Breakthrough Behavioral Inc.

Tele-Behavioral Health Practitioner Training

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Behavioral Health Telemedicine Defined:

Although the term more broadly can encompass a variety of communication techniques including telephone, email, text, and remote monitoring, we will more narrowly define behavioral telemedicine as the provision of mental health diagnostic, therapeutic or management services via real-time, interactive video-conference.

Fast Facts on Telemedicine:

- Telemedicine has more than 50 years of history of providing medical care to patients via technology in distant and remote locations
- Provision of behavioral health care is one of the earliest and most common healthcare specialties offered over telemedicine
- Psychiatry and other behavioral health services are the second most frequent type of telemedicine, second only to radiology
- Recent improvements in technology cost and quality have made deployment possible for the routine practice of medicine
- The empirical base of tele-mental health consistently shows that diagnostic accuracy and treatment efficacy is equivalent to face-to-face for most populations and settings
- A variety of patient populations have been studied in research settings, ranging from child/adolescent to geriatrics and a range of presenting problems and diagnoses. There are no absolute or specific contra-indications to patients assessed or treated via telemedicine, and the inclusion/exclusion of clients is at the discretion of the referring and treating clinicians.
- A variety of services, ranging from initial assessment/diagnosis, medication management, case management, to multiple psychotherapy modalities have been studied in telemedicine-format and are considered to be essentially equivalent to the same services delivered face-to-face
- Reimbursement climate for telemedicine services has gradually improved, with Medicare approval for certain services and locations for more than 10 years
- Telemedicine covered in many State Medicaid regulations
- Fifteen states currently have insurance regulations which mandate to some extent telemedicine coverage in commercial plans
- However, telemedicine reimbursement remains a hurdle and a moving target and must be carefully researched for any new applications
• Breakthrough Behavioral has contracted with select payers for reimbursement of commercial members in Texas reducing this hurdle for its providers.

• Current practice requires state licensure in the state where the patient is seen.

• Legislative proposals have created some movement towards license portability and limited telemedicine licenses, but the standard of care remains for a practitioner licensed in the state where the patient is located.

• For hospital settings, the doctor must also be credentialed and privileged as a member of hospital medical staff.

Technology Needs for Breakthrough Clinical Services

• Broadband service at Practitioner and Client location – at least 1MB/s download and upload speed. Dial up, satellite or 3G service are not acceptable.

• Broadband not over-utilized for other uses while video call in progress.

• Newer computer – no older than 4 years old with at least 4 GB of memory – with embedded or attached HD webcam and high quality microphone.

• Adjustable camera setup to optimize view of practitioner/patient regarding picture size and eye-contact.

• Technical support is provided by Breakthrough’s Client Services group so that service and assistance is rapidly available.

• Testing of equipment and provision of user-instructions prior to first clinical contact to insure that competent video session is available.

Legal and Ethical Considerations

Practitioners new to telemedicine are urged to carefully consider the new and emerging legal and ethical issues that are related to this delivery model. While many aspects of traditional practice translate directly into the telemedicine environment, the nature of the distant and electronic connection between practitioner and client creates additional considerations. Breakthrough works to support you in meeting these legal and ethical considerations.

Licensure and Credentialing

Licensure and credentialing are key considerations in undertaking telemedicine services to clients. Physicians and other practitioners obtain licenses that enable practice in that state only, with the assumption that both practitioner and client are physically in the same state. While connectivity can
potentially link practitioner and patient anywhere on the globe, the prudent practice of telemedicine or tele-behavioral health dictates that the client is physically located in the state in which the practitioner holds a license. Practitioners may obtain licenses to practice in multiple states, which will allow telemedicine practice across state lines. Today, Breakthrough only allows providers to practice within the state they and the patient are physically located to mitigate any issues with cross-state regulations.

Practitioners are encouraged to review relevant regulations developed by their state licensing board to determine if any special provisions or limitations exist. Some states have developed limited telemedicine licenses that facilitate practice across state lines, but regulations associated with a limited license must be carefully reviewed to determine any special provisions that regulate the practice of telemedicine. Those provisions may concern informed consent, need for initial or periodic face-to-face contact, management of prescriptions (particularly controlled substances), and delivery of services to patients’ homes.

