Disclaimer

- WHO I AM: I am a licensed psychologist, not an attorney, physician, marketing or information technology (IT) professional.

- MY GOALS: I hope to inspire you. I will outline the issues in an educational format and alert you to what's happening to help you think through the issues. No warranty, guarantee, or representation is made as to the accuracy or sufficiency of the information contained in my presentation for your specific circumstance. I assume no responsibility in connection with your choices.

- YOUR PART: Seek documented training for “competence.” Seek written approval from your legal, regulatory, ethical and malpractice bodies before offering any online services or programs to consumers. Have your informed, trusted, local, clinical and legal consultants review all written responses from the authorities for their full significance.
For slides and other resources:

www.Telehealth.org/cibhs
Telehealth vs. Telemedicine

Telehealth
- Health Professions Education
- Administration
- Evaluation Research
- Homeland Security

Telemedicine
- Regional Health Information Sharing
- Consumer Education
- Public Health
-TeleMental Health Institute
Traditional Video-Based Telehealth

- Hub-and-spoke model can serve many patients from a central site
  - Only work with previously identified clients/patients
  - Detailed and documented referral requests
  - Detailed health record at fingertips of clinician
  - Client/patient is at the “originating site”
  - Clinician is at the “distant” site
  - Community collaborator is available
- Client/patient is pre-trained by staff
- Technology is stable
  - IT staff is available during clinical encounter with client/patient
Evidence-Base
Benefits of Video-Based Telehealth

- Increased client satisfaction
- Decreased travel time
- Decreased travel, child & elder-care costs
- Increased access to underserved populations
- Improved accessibility to specialists
- Reduced emergency care costs
- Faster decision-making time
- Increased productivity / decreased lost wages
- Improved operational efficiency
- Efficacy is on par with in-person care for many groups
- Decreased hospital utilization

Why Telemental Health?

- Governments worldwide have been building the telehealth infrastructure since 1950’s
- Security / privacy / reliability and ease-of-use of technology has increased
- Many evidence-based models shown safe and effective for behavioral care
Supporting Research

- Godleski, Darkins & Peters reported in April of 2012 that hospital utilization in psychiatric populations at the Veterans Administration were decreased by an average of 25% since the use of telehealth. It is worthy of note, however, that:
  - This study focused on clinic-based, high-speed videoconferencing and did not include any home telehealth encounters. Mental health patients were referred for telecare by clinicians. Typically, telemental health services were provided remotely at community-based outpatient clinics by mental health providers of all disciplines located at larger parent VA hospital facilities. Equipment consisted of either room or personal desktop videoconferencing units transmitting at 384 kbps or greater.

Reviewed a total of 755 studies and included 85 studies.

Results: Telemental health is effective for diagnosis and assessment across many populations (adult, child, geriatric, and ethnic) and for disorders in many settings (emergency, home health) and appears to be comparable to in-person care. In addition, this review has identified new models of care (i.e., collaborative care, asynchronous, mobile) with equally positive outcomes.
SYNCHRONOUS TELEHEALTH TECHNOLOGIES IN PSYCHOTHERAPY FOR DEPRESSION: A META-ANALYSIS

Janyce E. Owenbach, Ph.D., Karen M. O'Brien, Ph.D., Matthew Mishkind, Ph.D., and Derek J. Smolenishi, Ph.D., M.P.H.

Background: Many patients suffering from depression lack immediate access to care. The use of synchronous telehealth modalities to deliver psychotherapy in one solution to this problem. This meta-analysis examined differences in treatment efficacy for psychotherapy administered via synchronous telehealth as compared to standard nontelehealth approaches. Method: We located 14 articles that met inclusion criteria of the use of a synchronous telehealth modality for treatment compared to a standard nontelehealth modality comparison group. Results: Overall, a statistically significant systematic difference between modes of delivery was not identified ($g = 0.14$, $SE = 0.08$, 95% CI $= [-0.03$, 0.30], $P = .098$, $I^2 = 49.74$%). Stratification methods and meta-regression were used to analyze the contributions of type of comparison group, intervention modality, and targeted mental health outcome to moderation of effect size (ES) estimates and heterogeneity. Type of comparison group (face-to-face versus care-as-usual) had the strongest influence on observed heterogeneity and moderated the summary ES. The only detectable difference in efficacy was restricted to studies that used care-as-usual as the comparison group ($g = 0.29$, $SE = 0.06$, 95% CI $= [0.16$, 0.41], $P < .001$, $I^2 = 34.14$%). Conclusions: Overall, we found no evidence to suggest that the delivery of psychotherapy via synchronous telehealth modalities is less effective than nontelehealth means in reducing depression symptoms. Depression and Anxiety 00:1–10, 2013.

