change. Core values extracted from the Baldrige performance excellence framework were used to assess and evaluate solutions gleaned from MEBHC leadership, individually, and as a team.

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Dedication

This doctoral study is dedicated to my husband, Larry L. Robertson, Jr., who has always been my biggest supporter, advocate, and closest friend. To my mother, Vivian Singletary, I'm everything I am because you love me. Lastly, to my daughters, Jesseca and Jazzmin Robertson, you have taught me unconditional love.

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I am so very grateful for my group of sister/friends who have been there to support me through the many challenges in this journey. My siblings always believed that there was no academic challenge too big for me to conquer. A special thanks to my Committee Chair Dr. Derek Rohde for challenging, supporting, and encouraging me through this journey.

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Section 1a: The Behavioral Health Organization

Introduction

The COVID-19 pandemic has caused healthcare organizations to make dramatic shifts in their service delivery models (Merz, 2021). One aspect of that service delivery shift has been the increased use of telehealth and technology as a means of promoting optimal physical and mental health. The Center for Medicare and Medicaid Services, in its response to the COVID-19 pandemic, made comprehensive changes to its regulations regarding telehealth (Grieco-Page et al., 2021). These changes have yielded three important developments in behavioral health care: increasing conversations to decrease the negative connotations associated with mental health, increasing awareness around the significance and impact that telehealth has on people and organizations, and the development of telehealth as a major factor in health care (Merz, 2021).

The focal organization, known throughout this study by the pseudonym Miss Emma's Behavioral Health Center (MEBHC), is a small behavioral healthcare organization that was established in January 2008 in the Middle Atlantic region of the eastern United States. This minority-owned behavioral healthcare organization is a mental health and training group that services individuals, couples, and groups for behavioral health treatment. The organization offers a plethora of outpatient mental health services as well as professional training for clinicians seeking further education and professional growth. The organization is led by a lead clinician/chief executive officer and is supported by a series of independent practitioners with their clientele. This privately owned behavioral healthcare organization provides a variety of therapeutic,

mental health, and professional training services to the Middle Atlantic region of the eastern United States.

Many of the services offered have shifted to the telehealth modality since the COVID-19 pandemic, which has highlighted some challenges with client engagement. The organization understands the need for traditional brick-and-mortar care for some clients; however, the organizational leaders are looking into ways of better engaging their clients with telehealth support.

The goal of MEBHC is to provide clients with high-quality clinical care to promote emotional, social, interpersonal, familial, and educational growth. Accomplishing these goals occurs through therapeutic deliverables in individual, family, and play therapy delivered through qualified clinicians. Clinicians with MEBHC specialize in three modalities of treatment (i.e., Beck's cognitive behavioral therapy, Minuchin's structural family therapy, and Yalom group therapy) that are evidence-based, data-driven, and proven to be effective modes of treatment working across age ranges and diagnosis.

Practice Problem

The global pandemic has increased the visibility and utility of telehealth services (Lynch et al., 2021). Mandates with social distancing and other safeguards, put in place to lessen the spread of COVID-19, have forced behavioral health organizations to change the way services are rendered. Recent data have shown that telehealth support has become the preferred delivery modality for mental health and most healthcare support (Blake et al., 2021). The increase in telehealth usage can be measured by the increase in

telehealth-related claims reported to Medicare, which was over 4,347% in a 1-year reporting cycle (Chang et al., 2021). Although the portability of telehealth, such as videoconferencing and telephone conferencing, has made the support more accessible to individuals with a lower socioeconomic status, there appears to be a disparity in engagement. Many clients identified as having lower socioeconomic status are those in rural communities, underrepresented populations, and receiving Medicare benefits. Lynch et al. (2021) reported how the clients, therapists, and behavioral health leaders are all key to the success and engagement with telehealth services. This implied collaboration presents an opportunity to leverage the convenience of mental health services through the various virtual modalities to individuals who need support and treatment but are not comfortable seeking assistance by traditional means (i.e., in-person care).

MEBHC has strived to create a pathway to wellness and optimal mental health for all individuals. Availing wellness and mental health resources to individuals within the lower socioeconomic status through telehealth options has been a challenge. The behavioral health leadership team has noted that there is a strong correlation between the lack of telehealth engagement and clients identified with a lower socioeconomic status. With this information, the behavioral health leadership at MEBHC has adjusted its service delivery model to accommodate the changing healthcare environment. The identified problem for this study is connecting and engaging individuals within the lower socioeconomic status population to telehealth solutions. Specifically, I addressed how the leadership can better support client engagement with clients identified in the lower

socioeconomic category. This challenge was examined by gathering data from two research questions (RQs):

RQ1: What are the current engagement challenges with telehealth?

RQ2: What strategies can lead to effective telehealth engagement?

Purpose

The purpose of this qualitative case study was to explore strategies contributing to enhancing client engagement of those clients identified within the lower socioeconomic population with the behavioral healthcare leaders at MEBHC. Working within the reputable performance excellence practices of the Baldrige framework, in this nonexperimental inductive research study, I aimed to uncover plausible solutions to the MEBHC to expand its reach in attracting and engaging with potential clients, specifically those in lower-level economic demographics. Ad hoc data collection and analysis (review of current organization records, manuals, client surveys, and other documents), interviews with MEBHC leaders, and empirical research methods were used to meet the purpose of this study. I explored the challenges each MEBHC leader faces with engaging clients of lower socioeconomic status in telehealth services. I specifically focused on the customer engagement components of the Baldrige excellence framework, where I looked at the following benchmarks for successful customer engagement:

- How do the leadership team and staff at MEBHC build and manage relationships with their client base?
- How are clients at MEBHC supported in seeking information and resources?
- How are client concerns addressed at MEBHC?

- How do leadership and staff ensure fairness in the treatment of all clients?

The Baldrige excellence framework (NIST, 2021), which is rooted in a set of interconnected core values and concepts, was used for assessing this study outcome. Key to the Baldrige framework of excellence is a set of 11 beliefs and behaviors that are foundational in the core values and concepts of well-performing organizations. The systems perspective suggests that all organizational parts work together toward their mission and vision. The second component, visionary leadership, speaks to the organizational leadership setting the vision, living the vision, and being the visual example of the vision. Customers are the third component in the beliefs and behaviors. This speaks to valuing the organization's customers, customer voice, and customer satisfaction. Fourth is valuing people. An organization that values all its stakeholders, including its workforce, yields successful results. A successful organization has the agility to change when the environment dictates and the resilience to endure difficulties. As outlined by Baldrige's beliefs and behaviors, continuous learning is a key factor in a successful organization. The seventh component, focusing on success and innovation, reflects an organization's ability to plan for future growth and improvement. Management by fact, the eighth component, requires the organizational leader to be reflective by utilizing data to make internal and external improvements. As with many organizations with a social responsibility element to their organizational mission, successful organizational leaders make positive societal contributions. Organizations that operate ethically and transparently throughout the workstream are peak performers. The 11th and

final component identifies organizational leaders who deliver stellar results based on organizational values as a key indicator of success.

These behaviors and beliefs are then manifested by these core values categories: leaders, strategy, customers, measurement/analysis/knowledge management, workforce, operation, and results that operate cyclically and are key to performance factors for successful organizations. The Baldrige framework of excellence framed this study by determining the ways the organization builds customer relationships and determines customer satisfaction and engagement which is rooted in the customer engagement category of the Baldrige performance system.

Using the Baldrige excellence framework (NIST, 2021) as a guide for assessing the ways the organization manages customer engagement, I gathered, examined, and presented data to the organizational leadership at MEBHC. The customer engagement components of the Baldrige excellence framework (NIST, 2021) was the lens through which this organization gauges its practices for client engagement and satisfaction, specifically how their clients build and maintain relationships with organizational contractors, how organizational partners provide information for current and potential clients, how the organizational leadership manages client feedback, and how the organization assures client confidentiality and fairness. With the Baldrige excellence framework as the standard for successful customer engagement, MEBHC's leadership team will be able to measure and adjust its current systems to meet or exceed excellence standards.

Significance

In this qualitative case study, I codified the presumed efficacy of telehealth services and their impact on the underserved and lower socioeconomic client sectors by looking at the Baldrige excellence framework as the measure. This capstone study has the potential to contribute to positive social change as the data results can enable behavioral health leaders to improve on practices that can lead to decisive changes within their client base. As positive social change looks to transform relationships, community cultural, and/or economic outcomes (Mandel & Howson, 2021), MEBHC is looking to make positive changes in the community, demographic, and client base it serves.

In this research, I exposed the barriers to higher engagement by members of the identified sectors and provided data to inform solutions that may mitigate distraction, disengagement, and apathy relative to telehealth services for these individuals. As the behavioral health environment is being inundated with requests for behavioral health services, it is essential to ensure that the use of telehealth opportunities does not contribute to access disparities among these targeted sectors (i.e., the underserved and those of lower socioeconomic status). A critical outcome of this study is to interpret the findings to develop the behavioral health organization's strategy to impact social change by creating innovative access and engagement plans that serve their clients.

The tool for assessing this study was the Baldrige excellence framework (NIST, 2021), which is rooted in a set of interconnected core values and concepts. Key to the Baldrige framework of excellence is a set of 11 beliefs and behaviorsthat are foundational in the core values and concepts of well-performing organizations. The systems

perspective suggests that all organization parts work together towards the mission and vision.

Summary

Prior studies have shown that implementing telehealth services has significantly improved patient health outcomes and reduced the number of emergency room visits (Adepoju et al., 2021). Before the COVID-19 pandemic, telehealth and telepsychology were few, especially for those in underserviced and lower socioeconomic communities (Adepoju et al., 2021). The Center for Medicare and Medicaid Services has recently changed policies, enabling broader access to telehealth under the Coronavirus Preparedness and Response Supplemental Appropriations Act (Adepoju et al., 2021). With this policy change, the Center for Medicare and Medicaid Services has opened a spectrum of support to demographics of clients who have experienced disparities in health care support and treatment. The expansion in access to telehealth support is a great possibility and can positively impact these underserved demographics. It is crucial to also consider the possible barriers to client access and engagement (i.e., internet access, patient readiness, and concerns with the use of technology).

