CORRECTION

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Correction to: An Interprofessional Framework for Telebehavioral Health Competencies

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Introduction

In 2001, the Institute of Medicine (IOM) released a report that highlighted the inadequacies of health care professional training and assessment of ongoing proficiency to enhance patient care and safety (IOM 2001). The IOM's subsequent *Health Professions Education Summit (HPES)* then identified objectives for educational reform for the following health professionals in the United States: nurses, pharmacists, physician assistants, physicians, and allied health professionals, including, for example, psychologists, counselors, and social workers (IOM HPES 2003b). The IOM thereby identified *a set of simple, core competencies that all health clinicians should possess, regardless of their discipline, to meet the needs of the twenty-first-century health care system* (p. 45). These included the ability to:

- Provide patient-centered care
- Work in interdisciplinary teams
- Employ evidence-based practice
- Apply quality improvement
- Use information technology (IOM 2003a, p. 45)

Since then, educational reform related to competencies has made significant advances. In fact, the above-mentioned competencies are now often considered a foundation for workforce development. They provide indicators

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that are necessary to develop effective curriculum for worker training, orientation and continued staff development. They also provide indicators to inform workers and their supervisors of job performance requirements. For example, the utilization of competencies in the training of Direct Service Workers (DSW) reinforces shared values of direct service workers' skills and growth (Hoge et al. 2008; Center for Medicare and Medicaid Services' (CMS) 2013, p. 13).

Searching for these principles in TBH, a review of the TBH evidenced-based literature across psychiatry/medicine, psychology, social work, counseling, marriage/family, behavioral analysis and other behavioral sciences produced a paucity of related research (Hilty et al. 2017). While professional guidelines and standards for the practitioner use of technology were available from various disciplines e.g., American Psychological Association (2013); American Telemedicine Association (ATA; 2009, 2013 and 2017), American Counseling Association (ACA 2014), American Association of Marriage and Family Therapists (AAMFT 2015), National Association of Social Workers (NASW 2017), the only TBH competencies available were specifically developed for telepsychiatry skills, training and evaluation (Hilty et al. 2015. The need for, outline of, and background context for such competencies is in a previous *JTiBS'* publication entitled, *Telebehavioral Health, Telemental Health, E-Therapy and E-Health Competencies: The Need For An Interdisciplinary Framework* (Hilty et al. 2017).

Current Paper

In the current paper, three of the five competencies identified by the above-cited IOM outline for educational reform are detailed for TBH. They are: interdisciplinary teams, evidence-based care and information technology. More specifically then, the first area of focus is that of *interdisciplinary collaboration, education and training*. The concept of *interprofessional collaboration* (Harrison and English 2001) and *interprofessional education* (Barr 2002) describe occasions when professionals from two or more disciplines work together to improve collaboration and quality of care; though the terms *interdisciplinary* and *interprofessional* are often used in synonymous ways, this article will use the more contemporary term *interprofessional*.

The IOM movement is being implemented in a variety of settings, including education (Angelini 2011). The Pew Commission has also been an active force in this movement, joining the IOM in examining the many ways that a lack of interprofessional cooperation and ineffective communication can stand in the way of best practice and improved patient outcomes, as well as suggesting alternatives to facilitate interprofessional cooperation and teamwork.

The second area of need identified by the IOM, and addressed herein is *evidence-based care*. Ongoing requirements for healthcare practice delivery to be evidence-based and supported in the literature has become a driving force behind the development and implementation of competency-based training models throughout healthcare. Evidence-based practice (EBP) is defined as:

> *A scholarly and systematic problem-solving paradigm that results in the delivery of high-quality health care. In order to make the best clinical decisions using EBP, external evidence from research is blended with internal evidence (i.e., practice-generated data), clinical expertise, and healthcare consumer values and preferences to achieve the best outcomes for individuals, groups, populations, and healthcare systems.* (ANA 2012, p. 16).

The third area of need identified by the IOM, and to be addressed herein is *information technology*. One of the most rapidly growing areas of use for information technology is telebehavioral health (TBH) in the delivery of behavioral health (BH) services (in this paper, BH refers to both mental health and addictions treatment). TBH has been demonstrated to be an effective mode of treatment for a variety of presenting problems, with outcomes comparable to therapy provided in-person when diagnoses and settings are controlled (Aboujaoude et al. 2015; Godleski et al. 2012; Hilty et al. 2013; Luxton et al. 2016). TBH is gaining increased acceptance both among practicing clinicians (Glueckauf et al. 2017) and consumers (Gros et al. 2016; Roberts et al. 2017). The current article then, is an attempt to advance the scientific discussion of competency-based, interprofessional practice using TBH.

Concise Review of the Literature

Historical Basis for Competencies

In the healthcare literature, competency is defined as *the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served* (Epstein and Hundert 2002, p. 227). Competencies are acknowledged as *a critical component of workforce development, satisfaction, and retention* by a variety of standard-setting groups, including CMS (2013, p. 12). The goal of competency-based training is to assess one's readiness for practice, from the perspective of direct skills and academic knowledge (Jones et al. 2011). As required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), hospitals and healthcare agencies are also focused on competencies. The Joint Commission also requires

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regular validation of employee skills competency using evidence-based competency assessments.

As defined by the Joint Commission, *competency assessment* is defined as *the systematic collection of practitioner-specific data to determine an individual's capability to perform up to defined expectations* (1998). More specifically, the Joint Commission's 2008 HR standards list the following expectations for competency:

- *Standard HR.1.20 A staff member's qualifications are consistent with his or her job responsibilities.*
- *Standard HR.2.10 The hospital provides initial orientation.*
- *Standard HR.2.20 Staff and licensed independent practitioners, as appropriate, can describe or demonstrate their roles and responsibilities relative to safety.*
- *Standard HR.2.30 Ongoing education, including inservices, training, and other activities, maintains and improves competence.*
- *Standard HR.3.10 Staff competence to perform job responsibilities is assessed, demonstrated, and maintained"* (Joint Commission Resources 2008; HCPro 2008, pp. 8–15).

Much of the work to identify BH profession-specific competencies relate to the cognitive domain framework for educational goals conceptualized by Bloom (1956), including *knowledge, comprehension, application, analysis, synthesis, and evaluation.* To further complicate matters, BH professional training has historically evolved from having a primary focus on the *knowledge-based* aspects of competency to including *skill-based* aspects. This issue then, is not yet addressed in TBH.

Furthermore, in reviewing the literature, the authors noted that the majority of scientific articles currently in the scientific literature is about the education, training, assessment and competencies of professionals-in-training, and *much less* about professionals who are already independently licensed to practice. Extending Bloom's model, and despite the lack of overt, interprofessional collaboration among the behavioral professions, there appears to be general consensus among these professional groups that competencies should now involve the three core learning features of knowledge, skills and attitudes (Kirkpatrick and Kirkpatrick 2009).

Such consensus also reflects an *interprofessional* need and corresponding effort to identify the *broad categories for competencies* (Calhoun et al. 2008; Hoge et al. 2014; Interprofessional Education Collaborative Expert Panel 2011; IOM 2003a), so as to avoid the discipline-specific definition of competencies, which can create often insurmountable differences that may perpetuate the concerns addressed by the IOM in 2001 and 2003. The previous lack of consensus in behavioral training has led to a variety of problems, including increased challenges in state *regulatory efforts*. For

example, in the United States, regulatory boards are increasingly giving more attention to skill-based competencies in the midst of a rapidly changing financing, service delivery and billing/reimbursement environments. For instance, when deviating from routine in-person care, there may be varying laws and policies for private insurance, Medicaid and Medicare, depending on the discipline, the setting of care, as well as regulatory variations from state-to-state. In turn, insurers of all types seem to be struggling to deliver the quadruple aim: better care, lower costs, greater access and improved provider satisfaction (Bodenheimer and Sinsky 2014). Competencies then, can be an important key to stabilizing these often conflicting forces.

Physicians, pharmacists and nurses have already incorporated skills-based competency assessments as a part of their licensure examination requirements (Philipsen et al. 2007; USMLE 2014; IOM 2003a). BH professionals are slowly joining the movement toward incorporating skills-based competencies. A prime example of a group advocating for more comprehensive, skills-based competencies in BH is the Association of State and Provincial Psychology Boards (ASPPB 2014). It is developing a skill-based examination for the licensure of psychologists to complement the knowledge-based licensing examination to approve new licensees. Evidence of movement toward interprofessional competencies in BH can be found in a 2017-related publication of the journal entitled, *Child and Adolescent Psychiatric Clinics of North America*, where Njoroge and colleagues stated:

> *In order for behavioral health providers to function effectively in collaborative care models, they require specialized training and professional competencies.*
> *Cross-discipline training and professional competencies for training behavioral health providers are recommended to support the effective provision of integrated primary care services….Child and adolescent psychiatry, psychology, and social work trainees involved in integrated primary care services should receive interdisciplinary training experiences that target these competency areas (p. 717).*

Methods

To address the mounting need for interprofessional consensus regarding evidence-based assessment and implementation of TBH competencies related to core knowledge, skills and attitudes, the Coalition for Technology in Behavioral Science (CTiBS), organized a TBH Competencies Task Force in 2014. An interprofessional organization dedicated to advancing the evidence-based use of technology in BH, CTIBS sought to develop a consistent set of core, discrete, measurable, interprofessional, evidence-based TBH competencies

shared by *all* BH professions, both at the graduate and post-graduate levels. As such, agreed-upon competencies in TBH would help establish criteria for addressing the growing needs for TBH workforce training and evaluation. CTiBS also sought to shed light on how competencies might be developed for telehealth in general, since such competencies had not yet been identified in the other telehealth disciplines.

CTiBS TBH Competencies

BH is most often understood as being served by eight, professional disciplines that address overlapping yet distinct needs in the United States. These disciplines are generally understood as including addiction specialists, behavior analysts, counselors, marriage and family therapists, psychologists, psychiatric nurses, psychiatrists and social workers. Professionals within these disciplines are increasingly being required to work together in teams (Hanley et al. 2017), oftentimes along with larger medical professionals, exposing the underlying theoretical disagreements and at times, conflicts and competition related to appropriate skills and their training (Martínez-Rodrigo and Martí-Bonmatí 2008).