Key words: depression; telehealth; telemental health; meta-analysis

INTRODUCTION

Depression is often referred to as the "common cold" of mental health; it is widespread, has established treatments, and is costly when not treated. According to results from the National Comorbidity Survey Replication, the 12-month and lifetime prevalence rates for depression in the United States are 6.7% and 16.2%, respectively. Moreover, 72.1% of lifetime cases and 78.5% of 12-month cases had comorbid DSM-IV diagnoses. Worldwide, depression has been cited as the leading cause of disability (1) and depression cases upwards of 40 billion dollars yearly in lost work time in the United States alone. Fortunately, various types of psychotherapy have proven effective in the treatment of depression symptoms (1) however, a significant portion of the population who stands to benefit from psychotherapy will not or cannot access it.

Only about 20% of patients with depression follow up on referrals for psychotherapy (6-12). In spite of consistent findings that patients report a preference for psychotherapy over medication (6-12), practical barriers to care offer one set of reasons for why follow up rates are low for many psychiatric concerns as it has been estimated that 77% of counties in the United States have a shortage of mental health providers, (13) and clinicians trained to
### SYNCHRONOUS TELEHEALTH TECHNOLOGIES IN PSYCHOTHERAPY FOR DEPRESSION: A META-ANALYSIS

Janyce E. Osenbach, Ph.D.,* Karen M. O’Brien, Ph.D., Matthew Mishkind, Ph.D., and Derek J. Smolenski, Ph.D., M.P.H.

#### TABLE 1. Publication descriptions

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Intervention modality</th>
<th>Comparison</th>
<th>Psychological focus</th>
<th>Depression outcome measure</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dorstyn et al. (2012)</td>
<td>7 bi-weekly sessions of SCT</td>
<td>TC</td>
<td>CAU</td>
<td>General mental health</td>
<td>DASS-21</td>
<td>Outpatients from a spinal injuries rehabilitation center</td>
</tr>
<tr>
<td>Fruch et al. (2007)</td>
<td>14 weekly group sessions of CBT TT</td>
<td>VC</td>
<td>FTF</td>
<td>Posttraumatic stress disorder</td>
<td>BDI</td>
<td>Combat veterans</td>
</tr>
<tr>
<td>Heckman and Carlson (2007)</td>
<td>8 weekly group sessions of coping improvement CBT TT</td>
<td>TC</td>
<td>CAU</td>
<td>General mental health</td>
<td>BDI</td>
<td>HIV-positive individuals</td>
</tr>
<tr>
<td>Lovell et al. (2006)</td>
<td>10 weekly sessions of exposure CBT TT</td>
<td>TC</td>
<td>FTF</td>
<td>Obsessive-compulsive disorder</td>
<td>BDI</td>
<td>Outpatients from a psychology clinic</td>
</tr>
<tr>
<td>Ludman et al. (2007)</td>
<td>8 semi-monthly sessions of CBT TT and pharmacotherapy</td>
<td>TC</td>
<td>CAU</td>
<td>Depression</td>
<td>HSCL</td>
<td>Outpatients from a psychology clinic</td>
</tr>
<tr>
<td>Lynch et al. (2004)</td>
<td>6 weekly sessions of problem solving CBT TT</td>
<td>TC</td>
<td>CAU</td>
<td>Depression</td>
<td>BDI</td>
<td>Outpatients from a family practice clinic</td>
</tr>
<tr>
<td>Miller and Weissman (2002)</td>
<td>12 weekly sessions of SCT</td>
<td>TC</td>
<td>CAU</td>
<td>Depression</td>
<td>HRSD</td>
<td>Ongoing longitudinal study of women</td>
</tr>
<tr>
<td>Mitchell et al. (2008)</td>
<td>20 sessions of CBT TT over 16 weeks</td>
<td>VC</td>
<td>FTF</td>
<td>Bulimia nervosa</td>
<td>BDI</td>
<td>Community sample</td>
</tr>
<tr>
<td>Mohr et al. (2000)</td>
<td>8 sessions of weekly CBT TT</td>
<td>TC</td>
<td>CAU</td>
<td>Depression</td>
<td>POMS</td>
<td>Outpatients with Multiple Sclerosis</td>
</tr>
<tr>
<td>Mohr et al. (2012)</td>
<td>18 sessions of CBT TT over 18 weeks</td>
<td>TC</td>
<td>CAU</td>
<td>General mental health</td>
<td>HAM-D</td>
<td>Outpatients from primary care clinics</td>
</tr>
<tr>
<td>Napolitano et al. (2002)</td>
<td>8 weekly sessions of CBT TT</td>
<td>TC</td>
<td>CAU</td>
<td>Depression</td>
<td>GHQ depression</td>
<td>Patients awaiting lung transplant</td>
</tr>
<tr>
<td>Nelson et al. (2003)</td>
<td>8 weekly sessions of CBT TT</td>
<td>TC</td>
<td>CAU</td>
<td>Depression</td>
<td>CDI</td>
<td>Children, ages 8 to 14</td>
</tr>
<tr>
<td>Simon et al. (2004)</td>
<td>8 weekly sessions of CBT TT</td>
<td>TC</td>
<td>CAU</td>
<td>Depression</td>
<td>HSCL</td>
<td>Outpatients from a primary care clinic</td>
</tr>
<tr>
<td>Strachan et al. (2011)</td>
<td>8 weekly sessions of CBT TT</td>
<td>VC</td>
<td>FTF</td>
<td>Posttraumatic stress disorder</td>
<td>BDI</td>
<td>Combat veterans</td>
</tr>
</tbody>
</table>