Section 1b: Organizational Profile

Introduction

MEBHC was the focus of this capstone study. MEBHC has provided behavioral healthcare services for over 14 years to clients dealing with acute and pervasive mental health challenges. MEBHC also provides professional development, training, workshops, and licensing exam supports for mental health professionals in the behavioral health profession. This organization offers a variety of mental health services, including outpatient therapeutic care and professional training for clinicians seeking further education and professional growth. Since the COVID-19 pandemic, many of the services offered have shifted to the telehealth modality, highlighting some client engagement challenges. The organization understands the need for traditional brick-and-mortar care for some clients; however, the organizational leaders are looking into better engaging their clients with telehealth support.

In Section 1b, the organization profile and key factors, background, and context are summarized as a reference for review when looking at the practice problem of how leadership can better support client engagement with clients identified in the lower socioeconomic demographic. Throughout the following sections, there are several relevant terms introduced to aid in understanding this study, which are listed and defined in Table 1.

Table 1

Overview of Selected Key Terms Used in Research Study

Term	Acronym	Definition
Chief executive officer	CEO	Develop and lead the strategic plan of the organization. Sets and leads the organization mission and vision. Communicates to all stakeholders.
Chief financial officer	CFO	Manages financial operations of organization and has accountability for maintaining the monthly payroll for employees and contractors.
Human resources	HR	Handles employee relations. Ensures safety, health and employment compliance. Manages employee benefits. Oversees hiring process.
Licensed certified social worker-clinical	LCSW-C	Master's level social worker with extensive professional training and expertise in mental health.
Licensed graduate social worker	LGSW	Social workers who want to perform non-clinical social work in a wide variety of settings or supervised clinical social work.
Licensed independent clinical social worker	LICSW	Social workers that practice in a range of capacities to assess, treat and diagnose clients with mental, emotional, and psychosocial ailments.
Behavioral health leader	BHL	Leaders, in the identified organization for this study, who hold the position of President/CEO, Administrator, CFO, HR Manager, Intake Director, and Office Consultant.
Behavioral health organization	BHO	The identified organization, for this study, that serves children and adults who need intense coordinated mental health services.

Organizational Profile and Key Factors

MEBHC is a minority-owned mental health agency. MEBHC offers services that include individual, play, family, couples, and group therapies. According to the organization's website, the mission is to provide the highest quality of clinical care, specifically designed to improve the overall emotional well-being of people experiencing difficulty managing depression, mood, anxiety, anger, impulses, obsessions, and trauma that include severe neglect, physical, emotional, and sexual abuse. The models of treatment used include Beck's cognitive behavioral therapy, Minuchin's structural family therapy, and Yalom's group therapy. These evidence-based models of treatment lend themselves to improved overall emotional well-being for individuals and improved family communication and relations and teach angry people how to manage their anger/rage. MEBHC also provides professional training and/or workshops to mental health professionals needing continuing education units. Training and workshops include the following: Diagnosing and Effective Treatment Planning: Utilizing DSM V, Understanding Ethics and HIV/AIDS, Clinical Note Writing, Adolescent Depression, Effective Case Management, and licensure prep courses including licensed certified social worker-clinical (LCSW-C), licensed graduate social worker (LGSW), and licensed independent social worker (LICSW) for those needing to pass the Social Work Licensure Exam.

Organizational Background and Context

The leadership team at MEBHC is composed of the president/chief executive cfficer (CEO), an administrator, the chief financial officer (CFO) and human resource (HR) manager, the intake director, and the office consultant. The number of clinical practitioners has varied since the COVID-19 pandemic, as they have been retained based on client demand. The president/CEO is primarily responsible for all communication regarding organizational purchases, changes, program development, and compensation. Contract acquisition to increase clientele and revenue is also the responsibility of the president/CEO. The organization administrator is responsible for program management, day-to-day business operations, the collaboration between departments, and reporting organizational needs to the president/CEO. The CFO and office manager is accountable for maintaining the monthly payroll for employees and contractors. The maintenance of all financial reports and securing of confidential records are also under the responsibilities of the CFO and office manager. The gathering of data on clients, scheduling of appointments, and intake process all fall under the responsibility of the intake director. The intake director is also accountable for creating, maintaining, and distributing the organizational process manually to all employees. Finally, the office manager is responsible for gathering clients' intake data, payroll distribution, and the overall maintenance of the organization's website.

MEBHC has a vision of enhancing lasting change within its community; thus, its client base is composed of the demographic mirroring the Middle Atlantic region of the eastern United States where it is located. Before the global pandemic, MEBHC had been

making substantial strides in fulfilling the company's vision of enhancing mental health change in the community. MEBHC was confident that the stakeholders had been providing quality and comprehensive mental health support to the targeted demographic. However, since the global pandemic, the quantity and methodology of service have been tremendously affected. The organization's leadership reported that over 90% of their service delivery was via in-person support before the global pandemic. Since then, the percentage of in-person service delivery has decreased to 10%, with 90% being via telehealth. A shift from 90% in-person service to 10% is worth examination, particularly because the shift in care has affected different communities differently. With the shift in the service delivery model, there has also been a major shift in client engagement for a specific demographic of clientele. Clients in the lower socioeconomic demographic experience a higher difficulty accessing quality medical/mental healthcare resources and telehealth support (Blake et al., 2021). As MEBHC's primary client demographic are those in the lower socioeconomic demographic, their service delivery modality and engagement have been significantly affected by this shift. In this study, I looked at some of the causes affecting client engagement, specific to those in the lower socioeconomic status, with telehealth support.

Summary and Transition

MEBHC is a small behavioral healthcare organization in the Middle Atlantic region of the eastern United States. This minority-owned behavioral healthcare organization established in 2008 was developed to be a mental health and training group that services individuals, couples, and groups for behavioral health treatment (. The

leadership team at MEBHC is composed of the president/CEO, an administrator, the CFO and HR manager, the intake director, and the office consultant. The organization has a traditional organizational structure where the president/CEO is the primary source of information and authority. The vision and mission of the organization are to enhance and effect lasting change within its community via holistic and family treatment. MEBHC recognizes that reaching those goals requires multiple modalities of treatment including telehealth. Thus, increasing awareness of the significance and impact of telehealth can help to increase client engagement (Merz, 2021).

As a means of improving mental health treatment and service delivery, telehealth services have become an integral modality of support in the healthcare delivery system (Goldin et al., 2021). Telehealth services have the potential to improve client access, increase client engagement, add to the continuity of care, and increase client and family participation. While there are positive data on service delivery and client engagement, equal data sources support some of the limitations to client engagement as lack of infrastructure and access to adequate technology. In a study on telehealth services provided to individuals experiencing homelessness, researchers observed that improving clients' accessibility to technology correlated to increased client engagement (Aykanian, 2023).

Section 2 encompasses a review of the supporting literature, sources of evidence, and leadership structure and assessment of the MEBHC. In addition, Section 2 addresses the strategy and methodology of the study.

Section 2: Background and Approach–Leadership Strategy and Assessment

Introduction

The challenges and nuances of human functioning during the COVID-19 pandemic, which is now in its unstable endemic status, have forced patients and healthcare consumers to shift from passive curiosity to active pursuit relative to their medical and mental health service needs. Telehealth options for mental health care are more prevalent and sought after in the wake of the pandemic. Telehealth usage had increased by over 4,000% in a 1-year billing cycle as reported to Medicare (Chang et al., 2021). Though a convenient and affordable alternative to traditional mental health services, there is a disparity in engagement particularly in the lower socioeconomic demographic.

MEBHC is a behavioral health organization with a demonstrative commitment to avail wellness and mental health resources to people of all demographics, especially those of a lower socioeconomic status. They have adjusted their service delivery model to accommodate the changing healthcare environment. MEBHC sees this as an opportunity to better serve this underrepresented demographic while expanding the delivery of needed mental health support, interventions, and resources. The problem now shifts from concerns of efficacy to those of apathy. In other words, is is necessary to address the barriers to engaging individuals within this demographic in telehealth solutions. The purpose of this qualitative case study was to explore strategies contributing to enhancing client engagement of those clients identified within the lower socioeconomic population with the behavioral healthcare leaders at MEBHC.

Supporting Literature

Through an exhaustive review of the literature (covering over 5 years of data) on telehealth, telemedicine, teletherapy, socioeconomic status, and working with the underserved, I gathered information to support the challenge of client engagement. Multiple databases were accessed to retrieve pertinent scholarly and peer-reviewed articles that were current and relevant to the RQs. The extensive list of databases used for this study included Academic Search Complete, APA PsycArticles, SAGE Journals, ProQuest Central, SocIndex with Full Text, Science Direct, Education Source, MEDLINE, APA Psyinfo, PubMed, CINAHL Plus, and Psychology Database Combined Search. With the search engine Thoreau and Booleans operators, the following descriptors were used as research keywords: *teletherapy/social economic status, telehealth/social economic status*, *telehealth and engagement*, *telehealth and involvement*, *telehealth and participation*, *telehealth services and SES*, *underserved/teletherapy*, *underserved/telehealth*, *telehealth/telemedicine/social-economic status*, and *behavioral health/behavioral health leaders/behavioral health organizations*.

Telepsychology Before COVID-19 Pandemic

To understand the impact of telepsychology as an effective alternative to traditional mental health service delivery, it is important to look at usage before and after the pandemic. This “revolution in mental health care delivery” framed by Pierce et al. (2021) depicts both the efficacy and opportunities in expanding telepsychology services to all demographics, including the lower socioeconomic group amplified in this study. In a national survey of licensed psychologists, researchers found that although 7.07% of

psychologists' clinical work was performed via telepsychology before the pandemic, this increased 12-fold to 85.53% during the pandemic (Baker et al., 2021). Psychologists were optimistic that over one-third of their clinical work would still occur via telepsychology after the pandemic, suggesting the high likelihood of lasting changes in U.S. mental healthcare delivery (Pierce et al., 2021).

Though efficacious all along, there are consistent barriers to the expanded use of telepsychology: (a) doubts of its ease and usefulness (Pierce et al., 2021); (b) psychologists' apathy, with 75% attesting to an unwillingness to refer clients to telepsychology (Perle et al., 2014); (c) lack of practitioner training in telepsychology (Perrin et al., 2020); (d) Medicare regulatory constraints relative to reimbursement for telepsychology services (Watson et al., 2023); (e) state licensure constraints (Pierce, 2021); and (f) technical issues on either the clinician's or patient's side, which can impact a willingness to use telepsychology (Pierce et al., 2021). Though barriers exist, there remains enthusiasm and support to effectuate the benefits and opportunities of telepsychology.