Substantial debate and proposed legislation directed at easing the interstate practice of medicine and other professions continue, but as a matter of practice, telemedicine and tele-behavioral health remains largely confined to practitioners treating patients in states in which the doctor is licensed.

To date, exceptions to the norm exist in the form of national registration for physicians employed by the Department of Veterans Affairs, Public and Indian Health Services, and federal correctional organizations (Legal Impediments to the Diffusion of Telemedicine, White Paper, Law & Health Care Program, University of Maryland School of Law, 2010).

Some progress has been made in streamlining of credentialing of practitioners to hospitals and healthcare organizations. Both The Joint Commission and the Center for Medicare and Medicaid Services have created pathways for streamlined credentialing of practitioners through inter-hospital agreements and ‘credential-by-proxy’ arrangements. (Joint Commission Standards LD.04.03.09 & MS.13.01.01; CMS 42 CFR Parts 482 & 485 2011).
**e-Security, Privacy, and Confidentiality**

Tele-Behavioral Health in multiple aspects falls under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and The Health Information Technology for Economic and Clinical Health Act (HITECH). The delivery model of Breakthrough clearly falls under HIPAA/HITECH provisions as it involves the transmission of protected health information in electronic form in connection with a health care claim. The same HIPAA privacy practices adopted by traditional office practices can be extended to telemedicine practices with several recommended additions.

HIPAA/HITECH is not specific in its privacy requirements for interactive video-conferencing, but clinicians adopting the practice of telemedicine or tele-behavioral health are urged to confirm and document that the video-conference systems used for patient care provide for data security and encryption and are sufficiently robust to prevent unauthorized intrusion into the patient care environment. A variety of encryption methods are in common use and should be documented by the manufacturer or vendor. Encryptions standards such as AES, providing 128 bit key size, are generally considered the minimum for healthcare applications of video-conference.

The nature of video-conference delivery of behavioral health services raises some additional considerations beyond typical office practice. Recording of sessions is typically advised against for a variety of reasons, including risk management. If a specific protocol (such as research) requires recording, then specific consent must be obtained, as well as development of policies regarding storage, access, retention, and destruction of materials.

Should a practitioner decide to offer services from a home office, particular planning should address privacy protection. Elements of home office preparation should include soundproofing, freedom from interruption or disturbance by family members, and secured access to files or electronic medical record. Computers should be password-protected, have robust anti-virus protection, and ideally are not used by other family members. Although Breakthrough’s messaging services are secure, adequate steps must be taken to secure other forms of e-health communication, including non-Breakthrough email, instant messaging, and texting.

**Informed Consent**

In addition to providing patients with a ‘HIPAA Notice of Privacy Practices’, practitioners should obtain a signed ‘Consent for Treatment’. Informed Consent refers to the client’s decision to allow a health care provider to perform a particular treatment or intervention, following the provision of understandable information about the risks, benefits, and alternatives of treatment which will enable the
client to make a knowledgeable decision about undertaking treatment. Under HIPAA standards, while other types of protected health information (PHI) may be accessed for treatment, payment or other healthcare operations without an explicit permission from the individual, use or disclosure of psychotherapy notes requires a signed authorization for release by the client.

*Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. (The HIPAA Privacy Standard: Frequently Asked Questions, American Psychological Association Practice Central, 2013)*

**Professional Liability and Risk Management**

There is little legal precedent for assessing the risk of telemedicine malpractice. The basic threshold for malpractice involve the establishment of a doctor/patient relationship, harm to the patient, and negligent acts on the part of the doctor that breached accepted standards of practice. Professional liability coverage may be limited to claims originating in the state in which the practitioner is licensed. Practice across state lines without licensure may expose the practitioner to licensing board sanction as well as denial of coverage by the liability carrier. Prior to beginning telemedicine services, practitioners should review their policy and obtain written assurances that the professional liability coverage covers telemedicine in general and specifically for all states in which the clinician provides services under an active license. (*Medical Malpractice and Liability*, Telehealth Resource Centers, 2012)

Additional risk management considerations for telemedicine include management of emergencies and provisions for technical difficulties. While practitioners typically have some awareness of resources within their home community, that knowledge may not extend to the variety of typically available and may even extend to a staff member or ‘tele-presenter’ accompanying the client in the exam or consultation room. Services provided to clients in their homes lack the immediate resources of
telemedicine services delivered to organized healthcare settings. Practitioners are advised to maintain some basic awareness of emergency services in the locale of the patient, such as proximity to a hospital emergency room or community mental health center crisis stabilization services. Practitioners should also engage in reasonable risk assessment which may on occasion include a determination that a client cannot be safely treated in a telemedicine environment and may need more traditional face-to-face services.