Note: BDI, beck depression inventory; CAU, care-as-usual; CBT TT, cognitive-behavioral telehealth therapy; CDI, children’s depression inventory; DASS-21, depression, anxiety, and stress scale; FTF, face-to-face; GHQ, general health questionnaire; HAM-D, Hamilton depression rating scale; HRSD, Hamilton rating scale for depression; HSCL, Hopkins symptoms checklist; ITT, intent-to-treat; POMS, profile of mood states depression-dejection scale; RCT, randomized controlled trial; SCT, supportive counseling via telehealth; TC, teleconference; TMH, telemental health; VC, videoconference.
Why Telemental Health?

- Cost of technology has decreased
- Professional associations have issued standards and guidelines in support of distance counseling
- Healthcare recognizing that behavioral care is essential to lowering healthcare “spend”
## Readmission Rates by Frequency

<table>
<thead>
<tr>
<th>Rank</th>
<th>Primary Diagnosis</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pneumonia</td>
<td>18.3%</td>
<td>13.3%</td>
<td>9.6%</td>
</tr>
<tr>
<td>2</td>
<td>Mood Disorders</td>
<td>20.2%</td>
<td>17.2%</td>
<td>10.2%</td>
</tr>
<tr>
<td>3</td>
<td>Osteoarthritis</td>
<td>5.4%</td>
<td>6.0%</td>
<td>3.1%</td>
</tr>
<tr>
<td>4</td>
<td>Congestive Heart Failure</td>
<td>25.3%</td>
<td>29.8%</td>
<td>19.7%</td>
</tr>
<tr>
<td>5</td>
<td>Cardiac Dysrhythmias</td>
<td>16.6%</td>
<td>18.5%</td>
<td>9.2%</td>
</tr>
<tr>
<td>6</td>
<td>Septicemia (except in labor)</td>
<td>22.0%</td>
<td>23.7%</td>
<td>15.7%</td>
</tr>
<tr>
<td>7</td>
<td>Coronary Atherosclerosis</td>
<td>15.3%</td>
<td>17.4%</td>
<td>9.0%</td>
</tr>
<tr>
<td>8</td>
<td>Childbirth Trauma</td>
<td>0.0%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>9</td>
<td>COPD &amp; Bronchiectasis</td>
<td>21.9%</td>
<td>25.0%</td>
<td>14.4%</td>
</tr>
<tr>
<td>10</td>
<td>Nonspecific Chest Pain</td>
<td>12.8%</td>
<td>14.8%</td>
<td>5.0%</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td>15.8%</td>
<td>16.7%</td>
<td>9.6%</td>
</tr>
</tbody>
</table>

Source: hcupnet.ahrq.gov
Why Telemental Health?

- Greater access to underserved consumers who cost the system the most $\$
- Epidemic proportions of citizens now recognized as having mental health disorders
- Predictions all point to a steady growth pattern
- Technology and automation to decrease $S, (especially in chronic illness)
- Consumers are ready – many are demanding telehealth
Best Practices
Behavioral Telehealth Best Practices Checklist
Derived from APA & ATA Guidelines, 2013
Marlene M. Maheu, Ph.D. & Massimo Agnoletti, Ph.D.