Telepsychology and Equity

As telepsychology is more widely adopted, it is important to understand how it may affect the experiences of those in racial and ethnic minority groups, the underserved, and those in low socioeconomic demographics. According to Blake et al. (2021), the use of telepsychology can improve the continuity of care for chronic disease management and COVID-19-related health challenges for marginalized communities by removing barriers such as transportation, missed work, and inadequate childcare.

One primary aspect of telepsychology that is receiving regulatory attention is the parity of payment for patient visits. Conditions of visits (i.e., where they take place, who provides them, and licensed supervision of providers) are clear but inconsistent from state to state. (Park et al., 2018). This inconsistency in parity can impact service delivery as providers avoid telepsychology because of the challenges of state reimbursement. The American Telemedicine Association rates state on selected coverage and reimbursement policies, including several on Medicaid telehealth policies specifically. States with fewer restrictions relative to providers, settings, and parity of coverage for in-person visits and telehealth get A or B ratings. Those with restrictions or who do not have parity laws get C or F ratings. In the 2018 study, "ten states [since 2014] have enacted parity laws that require private insurance plans to cover services through telehealth to the same extent as those services are covered in person, bringing the number of states with parity laws to thirty-one" (Park et al., 2018, p. 2060). These regulatory changes have significantly increased outpatient telehealth visits in states with parity laws.

In a study conducted by Park et al. (2018), several key findings were germane to what the stakeholders at MEBHC are looking at. First, it was concluded that clients presenting with physical/mental/emotional challenges, limiting their mobility, had a greater engagement with telehealth support than those with greater or complete mobility. The second and most applicable finding was the greater engagement factor of clients who were identified in the higher income category (Park et al., 2018). This finding correlates with MEBHC's problem of practice by looking into challenges with client engagement for those identified in the lower socioeconomic demographic.

A recent study in West Baltimore illustrated the impact of telehealth-focused initiatives in underserved communities. This initiative took place in West Baltimore, an area that has significant adverse health outcomes and is the poorest among Maryland's 24 counties. The majority of residents in West Baltimore are Black and have a life expectancy of 64 to 68 years of age, compared to the U.S. large city average of 79 years of age (Johnson Foundation, 2017). Little has changed with this statistic as in a published article by Narh-Mensah (2022), documenting racial life expectancy disparities in Maryland, data showed a life expectancy of 63.9 years for Black males in West Baltimore compared to the National average of 76.1. According to the Johnson Foundation report (2017), residents had a higher prevalence of COVID-19 vulnerability risk factors, including diabetes, hypertension, and obesity. The initiative facilitated by the LifeBridge Health organization provided telemedicine visits with a nurse to complete basic clinical health screenings, educate patients about COVID-19, conduct COVID testing, prepare lab specimens, and link the patients electronically to advanced practice providers at a virtual hospital. The televisit allowed the provider to speak with the patient and nurse and collect medical information personally to increase accuracy and efficiency (Blake et al., 2021).

During the initiative's 6-week implementation, 314 teleconsultations were provided in six zip codes in West Baltimore. By Week 5 of the initiative, the program experienced a 2.9-fold increase in telemedicine visits compared with Week 1 (Baker et al., 2021). The initiative validates how valuable telehealth can be in reaching underserved communities, even those communities considered to be at an elevated risk for chronic

medical conditions and mental health treatment. Baker et al. (2021) summarized their findings and impressions in their *Report From the Field:*

> Our telehealth-equipped mobile clinic and virtual hospital were able to respond to the emergent need and increase COVID-19 testing and enhance healthcare access in an under-resourced urban setting, where a large proportion of the residents is African American. Our descriptive results suggest the feasibility and success of this model to reach individuals remotely. Embedding telemedicine technology and processes within health equity strategies can help mitigate the many health inequities that disproportionally affect marginalized communities. (p. 193)

Telehealth Impact on Patient-Provider Relationship

Traditionally, patients relied on healthcare providers to convey and interpret medical information; however, with the prevalence of medical information readily available through electronic sources, it is important to consider how the availability of crowd-curated medical information (e-health consumption) impacts telehealth usage. New technology, with telehealth options, enables clients to interact and engage in a more connected way. Some of this technology allows clients to personalize their programs to receive feedback and support (Barakat et al., 2019). In studying the efficacies and opportunities of telepsychology, particularly for those underrepresented and lower socioeconomic clients, it is important to consider the adverse impact of readily available health information on the Internet. In other words, if patients will self-diagnose and treat instead of seeking qualified medical advice and care.

According to Xiang and Stanley (2017), e-health consumption moderates telehealth usage: "Even with the high usage rates and affordances new technology provides, e-health consumption has not negated the role of doctors in health information seeking or service" (p. 447). New technology has altered the patient-provider relationship. Studies examining the patient-provider relationship have found positive outcomes resulting from e-health consumption, including increased medical knowledge, more physician information, and additional visits. In a COVID-19 (Moorman, 2022) study, researchers found that clients reported cost savings and time as added benefits to their e-health involvement. Some of the examples of cost savings were transportation and eating, as they related to not having to travel to and from appointments. An example of saved time was the travel times that would have been associated with traveling to appointments.

Price et al. (2022) took a slightly different approach and gathered data on the practitioner’s view of factors affecting client engagement with telehealth supports. Some of the findings detailed contradicted the proposed correlation between lower socioeconomic status and client engagement with telehealth. Instead, the researchers proposed that there were correlations between patient-client relationships (Price et al., 2022). The findings of this study have a significant impact on patient care and treatment, as it places the responsibility of engagement with the practitioner.

In a study conducted by Baker et al. (2023), the researchers determined that clinicians noted many benefits to the telehealth experience, such as scheduling, client access, and service utilization. It was noted that some of the clients studied preferred the

telehealth modality to in-person services. Some of the notable challenges with telehealth that were outlined in this study were improving clinicians' technology (i.e., hardware and software). Clinicians also noted a need for an increase in training, support, and resources to increase their knowledge, skill set, and delivery models with telehealth. Although telehealth has been used for a while, the increased usage and delivery require additional training and support. One of the key findings of the Baker et al. (2023) study, and one that has the biggest financial implication, is that there is a need for advocacy with regard to the practice of teletherapy. This advocacy can help with issues of equity in insurance reimbursement and federal funding.

Tar-Mahomed and Kater (2022) conducted a study with speech and language pathologists and their perspectives on teletherapy service delivery during the COVID-19 pandemic. This study yielded results in support of telehealth from both clinician and client perspectives. It was reported by clients that the telehealth option provided clients with greater access to therapy, decreased their time and financial obligations with travel, and lowered their risk of exposure to various illnesses that are at risk in medical facilities. It was also noted that there was a greater percentage of family involvement with therapy, as the barriers to accessibility were removed with the family being home with the client. As with many other study findings, Tar-Mahomed and Kater also noted that some of the major challenges with telehealth were with technology and clinician training.

Sources of Evidence

The sources of evidence for this research study included interviews with the behavioral leadership team, including the president/CEO, the administrator, the CFO and

HR manager, and the intake director. Approval to conduct the research study at MEBHC was granted by the organization's president/CEO. The president/CEO and office consultant availed themselves frequently and consistently for questions and discussions. Access was granted for me to review the organization's employee and organizational manual. In addition, I reviewed the organization's website, mission, and vision statement. Secondary sources of evidence, which included client surveys and demographic information, were made available for this study as well.

Data for this study were gathered from interview sessions and coded. The secondary data sources from the literature, organizational manual, and organizations website were documented, categorized, and referenced. I gathered all data sources from interviews with organization leadership, internal organization memorandums, and statistical reports. These primary and secondary sources were combined to summarize how different communities have been differentially affected by the increase in reliance on telehealth and to synthesize recommendations for remediation where problems are uncovered.

Leadership Strategy and Assessment

The leadership team at MEBHC is composed of the president/CEO, an administrator, the CFO and HR manager, the intake director, and the office consultant. The organization has a traditional organizational structure where the president/CEO is the primary source of information and authority. One might characterize the president/CEO as being a transformational leader, as the emphasis is placed on encouraging growth, recognizing employees' accomplishments, building connections, and working towards a

collective vision (Northouse, 2019). The president/CEO has a goal of raising the motivation and knowledge base of the organization's workforce. This is evidenced by the plethora of workshops, training, and professional development that the organization offers. Additional evidence of this transformational leadership style is the community education outreach efforts that happen via podcasts and speaking engagements. The president/CEO is committed to educating the community and others about trauma and mental health issues and has written and published books to help support people who face those challenges.

The leadership team has a goal of developing and nurturing professional and personal growth among their workforce. This happens through mental health training and clinical support, which should render excellent therapeutic services to their client base. All contract employees are 1-year term, from the date the president/CEO signs their contract. All contract employees are evaluated by their managers, after completing their first 90 days of employment probationary period. The 90-day probationary period begins on the first day that the contractor and president/CEO sign the agency agreement. Annual performance reviews are conducted during the 12th month of the contractor's hire date.

MEBHC has a six-member leadership team and 10 contract clinicians. Since the COVID-19 pandemic, the 10-member contractor number has fluctuated; however, that number is fluid based on the increase or decrease in client needs.

The MEBHC leadership team evaluates their contracted employees, monthly, based on feedback from client surveys, service delivery data, and record compliance (MEBHC, personal communication, October 2, 2022). For the senior leadership team,

when determining, monitoring, and evaluating their progress toward the organization's annual goals, the method of measure utilized is a balanced scorecard (MEBHC, personal communication, October 2, 2022). This method of measuring allows the senior leadership team to look at their four identified areas of organizational growth:

- Customer service: Maintaining positive client perspectives of support at MEBHC; Maintaining high-quality clinical care; Clients are experiencing improvement in their overall well-being; Clients experiencing a decrease in presenting symptoms; Improving virtual accessibility and engagement options for clients.
- Organizational finances: Maintaining financial solvency. Securing multiple streams of income. Expanding service delivery options.
- Organizational programs**:** Increase service modality options.
- Organizational capacity: Build contract employee pool; Expand community partnerships.

MEBHC's overarching goal, for its leadership strategy, is to create and align services to meet the needs of its identified client base; educate on and expand access to quality mental health services; disseminate knowledge to their identified community base; and strengthen organizational financial solvency.