Loss of connectivity because of technical difficulties presents another potential risk. Access to technical support and another means of reaching the client (such as telephone) in the case of an interrupted session are important ‘safety nets’ for telehealth providers.

**Considerations on Electronic Communication with Clients**

As clinicians move into new, technologically-mediated practice models such as telemedicine, a host of considerations will be addressed by the thoughtful practitioner. Long experience and practice have generally informed clinicians about practical and effective policies for contact with clients. Optimally established at the beginning of a therapeutic relationship, the office practitioner will typically communicate policies about scheduling, cancellation, payment and invoicing, management of emergencies, and inter-session communication. The move into telemedicine will almost invariably move the practitioner into new forms of electronic communication with clients, with a variety of media possible including general email, dedicated email within a practice portal, and text messaging. Secure forms of email are strongly recommended. We recommend that clinicians clearly define the preferred means of contact/communication with clients and provide expectations on the nature of communication between sessions. Prescribing psychiatrists may choose to set a different threshold (for example, reporting on side effects of a new medication) than talk therapists, who may choose to limit expected communication to logistics such as schedules or cancellation. We recommend that therapists carefully think though extending broader options related to clinical communication between sessions. Some modalities such as Cognitive Behavioral Therapy depend on homework assignments, which may be facilitated via email communication and are an expected aspect of care introduced by the clinician at the start of treatment.

To the extent that email or text be used for anything other than routine functions such as scheduling or invoicing, clinicians should be mindful of the inherent challenges of electronic communication, including the likelihood of misinterpretation of content or intent. It is no wonder that ‘emoticons’ have emerged to help email senders cue their readers to their intentions by representing emotional intent,
facial expression, and body language in text-based communication. Expected response time on the part of clients is an additional consideration. A report on consumer satisfaction related to customer service by Forrester Research in 2008 indicated that 41% of consumers expected on-line retailers to respond to emails within six hours. While this is far from a recommendation that therapists attempt to conform to these expectations, nevertheless this time frame gives some benchmark to common expectations for response time.

It is likely that there are significant individual variations in expectations of clients should a therapist take part in clinical communication via email or text message, and that those variations may be heightened as well by the nature of the communication, sense of urgency or emergency, and presence or lack of explicit expectations/boundaries set by the therapist. While mental health professionals are extensively trained in the sensitivities and potential distortions of communication, they are nevertheless urged to remain mindful of both the potential advantages as well as complications of electronic communication with clients.

Optimizing the Consulting Room Environment

Empirical evidence and practice experience show that patients readily accept telemedicine as a means of receiving behavioral healthcare. Given that the foundation of tele-behavioral health is sound and well-supported, it is essential that we pay attention to and optimize the environment that we show our patients. Otherwise, poorly designed or maintained telemedicine environments can negatively influence the patient care experience, with risks to outcomes, satisfaction, and the physician or organization’s reputation for quality care.

As a clinician, maintaining your telemedicine environment is as important as furnishing a physical office location. In general, the room should be treated as any mental health consultation room. In the office setting, good lighting, comfortable furniture, comfortable cooling/heating, and waiting room décor are all standard areas of attention to the practitioner. Setting a high quality ‘virtual office’ is even more important in the emerging practice of tele-behavioral health. The ‘virtual environment’ of telemedicine is not as intuitive as a physical office and is more subtle to assess and tweak. Please give some thought to the following dimensions:
**Testing and Training:** Prior to the first sessions of actual patient care, the clinician will be trained on use of the video-conference system, including adjustment of camera and microphone. Optimally, adjustments to lighting, camera placement and other aspects of the office environment should be made with assistance from a Breakthrough Client Services staff member, who is viewing the clinician on video-conference and can make suggestions from the perspective of a client. Adequate soundproofing should be provided as well as protection from unauthorized access whether physical or visual.

