Telebehavioral Health: Overview, pragmatics, and innovation

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Overview

I. Terms
II. Rationale
III. Evidence base
IV. Standards of practice
V. Logistics and Considerations
VI. Innovation

I. Terms

"Telehealth"

The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education through interactive video, audio, or data communications.

ARS-30-301
I. Terms

Examples of applications to medical field:
- Dermatology
- Radiology
- Pathology
- Dental
- Emergency medicine
- Primary care/school health

Examples: Medical

- Views from a video otoscope

http://www.preferredproduct.com/new_page_1.htm
Examples: Medical

I. Terms

Examples of applications to psychology/psychiatry
- Neuropsychology
- Pediatric psychology
- Primary Care psychology
- Geropsychology
- Prison-based intervention
- Veteran’s Administration
- Native Americans
- Generalist Practice

I. Terms

Methods:
- Two-way video conferencing
- Store-and-forward technology
- Home health monitoring
- Web-based interventions
- Desktop conferencing
Two-Way Videoconferencing

Equipment:
- Monitor-Based
- PC-Based, “Web Cams”

II. Rationale

• To address problems with access to services

II. Rationale

• Wyoming Network for Telehealth-WyNETTE
• AIANP Telepsychiatry Clinics – Colorado
• University of Virginia Telemedicine Program
• Mayerson Center for Safe and Healthy Children - Ohio
• Care Coordination Home Telehealth - Utah
II. Rationale: Rural Nebraska

Pediatric Behavioral Health Outreach Program

Mission
1. Provide Primary Behavioral Health Care
2. Train and Retain Providers
3. Conduct research
4. Address public policy

Adjunct Service:
“The Parenting Solutions Call-In Service”

Aims
• Provide needed specialty service
• Prevent/intervene early
• Triage to co-located clinic
• Save physicians time
II. Rationale: Rural Nebraska

Adjunct Service:
“The Pediatric Behavioral Telehealth Clinic”

Aims
• Provide temporary services as needed
• Provide “permanent” services as needed
• Provide specialty services
• Give consumers choice

II. Rationale: Rural Nebraska
The Pediatric Behavioral Telehealth Clinic

1st 15 months:
• 49 families in over 150 visits
• 4-10 visits provided weekly
• From 11 remote sites as far away as 420 mi.

II. Rationale: Rural Nebraska

Patients Seen:
• Age: Avg. = 7.3 yrs
• Insurance: 50% Medicaid
• Referral: Primary care physicians
• Sessions: Avg. = 4
• Distance: 14 miles
II. Rationale: Rural Nebraska

III. Evidence Base

- Satisfaction
- Outcomes
  - Specialty
  - Primary Care

- Patients reported higher satisfaction of physician interpersonal and clinical skills, use of patient-centered communication, and convenience (Agha, et al., 2009)
- Participant’s average satisfaction rate of 88% after initial assessment and 95% after review sessions (Styles, 2008)
- Rural patients reported greater satisfaction with telepsychiatry consults than urban patients (Hilty, et al., 2007).
- 81% of patients rated the ability of telemedicine to meet their medical needs as “excellent” or “very good.” (Nesbitt et al., 2005)
- 99% of patients rated their overall satisfaction with telemedicine as “excellent” or “very good.” (Nesbitt et al., 2005)
III. Evidence Base

Outcomes: Telemental Health

• Majority of evidence base from outpatient clinics
  – Patients can be reliably assessed, diagnosed and treated in outpatient settings with various equipment and communication protocols
• Evidence shows that patients adapt easily to telemedicine and are able to build rapport with providers
• Adult diagnostic assessments conducted via videoconferencing are comparable to face-to-face
  ▪ Good reliability and validity for a variety of diagnostic and neuropsychological assessments
• Evidence supports use for psychoeducation, individual psychotherapy, and group psychotherapy

III. Evidence Base: Example

Example #: University of Texas Southwestern Medical Center at Dallas

▪ Satellite clinic for Alzheimer’s in Talihina, OK
▪ Polycom units at both sites
▪ Use of common neuropsych measures for dementia evaluations
▪ Pilot study of about 30 mildly impaired older adults (60+)
▪ Assessment results equivalent for face-to-face and telehealth assessments