The term competency as used by the CTiBS Task Force refers to as a measurable human capability required for effective performance, and may include individual and aggregate components of knowledge, skills, attitudes. Meeting competency-based goals requires careful listening, systematic collecting of information and deliberate reflection and planning (Dreyfus and Dreyfus 1980; Hilty et al. 2015; Marrelli et al. 2005; Miller 1990).

Since the literature review of TBH-related competencies yielded such sparse results (Hilty et al. 2017), the authors – also the developers of this CTiBS TBH competency set – suggested interprofessional TBH competencies across the specific behavioral professions. Specifically, they suggested 1) novice/beginner, competent/proficient and expert levels; 2) domains of patient care, communications, system-based practice, professionalism, practice-based improvement, knowledge and technological know-how; and 3) andragogical methods to teach and evaluate skills (Hilty et al. 2015). It noted a potential challenge to develop competencies across disciplines in terms of finding consensus, varying scopes of practice, training differences and faculty development priorities – but this was also seen as an opportunity. The review also suggested that disciplines and organizations involved with TBH need to consider certification/accreditation and ensure quality care (Hilty et al. 2017).

The review's suggestions built upon two recent efforts to identify TBH competencies for psychiatry and psychology (Hilty et al. 2015; Ohio Psychological Association 2013). Still, the majority of BH professional organizations have not yet formally acknowledged that their professions share core TBH competencies with other behavioral healthcare or science disciplines. However, a number of professional organizations in the United States and abroad have developed and promulgated TBH standards and guidelines for populations of all ages and cultures e.g. ATA 2009, 2013 and 2017; American Psychiatric Association 1998, American Psychological Association 2015, ACA 2014 and 2015; Ohio Psychological Association (OPA) 2013, Australian Society of Psychologists (ASP) 2011; Johnson 2014; National Association of Social Workers (NASW) 2005 and 2017).

CTiBS Competency Task Force Members

A high priority for the CTiBS Task Force was to establish and maintain a broad interprofessional representation of Task Force members so as to better assure that the group's effort would represent diverse, informed and broad perspectives. This interprofessional Task Force has substantial, notable TBH experience, including: the development or review of national association standards or guidelines related to TBH i.e., counseling, psychology, medicine, telemedicine; appointments to national association standards or ethical boards i.e., counseling, psychiatry, psychology and social work; stewardship of TBH as a presidential initiative in a national association i.e., counseling; developing and teaching TBH as faculty i.e., counseling, marriage and family therapy, psychiatry, psychology, medicine; board membership with a national professional association when the association's *guideline for guidelines* was re-written i.e., psychiatry, psychology; significant regulatory board experience i.e., counseling, marriage and family therapy and psychology; peer-reviewed publications related to TBH i.e., addictions, communication, counseling, marriage and family therapy, psychiatry, psychology. Members also have prior experience with delivering professional TBH presentations or workshops related to legal/ethical/policy issues at national association conferences i.e., addictions, communication, counseling, marriage and family therapy, psychology, psychiatry, social work; and/or experience in developing and assessing TBH training based on pedagogy i.e., counseling, marriage and family, psychiatry, psychology. One member speaks English as a second language.

Charge and Scope of the CTiBS Task Force

The Task Force was charged to develop TBH competencies for practitioners, trainers, graduate students, and supervisors to address the disparities between behavioral disciplines, which seemed to each be separately addressing the issues, but inadvertently adding confusion interprofessionally by re-inventing the nomenclature, basic concepts and defining relevant knowledge, skills and attitudes within their own discipline for the use of technology, but not yet reflecting the IOM call for interprofessionalism across disciplines.

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The Task Force also identified an interprofessional reference list and other resources, augmented by publications that explain the rationale for a competency framework; developed the framework itself and outlined educational/training applications of the framework (Hilty et al. 2017). The Task Force agreed to limit the focus on broad competencies related primarily to video teleconferencing rather than those related to specific technologies e.g., email, telephone, use of mobile apps, texting, but many of the identified competencies are applicable to these other technologies.

CTiBS TBH Competency Framework

The CTiBS TBH competencies consists of 7 general domains of expertise. They are: 1) *Clinical Evaluation and Care*, with subdomains addressing *Cultural Competence and Diversity, Documentation and Administrative Procedures*; 2) *Virtual Environment & Telepresence*; 3) *Technology*; 4) *Legal & Regulatory Issues*; 5) *Evidence-Based & Ethical Practice,* with a subdomain addressing *Social Media*; 6) *Mobile Health and Apps* and 7) *Telepractice Development*. The Task Force further categorized these seven domains into 51 telebehavioral objectives, grouped according to level of expertise (Novice, Proficient and Authority). Each of these telebehavioral objectives more specifically identified discrete areas of knowledge, skills and/or attitudes to be expected of a professional functioning at a defined level. As a whole, this organizational structure provides the framework for 149 individual telebehavioral practices. The framework as well as the majority of the discrete telebehavioral objectives and individual telebehavioral practices can be applied more generally to telemedicine telehealth.

Task Force Approach and Process

The Task Force met via telephone approximately twice per month for the first two years, developing the initial draft of competencies and integrating comments obtained in the summer of 2016. Task Force Members completed individual assignments between meetings e.g. reviewing articles, writing segments, soliciting feedback from colleagues who were not members of the Task Force. They subsequently met weekly for two hours for much of the last year to integrate comments and finalize the associated documents.

Task Force Members conducted extensive literature reviews into how BH disciplines have defined, researched, evaluated, and used competencies in their training and practice. These reviews confirmed that BH professions lag other healthcare professions in identifying and applying the concept of competencies in their training and practice. Although there are examples of identifying and assessing competencies for each profession (Bienenfeld et al. 2000; Blumer et al. 2015; Dombo et al. 2014; Hensley et al. 2003; Hilty et al. 2015;

Kaslow et al. 2009, Melnyk et al. 2014; Meyer-Adams et al. 2011; Nelson et al. 2007; Morris, & Lazenby, 2011; Rodolfa et al. 2005; Swick et al. 2006; Swank et al. 2012; Tilley 2008) the uses of such competencies often are not apparent in practice once individuals have completed their training.

In addition to a review of the pertinent BH competencies literature by profession, the Task Force also reviewed other noteworthy contributions to the literature. This review included the early Online Clinical Practice Model (OCPM) outlined by Maheu (2003), and further detailed by Maheu et al. (2004) as a foundation for identifying interprofessional competencies. Also examined were standards and guidelines published by specific disciplines (American Association for Marriage and Family Therapy 2015; American Counseling Association 2014 and 2015; American Nursing Association 2012, American Psychiatric Association, 2000; American Psychological Association 2013; American Telemedicine Association 2009, 2013 and 2017; Association of Social Work Boards 2015; ASP 2011; Canadian Psychological Association, 2014; and National Association of Social Workers, Association of Social Work Boards, Council on Social Work Education, and Clinical Social Work Association 2017, and the Association for Addiction Professionals 2016 (NAADAC). Lastly, competency development studies using the Delphi method were reviewed (Coleman et al. 2013; De Villiers et al. 2005). A detailed review of nursing competencies and how they are being taught and measured at a U.S. Department of Veterans Affairs hospital was particularly helpful in the initial stages of the Task Force's efforts to conceptualize competencies based upon demonstrated skills. Two of the members of the task force working at the Veterans Administration provided valuable insight into the specific wording for competency statements (Luoma 2015). Other pertinent publications reviewed included Johnson's (2014) proposed model of telepsychology practices in Canada, focusing on knowledge and skills; the 2016 accreditation standards developed by the Council for Accreditation of Counseling & Related Educational Programs (CACREP 2015). Each of these documents proved helpful in formulating the categories of knowledge and skills needed for TBH practice.

External Review Process

Input was requested from leaders of a variety of professional organizations in order to be inclusive. Leaders and organizations included, but were not limited to: AAMFT, ACA, the American Psychiatric Association, American Psychological Association, the National Association for Alcoholism and Drug Abuse Counselors (NAADAC; now called, the Association for Addiction Professionals (AAP) and the NASW, and the ATA. An initial draft set of TBH competencies developed by the CTiBS Competency Task Force was disseminated for review and comment by a large

interprofessional sample of BH professionals. This effort was attempted in two waves delivered a year apart, in the summer of 2016 and then again in the summer of 2017. The request for comments included a letter explaining the goals of the project and asking for input.

For the first wave, an invitation to comment on the draft competencies was posted on multiple professional listservs across the involved disciplines. CTiBS also disseminated the competencies to those leaders and organizations, as well as members across the variety of disciplines via listservs, conferences, licensure lists, and other networking opportunities in counseling, psychiatry, psychology, marriage and family therapy, social work and telemedicine. Requests were also made to numerous state BH professional organizations to share the request with their members. The comment period was open for six weeks.

The second wave of requests for comments was issued by CTiBS in August of 2017. For this wave of comments, the competencies were disseminated to a larger group of professionals, including the leadership of several national and international organizations. The comment period was open for four weeks. A rating scale was organized for each domain of the competencies through an online surveying tool (Qualtrics).

