Technology-Based Interventions
Exploring New Models of Care & Navigating New Ethical Dilemmas
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This training is designed to introduce participants to *Technology-Based Interventions* in order to help participants:

- understand the benefits, ease of use, and clinical application to enhance health care services ... *AND*

- be aware of the positive and negative factors that impact adoption by practitioners and organizations
This training is not about identifying devices and platforms to be used in the delivery of technology-assisted services.
Presentation Outline This Morning

Use of Technology
- Definition and Use of Technology-Based Interventions
- Organizational, Staff, and Patient Issues with TBIs

Models of TBIs

Research on TBIs
- Organizational Change/Technology Capacity Assessment Tool

Resources
Presentation Outline This Afternoon

1. Digital Types
2. Social Media
3. Ethics - Self Disclosure
4. Email/Texting
5. Policy Considerations
Seven billion people (95% of the global population) live in an area covered by a mobile-cellular network.

By the end 2016, 3.9 billion people (53% of the world’s population) will not be using the Internet.

International Telecommunications Union, 2016
In a national sample of adults who had smartphones or tablets...

- **36%** had mHealth apps on their devices
- Among those with apps, **60%** reported the usefulness of mHealth apps in achieving health behavior goals, **35%** reported their helpfulness for medical care decision-making
- **38%** reported their usefulness in asking their physicians new questions or seeking a second opinion

Bhuyan et al., 2016
By 2018, an estimated 50% of the more than 3.4 billion smartphone and tablet users, including healthcare professionals, consumers, and patients, will have downloaded mHealth apps.

Kuersten, 2010
Use of **online and mobile technologies** is increasing across age, race/ethnicity, and geography.

Increasingly, consumers rely on Internet- and smartphone-based tools for health information and tracking.
The rapid technological advancements and developing evidence base supporting these approaches have effectively positioned technology-based interventions at the forefront of behavioral health care innovation.

Jones et al., 2013
Technology-based behavioral health interventions, which involve the delivery of evidence-informed practices via computers, web-based applications, mobile phones, wearable sensors, or other technological platforms, are rapidly being developed.

Marsch, 2012; Carroll & Rounsaville, 2010
Behavioral Intervention Technologies (BITs)
- the application of behavioral and psychological intervention strategies through the use of technology features to address behavioral, cognitive and affective targets that support physical, behavioral and mental health
  
  Burns & Mohr, 2012

Digital Health Technologies (DHTs)
- include assessments and interventions delivered via computer, Internet, mobile phone, and wireless or wearable device technologies

  Muench, 2015
Technology-Based Interventions

- may consist of text, audio, video, animations, and/or other forms of multimedia
- use information from medical records, physiological data capture devices, or other sources
- may be interactively customized, or tailored, to an individual user’s needs

Aronson, Marsch, & Acosta, 2013
Technology-based interventions range from simple text-based reminders to complex interactive computer-based counseling interfaces, to smartphones with GPS and biomedical sensors.
To date, more than 100 different technology-based interventions have been developed for a range of mental disorders and behavioral health problems.

Klein et al., 2012; Moore et al., 2011
Technology-Based Interventions have been used to augment care and support for:

- Cancer
- Diabetes
- Heart Disease
- Mood Disorders
- Depression/Anxiety
- Poor Nutrition
- Sexual Risk Behaviors
Even chronically ill patients spend only a few hours per year with a doctor or nurse, leaving at least 5,000 hours per year in which they are engaged in other health-related behaviors.
That leaves a lot of time for patients to

• take prescribed medications;
• follow other medical advice;
• decide what to eat and drink; or
• whether to smoke, drink, or take drugs

All of these choices can profoundly influence their health
The goal of U.S. health care should be good health for every American. This daunting goal will require closing the health care gap across social-economic and racial and ethnic groups...

The factors contributing to this gap are multi-faceted, including psychological barriers such as perceived stigma and embarrassment, as well as logistical barriers such as lack of transportation and availability of providers in rural areas especially for behavioral health.

Cunningham et al., 2011

Gabow, 2016
Technology has the potential to narrow the “access gap” to behavioral health interventions and reduce health disparities in disadvantaged and hard-to-reach populations

Gibbons et al., 2011
TBIs can Address Barriers to Accessing Treatment in both Rural and Urban Areas
Technology-based interventions also have the ability to lower consumer threshold for initiation of treatment.