Clients/Population Served

MEBHC provides clinical and therapeutic services to individuals, families, or groups having trouble managing a mental illness. The organization offers outpatient services to clients experiencing mental health issues, professional training for those

seeking clinical licensing and certification, and continuing education for those wanting advanced training support.

The president/CEO shared that most clients are covered through private insurance or self-paying. Although keeping with the vision of having a lasting change in the community, the president/CEO secures a certain percentage of client availability for those under-resourced populations that may be receiving Medicaid or Medicare.

Figure 1 represents the percentage of clients serviced, by gender, spanning a period of five years. The distribution of male to female client ratio with 48% males and 43% females with the rest unspecified in the data. Figure 2, the Demographics by Plan data, outlines the client's sources of the payment stream. These data illustrate that MEBHC's revenue is based on three primary funding sources: commercial (i.e., private insurance), Medicaid (i.e., federal, and state-funded), and self-paying clients.

Figure 1

Demographics by Gender

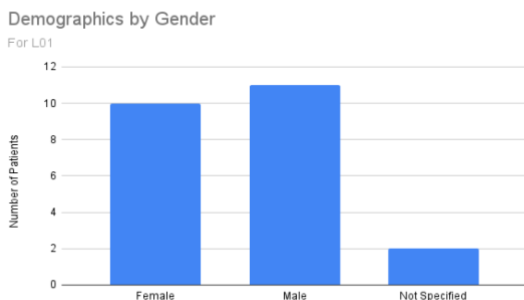


Figure 2

Demographics by Plan

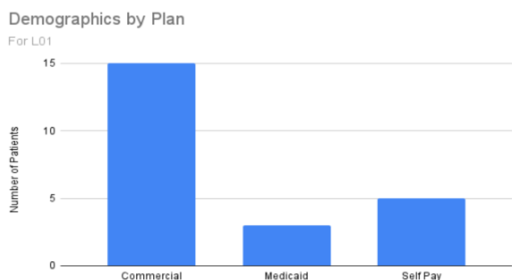
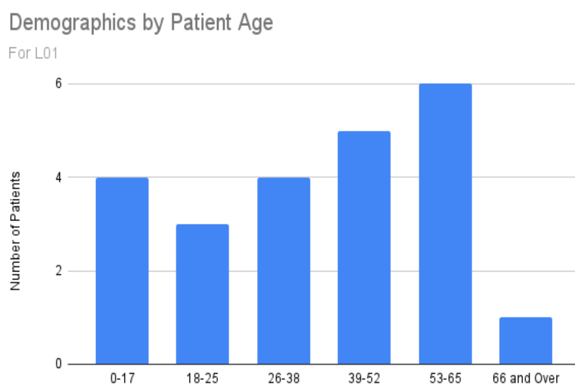


Figure 3, Demographics by Patient Age, give a visual of the age ranges for the clients supported by MEBHC. As listed in the chart, the majority of clients supported at this organization are between the ages of 0 to 35, with the second largest grouping of clients in the 543 to 65 age range.

Figure 3

Demographics by Patient Age



Analytical Strategy

The qualitative research study approach was chosen, as it is often used by a researcher who wants to take a deep dive method into a multi-tiered challenge (Crowe, et al., 2011). Data will be collected, reviewed, analyzed, and presented to the leadership team at Miss Emma's Behavioral Health Care Center. Data collection methods will include interviews with the organizational leaders, pre- and post-therapy surveys from clients, a review of the organization's mission and vision statements, client demographic records, and the organization's employee manual.

Methodological Triangulation

When data collected in different ways infers the same conclusion, it supports the claims of the researcher and strengthens their arguments and conclusions. Methods triangulation is a form of data collection that uses multiple methods to collect information from one participant group (Patten & Newhart, 2018). In this study, the methods of interviewing organizational leaders and observing the CEO/President's community engagement activities were used. In addition, and relative to the data collected, the organization's operations manual, website, annual report, and aggregate client profile were reviewed and analyzed. The use of this technique is helpful in establishing the dependability and trustworthiness of the data (Patten & Newhart, 2018).

The context of this study is the Baldrige Excellence Framework (NIST, 2021). The core values and concepts for customer engagement that are articulated in Baldrige serve as the conceptual framework of this study. These values and concepts include relational management, patient and stakeholder access to support, complaint

management, and fair treatment (NIST 2021, p.14). The values and concepts are used to address the aforementioned RQs of this study:

RQ1: What are the current engagement challenges with teletherapy?

RQ2: What strategies can lead to effective telehealth/teletherapy engagement?

The Baldrige Excellence Framework is a valid and reliable system and process-thinking approach to helping organizations improve service to customers and stakeholders. Recipients of Baldrigecommendation and recognition have demonstrated their ability to effectuate this approach in enhancing service delivery to clients, customers, and patients. With the aim of providing mental health services to members of the community (specifically those in the lower socioeconomic demographic), this framework becomes effective in building a roadmap to equitable service delivery. This qualitative case study serves as that roadmap to helping MEBHC leadership in connecting and engaging individuals within the lower socioeconomic demographic to valuable telehealth support.

Role of the Researcher

My role as the researcher in this capstone study is that of a consultant and advocate. As a consultant, my role is to provide evidence-based solutions to the articulated leadership and organizational challenge of promoting mental wellness solutions, specifically the efficacy of telehealth to those in the lower socioeconomic demographic. As an advocate, I will partner with the leadership of MEBHC to develop a plan to promote and increase the utilization of telehealth services toward the solution of equitable mental wellness for the underserved demographic.

As a researcher, it is my responsibility to facilitate this study in a manner that is aligned with ethical research principles. The overarching mantra of ethical research principles is to protect all involved from physical and psychological harm. Patten and Newhart (2018) refer to this as the principle of beneficence, which means that research should strive to not harm, to maximize possible benefits, and use a research design that is best suited to minimize risks and maximize benefits (p. 34). Ethical research also ensures the equitable and autonomous treatment of participants. It is my responsibility to ensure that participants understand that they are voluntarily participating in this study and can withdraw at any time.

Data Collection

Data for this study was collected using the semi-structured interview method, which is widely used in qualitative research. An interview guide was developed in advance to ensure consistency from one interview to the next, with the flexibility to deviate from the interview guide to ask follow-up or clarifying questions, ensuring that the most complete information was collected. The goal of interviewing is to attain consistency by asking the same questions of all participants. Semi-structured interviews are also effective because thinking through question-wording carefully in advance allows researchers to consider if the question is complete, or if it is biased or leading (Patten & Newhart, 2018, p. 161). This approach also allows for follow-up or probing to clearly understand responses to interview questions.

The interview guide was created using the Baldrige Excellence Framework (NIST, 2021) targeted at understanding the utilization of telehealth services by current

clients of MEBHC and the potential clients in the focal demographic. The goal of each interview was to get a complete picture and understanding of past strategies and tactics in availing mental wellness services to those in lower socioeconomic (underserviced) demographics.

Three key members of the leadership team at MEBJC were interviewed: (1) Chief Executive Officer/President, (2), Administrator, and (3) Office Consultant. Each was able to respond to the questions adding their perspective and evaluation of past efforts through the lens of the professional level and locus of control. Specific follow-up questions based on their areas of responsibility were asked, facilitating a complete understanding of efforts relative to the goal of extending telehealth services toward the expansion of mental health wellness services.

Informed consent was obtained from all individuals interviewed in the data-gathering process. All interview questions were documented and distributed, via email, to the leadership team before the in-person interviews. The questions were developed to gather crucial information regarding the current client engagement levels and strategies utilized. The questions sought to develop a baseline for measuring what positive telehealth engagement looked like at MEBHC, what were some of the speculated barriers to positive engagement, and possible strategies to increase engagement with a targeted demographic.

Foley (et al., 2021) reported that one of the most widely used forms of data collecting, for qualitative research, is interviewing. The process of interviewing allows the researcher a level of flexibility that is amenable to various theoretical approaches.

Utilizing this data collection tool, enabled the flexibility and personal touch of thematic coding that I believe was successful with my study. Thematic coding allowed for capturing significant data in a planned and organized way. Categories were developed from these themes, and common trends and challenges were identified.

Data collection was synthesized, and results were captured via Google Docs. Final results were forwarded to the Senior Leadership Team with MEBHC, with planned follow-up consultation.

Summary and Transition

The many potential advantages of telehealth have become even more prominent since the COVID-19 pandemic (Chang et al., 2021). Organizations that are making the shift and investment to increase telehealth usage are closing the gap of engagement for those of a lower socioeconomic status. Coupling that investment with researching and addressing the barriers to client engagement will help to close the equity divide between client access.

Section 3 of this research study will provide information on how the staff at MEBHC are provided with a supportive workforce environment, promotes professional growth and work performance, and provides positive feedback that enables employees to serve clients.

Section 3: Measurement, Analysis, and Knowledge Management Components of the Organization

Introduction

MEBHC has a client base primarily consisting of the working class, underserved, and lower socioeconomic families. In the wake of the recent Covid-19 pandemic, MEBHC has embraced telehealth as both an organizational solvency measure and a plausible solution or approach for the underserved demographic, which is an area focus for practice with MEBHC.

Despite the societal pivot from traditional in-person mental health treatment to virtual modalities such as telehealth, members in lower socioeconomic demographics are often not embracing virtual mental health treatment options. Researchers have suggested that this low participation dynamic is resultant of several factors: access to technology endpoints, the internet, underserved communities, lack of knowledge to use technology, and questions about the efficacy of virtual treatment modalities. There is a disproportionate number of these barriers among socioeconomic disadvantaged and underserved populations (Chang et al., 2021). It is further suggested that this same demographic, primarily composed of older adults, low-income patients, less-educated patients, and ethnic minorities, are less likely to use telehealth options when available (Chang et al., 2021). In this study, I examined how the leadership team at MEBHC helps to engage their clients in the lower socioeconomic demographic with telehealth and teletherapy support. The Baldrige excellence framework (NIST, 2021) was the tool used to measure how well MEBHC was supporting clients with engagement.