Findings

Competency Domains

The CTiBS Task Force initially identified seven TBH competency domains based on the review of the literature, technological advances and day-to-day clinical practice. The amount of information of relevance to competencies was daunting, particulalry because it continues to grow across dimensions as technology proliferates. For the convenience of the reader, the following are brief descriptions of each of the seven competency domains identified by CTiBS:

1. Clinical Evaluation & Care: TBH professionals can demonstrate how to make evidence-based decisions in the best interest of clients/patients. They can demonstrate working knowledge, skills and attitudes relevant to TBH clinical issues as they pertain to evaluation and care as it relates to in-person or technology-based intake, triage, assessment, diagnosis, and therapeutic services across the client/patient lifespan; cultural, linguistic, socioeconomic and other characteristics related to diversity and appropriate documentation.
2. Virtual Environment & Telepresence: TBH professionals can demonstrate how to apply appropriate techniques to maximize therapeutic atmosphere in both physical and virtual environments as well as minimize distraction and interruptions.Professionals can show how to approximate

an in-person relationship and foster spontaneity through TBH.
3. Technology: TBH professionals can demonstrate how to make informed decisions that reflect understanding their own and their clients/patients preferences for and, experience with using technology. Professionals are responsible for understanding how to responsibly use the technology they choose and can demonstrate a functional knowledge of its strengths, applications and limitations e.g., privacy, confidentiality, data integrity and security.
4. Legal & Regulatory Issues: TBH professionals are aware of and can demonstrate adherence to relevant federal, state/provincial, and local laws, regulations and policies/ procedures regarding TBH practice components e.g., issues such as privacy, confidentiality, data protection/ integrity and security. They can also demonstrate adherence to relevant mandated reporting, informed consent and documentation requirements. They are able to demonstrate compliance with legal technology-related mandates, including the appropriate use of business associate agreements.
5. Evidence-Based & Ethical Practice: TBH professionals are aware of and can demonstrate adherence to TBH interprofessional and discipline-based professional standards, guidelines, consensus and evidence-based documents based on domestic and/or international practice. TBH professionals can also demonstrate adherence to professional boundaries and other best practice guidelines relevant to a virtual setting when engaging in social media and digital information collection sources. Professionals develop written social media and digital information policies and discuss them with clients/patients as appropriate.
6. Mobile Health Technologies Including Applications (Apps): TBH professionals choosing to work with mobile health technologies including apps can demonstrate how they are used in accordance with therapeutic goals, how they can have distinct positive and/or negative effects on the therapeutic relationship based on evidence, can demonstrate how they adhere to and apply to relevant professional standards and state/provincial and/or federal law; help clients/patients select options based on evidence; demonstrate an understanding of the privacy limitations of mobile technologies utilized/recommended and discuss these with clients/patients.
7. Telepractice Development: TBH professionals can demonstrate how to use TBH and other forms of telecommunication technology to create and maintain one's professional identity and to engage the community at large e.g., soliciting testimonials from current or former patients/clients, in accordance with local, state/provincial and federal regulations and professional association standards. Professionals can show how to ensure the accuracy and validity of information disseminated.

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Competency Levels

Traditional competencies organized are based on a developmental progression – usually longitudinal training (all; advanced students, residents or interns) – to a licensed clinician (many; teaching faculty, supervisor) – to Authority/advanced practice (few; specialists in a given area like refractive mood treatment). For example, Dreyfus and Dreyfus (1980) used a five-level framework offering the "Novice, competence, Proficient, expert and mastery" levels. This framework was simplified by Hilty and colleagues to novice/advanced beginner, competent/Proficient and expert levels (Hilty et al. 2015). A similar structure used by the National Hospice and Palliative Care Organization (2010), offering the Novice, Proficient and Authority levels. Following this example, the CTiBS TBH competencies were organized into three levels of proficiency for each of the seven identified competency domains, starting with Novice, then Proficient and moving to Authority levels. The Figure below then, illustrates the overall framework for TBH competencies offered by CTiBS (See Figs. 1 and 2).

Also, generally speaking, within a competency framework, a practitioner has to master all (or most of) the previous level's skills to advance to the next level. Task Force members however, noted that with technology in particular, professionals in training (Novices) may have technology-related knowledge and skills that surpass their instructors and mentors. If such Novices have transitioned from personal use to thoughtful professional use of technology, they may be more *advanced* than clinical supervisors who have little/no experience with technology in their professional practices. Nonetheless, the TBH competencies are framed with requisite in-person clinical expertise as a minimum. The CTiBS competencies are designed to help such a clinician focus on the development of additional TBH competences to deliver relevant clinical
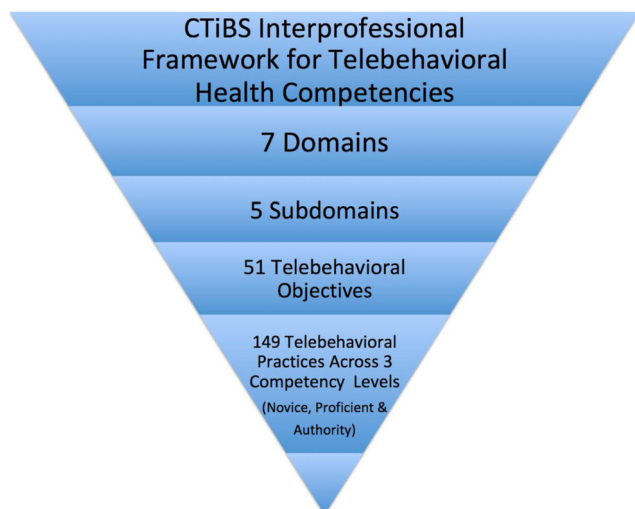

Fig. 1 CTIBS interprofessional framework for telebehavioral health competencies

expertise through technology to clients/patients who are not in traditional, brick-and-mortar settings.

Again, the three levels within the seven competency domains describing progressively higher professional TBH knowledge, skills and attitudes were organized as 1) the *Novice*, and used to describe expectations to be made with regard to advanced students, residents or interns; 2) *Proficient* describes expected levels competence in professionals who are nearing or have completed graduation as well as those independently practicing or supervising TBH supervisees and 3) *Authority* describes professionals who are researching, training and consulting at an advanced level of performance.

Each of these three competency levels will be further described next. First, the *Novice* in TBH can identify and describe issues, conduct basic screening; list pros and cons of using various technologies and related strategies; protect security, privacy and confidentiality; and when appropriate, educate clients/patients about fundamental TBH, laws, rules, regulations, ethical requirements, policies, procedures, assessments, interventions, standards and communication styles. They can demonstrate the basics of using computers, remote patient monitoring, social media and mobile health and the issues related to recommending the use of apps. They also have the ability to discuss how to legally and ethically market their own services online.

Second, the *Proficient* level includes graduating residents or fellows, licensed and advanced residents, experienced practitioners, independent practitioners, faculty, attending or interprofessional team members. These professionals are not only able to *identify and describe* the areas listed for those at the Novice level, but also *implement* the use of appropriate documentation, procedures, policies and telepractices needed for the responsible delivery of TBH. They are able to find and engage with the digital tools to facilitate telepractice while increasing client/patient comfort in compliance with expectations of professionals who are culturally competent. Their telepractices are compliant with all relevant laws, rules, regulations, ethical codes, administrative policies and procedures for not only computers, but all digitized tools they use, including mobile health, remote patient monitoring, apps, wearables, artificial intelligence, robotics and other technological innovations prior to utilizing them with the public. This mid-level group also includes supervisors who help novices or other professionals to learn telebehavioral best practices. When using digitized systems to market their services, they know how to follow the relevant laws and ethical codes related to digital marketing.

Third, the *Authority* may function as an advanced faculty/ attending, interprofessional team leader, scholar, researcher, policy maker, advanced practitioner, supervisor, trainer or consultant. They may actively review policies, develop new policies and strategies based on changing criteria in the

NOVICE	PROFICIENT	AUTHORITY

Fig. 2 Competency levels within each ctibs TBH "telebehavioral practice" reflecting core knowledge, skills and attitudes

telebehavioral or related fields. Members of this advanced, Authority group may assist with evaluating work flow and needs assessments. They may consult so as to help others comply with best practices, optimize settings or technologies, and maximize therapeutic alliance when using technology. TBH Authorities may also conduct telebehavioral research, integrate paradigms, develop consensus statements across professions, disciplines and countries. They may also develop new methods for documentation, conduct evidence-based research, identify new best practices to address inconsistencies or resolve implementation problems with non-routine telepractice.

Lastly, the TBH competencies herein described have been developed so as to be used from either the perspective of the learner or the supervisor. The learner is to provide a self-evaluation across three levels: whether they can perform the tasks independently, they need further practice, or they have had no experience with that particular model. The supervisor is to evaluate three criteria – whether the knowledge, skills and/or attitudes was demonstrated, or whether it was observed or verbalized, or whether it was tested in each category.

Input from External Review

The first wave of feedback from commenters shaped the TBH competencies in several ways, but overall, there was agreement on the structural approach. The input suggested changes that the language reflect more inclusivity regarding all behavioral disciplines, rather than just a few. Commenters noted that the competencies needed to be more representative of the tasks required for clinicians in private practice as well as for those employed in institutionalized work settings. They also requested that distinctions between Proficient and Authority practitioners be more discrete and measurable. Extensive revisions were discussed by the group on a weekly basis for twelve months and changes were incorporated into the document. These subsequent changes included collapsing the number of domains from ten to seven. Overall, this feedback had qualitative and quantitative dimensions.

The results of the second wave of requests for comments was issued by CTiBS in August of 2017. This second draft of the CTiBS TBH competencies were disseminated to members of professional communities of all eight previously identified behavioral disciplines, listservs and social media groups. The structural approach was reaffirmed, the domains were well supported and the work was seen as helpful and practical. Most of the constructive feedback amounted to changes in fine details i.e., quantitative dimensions.

As a result, Maheu and colleagues (2017) finalized these seven TBH competency domains: 1) *Clinical Evaluation and Care*, with subdomains addressing *Cultural Competence and*

Diversity, Documentation and Administrative Procedures; 2) *Virtual Environment & Telepresence*; 3) *Technology*; 4) *Legal & Regulatory Issues*; 5) *Evidence-Based & Ethical Practice*, with a subdomain addressing *Social Media*; 6) *Mobile Health and Apps* and 7) *Telepractice Development*. They provided a framework to make these competencies measurable for novices, Proficient professionals and Authorities. The framework describes 51 telebehavioral objectives and 149 discrete, meaurable telebehavioral practices that include knowledge, attitudes or skills for clinicians who cumulatively span the Novice, Proficient and Authority levels of professional development. See Appendix 1 for details.