**Eye Contact:** It is important that both the patient and clinician are able to establish natural eye-contact while engaged in video-conferencing. This can be done by adjusting camera placement and angle relative to the display screen to provide optimal eye contact. Minor variations can have significant effect on patient perception. One clever study experimented with camera angle, which varied from 7 to 15 degrees. Direct patient eye contact (7 degree angle) with the physician led to perceptions of the doctor as interested, competent, and attentive. When adjusted camera angle showed the same doctors with a downward gaze (15 degree angle), the patients tended to perceive the MD as disinterested, sad, or even ‘on drugs’. In addition to camera angle, the practitioner can vary distance from camera to create optimal image size as well as to create enough distance so that eye contact is not so acutely affected by camera angle. *(Perception of eye contact in video teleconsultation,* Tam et al, *Journal of Telemedicine and Telecare, 13, 35-39, 2007)*.

Prior to first clinical contact, feedback from Breakthrough Client Services staff is essential, as the practitioner on camera will not be able to adequately judge eye contact independently. Testing of equipment prior to the implementation of telemedicine will include adjustment of camera placement and angle to establish optimal settings.

If the practitioner is taking notes or entering documentation on an electronic medical record during visits, care must be taken to minimize distraction to the client. Documenting on a computer to the side of the camera will interfere with making sustained eye contact with the patient. The practitioner should carefully weigh the merits and disadvantages of documentation while sessions are in progress, so that practice efficiency as well as optimal attention and attunement to client is preserved.

**Image Size:** The client should see you essentially as though sitting across a desk. Your image should fill most of the screen, with bottom view starting just above the waist and a bit of clearance from top of head to top of screen.

**Background and Lighting:** What the patient sees on screen creates strong impressions, both conscious and unconscious. Aiming the camera into a window or light source behind you degrades picture quality. Even lighting is important, so both sides of the face...
are equally and warmly lit. Adjustment of lighting type and direction can greatly improve the patient experience of the practitioner. The American Telemedicine Association Practice Guidelines for Videoconferencing-based Telemental Health recommend light sources of approximately 150 foot/candles from fluorescent day-light or full spectrum bulbs resembling natural daylight.

Backgrounds should be professional but not austere. Wall coverings behind you can be varied: bookshelves, diplomas, or just your office wall. Stripes or complicated designs (whether clothing or wallpaper, etc.) are unfriendly to videoconferencing.

Audio: Echo and delay are the most common audio problems in videoconferencing. Either can significantly impair practitioner/patient communication. The experience of the video-conference session is probably more negatively affected by poor audio than by momentary lapses in video such as pixilation. Audio problems should be reported to Breakthrough Client Services so that the problems can be investigated and corrected. Audio delay may be a symptom of inadequate or variable bandwidth and should be reported to Breakthrough Client Services. Echo can be investigated and corrected, typically by adjustment of microphone and speaker placement. In many cases, the use of a USB headset and microphone (or simple earbuds as used with a music player or smartphone) can eliminate audio issues. Smartphone earbuds with a built-in microphone should never be used, however, as the microphone quality is insufficient for videoconferencing.

In addition, when participants are speaking at the same time, loss of audio quality can be significant and disruptive to communication. While interrupting clients is poor form in the traditional office setting, the problems tend to be magnified in the telemedicine environment, to the point that loss of intelligibility can occur. Practitioners should establish that the client has finished speaking before starting a new sentence. Any audio delay in the system will heighten problems with 'speaking over' one another. Practitioners are encouraged to ask clients to repeat themselves or to assure that they were understood should audio quality be problematic.