Clarke & Yarborough, 2013
Allow for on-demand access to therapeutic support outside of formal care settings anytime/anywhere

Marsch, 2012
TBIs can Enable Anonymity

Marsch, 2012
Technology-Based Interventions

• **for Individuals** with low problem severity who perceive barriers TBI may provide the optimal lower dose of treatment to foster service access

• **may instill** an enhanced sense of empowerment while still providing evidence-based care

Clarke & Yarborough, 2013
As Fox (2013) suggests, the clinical value of technology lies not in its computing power but in its ability to connect providers to their patients.
So, what's your point?
<table>
<thead>
<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>• Booked travel arrangements online</td>
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<tr>
<td>• Purchased an item costing more than $100 online</td>
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<tr>
<td>• Checked bank account information or moved money between accounts online</td>
</tr>
<tr>
<td>• Applied for a credit card online</td>
</tr>
<tr>
<td>• Signed up for insurance online</td>
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<tr>
<td>• Signed up for telephone, cable services, or utilities online</td>
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<tr>
<td>• Paid a bill online</td>
</tr>
<tr>
<td>• Owned a Kindle or iPad</td>
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<tr>
<td>• Owned access to an electronic book to read on your computer</td>
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<tr>
<td>• Purchased audio files (e.g., music, books) online</td>
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<tr>
<td>• Purchased/rented video media (e.g., movies, TV shows) online</td>
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<tr>
<td>• Owned a cell phone with a digital camera or smart phone with Internet access</td>
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<tr>
<td>• Owned a robotic cleaning device (e.g., Roomba)</td>
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<tr>
<td>• Filed your taxes online</td>
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<tr>
<td>• Used a bank that was online only (i.e., one with no physical structure)</td>
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<tr>
<td>• Owned or interested in owning a vehicle with voice activation technology for cell phone use and/or interfacing with stereo or comfort control systems</td>
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“The successful practitioner of the next century will need to master technologies in order to effectively manage the care of their patients.

As the microscope allowed practitioners in an earlier era to see the microbial agents of infection... the computer will also change the patient.

As patients arrive with better and more information, health care professionals may find themselves increasingly in the role of counselor and consultant”.

Organizational

Patient

Issues with TBIs

Staff
Adoption of Technology

3 Diffusion of Innovation Constructs

• Relative Advantage
• Complexity
• Compatibility

Most relevant constructs to technology adoption research

Van Slyke et al., 2004; Corneille et al., 2014

Rogers, 1995
• **Relative advantage** – belief that a new system has benefits above and beyond the current system. *Someone who believes a text message-based intervention is more useful than existing interventions will be more likely to adopt this innovation.*

• **Complexity** – perception of difficulty associated with adopting a system. *Someone who believes a text-message based intervention will be easy to use will be more likely to accept this technology.*

• **Compatibility** – more likely to adopt an innovation if it is consistent with one’s values, views, beliefs, and customs. *Someone who uses a mobile phone to participate in other electronic services will be more likely to adopt a TBI*.”

Corneille et al., 2014, p. 2761
The fit of any innovation with the attitudes and values of the agency and providers adopting it is critical to the acceptability, efficiency, and effectiveness of the implementation process.

(Ramsey et al., 2016)
Activity #1
Thinking of technological innovations you have used at work, identify the ways in which these various tools have:

• facilitated your work/introduced efficiencies

• impeded your work/created challenges
Agencies with annual operating budgets of greater than $10 million reported significantly fewer barriers than those with budgets of $10 million or less.
Agencies serving more than 3,000 patients per year reported significantly fewer implementation barriers than those serving less patients annually.

Ramsey et al., 2016
How will technologies change how the provider does business?

“I suppose I’ll be the one to mention the elephant in the room.”

Muench, 2015
Most providers will need to re-structure operations to understand how technology will impact clinician workload...