The TBH Competencies: Highlights from two Competency Domains

As the reader may appreciate, detailing all seven CTiBS domains with their 51 behavioral objectives is a task worthy of an entire handbook and/or certification professional training program. However, for illustrative purposes in this introductory article, two of the 51 TBH *competency telebehavioral objectives* (including discrete telebehavioral practices) are briefly detailed below to illustrate the specificity that educational and training programs, employers, insurers, regulators and other stakeholders may wish to consider when evaluating the interprofessional, evidence-based TBH knowledge, skills and attitudes of competent professionals offering TBH services at various stages of professional development. The reader is given a short introduction to the domain, then the discrete telebehavioral practices at all three levels (Novice, Proficient and Authority) for each subdomain described.

Clinical Evaluation & Care

CTiBS describes the TBH domain of clinical evaluation and care as commonly including triage, assessment, diagnosis, and therapeutic services across the client/patient lifespan. CTiBS draws attention to the fact that underlying best practices for professionals striving for competence not only vary across behavioral disciplines, but also are defined by not only different, but often incompatible federal, state/provincial, local and professional standards. Such services typically involve a juxtaposition of not only client/patient, family, other professionals and/or healthcare team members, but also the various technologies to deliver care, as potentially chosen by any given professional or team e.g., email, text messaging, telephone, video conferencing, apps, instructional videos, machine learning, affective computing, wearables. In spite of all these variables, professionals are expected to therapeutically engage

clients/patients, communicate clearly, attend to boundaries and adjust to TBH technology-mediated options as needed to optimize care and safety.

Other fundamental differences in clinical evaluation and care can also dominate the day-to-day delivery of TBH services. While in-person and TBH care have many similarities e.g., interview style, treatment planning, experiencing emotions, *substantive differences* can suddenly become apparent to those who engage in TBH practice e.g., establishing boundaries, administering assessments, managing emergencies. TBH professionals may also face increased management challenges at a distance with other factors e.g., protections for privacy and security, adjustment to unpredictable settings, failing technology, uncertainty related to potential interruptions, the need for increased caution when addressing delicate topics. The clinician's personal issues can also surface, including powerlessness in an emergency as when dealing with mutilation behavior.or suicidal ideation. Failure to acknowledge and prepare for these challenges can leave the clinician at a loss for how to proceed when they arise. However, thoughtful training and preparation can be undertaken to prevent as well as remediate such challenges.

Given the complexities described above, the *Clinical Evaluation and Care* domain is the largest of all, and contains three subdomains to cover its breadth of knowledge, skills and atttidues (i.e. Assessment and Treatment, Cultural Competence & Diversity, Documentation & Adminstrative Procedures). The prudent professional considers the needed knowledge, skills and attitudes for TBH care by focusing on each of these three areas, and then, the telebehavioral objectives in each of these subdomains, Again, due to space limitations, only the first subdomain (Assessment and Treatment) is described below. This first subdomain is further delineated into these six *telebehavioral objectives* by CTiBS:

1. Assessing for client/patient appropriateness for TBH services
2. Assessing and monitoring client/patient comfort with TBH
3. Applying/adapting in-person clinical care requirements to TBH
4. Implementing and adapting a TBH service plan with policies/procedures adjusted accordingly
5. Monitoring therapeutic engagement related to each TBH modality
6. Providing training, supervision and/or consultation to others (for Proficient and Authority).

Again, due to space limitations, only the first of the above six telebehavioral objectives will be discussed next in the illustration (Fig. 3),below. Titled, *Assessing for client/patient appropriateness for TBH services,* this telebehavioral objective is further delineated into three discrete telebehavioral

practices, that is, one for each of the Novice, Proficient and Authority levels of competence.

The more detailed discussion below then, is intended to provide the reader with yet more information with which to consider the education, training, experience and/or consultation needed for delivering interprofessional, evidence-based TBH clinical care related to this domain.

Novice

As can be seen in Figure 3, the TBH Novice is expected to be able to identify client/patient appropriateness for TBH. For example, these beginners could be trained able to interact with the client/patient, administer a screening inventory for TBH appropriateness and report on findings.

Proficient

The Proficient professional encompasses the same basic assessment skills as the Novice, but can also identify and make selections for TBH based on a number of more granular considerations. Such considerations include the clinical needs of the patient given the age, intelligence or diagnosis of the client/patient. In addition, the ability to engage in more sophisticated diagnostic approaches may be relevant, such as ability to participate in the session with or without a *telepresenter*, who is a trained third party who is present in the client/patient room/environment to assist the distant practitioner.

More specifically, at a more granular level, the Proficient clinician would understand the importance of know how to initiate a series of queries to establish the privacy of the location of the client/patient, identify possible interruptions and/or intrusions and other factors of clinical relevance to the session. As a safety measure against being caught off guard, they may routinely implement this process at the beginning of every session in an *opening protocol*. Such clinicians engage in anticipatory thinking, creating structures that help determine which factors could disrupt a session, both on the client/patient setting, as well as their own. For example, is particularly important when If the client/patient is at home with children or elderly parents at home, the opening protocol query would involve questions about who might be with those individuals at the time of the call. Likewise, if a spouse is often at home and perhaps even using Bluetooth wifi in the setting, is the Bluetooth turned off so that the spouse cannot listen to the clinical exchange from another room. In a more general sense,. Given the population of clients/patients being served, the clinician would also have a sense of potentially needed local emergency information and appropriate referrals prior to engaging with a potentially at-risk client/patient from a distance.

Again at a granular level, opening protocol questions may need to include verification that the clinician is alone with the

NOVICE	PROFICIENT	AUTHORITY
I.A SUBDOMAIN -- Assessment and Treatment	**I.A. SUBDOMAIN -- Assessment and Treatment**	**I.A. SUBDOMAIN -- Assessment and Treatment**
I.A.1 Identifies factors related to clients'/patients'[1CEC1] appropriateness for TBH services and considers that some clients/patients may not be appropriate.	I.A.1 Systematically assesses and identifies clinical, diagnostic, setting, population and other factors that would preempt, complicate or exclude a technology e.g., prisons may not allow use of Internet; adaptive devices may be needed for special populations. Identifies and resolves conflicting administrative, clinical and other barriers.	I.A.1 Develops, researches and disseminates peer-reviewed and when possible, evidence-based procedures to address complex clinical, setting, population and other factors that would otherwise preempt, complicate or exclude TBH service. Investigates conflicting administrative, clinical and other barriers.

Fig. 3 Knowledge, skills and attitudes across three competency levels for "telebehavioral practice i.a", in "clinical evaluation and care" domain, "evaluation and treatment" subdomain

client/patient. This process can involve pre-established code words or phrases that the client/patient would be invited to mention if indeed, an unwanted lurker is present in the room or on the other side of the wall. The clinician, then, would thereby know to disengage the exchange, perhaps feigning a reason to leave so as to not endanger the client/patient.

Different situations could call for different interventions or lines of questioning. The clinician may need to be prepared to redirect clients/patients who appear for treatment from unusual settings, such as public areas. For instance, special agreements or adaptations might be needed in advance to determine that the conversation will not be overheard by passersby.

This series of initial inquires, then, could also be used to establish the appropriateness of one technology over another. Consider the event whereby arrangements had been made for full videoconferencing, but that the connection was failing, due to a local situation. The clinician may choose to use a telephone to establish contact and/or maintain the clinical relationship rather than abandon the effort and await the next appointment. Clinician judgment then would be needed to determine whether the telephone always an adequate secondary technology for continued care, given the client's/patient's particular clinical need. Such issues become relevant when for example, video conferencing is used to engage and client/patient with a stress inoculation protocol or EMDR for Post-Traumatic Stress Disorder (PTSD), and the video connection fails. The clinical appropriateness of using the telephone to re-establish contact may be important, but continuing the session via the telephone may or may not be appropriate. The Proficient clinician then, would be expected to determine if continuing the session by telephone would be clinically appropriate, and he or she would document the clinical decision accordingly. A Proficient clinician in this instance would also know where to go in the TBH literature to find relevant research to clarify any related questions, and done so prior to starting the treatment protocol via videoconferencing. With complications, they would make the effort to seek training and or consultation to clarify such questions for any current or future client(s)/patient(s) being served.

The discussion above can lead to yet deeper levels of granularity with competence. To be even more specific, assuming that the chosen technology is video conferencing, it is appropriate for the clinician to have developed the competencies to not only treat, but also assess and triage the client/patient using video. Particularly in states where in-person assessment is not required for TBH, it is incumbent upon the clinician to have undergone adequate TBH training to know how to assess all types of clients/patients being initially served via video, and not just routine or uncomplicated clients/patients.

To do so, Proficient clinicians using a video conferencing system must know how to maneuver their way through essential components of an intake and assessment process by using a camera, microphone, monitor and speakers to not only collect essential information (relevant psychobiosocial and substance use histories), but depending on discipline and setting, also to conduct a mental status exam, a hygiene check and a gait analysis - all of which are intake/assessment procedures that are in accord with the standard of care in a traditional, brick-and-mortar setting. Next, the clinician choosing to use videoconferencing to mediate a therapeutic relationship also needs to be Proficient at using the camera to show empathy, engagement, attunement and at the very least, emotional connection and availability with the client/patient. In this decision-making, factors such as setting, resolving technical conflicts and population factors are also of relevance. These factors are more thoroughly described below.

Setting The mid-level practitioner is expected to understand and control both their own setting and that of the client/patient. If working from home, the mid-level clinician would have established a communication system with their own family or other household residents to eliminate the possibility of intrusions or other disruptions to the clinical interaction with a client/patient. As hinted at above, the mid-level clinician would have the expertise to secure the privacy of the client/patient location, and assure through an opening protocol and other factors that the patient is alone, preferably in a room with a locked door, and that the risk of interruption or intrusion by others in the client/patient environment would be eliminated. When the setting is not ideal, the interaction is gently terminated or clinically appropriate accommodations are negotiated and thoroughly documented.