Poor microphone placement can cause significant disruptions in the care environment. External video-conference microphones are very sensitive and are often best placed on a small table away from the desk. Embedded microphones in typical laptop configurations are less sensitive. However, keystrokes, paper-shuffling, finger tapping or other extraneous noises that you may not notice in person are very noticeable and aggravating at the patient care side in the video-conference setting.
**Freedom from Distractions:** Patient-focused care means guaranteeing a virtual office environment free from distractions. Cell phones should be off or on vibrate. External noise (noises from adjoining offices, music, appliances) must be controlled wherever possible. In the rare event that someone else could be in or enter the office, explanation should be provided and permission obtained from the patient. Should someone else remain in the office (for example, teaching or demonstration to another physician), that individual should be introduced, consent to view obtained, and that individual moved off camera while patient care is conducted.

**Patient Orientation:** On the first visit with the patient, the clinician may introduce the telemedicine encounter to the client in such a style:

“Have you ever talked to a doctor on camera before? We will be talking today just like we were in the same office together. Please let me know if you have any problems seeing or hearing me. If you have any trouble hearing or understanding me, please let me know, and I’ll be happy to repeat myself. I will ask you to repeat if I have any trouble understanding you. I’ve taken steps to make sure that our visit is private and confidential. Our visit will not be recorded. Please make sure as we continue to visit that you are in a place where you can expect privacy and be free of interruptions or distractions.”

**Quality Improvement:** The telemedicine environment needs to be considered as an essential ingredient of quality care. Problems in room set up, lighting, sound or video quality must be noted and corrected. Many solutions are achievable through simple adjustments. When problems are noted, you should promptly notify Breakthrough Client Services so that problems can be addressed immediately. Often, testing will be necessary to troubleshoot problems and verify that adjustments have been successful.

The practitioner should encourage the client to point out any difficulties in video or audio quality so that corrective measures can be taken. Problems in the patient care environment may only be noticed by the ‘other side’ and should be directly identified and addressed. As clients are sometimes reluctant to bring technical problems to the clinician’s attention, it can be useful for the practitioner to regularly ‘check in’ at the start of sessions to make sure that session quality has been established.

**What to Do if Technical Problems Develop In-Session:** It is preferable if the clinician initiates the phone call and directs the steps to follow. The clinician should have the client’s telephone number on hand should the video-conference connection be lost or disrupted. Unless the video call can be re-established immediately by the therapist, contact should be established by phone. The therapist has the option of re-scheduling the session or of continuing and completing the session by phone. We recommend that the therapist review disrupted sessions afterwards with Breakthrough Client Services.
Services to determine the source of the problem and make any system adjustments necessary to prevent recurrences.

**Clinical Nuances in Video-Therapy**

Although conducting therapy over video is fundamentally the same as doing so in an office environment, the new medium does present some special considerations. There is no doubt that the full range of senses and observation is reduced in the video-conference environment. While the empirical literature strongly suggests that outcomes are as good in the tele-behavioral health as in face-to-face, the practitioner may nonetheless need to make some adjustments in conducting therapy to optimize the care.

We place some special emphasis on setting up equipment so that good eye contact is the norm. Without that attention to detail, we won’t be able to detect the client avoiding eye contact and thus miss clinically meaningful information.

Our experience is that clients may sometimes tolerate silence on the part of the tele-therapist somewhat less than would be expected in a traditional office setting. Also keep in mind that it is more possible to mis-hear or misinterpret communication in a video-session. When in doubt, it is important to ask the client tactfully to repeat him/herself to avoid misinterpretation.

We place some special emphasis on maintaining a good technical connection with clients and encourage the patient to communicate about any technical disruptions in the connection. Those technical disruptions should be corrected as quickly and unobtrusively as possible so that they don’t interfere with the real connection between therapist and client (i.e., damage the therapeutic alliance). However, here’s an additional consideration. A client with a good therapeutic alliance will take minor ‘blips’ in the technology in stride. A client with self-esteem problems and difficulties with assertive communication may tolerate poor session quality that he or she should ideally speak up about. A client in acute distress and/or whose sense of therapeutic connection is shaky may be very sensitive and reactive to those same ‘blips’ in session quality. The practitioner, while careful to fix any problems in the technical connection, should be aware that undue concern about the technical connection on the part of the client may also be a proxy for their concern about the therapeutic connection with the clinician, which may need to be addressed at least as seriously as the technology ‘fix’.