This best practices and documentation checklist is derived from a TeleMental Health Institute review of 2013 American Psychological Association and American Telemedicine Association’s Guidelines.*

### 2013 APA & ATAGuideline Similarities

Both documents do not purport to establish binding legal standards and defer to clinical judgment in any specific circumstance.

Both documents recommend:
- Adherence to local, state (licensing laws, interjurisdictional practice, mandatory reporting), federal laws (e.g., HIPAA and HITECH), ethical codes of profession
- Competency of practitioner (adequate professional and technical knowledge and skills, etc.)
- Competency of client/patient (e.g., appropriateness for telepractice services, technical competencies, cooperation)
- Informed consent
- Careful and ongoing assessment
- Emergency planning
- Privacy, security and confidentiality and risk management
- Documentation

### 2013 APA & ATA Guideline Differences

<table>
<thead>
<tr>
<th>APA Written for Psychologists</th>
<th>ATA Written for All Telemental Health Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global perspective</td>
<td>Specific perspective</td>
</tr>
<tr>
<td>Scope is email, telephone, social networking and video teleconferencing (requires broad principles)</td>
<td>Scope is real-time, videoconferencing via personal computers and mobile devices allows for specificity (e.g., connectivity)</td>
</tr>
</tbody>
</table>
Inter-jurisdictional Practice

Licensing Boards that may assert jurisdiction:

- The one in your state(s) of licensure
- The one in the client/patient’s state of location at time of call
- Both

Safest Practice:

- Provide services only where licensed
- Require client/patient to attest to his or her location on every call
State-Dependent Regulatory Rules:

- Intake
- Informed Consent
- Termination
Mandated Reporting

Behavioral professionals are mandated reporters

- Duty to Report
  - Child abuse
  - Elder Abuse
  - Spousal Abuse

- Duty to Warn
  - Tarasoff
Safety Risks

- Patient threatens harm to self or others
  - Top priorities
    - End-of-session comments
    - Patient suddenly terminates session
    - Patient has access to firearms
    - Patient is intoxicated
  - Patient is experiencing emotional extremes (especially when vulnerable others are in same location (e.g., children, elderly))
    - Has a break with reality (psychotic process)
    - Panic attack
    - Anger outburst
  - Patient has medical emergency
  - Patient experiencing an increasing in severity of depressive symptoms
Safety Risks

- Technical issues that compromise connection when safety threat appears and assessment is hampered
  - Poor audio
  - Poor lighting
  - Slow internet connection
  - Inadequate video monitor
Managing Safety Risks & Emergencies

Have a safety plan

- Discuss carefully w/ patient
- Write plan in your informed consent document
- Develop prior relationships with local community:
  - Physician
  - Family
  - School personnel
  - Other leaders (AA, religious?)
  - Emergency response team
  - Know community resources (hospitals, drug/alcohol treatment facilities, etc.)
  - Know your local collaborators

Know who and when to call for local assistance

- Inform client of when you will contact local leaders & what you will tell them
- Cover your termination procedure (i.e., “I will make 2 telephone calls, leave you 2 messages, send you a letter in surface mail with a copy to your physician.”)
OCPM: Online Clinical Practice Management

HIPAA, HITECH & Your State Law
Three HIPAA Rules:

• Transmission
• Privacy
• Security
Privacy

- #1 concern of patients re: digital health
- Increased hacking of Private Healthcare Information (PHI) and devices
- Increased privacy concerns by consumers as they get more info-engaged
- Greater number of audits in 2016 of professionals and how they deal with PHI
  - ICD-10 audits
  - HIPAA audits
Legal Documents

Oculus Terms Of Service

Last Updated: March 28, 2016

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THESE TERMS OF SERVICE CONTAIN IMPORTANT TERMS AND CONDITIONS THAT AFFECT YOU AND YOUR USE OF THE SERVICES, INCLUDING, UNLESS YOU CHOOSE TO OPT OUT, A PROVISION REGARDING BINDING ARBITRATION OF DISPUTES (OTHER THAN CERTAIN SPECIFIED INTELLECTUAL PROPERTY CLAIMS AND SMALL CLAIMS) AND A WAIVER OF CERTAIN
6. User Content

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HIPAA Privacy Rule

- Data are “individually identifiable” if they include any of the 18 types of identifiers, listed below, for an individual or for the individual’s employer or family member, or if the provider or researcher is aware that the information could be used, either alone or in combination with other information, to identify an individual:
HIPAA Privacy Rule (cont.)