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Resolving Conflicts Another responsibility of the Proficient clinician and/or administrator is that of resolving conflicts surrounding the use of technology. The example of might involve the college counselor serving students from other states is a good example of a common TBH conflict. Similar is the plight of a clinician serving a student who travels to a foreign country for a semester, yet wishes to maintain their therapeutic connection. College administrators have been reported to inadvertently require such counselors to put their own licenses at risk for practicing illegally over jurisdictional boundaries, citing the clinical need for continuity of care over licensure requirements by their counselor employees.

A second situation exists with counselors who work in residential treatment facilities, where patients may travel from other states or countries to receive care for several weeks at a time. When in-patient, these patients often are given *family therapy* whereby families from distant areas are treated by the licensed clinician in the treatment facility. A third example might be the licensed Employee Assistance professional who serves a worldwide network of employees for a fortune 500 company, all from her office in New Jersey.

Conflicts related to the use of communication technology therefore, can easily arise. They require sensitivity to all parties and understanding of the positions taken by Authorities, including licensing boards and malpractice carriers and other liability carriers. Administrators of all these services may also be under mandate to comply with a number of oversight agencies who have their own, perhaps conflicting set of requirements e.g., Joint Commission, Council on Accreditation, Commission on Accreditation of Rehabilitation Facilities, Utilization Review Accreditation Commission, American National Standards Institute in the U.S. and according to other Authorities in other countries. A Proficient telepractitioner will navigate these waters with an eye to meeting the needs of the patient first and foremost, yet also complying with program requirements as well as those of their professions and regulatory boards. As depicted above, clinicians in some settings however, often feel disempowered to address these issues, lest they incur potential sanctions from their employers.

Another situation may be experienced by a clinician who purchases a video or other type of technology platform from an online vendor. They may be seeking such a platform to migrate their clients/patients to TBH, or they may sign onto a platform that promises to introduce them to such clients/patients by listing their profile and collecting payments. Whether or not the platform allows the clinician to deliver appropriate clinical services is sometimes at question, however.

Even if digitized services are not explicitly mentioned in state laws, applicable ethical codes or other standards and guidelines, required clinical services when working through technology includes all practices that are required for in-person care. These practices may include knowing how and

to whom one markets one's services regardless of technology platform engaged. That is, clinicians are not allowed to shift blame for interjurisdictional practice to a website directory that is accessed by an international community. For every client/patient accessed through technology, the clinician is expected to have ascertained their own ability to legally serve that individual, regardless of the website or technology used. An example of this principle can be drawn from the medical world, where a physician cannot shift the blame for their inability to hear a heartbeat through an otoscope. Rather, the physician's duty was to use the appropriate technology, which in most cases, would include a stethoscope. Similarly, the TBH clinician is expected to use a platform that advertises a clinician's services to an international platform cannot be blamed for a clinician work with a prospective from outside their area of licensure. Defined by one's licensure and other professional affiliations, other mandates include the responsibility to set up one's office or service in a manner that is supportive of evidence-based care, including the means to conducting of full and proper intakes, mental status exams and other assessments – all as expected in one's typical brick-and-mortar practice. They may include obtaining full and appropriate informed consent (both initial as well as dynamic); gathering a full history, giving and receiving local referrals; accurately documenting goals and the course of treatment; preventing and handling emergencies; offering a continuity of care and meeting other typical clinical obligations. These issues however, are often obscured to the unwitting, untrained clinician enamored by contemporary technological tools. Choosing the appropriate technology, then, can be difficult. The Proficient clinician knows when to obtain appropriate training and/or consultation and how to document both accordingly.

Population Population factors might involve issues of particular relevance to the client/patient's membership in a particular group needing additional care. For instance, a disabled (i.e., deaf, hard-of-hearing, blind, wheelchair-bound, bedridden client/patient) may require attention to external factors that need to be in place prior to the start of a therapeutic session. These may include adaptive devices, or additional personnel who can be called if the client/patient loses control of the digital interface. Such factors may also include common cultural or linguistic expectations of working with a clinician at a distant site (see CTiBS Competencies subdomain related to *Cultural Competence & Diversity* for more information.)

Authority Authorities may teach the fundamentals of TBH clinical care, supervision, and training to help others apply information and resolve dilemmas/conflicts in complex clinical, legal, regulatory and other issues. They may help with the integration of clinical care across settings, clarify documentation requirements, and work with interprofessional teams

where requirements can differ across disciplines. They can help resolve conflicts that might otherwise preempt TBH. An example of such a professional would be the consultant who helps a state agency meet the needs of clients/patients who are dependent on opioids. The TBH Authority, then, would assist clinicians with their respective clinical protocols, assuring that they meet all professional ethical and legal, regulatory requirements related to TBH, as well as those of their referrals sources, such as local hospital emergency departments. The Authority would investigate all relevant requirements and assist the agency in resolving conflicts so as to maximally serve the populations they seek to serve through TBH.

Legal and Regulatory Issues

The second CTiBS TBH competency domain to be discussed in this article is that of *Legal and Regulatory Issues*. As with the first domain of *Clinical Evaluation and Care* described above, due to space limitations, only the first of the four identified telebehavioral objectives will be discussed herein: *Adheres to relevant laws and regulations*.

The *Adheres to relevant laws and regulations* telebehavioral objective is further delineated into three discrete telebehavioral practices, that is, one for the Novice, Proficient and Authority levels of competence. The discussion below then, is intended to illustrate the education, training, experience and/or consultation needed for delivering interprofessional, evidence-based TBH clinical care. This discussion will first define terms, offer a sampling of issues relevant to these three telebehavioral practices, and end with a case vignette to further illustrate the telebehavioral practices of a TBH Authority.

Legal and regulatory issues affect TBH practice internationally. The term *legal* is defined as allowable or enforceable by being in conformity with the law of the land and the public policy. *Regulations* are defined as benchmarks promulgated by a regulatory agency, created to enforce the provisions of legislation. *Federal governmental laws and regulations* for TBH practice also include the following: privacy, confidentiality, data protection/integrity and security; inter-jurisdictional practice; communications standards in the U.S and other countries e.g., Federal Communications Standards. They also include prescribing e.g., Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH), Health Information Technology for Economic and Clinical Health (HITECH), Food and Drug Administration issues related to the Ryan Haight Act, Personal Information Protection and Electronic Documents Act (PIPEDA).

State/provincial laws and regulations for TBH practice may be further defined, implemented, enforced and interpreted e.g., inter-jurisdictional practice. For example, in the U.S., there are a variety of licensing boards that establish

practice requirements i.e., medical, nursing, pharmacy, behavior analysis, counseling, marriage and family therapy, psychology, social work. Relevant state/provincial and federal laws and regulations may also overlap. Legal and regulatory issues also affect TBH practice internationally.

Non-governmental regulatory requirements and recommendations from professional organizations, agencies and other authorities in other countries may also apply to TBH practice. Examples of such entities include Joint Commission, Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), Utilization Review Accreditation Commission (URAC), American National Standards Institute (ANSI) and Healthcare Information and Management Systems Society (HIMSS) in the U.S. and according to other authorities in other countries.

In the clinical arena then, the prudent clinician can develop the needed knowledge, skills and attitudes for legal TBH care by focusing on each of the four telebehavioral objectives as identified by CTiBS within the CTB domain of Legal and Regulatory Issues:

1. Adheres to relevant laws and regulations
2. Practices in accordance with and educates others on the need to follow relevant legal and regulatory standards
3. Applies/adapts in-person standards to TBH
4. Attends to contextual and overarching jurisdictional issues in a reasonable fashion.

Next, a sampling of laws and rules applicable in the United States illustrate the range of pertinent laws and regulations applicable to the three levels of the first of Legal and Regulatory domain of telepractice described (Figure 4) below. Similar legal and regulatory requirements for health professionals may exist in other countries and jurisdictions outside of the U.S.

Novice

The Novice is expected to be knowledgeable about the laws and regulations relevant to providing TBH services in the jurisdiction where they are located and where clients are located at the time of service. In addition to applicable professional licensure laws, relevant laws and regulations include other pertinent state/province or national laws. For instance, the Novice would be expected to be knowledgeable with HIPAA in the U.S. or PIPEDA in Canada. They also would need to know that additional privacy and security laws and regulations exist in some states or provinces.

Proficient

The Proficient professional not only is compliant with laws and regulations relevant to TBH, but also understands the

NOVICE	PROFICIENT	AUTHORITY
IV.A.1 Communicates with all relevant authorities to identify and adhere to the relevant laws and regulations in the jurisdiction of client/patient (and the professional's, if different) at the time of contact, including informed consent, even if the authority does not detail updated requirements in "telehealth-related" terminology on public websites.	IV.A.1 Applies and if necessary, adapts clinical care and informed consent to relevant laws and regulations in any/all jurisdiction(s) being served (i.e. federal, state/provincial law). The professional's choice of technology and related risks and benefits must be identified in the informed consent. Professional ensures that the chosen technology, provider networks or other digital employers allow all functions mandated by relevant laws and regulations e.g, full intake, history, informed consent, mandated reporting and continuity of care in relevant jurisdictions.	IV.A.1 Consults, develops and provides potential resolutions for TBH-related legal and regulatory dilemmas or conflicts e.g., references/guidelines, different agencies, provider networks, digital employers and across different disciplines and professions. Advocates for timeliness and clarity in wording of laws and regulations, as well as in all public statements.

Fig. 4 Knowledge, skills and attitudes across three competency levels for "telebehavioral practice ii.v.1" in "legal and regulatory issues" domain

basic principles and is able to independently apply them in situations in which there may be no clear answers. This may mean for instance, that when working in a geographic area where no explicit telehealth laws exist, they nonetheless understand their requirements as a licensed professional where they work. This is true, even if the practitioner calls themselves a "coach."