III. Evidence Base: Example

Example #2: Kansas University Medical Center

▪ 8-week CBT intervention for children with depression
▪ 2 PC-based PictureTel Systems (slow speed)
▪ 28 children randomly assigned to receive CBT treatment via face-to-face or videoconferencing
▪ Faster rate of decline in depression score for video group

III. Evidence Base: Example

Example #3: University of Sydney

- 51 discharged psychiatric inpatients; assigned to care-as-usual versus psycho-education by videoconferencing
- Video sessions included patient, nurse, psychologist, and social worker and family member
- Group receiving telemedicine reported greater treatment adherence, fewer medication side effects, and greater treatment satisfaction than control group


III. Evidence Base

Outcomes: Primary Care

- Rural and urban patients willing to see providers via telemedicine for medical or psychiatric appointments (Grubaugh, et al., 2008)
- Rural providers and patients believe that telemedicine can help to solve problems accessing care (Hilty, et al., 2007; Swinton, et al., 2009)
- Telepsychiatry services can effectively support primary care services in rural areas (Pignatiello, et al., 2008)
- Telepsychiatry appointments more likely to be kept than face to face appointments (Leigh, et al., 2009)
- Cognitive-behavioral group treatment of anger associated with PTSD delivered via videoconference as effective as face to face treatment (Morland, et al., 2010)
- Depression treatment outcomes equivalent for treatment via videoconferencing and face to face (Ruskin, et al., 2004)

IV. Standards of Practice

- ATA Telehealth Standards for Mental Health
- ATA Standards for Two-Way Videoconferencing
IV. Standards of Practice

The APA Ethics Code 2002

“This Ethics Code applies only to psychologists’ activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions.”

IV. Standards of Practice

- Caveats to typical practice
  - Reporting laws for distal sites
  - Informed consent
  - Licensure
  - Privacy and confidentiality
  - Emergencies and crisis management
  - Familiarity with technology

V. Logistics & Considerations

- Equipment
- Payment
- Administration
- Therapeutic
- Cultural
V. Logistics & Considerations

• Equipment
  – PC-based vs. Monitor-based
  – Internet vs. T1 lines
  – Ancillary equipment
    • Phone/fax in proximity
    • Materials at distal site(s)

V. Logistics & Considerations

• Who pays for telehealth visits?
  – Most insurers (see handout)
  – Use modifier
  – Some support for assistance at distal site
  – A word about grant funding

V. Logistics & Considerations

• Points regarding administration
  – Central scheduler/manager
  – IT personnel
  – Site coordinator
V. Logistics & Considerations

• Therapeutic Considerations
  – Sit > 8’ to improve “eye contact.”
  – Frame head and tops of shoulders.
  – Use PIP to insure your image.
  – Practice with the remote.
  – Be aware of “mute.”
  – If possible, keep your materials in front of you.

V. Logistics & Considerations

• Therapeutic Considerations
  – Wear blue, or at least, no stripes.
  – Exaggerate nonverbal behavior.
  – Label your “off screen” behavior.
  – “Mute” your microphone when not talking.

V. Logistics & Considerations

• Therapeutic Considerations
  – Discuss concerns or skepticism at outset and throughout.
  – “Shape” interaction with equipment by reinforcing verbalizations, use of remote, response to delay, etc.
  – Consider having children or others who may be disruptive “skip” the first visit.
  – Vocalize/ask about what you can’t see/hear.
  – Reinforce patient responsiveness to atypical framework.
V. Logistics & Considerations

• Cultural Considerations
  – Engage site visits at intervals.
  – Consider focusing on one geographic area.
  – Know as much as possible about client’s town/geographic area.
  – Acknowledge needs while working toward increased cultural competence.
  – Take action when clients are not responding well.

VI. Innovation

Southern Appalachian Children’s Telebehavioral Health Clinic

• Funded via subaward from OAT grant (HRSA)
• Builds this service into existing specialties
• Focus on behavioral pediatrics especially obesity, diabetes management
VI. Innovation

Moving toward integrated care
- Building rapport with physicians; fluency in use of technology
- Developing abbreviated referral process
- Piloting an “open hours” clinic

VI. Innovation

Store-and-Forward Technology

VI. Innovation

Home-Health Technology
VI. Innovation
Web-Based “Digital Coaching”

II. Rationale
• To improve access
• To engage a population-based approach
• To provide more efficient and more effective care
Resources

- HRSA Guide to Getting Started
  http://telehealth.muhealth.org/general%20information/TAD.html