The sources of evidence were gathered through recent survey data primarily gleaned from client intake and exit surveys. The intake survey is a checklist to determine the client's well-being and the treatment options that may be appropriate. The intake survey is the primary instrument used to create treatment plans for clients. This is typically conducted before the client receives mental health services. Like most behavioral health organizations, MEBHC uses intake surveys for all the reasons listed and to gather information to address the client's immediate needs and to encourage their engagement and retention in services. According to Price et al. (2017), these intake surveys/assessments help to enable better healthcare delivery to clients in the lower socioeconomic demographic.

The exit surveys are used to capture important information about the client's overall experience with the service provider. It has two main purposes: one is relative to the treatment aspects of the engagement and the business or process components. In other words, did the treatment plan work, and were the organization's, processes, procedures, and business practices realized by the client? This includes assessing the client's probability to recommend the organization to others, their return for further treatment, and identification of areas the organization can improve.

All clients at MEBHC participate in intake activities. Exit surveys, though voluntary, have high participation though not equally rated to the intake process. The exit survey rates are still considered to be acceptable, and the behavioral health leaders have contributed this factor to anonymity and psychological safety in sharing their opinions

and ideas. All qualitative data gathered from these interviews and surveys were deemed vital to addressing the practice problem.

Analysis of the Organization

Supportive Workforce Environment

In aggregate, according to the Operation and Procedure Manual, MEBHC prides itself on having a supportive workforce environment. This is deemed critical in behavioral health organizations as there is research that suggests that employees with high engagement consistently produce optimal results. Shuck et al. (2017) theorized employee engagement as "an active, work-related positive psychological state operationalized by the intensity and direction of cognitive, emotional, and behavioral energy" (p. 2). The MEBHC Operation and Procedure Manual highlighted that this environment is facilitated by the implementation of key workforce elements, including professional training and development, continuing education units to support licensure attainment and compliance, and other staff-focused initiatives, such as a safe work environment, drug-free posture, career, and professional development planning, and compensation philosophy that is internally equitable and externally competitive. The overall organizational performance can be improved if employees are engaged, as they are intrinsically motivated, participate in learning, and have improved work performance (Kwon & Park, 2019). According to the president/CEO at MEBHC, all employees are offered and have access to the wealth of training and professional development opportunities offered by the organization. MEBHC also encourages employees to seek outside professional development and training opportunities that can help to enhance

and/or further develop their clinical skills to help better serve the organization's clientele. The organizational handbook outlines MEBHC's commitment to providing a supportive and progressive workforce environment, which is reviewed and signed by all employees.

High-Performance Workplace

Similar to how the organization builds and engages a positive workforce, the organization is deliberate in rewarding and recognizing performance that consistently meets or exceeds expectations. Performance standards and behavioral expectations are clear and discussed during performance reviews and coaching sessions between employees and the president/CEO. Mistakes are seen as opportunities for improvement, and collaboration is required for high-performance recognition. Staff members who are not meeting performance and/or behavioral expectations are counseled and (if necessary) quickly removed.

Talent acquisition practices involve interviews with peers and the inclusion of peer feedback in decision selection. According to the president/CEO, most contract employees have been through colleague referral or previous clinical supervisees. These means of employee referrals assure brand security and confidence that the modality of treatment is congruent with the mission and vision of MEBHC.

Process improvement measures are part of the overall organization and staff values. Through frequent and collective reflection, the staff works in collaboration to meet and exceed business and staff effectiveness goals. Contract employees are evaluated on a consistent and ongoing basis by their identified supervisor. Supervisors with MEBHC are expected to give contractors constructive feedback geared to improve their

practice and service delivery. Client conflict resolution, service feedback, and suggestions are also topics to be addressed in consultation with organization supervisors. MEBHC takes pride in having an open-door policy for employees to discuss any performance and/or other work-related concerns.

Key Services and Work Process

The president/CEO is primarily accountable for the design, management, and improvement of key organizational services and work processes. The key work processes are captured in the organization's standard operating and procedures manual and are developed, updated, and maintained by the president/CEO. With a small staff size, the president/CEO (with input from the leadership team) is accountable for the articulation of service delivery and business operation standards and expectations of the organization. Data collected from exit surveys are used to evaluate services and make necessary changes or improvements.

Contractors and employees are required to inform MEBHC leadership of any outside employment that maybe causes a conflict of interest, such as contracting or working for other organizations with a similar business to MEBHC. The goal of this policy is to help mitigate any negative and/or adverse impact on the MEBHC client base.

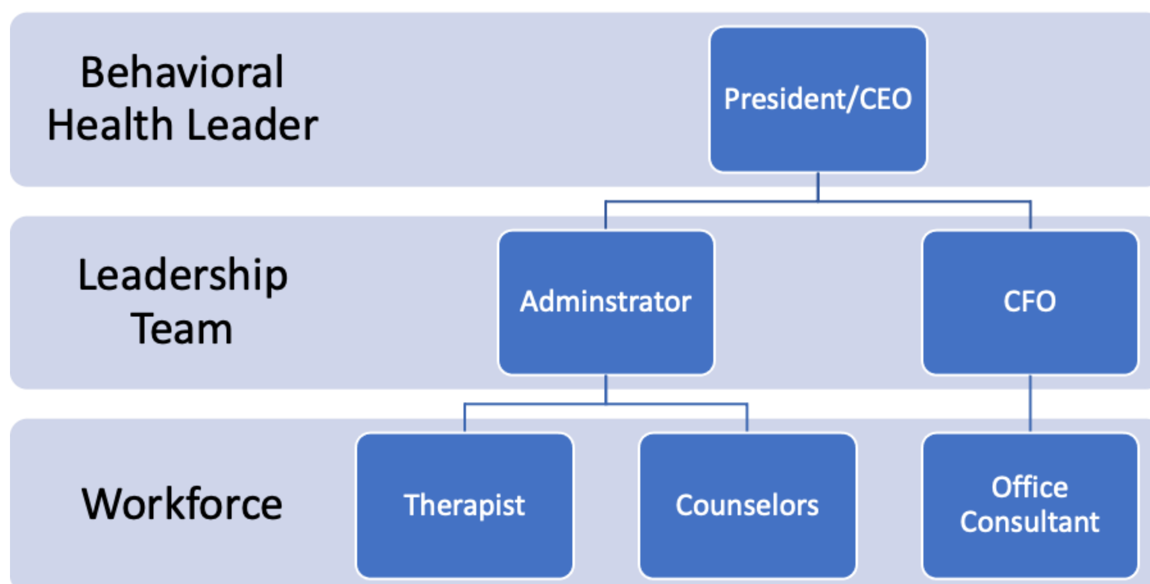
Management of Operations

The president/CEO is accountable for the operations of the organization. Members of the leadership team provide discussion, data, and feedback relative to the improvement and sustainment of organizational operation standards. The leadership team consists of the president/CEO, administrator, CFO and HR manager, intake director, and

office consultant (see Figure 4). Members of the leadership team are required to continuously evaluate the services and operation of their relative departments and bring suggestions for initiation, improvement, or elimination of programs, processes, and services.

Figure 4

Organizational Chart



Knowledge Management

The knowledge management processes of MEBHC are defined by the practices used to identify, create, present, and distribute knowledge among the workforce. These processes occur in the following ways:

1. Identify: Information gathering happens from the moment of client intake to the point of the client exit surveys. Client cases and pertinent information is discussed and distributed to the identified clinician by a member of the

executive team. Client records and documentation are kept secure and in compliance with all governmental or non-governmental mandates.

2. Create: The president/CEO uses established and empirical research to develop course curricula for identified areas of growth and/or need. MEBHC is a recognized professional training agency for mental health professionals; thus, all contractors and employees with the organization can attend training and professional developments to strengthen their practice and provide resources.
3. Present: The president/CEO conducts training programs for practitioners, training for staff, and training for community organizations.
4. Distribute: The president/CEO is a published author and speaker in the treatment of trauma; the organization creates informative pamphlets, has an updated website, distributes client resource information, participates in a weekly podcast, and speaks internationally.

Summary and Transition

MEBHC is intentional and strategic as they are focusing on ways to increase telehealth engagement with clients in the lower socioeconomic demographic. The president/CEO and leadership team are committed to helping this demographic find solutions to overcoming the barriers to telehealth access and engagement. The organizational leadership, through community outreach, has made efforts to decrease the negative stigma associated with mental health treatment, increase community awareness about telehealth, and help to support community access to technology and infrastructure necessary to support telehealth.

Section 4 of this study provides an analysis of factors that have contributed to the barriers to client engagement in telehealth, specifically those in the lower socioeconomic demographic, as identified in the practice problem. Sources of evidence gathered from MEBHC are evaluated, analyzed, and interpreted for a final presentation to the leadership team.

Section 4: Results–Analysis, Implications, and Preparation of Findings

Introduction

MEBHC is a small behavioral healthcare organization that has been in providing quality mental health treatment Middle Atlantic region of the eastern United States for over 15 years. MEBHC is a minority-owned behavioral healthcare organization that offers a plethora of mental health services to the community, such as individuals, couples, and groups for behavioral health treatment. The organization offers outpatient mental health services as well as professional training for clinicians seeking further education and professional growth. As with many other behavioral health organizations, the COVID-19 pandemic uncovered the dire need for affordable, accessible healthcare options and telehealth treatment has become one of the most viable options (Adepoju et al., 2021). As the patient care option of telehealth increased, the team at MEBHC noted a decrease in client engagement, specifically with those clients identified in the lower demographic. The goal of this qualitative case study was to explore strategies that would contribute to enhancing client engagement for those clients identified within the lower socioeconomic population.

In Section 4, I use the data collected in this study to address the identified RQs developed to better help MEBHC support its client base. The identified RQs are as follows:

RQ1: What are the current engagement challenges with telehealth?

RQ2: What strategies can lead to effective telehealth engagement?

In preparation for this qualitative study, a comprehensive and detailed literature review was conducted connected to the practice problem. Additional evidence for this study was gathered via interviews with some of the behavioral health organizations' leadership team members. Data were collected through semistructured interviews, conveyed by oral and written questioning. Interviews were recorded via audiotape to capture interviewee data, which were later documented and coded.