Continuity of Care The Proficient professional realizes that when delivering TBH to a client/patient in a foreign jurisdiction (state or country), laws regarding continuity of care may be different from their own. They are aware that licensure requirements "follow the patient" in that the clinicians needs to be compliant with the law of the state/province/country when the client/patient is located *at the time of contact*. The fact that the client/patient legally resides in New York is irrelevant to the Florida licensing board if the client/patient is in Florida at the time of service delivery. Also, states such as Florida may impose yet more restrictions with out-of-state clinicians. For instance, they may require that the clinician be licensed in Florida even if when serving clients/patients from their original states of licensure while they themselves are visiting or living in Florida. Assumptions can be problematic, in that regulatory boards *should not be underestimated* in terms of their differing and at times, contradictory requirements. Each state/province/country must be investigated individually and compliance with all state and federal/national laws is required.

Furthermore, interruption of services could occur and must be anticipated, preferably in writing. The clinician could be retiring from actively providing clinical services, the client/patient may have moved to a jurisdiction where the clinician is not authorized to provide TBH, or the clinician might determine that the current functioning of the client makes them no longer suitable for TBH. Rather, the clinician may decide that the client/patient is in need of in-person care.

The clinician in such situations is wise to have pre-determined, readily available and appropriate safety plans as well

as local referrals and safety-net resources to help all clients/patients served through TBH. In fact, in many states and provinces, if such local resources have not been identified before starting the delivery of care, it is considered unprofessional for the clinician to have started the delivery of service. A competent clinician then, does not initiate service if appropriate safety plans and local community safeguards are not in place. Additionally, if a clinician determines that he or she is out of their range of competence clinically with a client/patient who poses a risk of harm to themselves or others, the competent telepractitioner does not abruptly cease services. Rather, giving appropriate referrals is in order, just as it would be in a brick-and-mortar practice.

Similarly, a competent telepractitioner who realizes that he or she has been practicing illegally over state or international borders does not suddenly cease services with an established client/patient. Rather, competent professionals in both these circumstances may have a duty to obtain experienced consultation to help deal with the ambiguous clinical issues that may arise. Of course, they will also want to document the issues carefully.

Coaching Thorny situations also may arise when a clinician licensed in one jurisdiction (state, province or country) has been calling themselves a "coach" to practice over jurisdictional lines by using technology, often including the use of the telephone. Such practice is rarely censored, but nonetheless, is most often illegal. As state regulatory boards develop or examine their state's definitions of telepractice, these issues are steadily being corrected in regulatory code, albeit at different places across different states and within states, across different disciplines. Until then, the prudent practitioner is wise to not engage or responsibly transition out of all such illegal activities, seek licensure in the states being served and/or advocate for more clearly articulated regulatory statements by their boards. Regardless of what the service is called or how the therapeutic relationship is maintained, i.e., by email, telephone, text messaging, video or apps, clinicians then, must deal with how to best care for the client/patient legally,

ethically and clinically. When Proficient but previously uninformed clinicians realize the error of their ways, they remediate the situation by obtaining appropriate clinical TBH consultation along with legal counsel. As a side note, while prosecution for illegal TBH activity is rarely disciplined as a stand-alone issue by most state boards, TBH issues readily surface when a legal action is taken by a board due to some other type of complaint, i.e., abandonment, sexual misconduct, insurance fraud.

Employment by Online Companies Another example that complicates the competent delivery of clinical services with relevant laws and regulations is when a clinician contracts with an online behavioral company to provide services to clients/patients. Such companies call their services a variety of names, e.g., online counseling, distance counseling, online therapy, telemental health, e-therapy, wellness coaching, health coaching, crisis intervention, telebehavioral health (and many more), but many contract with licensed behavioral health professionals to provide professional services to clients/patients/consumers online. The clients/patients/consumers are typically organized and prepared for therapeutic intervention by the company, and all digital systems are chosen and maintained by the company as well.

Issues arises when such companies create unrealistic expectations or make unrealistic promises to clients/patients/consumers. They may simultaneously (inadvertently or intentionally) limit the information they provide to clinicians for meeting legal and ethical requirements when using their software platforms to deliver care. Attempting to sidestep legal responsibility for the constraints imposed on the client/patient or clinician with elaborate Terms and Conditions files posted on their websites, they in fact, frequently place full responsibility squarely on the shoulders of the often unwitting clinician. Such a shift in responsibility usually involves a written agreement to be signed by the clinician who is invited to *attest* to being licensed. Such attestation in fact, has legal implications that often go far beyond the understanding of the traditional clinician. They imply that the TBH clinician is fully competent to deliver services, which means that they are aware of and fully compliant with the requirements of their professions, relevant state licensing boards and all federal laws. As previously described, many of these requirements not only from state to state, but also from discipline to discipline. The requirements may be fully explained by the licensing boards, or not mentioned at all. If they are mentioned, they may be buried in state statutes and regulations that use any of two dozen terms to refer to telebehavioral health, and thus practically impossible to find without careful research. Professionals considering such contractual arrangements then, need to exercise due diligence in evaluating the online service.

An clinician also may – or may not – be made privvy to the collection and various implications of digital information "data sets" automatically gathered by an online employer, video or other technology platform vendor. They may not understand the implications of such "Big Data" collection systems or to whom this information is being sold.

One form of due diligence is to ask questions. Proper training in TBH may suggest to that the competent telepractitioner ask questions of their online software company such as the following:

- Does the company's website restrict referrals from clients/patients located outside the geographic areas allowed by the clinician's licensure?
- Do the company's policies and procedures for clinicians meet the clinician's legal and ethical practice standards and guidelines?
- To what extent does the company allow the clinician to provide adequate informed consent, based on the requirements of each state being serviced?
- Are clients/patients allowed to obtain services anonymously? If so, how can mandated reporting requirements be met by the clinician?
- How are community resources made available to clinicians facing emergencies when the company provides access to client/patients solicited from distant communities?
- Does the company inform the clinician of differing laws in states accessed by the comapny's technology, or does the company leave it to clinicians to fend for themselves with issues such as different state laws regarding mandated reporting, such as abuse, suicidality and Tarasoff duty to warn?
- What are the financial policies imposed on clients/patients by the company? Are they in keeping with different state regulations for licensed professionals?
- What records or data are kept by the company and who/when/under which circumstances will others be given access to those records? What is the company's policy if served with a subpoena? Where is the company's technical staff located? Do they have access to client/patient files? If in a foreign country, what assurances do they provide that all the clinician's state and federal laws are being honored?
- Is the clinician given written assurance of legal compliance? For example, does the company collect "Big Data" if if so, which type? How it is analyzed, how does it benefit the client/patient, and is it re-sold? If re-sold, to whom? For which purposes? Does the company provide written, legal asurances that such digital information collection processes and datasets are indeed stripped of any protected health information (PHI)?

- Does the vendor offer a Business Associate Agreement (BAA) and if so, how closely does it match the wording suggested by the U.S. Office for Civil Rights (OCR)?
- Can the service be discontinued by the company without cause and/or without notice?
- Does the company submit reimbursement documentation to payers, and if so, how can those documents be regularly reviewed by the clinician for accuracy?
- Does the company provide liabilitiy insurance for professionals in the case of a large-scale legal infraction, where several clinicians may concurrently seek financial reparations from the company?

Finding answers to these and other questions are important for the clinician to judge if their contracting with a company is reasonable, given their legal and ethical mandates; liabilities, reputations and financial stability.

Authority

The Authority consults and teaches others regarding TBH-related legal and regulatory issues. They may be called upon to advise or assist in problem solving complex legal or ethical TBH questions. The following vignette and subsequent discussion illustrates how a TBH Authority contracted by a drug treatment program provided competent TBH services:

An addictions treatment group providing residential services was seeking to grow their business by retaining program graduates after release by offering follow-up services with the client/patient's primary counselors for after-care. Benefiting from a good reputation, the group offered local services in three different states. The group was recently challenged by an influx of new clients/patients whose were immigrants and whose first language was not English. The group hired a TBH consultant to assist with the development of program policies, procedures and workflow issues, starting with interjurisdictional supervision and consultation.
The primary treatment team consisted of counselors, psychologists, a psychiatrist and social workers. All provided services in-person while client/patients were in residence. Since many referrals were coming from out-of-state, the group had begun offering "family sessions" via videoconferencing. They were delighted with the results and now sought to extend their services by offering follow-up care via videoconferencing.
The group had sent one clinician to obtain certification in TBH competencies, and learned that they and their clinicians were in violation of state licensing laws in several respects, including interjurisdictional practice. They then hired the TBH Authority to remediate their legal and regulatory policies, decide how to responsibly

deal with families who were already dependent on them for care over state and international borders, and obtain proper licensure for their clinicians within the context of a business plan that would allow them to grow their services through TBH.

TBH Authorities, then, can be called upon to help with a number of complex TBH issues, including the remedying of existing services being offered by groups who had no prior knowledge of infractions, but who sought to remedy their practices.

Licensure Status of the Staff In the above vignette, the social workers and counselors were licensed in only one state, where they currently offered in-person services only. Two psychologists supervised the master's level staff in all three states and coordinated medical issues with the psychiatric staff. This supervision was conducted by telephone and video teleconferencing. The psychiatrist was a full time contractor who was hired to assist with medical evaluation and medication management for the group in all three states. The group wanted the psychiatrist to be licensed in all three states. As the group offered follow-up care, all clinicians would be asked to obtain licensure in multiple states, so as to be able to offer follow-up care to residence after discharge.

Interjurisdictional Issues Interjurisdictional issues became an initial first focus for the TBH Authority. She helped the addictions group administrators confirm that the social workers and counselors are in compliance with their licensing laws within their state of licensure for TBH. She found that when crossing state lines with direct care, and also when receiving supervision from the psychologist in a neighboring state, these clinicians were being asked to engage in activities that ran afoul of their own licensing regulations and ethical standards. The psychologist was also practicing without a license and therefore illegally when offering supervision to clinicians outside of his own state of licensure. One state's licensing board for the master's level clinicians had adopted the national association ethics code as state law, further confusing the issue when compared to licensing requirements in the other two states. The psychologist then, needed to obtain licensure in the two additional states so as to be able to deliver supervision legally. Until such licensure was obtained, the group would need to obtain alternative supervision for the master's level staff.