1. Name
2. Address (all geographic subdivisions smaller than state, including street address, city, county, zip code)
3. All elements (except years) of dates related to an individual (including birth date, admission date, discharge date, date of death and exact age if over 89)
4. Telephone numbers
5. Fax number
6. Email address
7. Social Security number
8. Medical record number
9. Health plan beneficiary number
10. Account number
11. Certificate/license number
12. Any vehicle or other device serial number
13. Device identifiers or serial numbers
14. Web URL
15. Internet Protocol (IP) address numbers
16. Finger or voice prints
17. Photographic images
18. Any other characteristic that could uniquely identify the individual
Substance Abuse Confidentiality Regulations

Frequently Asked Questions (FAQs) regarding the Substance Abuse Confidentiality Regulations.

Applying the Substance Abuse Confidentiality Regulations

Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
42 CFR Part 2 (REVISED)

These Frequently Asked Questions (FAQs) are for information purposes only and are not intended as legal advice. Specific questions regarding compliance with federal law should be referred to your legal counsel. State laws may also apply.

In 2010, the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) and the HHS Office of the National Coordinator (ONC) published FAQs “Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE).” The 2010 FAQs are available at Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE) (PDF | 351 KB).

QUESTION 1
When a patient has signed a consent form allowing disclosure to multiple parties, can the patient revoke consent for disclosure to one or more of those parties while leaving the rest of the consent in force?

Yes. Under 42 CFR Part 2 (hereafter referred to as "Part 2"), a patient can revoke consent to one or more parties named in a multi-party consent form while leaving the rest of the consent in effect. In a non-Health Information Exchange (HIE) environment, this can be accomplished simply by the Part 2 program indicating on the consent form or in the patient’s record that consent has been revoked with respect to one or more named parties. In a HIE environment, the revocation with respect to one or more parties should be clearly communicated to the Health Information Organization (HIO) as well as noted in the patient’s record by the Part 2 program.

NOTES: Health Information Exchange ("HIE") is a generic term that refers to a number of methods and mechanisms through which information can be exchanged electronically. As used in these FAQs, the term Health Information Organization "HIO" means an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

To ensure compliance with consent requirements, an HIO should have policies and procedures in place for implementing patient decisions to give and revoke consent. Once a patient has revoked a Part 2 consent with respect to one or more parties, that revocation should be immediately communicated to the HIO by the entity obtaining the patient’s revocation so that it implements the revocation decision and no longer transmits the Part 2 program’s protected patient information to those one or more parties. Part 2 permits a patient to revoke consent orally (42 CFR §2.31(a)(8),(c)(6)). While oral revocations must be honored under Part 2, SAMHSA recommends the entity obtaining the revocation get it in writing and/or document the revocation in the patient’s record. Part 2 prohibits a program from making a disclosure on the basis of a consent which it knows has been revoked. A program however is entitled to act in reliance on a signed consent prior to a revocation, and such disclosure would not be improper (42 CFR §2.31(c)(3) and § 2.31(a)(8)). SAMHSA recommends that a revocation be communicated as soon as practicable to entities relying on such consent.

We note that the requirements of the HIPAA Privacy Rule must also be considered. For information on HIPAA, see the HHS Health Information Privacy website at www.hhs.gov/ocr/privacy/index.html or http://archive.samhsa.gov/HealthPrivacy/docs/SAMHSAPart2-HIPAAComparison2004.pdf (PDF | 379 KB).
HIPAA Risk Analysis

- Process of risk analysis
- Documentation of risk analysis
  - Know your vulnerabilities
  - Realize you may not be able to find all problems
  - Identify 10 biggest things that are risks
  - Document that you are diligently working to fix those things
Managing Risk

- If you don’t need 5 pieces of equipment, use fewer for your practice
- Rule out the use of coffee shop networks or hotels
- Stop looking at very easy ways to use new technology – they interject new risks
- Only use vendors who give “Business Associate Agreements” ("BAAs")
- Mention in informed consent that you are sharing protected health information with vendors
- Get paid version of email software (Gmail?) so they give you a business associate’s agreement
HIPAA, Business Associates & HITECH

- All Business Associates in healthcare must sign an agreement stating their adherence to HIPAA standards
  - Transactions
  - Security
  - Privacy
- True for any service you hire
- It is now enforced by the HITECH ACT
Email

- HIPPA Omnibus Act allows us to have email contact without meeting usual HIPAA standards when risks are fully disclosed in.