Both literature and experience demonstrate that clients with psychotic disorders can be effectively evaluated and treated via telemedicine. However, most of that practice experience is based on clinic settings, usually with a trained tele-presenter available to the client and clinician while services are being provided. We recommend caution for
practitioners undertaking care of clients with psychotic disorders or other high-risk clients (such as those at risk of self-harm) in a home setting unless initial evaluation and risk assessment has taken place in a formal clinical setting and home-based care is judged advisable or unless care is initially provided in-person and then transitioned to tele-care when a reliable clinical relationship has been established.

In addition to the limitations of tele-behavioral health, there are certain advantages as well. The literature on tele-health patient satisfaction generally demonstrates that clients are well satisfied with the care received and prefer the access to tele-health when compared to the option of travel of significant distance to receive care. Clients also tend to indicate that the actual tele-behavioral health experience exceeds their initial expectations. The literature also suggests that certain patient populations, including children and adolescents, readily adapt to the tele-health setting. Tele-behavioral health has significant evidence support for treatment of anxiety disorders. Patients with severe agoraphobia or other home-bound conditions may be better candidates for tele-therapy than traditional in-person settings.

There are anecdotal and experience-based speculations that tele-behavioral health may have some other advantages. The experience of engaging a practitioner by video-conference may offer a novelty factor that leads to positive expectancies of the therapeutic relationship. Some clients will feel more comfortable with addressing sensitive issues with the added ‘distance’ that the tele-health environment provides. The ability to engage a therapist on-line may also create some increased comfort about confidentiality, particularly in small communities in which the complications of a client and therapist encountering one another or navigating potential dual relationships is magnified compared to large urban areas. The client in a small or rural community may almost certainly gain greater access to expertise and specialty training by engaging in tele-healthcare.

With some loss of visual cues, the practitioner will be unable to see some clinical cues. Anxious behavior such as toe tapping will not be visible. The walk to the consulting room, with perhaps a handshake, will not be possible. The new tele-practitioner should expect some transition time to become accustomed and comfortable with the tele-health practice model.

Breakthrough has incorporated systems not typically available in office practices that can provide important clinical information to the practitioner; those enhancements may improve client/therapist communication and compensate for the cues lost in the video-conference environment. We’ll address those next.
Breakthrough Health Outcomes Measurement Model

Breakthrough has incorporated a robust outcomes measurement protocol into its clinical systems, embedding regular client self-report measures into the routine standard of care. Systems such as that provided by Breakthrough may reduce some potential complications stemming from unclear expectations for client and clinician communication. In conjunction with Ed Jones, PhD (former president of the commercial division of ValueOptions and former chief clinical officer at Pacificare Behavioral Health), Breakthrough provides an integrated, on-line 13 item patient questionnaire which is completed before each session and then scored and electronically transmitted to the clinician. The practitioner subsequently has access to client ratings of global distress for the current session as well as a graphical representation of change-over-time in the client's level of psychological distress. Evidence of severe distress, suicidal ideation, or continuing substance abuse from the self-report questionnaire may assist the clinician in treatment planning, risk management, and development of emergency back-up plans.

In addition to clinical self-report, clients are asked to complete a brief three item questionnaire assessing satisfaction with the clinical experience as well as the video-conference systems. Breakthrough will use the client satisfaction system to provide feedback to individual clinicians as well as to aggregate data to document and improve the practices and outcomes of the entire Breakthrough network.

Based upon a database of tens of thousands of patient encounters, algorithms have been developed to calculate the expected trajectory of change for patients with the comparable scores on initial administration of the questionnaire. Over time, Breakthrough clinicians have the ability to track patient progress mapped against the expected trajectory of change generated by the clinical algorithm.

Breakthrough Adult Outcome Questionnaire

The item content is divided into three broad domains: Global Distress, Substance Abuse, and Alliance/Satisfaction. The Global Distress domain includes four subdomains: symptoms common to many disorders, thoughts of self-harm, functionality in day to day activities, and quality of social relationships.

Items are presented using a 5-point Likert scale. Global Distress and Substance Abuse items utilize frequency anchors.

Clients are asked, “How often in the past two weeks did you...”

Never=0; Rarely=1; Sometimes=2;
Often=3; Very often=4;
“How often in the past two weeks did you....”