- accept e-mails or phone messages on work phones
- develop on call lists or use peer specialists to manage alerts/requests for help and client check-ins if not automated

(Muench, 2015)
Adoption of New Technology

- agencies should focus on integrating new procedures into existing workflows
- create new staff roles (e.g., project managers who will train staff and deal with resistance to or fear of integration)
- balance a DHT’s financial costs against its potential rewards
- understand how technology shifts certain roles and responsibilities

Muench, 2015
Selection of appropriate training to increase staff confidence in navigating potentially foreign technologies is essential.
"In every office there's always someone who didn't get the message."
The most pressing staff concerns usually fall within the realms of **level of comfort** with the use of technology

Muench, 2015
... and the time burden
a substantial portion of providers reported a lack of basic knowledge about how technologies can be used for behavioral health care

Ramsey et al., 2016
debunk fears cited by providers regarding the use of technologies

Ramsey et al., 2016

compromised client care and job replacement
In some cases, TBIs may change practitioners’ roles and work duties. Muench and colleagues (2013) found that although 80% of providers want to be alerted if their client is at risk of relapse, only 8% would want an immediate mobile alert.
Clinician Extenders allow providers to work at their highest level of training and focus on the most high need client issues.

Bickel et al., 2008; Carroll & Rounsaville, 2010; Des Jarlais et al., 1999; Marsch, 2011
Brainstorm how you could use existing technology to extend the reach or enhance your organization’s services.
Example of a Technology-Based Intervention that can extend the reach of clinical staff

**Treatment Orientation Video**

- useful and efficient means to orient someone to the treatment process (Zwick & Attkisson, 1985)
- as effective as in-person orientations for many health and behavior problems
- improves overall outcomes compared with no-orientation control groups (Walitzer et al. 1999; Zwick & Attkisson, 1985).
Patients’ Acceptability of Technologies
Current evidence demonstrates that patients use and are interested in using technologies as part of their treatment or continuing support.
Patients’ Issues Regarding Using Technologies for Treatment and Recovery

• Make sure patients’ understand:
  – technologies that may monitor them and their locations
  – how to use the technologies
  – what to do in the case of emergencies and service problems

Muench, 2015
Other Technology Issues with Clients

- Many clients change phone numbers or experience disruptions in their phone service which interferes with use of technology-based interventions.
- Approximately 20% of participants had their phone service turned off at least once over the course of a 5-week study as a result of nonpayment.
- Clients sharing phones with family members/others raises issues with privacy/security and confidentiality.
- Warn clients about technology failures and that their messages might not go through.
- Determine the percentage of clients that have access to smart phones before implementing technology.
Technology can be a powerful partner in helping people manage their health conditions.

Cohn et al., 2011
“Models” of Integration for Technology-Based Interventions

• **Brief Intervention** - particularly in settings where SUD treatment services are limited (e.g., primary care [FQHCs], mental health, etc.)
  – Could improve motivation and/or readiness?

• **Stand alone treatment** - comprehensive service (up to 65 modules available) delivered over a structured period of time (e.g., 12 weeks)

• **Clinician extender** - administered as an adjunct to treatment whereby clinicians “prescribe” TBIs (or portions of) to enhance therapeutic intervention.

Marsch, 2012
Examples of EBPs Used by TBIs

- Cognitive Behavioral Therapy
- Community Reinforcement Approach
- Contingency Management
- Motivational Enhancement
- Motivational Interviewing
- Brief Intervention
- Screening
- Relapse Prevention

Aronson, Marsh, & Acosta, 2013; Carroll & Rounsaville, 2010
Four characteristics that help with implementation

- product’s ease of use
- eHealth intervention’s compatibility with the clinical setting
- presence of tools that make it easier for the user to engage in therapeutic activities
- provision of a feasible therapeutic pathway to growth

Baumel & Muench, 2016
Potential Benefits of TBIs

- Can be delivered with low cost or cost savings
- Accessible in a wide array of settings
- Easily exportable
- Fidelity/replicability is assured
- Less threatening in addressing sensitive topics
- Permits more rapid diffusion
- Increase adoption of science-based interventions
- Permits expansion of treatment

Marsch, 2012
Examples of TBI Studies

- Rodgers et al. (2005). *Do u smoke after txt?* – smoking cessation using mobile phone text messaging
- Franklin et al. (2008). *Patients’ engagement with ‘Sweet Talk’* – text messaging support system for young people with diabetes
- Woolford et al. (2011). *OMG do not say LOL* – obese adolescents’ perspectives on the content of text messages to enhance weight loss efforts
- Malbon et al. (2013). *Text in the city* – implementation of a clinic-based text messaging program to educate and inform
- North Carolina (APPCNC). *Birds n Bees* – adolescent pregnancy prevention campaign (www.appcnc.org)
**Touch Points in Care: Which technologies can you integrate in different points in care**