To further complicate matters, one of the three states' regulatory boards did not mention TBH in its licensing rules and regulations for both the psychologist and master's level staff, leaving the addictions group and its staff in a gray zone with interpret existing requirement. The TBH Authority assisted with this process, explaining that a state's lack of guidance with respect to privacy when using any technology i.e., email,

text messaging, telephone and video, does not negate the need for the clinician and the group to protect the client/patient when using any one or combination of these technologies.

She also explained that different technologies would conceivably require different policies and procedures. For example, a client/patient's privacy would need to be protected differently with regard to the telephone, based on whether the state in question recognizes the telephone as part of their definition of telehealth, telemedicine, telepsychiatry, telepsychology telemental health, distance counseling or by using any other terminology for TBH. Also of relevance to state regulations for privacy were two of the apps used by the staff to engage clients/patients with behavioral diaries and daily self-assessments that were transmitted to the staff, thereby qualifying at TBH services across state lines. In other words, the TBH Authority explained that if the group chose to use any form of electronic communication with clients/patients, it was their responsibility to understand all relevant issues, regardless of the lack of specificity of existing licensing requirements.

The psychiatrist was currently licensed in a state that had joined the "Interstate Medical Licensure Compact" (http://www.imlcc.org/). Luckily for him and his employer, the psychiatrist was being asked to work in a foreign state that had also joined the same licensure compact. Because of the compact, he would enjoy an expedited licensing process and would likely be able to offer services within two or three months.

The TBH Authority also informed the psychiatrist that the licensing board in the third state had differing requirements for TBH intakes. It required in-person intakes, therefore disallowing TBH until the in-person intake was completed. In response, the addictions group began a search for another psychiatrist or nurse practitioner in the state requiring an in-person intake.

Professional Training To help the addictions group efficiently and expediently manage risk, the Authority suggested that each practicing clinician obtain formal training in TBH best practices – and have that training fully documented. She recommended that the group find a professional training program leading to course completion certificates, certification or credentialing related to evidence-based TBH competencies. She explained that such training and its documentation could help the addictions group administrators and staff develop policies and practices related to issues such as informed consent; intakes and assessments, progress notes, termination notes and their documentation; mandating reporting, i.e., suicide, homicide and abuse reporting; continuity of care; termination.

The TBH Authority then, was able to help the addictions treatment group and its clinicians to be compliant with state laws and regulations. She provided guidance to help the group develop a competent, efficient and confident workforce. Such focused training and consultation at program inception that allowed the group to avoid undue risk, start offering services and commence billing for TBH services. As illustrated by the above vignette, a TBH Authority can help both groups and individual manage some of the many complexities that can arise with delivering traditional care through technology.

As discussed in the examples of the TBH competency domain of Legal and Regulatory Issues, the first telebehavioral objective (Adheres to relevant laws and regulations) implies that TBH professionals fully understand and are compliant with all relevant state, federal and professional mandates. The discussion not only illustrates how the uninformed clinician may easily be led astray with erroneous assumptions and misinformation, but also how focused TBH education, training, experience and/or consultation can be of assistance to professionals seeking to develop responsible TBH services.

Discussion

Core TBH competencies across professions have been developed by an interprofessional Task Force of behavioral professionals convened by CTiBS in 2014. The charge of the Task Force was to identify core skills, attitudes and knowledge shared by the behavioral disciplines of counseling, marriage and family therapy, nursing, psychiatry, psychiatry and social work. Seven competency domains are outlined. The resulting competency domains are segmented into three levels: Novice, Proficient and Authority so as to differentiate between reasonable expectations of regulatory boards, ethical boards, attorneys, employers, insurers and clients/patients when evaluating the work of professionals engaging in the delivery of TBH. Due to space limitations, only two of 51 telebehavioral objectives describing the three competency levels are discussed by the authors to illustrate the breadth of knowledge, skills and attitudes needed for imparting best practices in TBH education, supervision and training. The two domains discussed to give the reader a sense of intricacies of developing a safe and competent workforce are 1) Clinical and Care and 2) Legal and Regulatory Issues. For a tabular representation of all seven CTiBS TBH domains, five subdomains, 51 telebehavioral objectives and 149 telebehavioral practices, see Appendix 1.

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Goals

The TBH competencies reflect a consensus process thatwas designed to lay the groundwork for further telebehavioral health advancement in several areas: policy development, research, law, regulatory and ethical requirements, training and practice of individual and interprofessional, integrated TBH services. Although differences in individual and aggregate components of professional knowledge, skills, attitudes and personal qualities will continue to plague behavioral and other disciplines, recognizing common areas for policy, workforce training and development, practice and outcome measurement will benefit both the professions and the public. As promulgated, the TBH competencies are intended to serve as a starting common frame of reference for continued interprofessional communication and collaboration.

For practitioners, they provide a way to conduct a self-assessment of one's own, or a colleague's readiness for TBH by helping to identify core areas for training and professional development. For educators, supervisors and trainers, they provide a framework for evaluating students', supervisees' or trainees' telepractice competencies. Similarly, they will help identify needed areas of future development. More specifically, Kennedy et al. (2014) note two primary barriers to trainee's ability to reach the 3rd and 4th levels of Kirkpatrick's levels: time and resources/support at the organizational level and expertise at the individual level. In education and training, relevant issues include: 1) the value of competencies in teaching and evaluation TBH 2) strategies for teaching TBH competencies across disciplines in graduate curriculum development postgraduate professional training and 3) learner-specific approaches to guide not only teaching but assessment and evaluation of skills and attitudes beyond knowledge acquisition.

Therefore, next steps should identify ways students, supervisees and trainees can have access to these resources. Such access might include dedicated time that is devoted exclusively to TBH that is built into educational, supervision and training processes. This may also require that the educators, supervisors and trainers themselves have some level of training and expertise to best pass that expertise on to those who entrust them with their development as professionals.

Lastly, the TBH competencies are also relevant for attorneys, administrators and policy developers. These types of professionals may benefit from competency-based training so as to better suggest ways that interprofessional TBH could be adopted; to assist in refining TBH research and best practices, as well as to encourage and support yet more collaborative efforts.

Limitations

As a first effort, the CTiBS TBH competencies have a number of limitations. First, the limitations of the TBH competencies are aligned with the limitations inherent in any evaluation system based on the Kirkpatrick four-level model. For example, the model does not consider the idiosyncratic elements and characteristics of some learners and learning environments. Therefore, this broad competency model may not be applicable to all learning types or represent realistic outcomes in all learning environments (Bates 2004). Secondly, the assumption in the Kirkpatrick model is that the greater the demonstration of the competency, the better learned that topic and that there is a causal linkage between the different levels when the research to date supports there is no such linkage and these levels may in fact operate independent of one another (Bates 2004). Third, some of the feedback received when sent to the stakeholders provided mutually exclusive directives about how to measure some of the skills, rendering it impossible to resolve some of the comments.

Fourth, although the selection of Task Force members is considered to have contributed to its strengths because it included representatives from six of the eight disciplines generally recognized as being involved in behavioral health care, it may also be a source of bias. Although a clear attempt to address cultural and linguistic competence issues were addressed within the *Clinical Evaluation and Care* domain, the focus is not likely to be adequate for all minority groups, and most certainly not internationally. While living in different geographic regions; emanating from different cultural groups; using English as their primary language but also including multilinguistic members; with various religious orientations; training and clinical specialty areas; as well as drawing upon extensive experience in different arenas; all members were U.S.-based Caucasians, and therefore is not representative of TBH professionals overall. It is possible that more diverse clinicians, including those in non-U.S. countries will find the CTiBS competency domains insufficient, given potential vastly different practices, settings and technologies. Perhaps the inclusion of Task Force members from different countries with different technological infrastructures and government supports would have been more representative, and efforts would have yielded different results. For example, clinicians using different technologies as their primary means of communication with clients/patients may find that the CTiBS competencies' primary focus on video technology to be insufficient. Different work flow issues and competency practices using audio or text-

based messages, or perhaps various combinations of such modalities will prevail over video for selected populations and their disorders. Without further research however, it is unclear how such selection bias may have affected the current results.

Fifth, although the list of 149 telebehavioral practices may seem extensive, it is possible that it is incomplete, or not entirely relevant to all practitioners in all behavioral disciplines attempting to deliver TBH, even in the U.S. or other westernized countries. A different group process, such as the Delphi Method (De Villiers et al. 2005), may have yielded a different group of competency items. Also, given the rapidly expanding areas of technology-related practice, such as mHealth, virtual and augmented reality, as well as the use of biosensors and artificial intelligence and will soon be included in TBH. The existing CTiBS competencies then, may soon be outdated.

Last and possibly most important, although it may have been useful to rank-order the finalized competencies on the basis of strength of agreement among Task Force members, the fluctuating membership of the Task Force over the three years and two separate comment periods did not allow for the drawing of statistically valid conclusions about the relative value of each competency.

Future Research

Research is suggested to demonstrate the benefit of using the TBH competencies as a basis for collaboration in the educational, training and the development of interprofessional teams for the workplace. Rigorous, clustered, randomized studies of these competencies may be needed to establish their validity and generalizability to a variety of settings, cultures and languages. Clear measurement outcomes need to be identified and assessed over time relative to client/patient care and safety. Such research should support methodologies that will shed light into how the competencies will serve as a basis for interprofessional collaboration and outcomes when using twenty-first Century technologies in BH care.