**Symptoms**

☐ feel unhappy or sad?
☐ have little or no energy?
☐ feel tense or nervous?
☐ feel hopeless about the future?
☐ have problems with sleep (too much or too little)?

**Self-Harm**

☐ think about harming yourself?

**Functioning at work, school and other daily activities**

☐ feel unproductive at work or other daily activities?
☐ have a hard time paying attention?

**Social**

☐ have a hard time getting along with family or friends
☐ feel lonely

**Substance Abuse**

☐ have someone express concern about your alcohol or drug use?
☐ have five or more drinks of alcohol at one time?
☐ have a problem at work, school or home because of drug or alcohol use?

**Recommended Alliance/Satisfaction Items:**

The Alliance/Satisfaction items address key elements of the therapeutic relationship and satisfaction with the therapy experience.

Alliance/Satisfaction items likewise use a 5-point Likert, with anchors reflecting agreement-disagreement.

Agree=0; Somewhat agree=1; Not sure=2; Somewhat disagree=3; Disagree=4;

☐ The Counselor and I worked well together
☐ I was satisfied with the Breakthrough online website experience
☐ I would recommend Breakthrough online video counseling to others
Clinical Use of the Adult Outcome Questionnaire

Routine use of the global distress questionnaire has been demonstrated to identify risk factors such as suicidal thinking/intent and substance abuse that may be overlooked or underestimated in ordinary clinical practice. With the somewhat reduced access to information inherent in the telemedicine environment (fewer visual cues, no handshake, no walk from waiting room to office, etc.), the routine use of self-report measures will not only provide important ongoing monitoring of distress and progress, but also provide a structured and systematic format for directing electronic communication from client to clinician. In this way, the Breakthrough clinical model may prevent some of the risks and ambiguities of electronic client/clinician communication outlined above.
Examples of Linking Adult Outcome Data to Session:

In reviewing your questionnaire today, I see you have been feeling hopeless about the future very often this week.

I see you are feeling lonely only rarely this week, can you tell me more?

I see you are sometimes thinking about harming yourself. Help me understand that better.

Somebody expressed a concern about your alcohol use this week. Who was that and what was their concern?

Looking at your symptom chart over the sessions we’ve had so far, it looks like your sense of distress has dropped quite a bit. Does that ring true?

The therapist’s review of the current session report as well as the progress-over-time graph can not only anchor the clinician’s judgment of client progress, but also enhance the clinical dialogue with the client. Use of the trend data over time can also help the clinician to be alert to discontinuities: i.e., whether the client’s verbalizations and behavior in session are consistent or inconsistent with the outcomes data.

Breakthrough Behavioral’s outcomes program provides you with valuable tools for monitoring patient progress and individualizing care. We encourage you at each session to review the client’s self-report for the current session as well as the summary graph. The self-report tool can also alert the therapist to ‘red flag’ issues that the client may or may not bring up in the early stage of the session. It may be useful in the early minutes of the session to highlight noteworthy changes in the client’s self-reported wellbeing or in the trend line in the summary graph. In this way, the practitioner can reinforce the use of the outcome system for the client and demonstrate its relevance.

Conclusion

Delivery of mental health services via interactive video-conferencing has sound empirical and experiential support. As a recent and growing model for service delivery, telemedicine promises to make routine and specialty healthcare available to individuals and populations that have historically lacked adequate access. The quality of services will depend on the combination of well-trained practitioners (both clinically and technically) and on robust and user-friendly systems which provide a high-quality interactive experience, reliability and prompt technical support, and related features such as scheduling and practice management support. Breakthrough is pleased to welcome you to the provider group. The training materials provided here are intended to give you the fundamental best-practices of tele-behavioral health and prepare you to launch your tele-practice with confidence.
Resources

Practice Guidelines for Videoconferencing-Based Telemental Health, American Telemedicine Association, October, 2009

Evidence-Based Practice for Telemental Health, American Telemedicine Association, July, 2009

Implementing Telemedicine: Completing Projects on Target On Time On Budget, Cuyler, R. & Holland, D., Xlibris, 2012


The Breakthrough Clinical Model: Outcome-informed Care, Edward R. Jones, PhD, ERJ Consulting, LLC, 2013