- **Intake** (Decision Support/Dashboard)
- **Consent** (What you need to know)
- **Waiting Room** (Use of video early and late)
- **Early Treatment Enhancing Care Using TBIs (Engagement)**
- **Ongoing Care/Addressing Comorbidities Through TBIs**
- **Post Treatment**
## Different Goals

<table>
<thead>
<tr>
<th>2010 Data*</th>
<th>Addiction Provider (N=34)</th>
<th>Patient (N=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would Use SMS System</td>
<td>87%</td>
<td>98%</td>
</tr>
<tr>
<td>Provider Alerts</td>
<td>80%</td>
<td>78%</td>
</tr>
<tr>
<td>Specific SMS Alerts</td>
<td>8%</td>
<td>---</td>
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</tbody>
</table>

### When would a system like this be most helpful?

<table>
<thead>
<tr>
<th></th>
<th>Addiction Provider (N=34)</th>
<th>Patient (N=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When treatment begins</td>
<td>27%</td>
<td>34%</td>
</tr>
<tr>
<td>During course of treatment</td>
<td>51%</td>
<td>22%</td>
</tr>
<tr>
<td>After treatment</td>
<td>11%</td>
<td>44%*</td>
</tr>
</tbody>
</table>

*Data provided by patients and providers.
Given the promise of these technology-based interventions, we feel encouraged that technology has become mature enough to capture at least some aspect of psychotherapy.

Luo & Campbell, 2014
TBIs

- Web-based Screeners
- Interactive Voice Response (IVR)
- Videoconferencing
- Apps
- Texting
Web-based Screeners
the strongest evidence supporting their efficacy based on randomized controlled trials are

- **The Drinker’s Checkup** (www.drinkerscheckup.com) (Hester et al., 2005)

- **Check Your Drinking** (www.checkyourdrinking.net) (Cunningham et al., 2012)
Studies found that web screeners that provided automated personalized feedback impacted participants' behavior more than those with non-personalized feedback.

Berwick, 2008
SBIRT program for DWI Offenders consists of:

- a self-guided, web-based, screening tool named Motivational Alcohol Treatments to Enhance Roadway Safety (MATTERS)
- assesses alcohol use characteristics and generates a personalized feedback report
- feedback report can then be used by staff to deliver a manualized brief motivational intervention and provide a referral to treatment

Mullen et al, 2015
CASI

• a touch-screen tablet computer that delivers the Alcohol Use Disorder Identification Test (AUDIT)

• is an interactive questionnaire, operating with large icons and headphones

• in both English and Spanish

Ewing et al., 2012
Results showed that...

- 2.45% patients reported at-risk drinking to in-person screening

- 11.5% patients reported at-risk alcohol consumption to the computer (CASI)

- CASI had a more than eight-fold higher probability in screening for at-risk alcohol use over in-person screening

Loftipour et al., 2013
This suggests that individuals perceive digital systems to be a safer means to disclose potentially stigmatizing information.

Muench, 2015
Interactive voice response (IVR)

- a telephone-based technology
- uses touch-tone phones to enable a caller to interact with a computer using the telephone keypad as the interface

Rose et al., 2009
IVR

• IVR is an auditory interactive process that is not hampered by low literacy.

• Privacy and anonymity are greater with an IVR than on a computer screen or written questionnaire because others cannot see or hear the questions or responses, even if others are present at the time of the call.

• Touch tone phones are familiar, easy to use, and more widely available than computers.

• Hardware and software of a centrally-housed IVR system can support multiple clinic sites and thus there are no on-site installation costs beyond telephone access.

(Cranford, Tennen, & Zucker, 2010; Mundt, et.al., 2006)
1/3 of calls to IVR-BI were made outside of clinic hours

IVR-BI produced greater exposure to needed advice and information
Recent Study Using IVR with Patients in Methadone Maintenance Program

- Patients used the system on almost 10 of the 28 days and found the system interesting, helpful, and easy to use
- Rated most modules positively
- Calls were generally brief (10 minutes), but most patients accessed the majority of the content domains
- Patients more likely to report abstinence on days they used IVR

Moore et al., 2013
Videoconferencing
Systematic Review of Videoconferencing Psychotherapy

- Patients and providers perceived a strong therapeutic alliance over videoconferencing.
- Studies that compared videoconferencing to in-person psychotherapy reported similar satisfaction levels between the conditions.
- High levels of satisfaction and acceptance with telemental health have been consistently demonstrated among patients across a variety of clinical populations and a broad range of services.

