1. What are the implications for cultural and linguistic competence in using telehealth strategies?

Steve Trout: The technology (I am speaking only to videoconference technology) is simply a tool to enhance access, efficiency and hopefully quality. Therefore, using this "tool" in the same manner one would address cultural diversity in an "in person" encounter would be the recommendation. In other words, having a physician, nurse, clinician, etc. who is linguistically competent, or making accommodations for an interpreter would be the same for an in person visit as it would be for a technology supported encounter. It is important to understand the perception of each end-user in determining the efficacy of service delivery supported by technology. If there are cultural taboos, general client unwillingness, or a clinical determination that technology supported clinical service is not recommended, then the technology should not be used.

Eve-Lynn Nelson: It is important to encourage best practice in cultural competence and professionalism across telemedicine providers and presenters. We generally utilize medical center interpreters who have extensive training in CLAS standards rather than ad-hoc interpreters at the distant sites. It is also important to consider competence related to serving rural families and differences based on rurality. The telemedicine clinics offer unique training advantages to allow healthcare trainees to work with diverse families and build professional competencies.

2. What is the capacity for expansion? Future plans?

Steve Trout: There is a direct relationship between bandwidth capacity and growth. Although T1 line technology is good and handles all current needs, there will come a time when we outgrow our T1 bandwidth capacity. Ohio needs to expand the fiber optic infrastructure, especially in Appalachia Ohio. I am pleased to say with the assistance of a new FCC supported initiative, we are addressing our future bandwidth capacity issues. On the short term, I want our system to reach a comfort level with telepsychotherapy. Future applications include expanding to serve the AoD service system, schools, juvenile justice and using the technology to aid the integration of primary and behavioral health, which includes the creation of one comprehensive electronic medical record.

Eve-Lynn Nelson: I agree with above concerning integration of multiple technologies to extend services. While technology and bandwidth are important, our expansion is more limited by human factors and time. Both providers (psychiatrists, psychologists, others) and rural presenters are already juggling multiple demands. We are working on creative ways to integrate telemedicine into workflow.

3. Are these numbers unduplicated counts?

Steve Trout: All Ohio numbers are duplicated numbers.

4. How are crisis situations handled if they arise as a result of the telehealth sessions, etc.?

Steve Trout: All clients are seen at one of our certified mental health clinics and any crisis can be met in quick fashion. There are times when a case manager may be included in the session, although including a case manager in every session becomes a billing issue and hurts efficiency. In a worse case scenario, the physician has direct telephone access to clinic staff for on-site support. I am happy to say that this has not been much of an issue and I would attribute this to the careful scrutiny by professional staff of when and with whom the technology showed be used.

Eve-Lynn Nelson: This is an important question to address both with protocols and with presenter training ahead of concerns, albeit rare occurrences. With an immediate safety concern, the telemedicine presenter and provider assist the family in seeking local crisis services through the hospital and

community. Just as in the traditional clinic settings, the telemedicine provider may set up a safety plan with the child/family over telemedicine and facilitate links to local crisis services.

5. I live in rural Ohio and have difficulty connecting my computer to the Internet. With dialup, it's more than difficult to "stream" or "video conference." How prevalent is Broadband service for you, and how do you prevent disconnect? May I ask what providers you utilize @ $400/month, please?

Steve Trout: The SCC system is supported by T1 line connectivity, in most cases. The cost of T1 connectivity is a negotiated rate for Ohio through the Universal Service Administrative Company (www.universalservice.org) for rural governmental or non-profit allied health providers but does not apply to individuals and/or private sector businesses. In a few instances we have used “business class” broadband through Time Warner, etc. for direct service. This is a fully encrypted service, which allows for complete confidentiality, meeting HIPPA requirements. The cost for business class broadband is less (approximately $150 per month) but the overall integrity of our current program could be compromised (bandwidth) if we switched completely to a private broadband provider. I use this method of connectivity only when I have an out-of-region physician who delivers direct service from a long distance. So, between dedicated T1 connectivity and business class broadband, I do not have connectivity issues and picture quality is excellent!

6. If you (Ohio) were to do it over again, would you change anything? Lessons learned?

Steve Trout: There is always a price to be paid when “blazing a trail!” Things did not always happen in the time frame I would have preferred, however I do not think I would change a thing. The most important step was to form a collaborative relationship with the Ohio University College of Osteopathic Medicine and their Office of Information and Technology. Once we had the technical expertise established we had the backbone to move forward. This enabled us to attract funding from Federal sources and build our current system. Provider agency and physician buy-in is always tricky, but persistence is the key virtue and always keep the vision of increased access, efficiency and quality as the ultimate prize!

7. What trainings are you using for the depression disorders? Do you suggest the use of a depression scale as an indicator for non-professional staff?

Eve-Lynn Nelson: For more formal trainings, speakers have addressed a variety of topics including evaluation and treatment concerns
(see http://www.connectedkansaskids.com/TeleHelp/TeleHelpProgram.aspx). For less formal trainings at the school sites, the warning signs of depression are addressed as well as treatment overview. We disseminate the book “Helping Your Depressed Child” (Barnard, 2003) as a resource. School personnel are asked to share together strategies they have seen successful in their own school settings.
We recently received support to develop an online curriculum for healthcare trainees/professionals and the course will follow the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) (see Pediatrics, November 2007, 120(5)). GLAD-PC gives tools for depression screening (see http://www.reachinstitute.net/documents/ShortGlad-PCToolkitforWeb.pdf). We have used the Children’s Depression Inventory as part of general telemedicine evaluation but not as a screener.

8. Have you been able to gather evaluation data linking school based telehealth services to academic outcomes or other outcomes important to the education system?

Eve-Lynn Nelson: This is a great idea but has not been our focus. Such work has been done with acute pediatric concerns and attendance (McConnochie et al., 2005).

9. What challenges and solutions did you find valuable in approaching schools - costs for these partners?

Eve-Lynn Nelson: We have found talks/outreach key to maintaining services at schools, including relationship building with presenters, administrators, and community groups. We have transitioned to requiring schools to have an investment in the program (through covering equipment, bandwidth, or other resources) in order to encourage more internal school buy-in and participation over time. We also emphasize from the beginning that telemedicine is not a fit for every need or school.

10. Has PBIS implementation been implemented in parallel with Safe Schools H.S. grants?

Jennifer Kitson: A number of Safe Schools/Healthy Students initiatives choose to implement Positive Behavior Interventions and Supports as one of the evidence-based programs in their project.
You can find information on the National Center for Mental Health Promotion and Youth Violence Prevention website – www.promoteprevent.org

- On the grantee locator page you can search for the SS/HS sites that have identified PBIS as a program they implement – www.promoteprevent.org/granteelocator
- Several PBS documents and webinars created for SS/HS can be accessed, including PBIS Guide, PBIS Resource page, PBIS series teleconferences – www.promoteprevent.org/Publications/PBISguide

11. Have the telehealth applications worked as well in high schools as they have in lower grades?

Eve-Lynn Nelson: From our limited experience with high school students, the answer is yes. We have had particular success with teens with depression utilizing telemedicine. To my knowledge, there are no telemental health trials specific to the adolescent group. There are anecdotal reports that some teens like the “distance” offered by telemedicine and may share/disclose more in the technology setting.