The organization is led by a lead clinician/CEO and supported by a series of independent practitioners with their clientele. In gathering information for this study, evidence was collected from various sources in an effort to respond to practice and organizational-related questions. These sources of evidence included interviews with some of the behavioral health organizations' leaders, the organization's website, the operations manual, and data from client entry and exit surveys. The team of behavioral health leaders from which information was gathered includes the following:

- President/CEO: Earned a doctorate in Clinical Psychology. Both Master’s and Bachelor’s degrees were earned in social work. Obtained additional licensing and certification as a LCSW and a certified anger management specialist I. A practicing clinician for over 20 years, with experience training and supervising clinicians seeking to license.
- Administrator: Earned a Master’s in business administration. Has worked in administrative roles for over 20 years.
- CFO and HR manager: Earned a Bachelor of Science degree. Has worked as an HR professional for over 20 years.

- Intake director: Earned a Bachelor of Social Work. Has over 15 years of experience in the field of mental and behavioral health.
- Office consultant: Earned a bachelor's degree in psychology and has over 20 years of experience in the mental health field.

This BHO provides outpatient mental health services to children, adolescents, and adults in the eastern mid-Atlantic region of the United States. A spectrum of therapeutic services is offered, which include individual, family, and couples therapy. At the end of this spectrum of mental health service offerings is the anger management groups, provided by the organization certified mental health specialist. This organization also provides professional development training (i.e., ethics, effective Dx & treatment planning, effective clinical note writing, adolescent depression, social work licensure exam) and continuing education courses for clinicians (see Table 2).

Table 2

Services Offered by MEBHC

Children	Adolescents	Adults	Clinical professional
Play therapy	Anger management	Anger management	Clinical supervision management/leadership seminar
Trauma therapy	Individual therapy	Couples therapy	Social work licensure exam prep course
Executive functioning	Family therapy	Individual therapy	Clinical practice & the business of mental health
Social anxiety	Mediation	Family therapy	Treating resistant clients
School phobia	Trauma therapy	Mediation	Understanding ethics & HIV/AIDS
Anxiety	Mentoring	Trauma therapy	Erikson's psychosocial stages of development and its relevance to clinical practice
Depression		Trauma bootcamp	Effective diagnosing & treatment planning
Grief counseling	Grief counseling	Mentoring	Adolescent depression
Anger and emotional regulation		Grief counseling	Understanding ethics
			Effective case management
			Enhancing clinical note writing workshop

Analysis, Results, and Implications

The initial coding of the interviews was comparable to the written thematic method, in that all data were entered via descriptive coding. The second entry for coding was to place the transcribed data in groupings of concepts so that data could be retrieved based on the specific commonality of concepts. The final area of coding was to group the interview data into patterns of information. The use of thematic coding via analytic memos was deployed as a tool to evaluate data collected from notes from Behavioral Health Leader's (BHL) interviews. Interviewees were provided with a list of questions (appendix) to review, prior to being interviewed. Responses to those questions were then documented in an Excel document. The Excel document listed each interviewee's response to the questions asked, and the responses were documented in two separate cycles of thematic analysis. The first cycle of analysis focused on the descriptive verbiage used for the interviewee's response. The second cycle of analysis focused on common themes or concepts used by the interviewee. The final documented notes in the Excel document were the interviewers' my notes that summarized thoughts and themes to specific questions responses. Quick referencing of the analytic memos assisted in recalling the specific interview and specific responses discussed. When entering the data for a second cycle of coding, all documented and coded information was entered into an Excel coding document. All information gathered from Behavioral Health Leader's interviews, the organization's website, the operations manual, and data from client entry and exit surveys were entered via three different coding methodologies. Below are the stages of coding that occurred and were captured in the Excel document for this study:

- Cycle 1: Descriptive coding: Reading through all responses to questions and coding based on topics.
- Cycle 2: Coding by concepts: Capturing the common theme that was documented in cycle one of coding.
- Cycle 3: Memo notes: Notes capturing the thoughts, ideas, and questions that were developed during the cycles of coding.

Thematic Results by RQ

RQ1 Theme: Education and Training

Members of the BHO had common responses regarding the education of all stakeholders about the availability, accessibility, and usability of telehealth support. Many of the responses to the interview questions pertained to both clients and staff not having the appropriate technology to access and use telehealth. This lack of access and use was particularly evident with the clients identified as being in the lower socioeconomic demographic. In the study, Chang et al. (2021) highlighted the digital divide that occurs with some clients in the lower socioeconomic demographic and their limited access to and infrastructure for telehealth support. In this study, I identified that clients' lack of training and education regarding what and how telehealth support works and offers contributed to decreasing engagement. The president/CEO reported that the client base lacked the understanding and scope of what support looks like with telehealth. Thus, this would require more training and exposure to telehealth to gain a better understanding and client buy-in. In terms of offering and providing clients with the training, support, and exposure necessary to increase telehealth engagement, this

organization is challenged with the capacity to provide all that is required. Improvements in technology infrastructure and accessibility are required to help support client training and education, which all can be cost-prohibitive for smaller BHOs such as MEBHC. There are concerns about costs related to training and education for infrastructure and capacity building, with smaller BHOs versus larger healthcare systems (Chang et al., 2021).

RQ2 Theme: Branding/Education

The success of any organization, be it big business or not-for-profit, is predicated on engaging current and potential customers and clients to actively understand the value of its products and services. Major and small brands posit to various segments of their audience to convey a compelling story of success and desired results, positioning their product or service as the solution to a problem or concern. Most understand this as the product or service's value proposition. In marketing, the value proposition is defined as an innovation, service, or feature intended to make a company or product attractive to customers. Payne et al. (2020) focused on the strategic intent of an organization and defined a value proposition as "a strategic tool facilitating communication of an organization's ability to share resources and offer a superior value package to targeted customers" (p. 245). It is through this strategic tool and critical communication channel that organizations not only increase sales and use but convey a compelling narrative about the unique value their service provides to current and future customers.

The same business and sales-centered strategies affixed to basic principles of marketing and branding can be potent and practical tools in promoting and positioning the telehealth

modality of treatment to members of all demographics, including those identified in the lower socioeconomic demographic, which was the focus of this study.

The data support that there need to be more opportunities for the BHO to promote the availability and benefits of telehealth. Currently, the president/CEO has various platforms (i.e., podcasts, books, speaking engagements) for messaging the benefits of mental health and trauma treatment; however, more exposure specific to telehealth support and availability are needed. As indicated by both the president/CEO and the office consultant, the majority of the organizations' client base has been via client and/or colleague referral. To increase that client base, which will effectively increase telehealth education and exposure, will hopefully effectively increase client engagement.

Similar to the marketing and communication approach used by high-reputation and popular brands in the marketplace, telehealth service providers must engage members of the target demographic by promoting the benefits of this treatment modality. Marketing and communication collateral must clearly describe the efficacy, benefits, access requirements, ease of utilization, and value of this treatment modality as a viable solution to a unique need. Segmented messaging (messaging to specific groups in the population) must be used to shepherd targeted clients from inquisitiveness to action. This approach may not be in the form of billboards or catchy slogans, but it is important to create the messaging and broadcast through appropriate vehicles to compel listeners to action, embracing the telehealth option as a viable solution to their mental health needs.

Key takeaways that may lead to increased engagement include the following:

- help make telehealth access simple

- help make technology access simple
- educate the targeted demographic about telehealth support
- promote accessibility, availability, and benefits of telehealth

Client-Focused Results

An analysis of data gathered from interviews with BHO leadership and organizational notes indicated that special attention had been given to increasing client engagement with telehealth. Special focus had been given to those clients in the lower socioeconomic demographic as that was the population identified as having a lower rate of telehealth participation. The BHO conducted community outreach activities that could help to educate, expose, and encourage greater client engagement in telehealth. Organization leadership deployed numerous multimedia and social media platforms as tools for education and to increase client engagement. In Figure 5, the large words are representative of the frequency with which interviewees used words to describe how the organization communicates its mission and vision.

Figure 5

Word Frequency Word Cloud for RQ1

Figures 6 and 7 provide a visual of how the organizational leadership articulates its communication plan relative to client/staff engagement with telehealth and how the challenges with telehealth engagement have been identified.

Figure 6

Word Frequency Word Cloud for RQ2

?

Figure 7

Word Frequency Word Cloud for RQ3

Client entry and exit surveys were additional tools for information gathering, as information collected informed a benchmark and goal for client engagement. The exit surveys indicated that client participation and engagement rates were primarily affected by funding sources. Based on financial records (see Figure 2) over 75% of this BHO's

client base were private or self-pay clients. The final 25%, which also correlated with the lower socioeconomic demographic, were grant, federal, and/or state-funded (i.e., Medicaid, Medicare). Also in Figure 8, interviewees identified some of the various ways the BHO collects client data.

Figure 8

Word Frequency Word Cloud for RQ4

Workplace-Focused Results

The Office consultant collected and synthesized the client entry and exit survey data. This data was charted, graphed, and distributed by the Chief financial officer. The BHO's president/CEO reviewed the data reports and discussed the areas of growth, routinely, as it is an organizational expectation to give feedback, suggestions, and solution-focused assistance to concerns identified as affecting client services.

The workforce with MEBHC is a one year term, or 12 months from the date signed contract with president/CEO. For the first 90 days of employment, all staffers are on a probationary period, in which they are subject to a successful evaluation by their

manager. Annual performance reviews are provided, within the first 12 months of hire, for all organization staffers.

The leadership team at MEBHC has experienced a decrease in the workforce since the spring of 2020. The organization's contractor staffing went from ten full-time contractors to the current status of two full-time clinical contract staffers. Prior to the global pandemic, the leadership team with MEBHC had secured a significant funding grant with Health Services for Children with Special Needs (CEO, personal communication, October 23, 2022). The funding from this grant enabled organizational leadership to contract additional staffers, as the grant required in-home therapeutic support to children, adolescents, and their families. When the global pandemic forced social distancing and isolation, in-home therapeutic support was drastically affected thus affecting staffing.

Leadership and Governance

Data were analyzed from information collected in interviews with the organization's president/CEO, Office consultant, and review of the strategic plan. This organization, established in January 2008, has not changed its leadership structure. The leadership has maintained the goal of providing clients with the highest quality of client care. While providing this clinical care, they wish to promote emotional, social, interpersonal, familial, and educational growth.

The leadership team with MEBHC shares in the vision and strategy for the organization’s goal. As part of the strategic plan for the next five years, the organization outlined several key areas:

- Developing and nurturing professional growth through mental health training.
- Providing clinical and/or therapeutic services to individuals, families, or groups experiencing mental illness.
- Providing trauma-focused therapeutic support.
- Providing mental health and/or therapeutic support to marginalized populations.