Backhaus et al., 2012
Evidence accumulated over six decades shows

- videoconferencing telepsychiatry/psychotherapy is an acceptable and feasible form of providing mental health-care
- videoconferencing-based assessments are reliable, and clinical telepsychiatric/telepsychology outcomes are comparable to conventional treatment among diverse patient populations on several measures

  Chakrabarti, 2015

- negative attitudes of clinicians and institutions are the most significant barriers affecting telepsychiatric services use

  Hailey et al., 2008
Studies on Videoconferencing in Addiction Treatment

• **Opioid Treatment-group counseling**
  (King et al., 2009 and King et al., 2014)

• **Alcohol Treatment**
  (Postel et al., 2005)

• **Alcohol Treatment**
  (Frueh et al., 2005)

• **Teleconferencing Supervision (TCS) - MI**
  (Smith et al., 2012)
eGetgoing uses videoconferencing technology to deliver therapy to patients with opioid dependence

(King et al., 2009 and King et al., 2014)
Apps can enhance motivation and increase knowledge.
Apps provide feedback

• Shows individual progress, e.g., scores on screeners, visual displays, graphs and tables, sobriety counter

• Gives virtual rewards for achieving goals or making progress. Examples include levels, reward images, and text-based reward messages
Smartphones travel with individuals throughout their day, providing instant access to information and inspiration, as well as sources of social support, sponsors, or health professionals when cravings and urges or the fear of a lapse are at their greatest.

Savic 2013, p.316
PE Coach – Key Features

In 2011, DoD and VA partnered to build “PE Coach”, a patient-facing smartphone app designed to provide:

- PTSD psychoeducation (e.g., common reactions to trauma)
  - PTSD symptoms assessed weekly or biweekly during PE
  - the app administers the PTSD Checklist

- PE treatment rationale with audio-visual presentations

- breathing retraining instruction (e.g., audio-visual demo on how to breathe in ways that reduce anxiety)
  - a coaching tool to practice the skill

- in vivo exposure treatment component allows patients to construct a fear hierarchy; then select and rate in vivo exposure items for homework

Reger et al., 2013
Example of Relaxation App

- Shrinking and expanding bar
- Duration of desired activity
- Option to shorten and lengthen the breathing cycle
- Desired activity (parallel to audio guidance)
Apps


- **PTSD Coach** – learn about/cope with PTSD-symptoms common following trauma

- **PTSD Family Coach** – supports family members of those with PTSD

- **Mindfulness Coach** – helps person stay grounded in the present to facilitate better coping with unpleasant thoughts and emotions

- **MY3 app** - stay connected when struggling with tough emotions or having thoughts of suicide [http://www.suicidepreventionlifeline.org/-gethelp/my3-app.aspx](http://www.suicidepreventionlifeline.org/-gethelp/my3-app.aspx)

- **Suicide Safe** – helps providers integrate suicide prevention strategies into their practice and address suicide risk among their patients – a free app based on SAMHSA's [Suicide Assessment Five-Step Evaluation and Triage](http://www.suicidepreventionlifeline.org/-gethelp/my3-app.aspx) (SAFE-T) card
ACHESS

- Monitoring and alerts
- Reminders
- Autonomous motivation
- Assertive outreach
- Care coordination
- Medication reminders
- Peer & family support
- Relaxation
- Locations tracking
- Contact with professionals
- Information
Text messaging seems to be a unique hybrid of writing and talking, recently being described as ‘fingered speech’

McWhorter, 2012

First peer-reviewed study of text messaging for health promotion was published in 2002; first RCT in 2005

Neville et al., 2002; Rodgers et al., 2005
Research Studies Using Texting

- **weight/obesity**  
  (Gerber et al., 2009)

- **diabetes**  
  (Franklin et al., 2009)

- **asthma**  
  (Neville et al., 2002)