- Be aware of inherent problems with soliciting email contact from websites and directories.
Skype?
FaceTime is HIPAA compliant and encrypted, could change the way physicians and patients communicate

Sep 26, 2011 by Brittany Chan

Healthcare communications is rapidly changing – patients now routinely email their physicians, physicians connect with each-other via mobile-based professional networks, and more. The introduction of Apple’s FaceTime video chat sparked excitement and discussion in the healthcare community about its possible use in telemedicine. However, many were wary about associated patient privacy issues and HIPAA compliance.

It seems that this question has now been answered. According to Apple, calls made via FaceTime can be HIPAA-compliant with the appropriate security configuration. The news that this ubiquitous, free communications platform meets these rigorous standards has potentially wide implications for how patients, physicians, and others in healthcare communicate.

To be fair, its not quite as simple as just opening FaceTime and calling your patient. Specifically, the WPA2 Enterprise configuration provides an extra level of authentication when establishing a wireless connection. WEP does not provide the appropriate level of security, and WPA and WPA2 personal settings are questionable. FaceTime calls are fully encrypted as well.
Which Technologies to Use?

- No Guesswork Needed
Internet-based, VTC Companies Claiming HIPAA Compliance*

www.telehealth.org/video

*TMH Institute has partnered with some of these companies and will receive a referral fee if you mention TMHI. You may also get an added discount.
HIPAA Policies

- Use HIPAA compliant technologies and develop written processes
  - Document policies
    - Security & privacy policies
    - Repairs
    - Staff training
    - Breach notification, etc.
HIPAA Documentation

- Risk Analysis
- Develop Policies
- Conduct training for Staff & Document
- Business Associates Agreement
- Informed Consent
Minimize Risk by Working Legally, Ethically and with Evidence-Based Clinical Training
Multicultural Issues & Diversity

Boundaries of Competence
Levels of Security

Reimbursement


States with proposed/pending legislation: In 2015, Arkansas, Connecticut, Indiana, Iowa, Minnesota, New Jersey, Rhode Island, and Washington

*Coverage applies to certain health services and/or rural areas only.

http://www.americantelemed.org/policy/state-policy-resource-center#tracker
Infrastructure?
Infrastructure

- Technology Choices
  - Legacy systems?
    - Audio (telephone)
    - EHR
    - Video
    - Integrated Systems
- Space
  - Work flow
  - Optimized client/patient rooms / provider rooms
- Staff
- Staff Training
Telemental health practice models that get reimbursed
1 Nursing Homes
Employee Assistance Programs (EAPs)
Employer Telemental Health Value

- **Reduce Healthcare Costs**
  - Unlimited visits for no additional costs or copay
  - Lower cost alternative
  - More frequent yet shorter visits = engagement

- **Reduce Absenteeism & Increase Productivity**
  - Most behavioral care is non-emergency care
  - Employees receive routine care without leaving work
  - Decreases absenteeism
  - Decreases presenteeism

- **Increase ROI**
  - Health care cost savings
  - Increased productivity
  - Makes cost-effective care readily available
  - Provides prevention of more serious dysfunction

- **Increase Employee Satisfaction**
  - Access to high quality care from specialists
  - Available at time of need
  - Available at point of care
3 Rural Hospitals
Schools
⑤ Specialty Schools, Residential Treatment, Hospitals
6 Migration Model
Private Companies Serving Consumers & Healthcare Systems*

- Register for employment with these companies here:

WWW.PROVIDERPANEL.COM
Home Health
Military & Veteran’s Administration
11. College Counseling Centers
12. Rehabilitation counselors and psychologists work in a variety of state-funded settings, such as hospitals, substance use settings, transitional homes, agencies...
13. Telephone services (e.g., hotlines, EAP), text-messaging systems, patient portals, social media, social support
14. Health Plans
Health Plan Challenges: Medical Loss Ratio

- Affordable Care Act requires commercial insurers to ensure that premium goes to health care costs or quality improvement
  - 80% of individual and small groups
  - 85% for large group
- If not, must rebate enrollees the following year

- Must demonstrate that your service contributes to the numerator as defined by ACA and National Association of Insurance Commission (NAIC) for a health plan to consider your telehealth offering
Questions?

Marlene M. Maheu, Ph.D
TeleMental Health Institute, Inc.
Phone: 619-255-2788
Email: contact@telehealth.ORG
WVLPCA Slides & Resources: www.telehealth.org/CIBHS