Financial and Marketplace Performance

The organization's financial and marketplace results were not a key area of focus in this study, as they did not have a direct impact on the practice problem. However, in interviews with the organization's president/CEO, the loss of one stream of revenue was an item of discussion. It was determined that as a result of the decrease in in-home therapeutic services, with the Health Services for Children with Special Needs contract, there was a significant decrease in organizational revenue. This required the organization to shift and reallocate financial priorities, as well as decrease their workforce. To maintain financial sovereignty, the organization had to pivot certain service modalities and secure additional streams of income. This pivot also required the organization to increase its services with other secured sources of income (i.e., Medicaid/Medicare, Private pay, and out-of-pocket payments).

Implications to Positive Social Change

The efficacy of social change, at its core, is to transform elements of the lives of others. Through the incremental application of learning acquired from scholarly reflection, critical thinking, and experimentation, social change can happen. Using

Stephan et al. (2016) definition of positive social change, “the process of transforming patterns of thought, behavior, social relationships, institutions, and social structure to generate beneficial outcomes for individuals, communities, organizations, society, and/or the environment beyond the benefits for the instigators of such transformation,” is the guide used for assessing the effects of the study. By providing training, professional development, community education, and outreach, the team at MEBHC is making an effort to effect positive social change.

Providing training and professional development to the organization's workforce, clinicians seeking licensure, and professionals seeking additional training enables the organization to aid in transforming the lives of individuals and their communities. Through community outreach tools from public speaking engagements, social media podcasts, and the Trauma Bootcamp, MEBHC has provided opportunities for effecting positive change in the lives of individuals and community members.

Findings from this study will help to address the gap in identifying some of the challenges to client engagement in telehealth. The results from this study might aid the organization in finding strategies to increase client engagement in telehealth, as well as distribute valuable information about the positive benefits of telehealth services. As access, technology, and negative stigma were identified as concerns with engagement, information derived from this study can aid in combating those obstacles.

Strengths and Limitations of the Study

Strengths

The purpose of this qualitative study was to explore the lived experience of barriers to clients' engagement with telehealth services. The organization wanted to take a laser focus on the barriers to disengagement when it came to clients within the lower socioeconomic demographic. Conducting this study from an ontological perspective enabled views of this disengagement from various perspectives, not just the lens of the leadership team with the organization. With this perspective one could prescribe the disengagement to a lack of access, technology, and education: however, not all will agree to those same contributing factors.

Collecting and analyzing data thematically, deepened this researcher's understanding of the experience from the perspective of the clients and targeted demographic. Information for this study was collected, coded, categorized, and organized by themes. This process included first collecting the data and assigning codes and categories to that collected data. In efforts to link the codes, thematic grouping was the second step. Then lastly, all data was detailed in a method that created a holistic picture of the identified information. Triangulation was implemented as a source to increase the credibility of the data collected.

Limitations

Knowing one's own biases and having a constant and consistent process for evaluating your perceptions and rationale for results is key in conducting qualitative research (Laureate Education, 2010). Researcher bias is one of the potential limitations of

this study. Creating a process for self-evaluation and reflection aided in minimizing some inherent biases, as a researcher that has worked within the field with similar demographics. A potential positionality issue that could have been a potential limitation was over-identifying with the targeted demographic experiences, and emotions, with having experienced that disengagement or disconnectedness.

Direct access to clients, as well as direct access to all contract staff, could have been a potential limitation, as it limits a holistic perspective of the responses to the identified practice problem. As the primary source of business is occurring remotely and via video conferencing, both contract staff and clients were not easily accessible.

Section 5: Recommendations and Conclusions

The goal of this qualitative case study was to explore strategies that contribute to enhancing client engagement for those clients identified within the lower socioeconomic demographic. Data were collected through semistructured interviews, conveyed by oral and written questioning. Interviews were also recorded to capture interviewee data that were later documented and coded. The results of the data analysis were used to provide recommendations for addressing the practice problem. Based on the data gathered and the synthesized analysis, recommendations are made to address the practice problem.

Recommendation 1: Internet Accessibility

In a study about medical clinic disparities that support the unserved, researchers found that close to 15% of households do not have internet access (Adepoju et al., 2021). That statistic, coupled with the correlation of lower socioeconomic status (a social determinant of health), lends itself to a greater disconnect with internet accessibility. The use of telehealth services assumes that clients have the technology and internet accessibility necessary to effectively engage in services. Assuring that clients have appropriate in-home internet accessibility and/or access to confidential facilities where internet support is accessible is key to increased client engagement.

If clients do not have access to in-home internet, providing clients with resources for securing and/or locating free and confidential internet-accessible locations would be a goal for the BHO leadership team. Assisting with these resources can enable increased engagement with the targeted client demographic.

Recommendation 2: Organization Infrastructure

Chang et al. (2021) identified the importance of having the appropriate technology infrastructure to support the increased capacity of clients using telehealth support. With larger behavioral health organizations, some of the costs required to increase infrastructure needs can be shared across the network or multiple facilities. With smaller, or independent behavioral health organizations, the cost to build the required infrastructure can be great.

Recommendation 3: Privacy

Adepoju et al. (2021) looked at how telehealth services were deployed to chronically underserved populations and reported that although over 94% of clients participating in telehealth services were happy with their visits, a third of those clients also reported preferring in-person visits. Some of the concerns outlined with the telehealth visits were the appropriate use of technology and personal privacy. Privacy can be a major concern even when the family is aware and in support of telehealth services. One of the biggest concerns noted was the fear of concerns being over-heard. As a proactive measure to securing client privacy, Burgoyne and Cohn (2020) suggested that one can troubleshoot for privacy breaches before the session begins using the following strategies:

- asking the client if headphones are available
- asking if there is a private space for the client to participate in telehealth
- assuring that the client is using a secured connection

Securing privacy for clients can help to support client engagement. This is a challenging task because with MEBHC, the third largest client population is children between the ages of 0 to 17 (see Figure 3). It is key when serving this population to set clear guidelines and expectations for all involved to aid in creating a secure and confidential environment for the child client.

Recommendation 4: Community Outreach and Branding

One method of addressing the technology challenge and privacy concerns is through community outreach and branding. MEBHC does an excellent job of reaching out to the community through specific social media sites and free workshops. MEBHC has increased its community presence by broadening their social media presence, updating the organization's website to include all speaking engagements and community appearances, as well as establishing a marketing budget to promote services and publications.

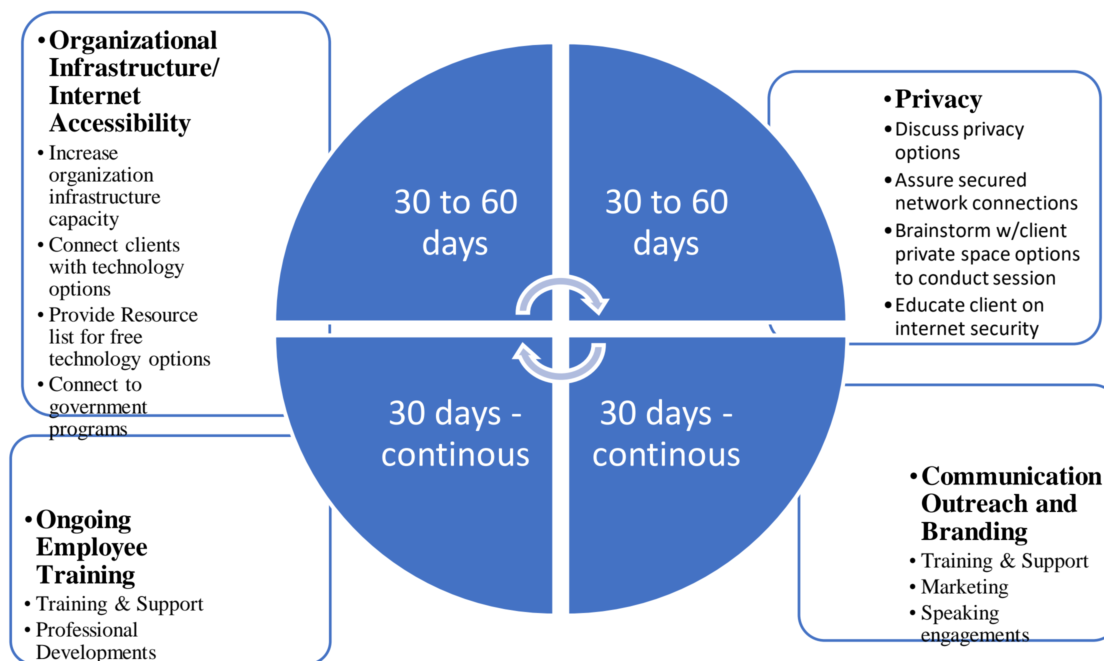
Recommendation 5: Ongoing Employee Training

Currently, all MEBHC contractors receive routine training and supervision from organization leadership. With the increased use of telehealth and the ever-changing guidelines for certification and reimbursement, it is crucial for staff to be knowledgeable about the appropriate way to engage clients.

Additional training and support with telehealth technology would also be beneficial for organizational staff as the usability, capability, and functionality of the telehealth modality is improving and evolving with increased usage.

Figure 9

Implementation Plan for Recommendations



Recommendation for Future Studies

In this research study, the practice problem addressed the strategies that could contribute to enhancing client engagement for those clients identified within the lower socioeconomic population. There were numerous barriers identified that had significant research to support the findings. Dissecting the findings to identify specific barriers based on age and gender as they relate to socioeconomic status could be a worthwhile follow-up study.

One specific area for further study may be the correlation of African American clients as it relates to the lower socioeconomic demographic and their engagement and access to telehealth support. Blake et al. (2021) noted that there is a dire need to

understand how African Americans understand healthcare services and digital options. The research further supports that this absence of understanding contributes to this demographic lack of access to and engagement with healthcare options. Taking a deeper look into how closely socioeconomic status and being of the African American demographic increase or decrease telehealth access and engagement could also be a useful topic of study.

Dissemination Plan

The plan for dissemination of the study results is with a final meeting with the BHO's president/CEO to discuss the study findings and provide recommendations to address the practice problem. In this meeting, an executive summary and PowerPoint presentation will be shared with the findings and recommendations from the study. The BHO leadership team will also be presented with a recommended implementation plan that outlines a 3-month suggested plan for recommendation deployment.