- **tobacco dependence**  
  (Rodgers et al., 2005)

- **sexual health**  
  (Leach-Lemens, 2009; Lim et al., 2008)
Texting benefits

- Allows for direct contact
- Asynchronous—can reach someone at any time; flexibility in timing
- Used routinely for reminders in medical settings—increases attendance
- Tailored messages can change behavior
- Therapeutic reminders can bridge gap between treatment and daily life
- Cost effective

Clough & Casey, 2011; Fjeldsoe et al., 2009; Gonzalez et al., 2014
TxTEXT: How is your MOOD right now? (0=extremely negative, 1=somewhat negative, 2=neutral, 3=somewhat positive, 4=extremely positive). Reply MOOD #

Mood 4

TxTEXT: Have a nice day!

TxTEXT: Did you take your medication today? Text back MEDS Y or MEDS N

Meds y

TxTEXT: Keep up the good work!
• Used youth to craft language

• Daily self-monitoring texts, a daily wellness recovery tip, and substance abuse education and social support resource information on weekends

• Compared with standard aftercare, texting reduced relapse risk and promoted recovery engagement

Gonzales et al., 2016
Text Messaging Examples

• “How many days in the past week did you feel stressed or have negative emotions (Text 0–7)?”
  - Participant texts back a 3 (Feedback text)

• “Think about 2 good things in your life right now—write them down and focus on those. Ignore everything else.”

• Youth were also sent one daily reminder text that provided them with a recovery tip of the day focused on wellness using the following text prompt throughout the 12 weeks:
  - “Today’s a new day in your recovery, think about the change you are working toward... (wellness tip).”

Gonzales et al., 2016
Technology-Based Interventions

1. feasible
2. patients interested in using them
3. initial studies demonstrate positive outcomes

hold great promise for reaching the large number of individuals who may benefit from earlier assessment and treatment but do not access services currently
Technology-Based Interventions can

1. help health care and other settings implement EBPs
   - greater ability to reach rural and underserved populations, and greater confidentiality, leading to fewer concerns about stigma
2. encourage patients’ disclose health conditions
3. extends the reach of clinicians
• Changes in adult professional behavior (knowledge and skills of practitioners & other key staff members)

• Changes in organizational structures and cultures to routinely bring about/support the changes in adult professional behavior and technology integration

• Changes in relationships to service recipients and other potential partners

Many Moving Parts
Understanding readiness is a **CRITICAL FIRST STEP** towards the successful adoption of technology-assisted care.

Conducting a **READINESS ASSESSMENT** prior to implementation can highlight enablers and barriers not otherwise apparent.
• Readiness of staff and stakeholders to accept and implement technology-assisted care
• Readiness of clinical and IT infrastructure
• Knowledge of technology solutions that will best serve the needs of the population
• Knowledge of the perceived barriers and facilitators for technology adoption

Readiness Examples
Non-Readiness

- Lack of awareness of the benefits technology-based interventions can offer
- Indifference toward technology-based interventions in larger communities where resources already exist
- Lack of genuine interest for technology-based interventions
Telehealth Capacity Assessment Tool

Is your Agency ready for Telehealth?
Successful implementation of a telehealth program requires attention to the interplay among many critical factors.

Need to assess organizational readiness to adopt telehealth technologies.
Purpose of TCAT

1) measure organizational readiness (capacity) in accordance with these factors

2) identify capacity building needs and plan for development in strategic areas

3) monitor and evaluate the impact of capacity building efforts
Six Domains

Key Readiness Elements have been shown in research and through key informant interviews to complement and reinforce each other, and ... together combine to enhance the implementation, quality, integrity, sustainability, and impact of telehealth initiatives.
Six Domains

Domain 1 - Organization Readiness
Domain 2 - Technology
Domain 3 - Regulatory and Policy
Domain 4 - Financing and Reimbursement
Domain 5 - Clinical
Domain 6 - Workforce
3-Step Process

- Use the TCAT to assess and guide discussions about the organization’s strengths
- Gather evidence through a review of telehealth resources and organization materials
- Develop a Capacity Strengthening Plan
Patients and consumers are already embracing technology and creating a patient-centered health movement...
However, technology-based interventions are most effective when combined with human support, reinforcing how providers will remain the foundation of care for those seeking help...

Muench, 2015