Conclusion

This qualitative study, conducted at a behavioral health organization located in the mid-Atlantic region of the United States, focused on strategies that contributed to enhancing client engagement for those clients identified within the lower socioeconomic demographic. When the World Health Organization announced the coronavirus outbreak as a global pandemic, clinicians had to change their service delivery model to maintain continuity of care (Burgoyne & Cohn, 2020). As a means of staying connected and providing needed support, many turned to telehealth as their primary service delivery

model. However, keeping clients connected and engaged became a challenge for most healthcare providers.

The increase in telehealth services highlighted a divide in digital access and digital education, specifically for those identified in the lower socioeconomic and medically disadvantaged demographic (Chang et al., 2021). The goal of this study was to identify some of these barriers and offer some possible recommendations for addressing the barriers.

References

Adepoju, O., Liaw, W., Chae, M., Ojinnaka, C., Britton, E., Reves, S., & Etz, R. (2021). COVID-19 and telehealth operations in Texas primary care clinics: Disparities in medically underserved area clinics. *Journal of Health Care for the Poor and Underserved, 32*(2), 948–957. https://doi.org/10.1353/hpu.2021.0073

Aykanian, A. (2023). A qualitative exploration of frontline homeless service worker experiences during the COVID-19 Pandemic. *Journal of Social Service Research*, *49*(1), 67–78. https://doi.org/10.1080/01488376.2022.2157523

Baker, A. J. L., Konigsberg, M., Brown, E., & Adkins, K. L. (2023). Successes, challenges, and opportunities in providing evidence-based teletherapy to children who have experienced trauma as a response to Covid-19: A national survey of clinicians. *Children and Youth Services Review*, *146*(0). https://doi.org/10.1016/j.childyouth.2023.106819

Baker, D. R., Cadet, K., Mani, S., & Chatterjee, P. (2021). Proactively connecting residents in underserved and low socioeconomic status communities with "virtual hospital" telehealth access in response to the COVID-19 pandemic. *Journal of Health Care for the Poor and Underserved, 32*(2), 189-197. https://doi.org/10.1353/hpu.2021.0057

Baldrige Performance Excellence Program. (2021). *2021-2022 Baldrige excellence framework (health care): A systems approach to improving your organization's performance*. U.S. Department of Commerce, National Institute of Standards and Technology. https://www.nist.gov/baldrige

Barakat, S., Maguire, S., Smith, K. E., Mason, T. B., Crosby, R. D., & Touyz, S. (2019). Evaluating the role of digital intervention design in treatment outcomes and adherence to eTherapy programs for eating disorders: A systematic review and meta-analysis. *International Journal of Eating Disorders*, *52*(10), 1077–1094. https://doi.org/10.1002/eat.23131

Blake, H., Bihm, J., Nkwanyuo, R., & Oshodi-Abikan, T. A. (2021). Beyond COVID-19: The state of telehealth equity and best practices in underserved populations. *The Journal of Law, Medicine & Ethics: A Journal of the American Society of Law, Medicine & Ethics, 49*(3), 410–414. https://doi.org/10.1017/jme.2021.61

Burgoyne, N., & Cohn, A. S. (2020). Lessons from the transition to relational teletherapy during COVID-19. *Family Process*, *59*(3), 974–988. https://doi.org/10.1111/famp.12589

Chang, J. E., Lai, A. Y., Gupta, A., Nguyen, A. M., Berry, C. A., & Shelley, D. R. (2021). Rapid transition to telehealth and the digital divide: Implications for primary care access and equity in a post-COVID era. *Milbank Quarterly, 99*(2), 340–368. https://doi.org/10.1111/1468-0009.12509

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology*, *11*(1), 100–108. https://doi.org/10.1186/1471-2288-11-100

Goldin, D., Maltseva, T., Scaccianoce, M., & Brenes, F. (2021). Cultural and practical implications for psychiatric telehealth services: A response to COVID-19. *Journal of Transcultural Nursing*, *32*(2), 186–190.

https://doi.org/10.1177/1043659620973069

Grieco-Page, H., Black, C. J., Berent, J. M., Gautam, B., & Betancourt, T. S. (2021). Beyond the pandemic: Leveraging rapid expansions in U.S. telemental health and digital platforms to address disparities and resolve the digital divide. *Frontiers in Psychiatry*, *12*, 1–5. https://doi.org/10.3389/fpsyt.2021.671502

Johnson, J. A. (2017). *Health organizations* (2nd Edition). Jones & Bartlett Learning. https://mbsdirect.vitalsource.com/books/9781284151954

Kwon, K., & Park, J. (2019). The life cycle of employee engagement theory in HRD research. *Advances in Developing Human Resources, 21*(3), 352-370. https://doi.org/10.1177/1523422319851443

Laureate Education (Producer). (2010). *Doctoral research: Ensuring quality in qualitative research* [Video file].

Lynch, D. A., Stefancic, A., Cabassa, L. J., & Medalia, A. (2021). Client, clinician, and administrator factors associated with the successful acceptance of a telehealth comprehensive recovery service: A mixed methods study. *Psychiatry Research*, *300*. https://doi.org/10.1016/j.psychres.2021.113871

Mandel, I., & Howson, A. (2021). Causes of social change. *Salem Press Encyclopedia*.

Merz, S. M. (2021). Behavioral health in the pandemic: Making the shift from mental illness to mental well-being. *Frontiers of Health Services Management*, *38*(1), 32–38. https://doi.org/10.1097/HAP.0000000000000122

Moorman, L. K. (2022). COVID-19 pandemic-related transition to telehealth in child and adolescent mental health. *Family Relations*, 71(1), 7– 17. https://doi.org/10.1111/fare.12588

Narh-Mensah, N. (2022, October 27). Maryland life expectancy data highlights racial disparities. *Washington Informer*, *58*(2), 13.

Northouse, P. G. (2019). *Leadership: Theory and practice (8th ed.)* SAGE Publishing.

Park, J., Erikson, C., Han, X., & Iyer, P. (2018). Are state telehealth policies associated with the use of telehealth services among underserved populations? *Health Affairs, 37*(12), 2060-2068. https://doi.org/10.1377/hlthaff.2018.05101

Patten, M. L., & Newhart, M. (2018). *Understanding research methods: An overview of the essentials* (10th ed.). Routledge.

Payne, A., Frow, P., Steinhoff, L., & Eggert, A. (2020). Toward a comprehensive framework of value proposition development: From strategy to implementation. *Industrial Marketing Management*, *87*, 244–255. https://doi.org/10.1016/j.indmarman.2020.02.015

Perle, J. G., Burt, J., & Higgins, W. J. (2014). Psychologist and physician interest in telehealth training and referral for mental health services: An exploratory study. *Journal of Technology in Human Services*, *32*(3), 158–185. https://doi.org/10.1080/15228835.2014.894488

Perrin, P. B., Rybarczyk, B. D., Pierce, B. S., Jones, H. A., Shaffer, C., & Islam, L. (2020). Rapid telepsychology deployment during the COVID-19 pandemic: A special issue commentary and lessons from primary care psychology training.

Journal of Clinical Psychology, *76*(6), 1173–1185. https://doi.org/10.1002/jclp.22969

Pierce, B. S., Perrin, P. B., Tyler, C. M., McKee, G. B., & Watson, J. D. (2021). The COVID-19 telepsychology revolution: A national study of pandemic-based changes in US mental health care delivery. *American Psychologist*, *76*(1), 14–25. https://doi.org/10.1037/amp0000722

Price, S. K., Coles, D. C., & Wingold, T. (2017). Integrating behavioral health risk assessment into centralized intake for maternal and child health services. *Health and Social Work*, *42*(4), 231.

Price, S. T., Mainous, A. G., & Rooks, B. J. (2022). Survey of cancer screening practices and telehealth services among primary care physicians during the COVID-19 pandemic. *Preventive Medicine Reports*, *27*, 101769. https://doi.org/10.1016/j.pmedr.2022.101769

Shuck, B., Adelson, J. L., & Reio, T. G., Jr. (2017). The employee engagement scale: Initial evidence for construct validity and implications for theory and practice. *Human Resource Management, 56(0),* 953-977.

Stephan, U., Patterson, M., Kelly, C., & Mair, J. (2016). Organizations driving positive social change. *Journal of Management*, *42*(5), 1250–1281. https://doi.org/10.1177/0149206316633268

Tar-Mahomed, Z., & Kater, K.-A. (2022). The perspectives of speech–language pathologists: Providing teletherapy to patients with speech, language and

swallowing difficulties during a COVID-19 context. *South African Journal of Communication Disorders*, *69*(2), e1–e7. https://doi.org/10.4102/sajcd.v69i2.902

Watson, J. D., Pierce, B. S., Tyler, C. M., Donovan, E. K., Merced, K., Mallon, M., Autler, A., & Perrin, P. B. (2023). Barriers and facilitators to psychologists' telepsychology uptake during the beginning of the COVID-19 pandemic. *International Journal of Environmental Research and Public Health*, *20*(8). https://doi.org/10.3390/ijerph20085467

Xiang, J., & Stanley, S. J. (2017). From online to offline: Exploring the role of e-health consumption, patient involvement, and patient-centered communication on perceptions of health care quality. *Computers in Human Behavior, 70*(0), 446–452. https://doi.org/10.1016/j.chb.2016.12.072

Appendix: Interview Questions

Initial Questions

- How are the organization's vision, mission, and values communicated to the program participants? Organizational partners?
- How is information regarding client engagement communicated with staff?
- How do you know that there are problems with client engagement? What is the measure?
- What type of client data is collected? How often?
- Who decides what is collected? How is that determined?
- How has the problem been addressed?
- How frequently do you check in with program participants?
- What attempts have been made to reengage clients?

Follow-up Questions

- What is the organizational structure?
- What are the organization's reporting relationships?
- What are the reporting relationships among the leadership team?
- Who is the organization's client base? Demographics? Age? Gender?
- Who are the organization’s community partners? Stakeholders?
- What are the organization’s funding sources?
- What are the organization’s main healthcare service offerings?
- Who are the organization’s compliance partners?
- What is the organization’s performance evaluation process?
- What are the organization’s community outreach efforts?