Additionally, the reader will recall that this effort and resulting paper only addressed three of the IOM's originally outlined areas of needed educational reform (IOM 2003a, p. 45). If a focus on TBH competencies is to be more complete, then subsequent research is also needed to specifically address the IOM's originally identified concerns regarding patient-centered care and quality improvement. For example, Medicaid reimbursement for continuing employee education and training has been described as indicative of the need to develop programs that *not only meet minimum training requirements and state regulations (when available), but also target specific competencies that workers need to deliver quality, individualized services* (Robbins, Dilla, The Lewin Group,

Sedlezky, and Sirek, in CMS 2013, p. 12). Such additional research into TBH-related competencies, then, are clearly needed for more complete educational reform as suggested by the U.S. IOM.

Conclusions

Telebehavioral health is proliferating worldwide in the healthcare workforce. In the early 2000's, the IOM-identified need for interprofessional competency training in all health care professionals. There is a well-defined theoretical basis and rationale for not only competencies, but interprofessional competencies and their implications for workforce development in BH.

This competency study is the first known attempt at developing TBH interprofessional competencies. They are designed to serve as a starting point for future research and communication. The CTiBS TBH framework organizes seven domains and five subdomains according to competency level i.e., Novice, Proficient or Authority. In turn, each competency level is categorized into 51 discrete telebehavioral objectives, which are then distinguished by 149 cumulative and measurable telebehavioral practices. As such, the CTiBS TBH competency framework is offered as an initial working document to identify and organize discreet, measurable telebehavioral practices derived from a review of the literature, technological advances and day-to-day clinical practice.

Additional consideration and research are needed for competency implementation and evaluation for education and training, faculty development, policy development, independent practice as well as institutional support and change. Regularly published updates to both the TBH domains and their framework will be needed. Clinicians, educators, trainers, regulatory and ethical board members, insurers and the public at large are invited to consider the implications of using these identified competencies in their respective areas.

Compliance with Ethical Standards

APPENDIX 1

INTERPROFESSIONAL FRAMEWORK FOR TELEBEHAVIORAL HEALTH COMPETENCIES

DOMAIN I -- Clinical Evaluation & Care: TBH professionals can demonstrate how to make evidence-based decisions in the best interest of clients/patients. They can demonstrate working knowledge, skills and attitudes relevant to TBH clinical issues as they pertain to evaluation and care as it relates to in-person or technology-based intake, triage, assessment, diagnosis, and therapeutic services across the client/patient lifespan; cultural, linguistic, socioeconomic and other characteristics related to diversity and appropriate documentation.

SUBDOMAIN I.A. Evaluation & Treatment: Evaluation and treatment abilities commonly include triage, assessment, diagnosis, and therapeutic services across the client/patient lifespan. Professionals should be mindful that these services vary and are defined according to federal, state/provincial, local and professional standards. Such services typically involve client/patient, family, other professionals and/or healthcare team members. Professionals must therapeutically engage clients/patients, communicate clearly, attend to boundaries and adjust to TBH technology-mediated options. Many technology terms are new, have multiple or ambiguous meanings and are used casually e.g., partial words, acronyms.

In-person and TBH care have many similarities e.g., interview style, treatment planning and differences e.g., a cognitive assessment, managing an emergency. TBH professionals may face increased management challenges at a distance e.g., protections for privacy and security; adjustment to the setting and technology; uncertainty related to potential interruptions; caution when addressing delicate topics; and powerlessness in an emergency e.g., suicidal ideation, mutilation behavior or other danger. With regards to financing, service delivery and billing/reimbursement, laws and policies for health insurance may vary depending on the setting of care, as well as vary by jurisdiction.

Within the Clinical Evaluation and Care **domain**, this *Evaluation and Treatment* **subdomain** is organized according to **competency level** i.e., novice, proficient or authority. In turn, each competency level is categorized into seven discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the TBH professional:

1. Assesses for client/patient appropriateness for TBH services
2. Assesses and monitors client/patient comfort with TBH
3. Applies/adapts in-person clinical care requirements to TBH
4. Implements and adapts a TBH service plan with policies/procedures adjusted accordingly
5. Monitors therapeutic engagement related to each TBH modality
6. Establishes and maintains professional boundaries
7. Provides training, supervision and/or consultation to others (for Proficient and Authority)

SUBDOMAIN I.B Cultural Competence & Diversity: *Cultural competence and diversity* for TBH practice is defined as applying principles relevant to professionals' making ongoing efforts to understand the manner in which cultural, linguistic, socioeconomic and other characteristics related to diversity impact the therapeutic engagement, assessment, triage, treatment and outcomes.
Clients/patients and professionals reflect on cultural commonalities and differences. Cultural awareness, humility and sensitivity help to engage clients/patients and facilitate expression, reflection and participation in care with attention to cultural identity, explanatory models, help-seeking behaviors and preferences for care. Assessment, triage and treatment may have to be adjusted when moving from in-person to TBH. It is important to assess language preference and skills to optimize communication e.g., need for interpreter.

Within the *Clinical Evaluation and Care* **domain**, this *Cultural Competence and Diversity* **subdomain** is organized according to **competency level** i.e., novice, proficient or authority. In turn, each competency level is categorized into three discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the TBH professional:

8. Assesses for cultural factors influencing care
9. Ensures communication with a reasonable language option
10. Creates a climate that encourages reflection and discussion of cultural issues in an ongoing manner

SUBDOMAIN I.C Documentation & Administrative Procedures: *TBH practice documents and administrative procedures* subdomain include: initial and ongoing informed consent; intake note/diagnostic assessment/initial evaluation; progress note(s); release(s) of information; and termination/discharge note. Other documents may include business and financial documents e.g. Agreement (BAA), TBH training certifications and continuing/professional education course completion certificates.

Within the Clinical Evaluation and Care **domain**, this *Documentation & Administrative Procedures* **subdomain** is organized according to **competency level** i.e., novice, proficient or authority. In turn, each competency level is categorized into six discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the professional:

11. Adapts TBH practices
12. Adheres to policies/procedures from in-person care
13. Applies/adapts policies/procedures to TBH
14. Adheres to professional, agency and other organizational policies/procedures (see Legal and Regulatory)
15. Documents TBH practices according to requirements
16. Distinguishes and adapts to non-routine components (for Proficient and Authority)
17. Offers supervision in how to comply with all documentation requirements (for Proficient and Authority)

NOVICE	PROFICIENT	AUTHORITY
I.A SUBDOMAIN -- Assessment and Treatment	I.A. SUBDOMAIN -- Assessment and Treatment	I.A. SUBDOMAIN -- Assessment and Treatment
I.A.1 Identifies factors related to clients'/patients'[1CEC1] appropriateness for TBH services and considers that some clients/patients may not be appropriate.	I.A.1 Systematically assesses and identifies clinical, diagnostic, setting, population and other factors that would preempt, complicate or exclude a technology e.g., prisons may not allow use of Internet; adaptive devices may be needed for special populations. Identifies and resolves conflicting administrative, clinical and other barriers.	I.A.1 Develops, researches and disseminates peer-reviewed and when possible, evidence-based procedures to address complex clinical, setting, population and other factors that would otherwise preempt, complicate or exclude TBH service. Investigates conflicting administrative, clinical and other barriers.
I.A.2 Assesses client/patient comfort with virtual environment e.g., ease, ambiance, privacy. Develops appropriate strategies for addressing difficult and sensitive scenarios.	I.A.2 Monitors natural engagement or disruptions in virtual environment and adjusts. More specifically, is able to identify and manage a continuum of scenarios that may lead to feelings of powerlessness for client/patient's, self and supervisees. Can articulate evidence-based strategies to work through powerlessness.	I.A.2 Teaches, trains, supervises and consults regarding scenarios that require innovative solutions for dealing with optimizing environment and finding solutions related to the professional's powerlessness.
I.A.3 Identifies in-person clinical care requirements and applies them to TBH services. Identifies requirements for assessment and/or triage to appropriate care. Requests consultation/supervision as necessary e.g., calls in law enforcement for imminent suicidal/homicidal threat.	I.A.3 Adjusts in-person requirements for TBH assessment e.g., engages a telepresenter, substitute a test and/or score/not score an item not appropriate for administration at a distance. Triages inappropriate and emergent client/patients and supervisees e.g., dangerousness such as suicidal ideation with plan/intent.	I.A.3 Develops and disseminates evidence-based TBH assessment tools and/or processes. Researches and develops new peer-reviewed and when possible, evidence-based policies/procedures for dealing with challenging clients/patients e.g., suicidal, homicidal threat.
I.A.4 Implements a TBH service plan appropriate to client/patient needs and consistent with relevant, legal and ethical standards; includes client/patient self-efficacy (satisfaction, confidence) and preferences.	I.A.4 Adapts/adjusts in-person policies/procedures and protocols to formulate and implements a TBH service plan to meet evolving client/patient and supervisee needs. When appropriate, assesses client/patient self-efficacy and technology or clinical preferences. Monitors engagement: behaviors that are ambiguous e.g., innuendo, nuance, colloquial expressions, use of technology slang and other behaviors that may reflect discomfort. Clearly sets boundaries and related expectations so as to encourage full disclosure in a central modality e.g., video, rather than piecemeal disclosures in different modalities e.g., discourages the transmission of key information in text messaging or email after a video session. Adapts such policies as needed with full documentation of rationale.	I.A.4 Researches best practices related to the alteration of clinical treatment plans as needed for the use of different technologies, or groups of technologies, i.e., settings accessed, populations served, diagnoses and contexts in accordance with all applicable practice guidelines as well as legal/license/professional requirements. Develops new peer-reviewed policies/procedures and protocols. Synthesizes information related to TBH client/patient behavior/attitude, and risk/protective factors to predict and measure service plan outcomes and potential complications.
I.A.5 Monitors development of therapeutic engagement, intimacy and other behaviors as well as abrupt accelerations and decelerations that appear/may be related to the technology.	I.A.5 Evaluates current and additional technology to develop and maintain the therapeutic engagement.	I.A.5 Researches and integrates peer-reviewed and when possible, evidence-based paradigms related to TBH therapeutic relationship, meta-communication, computer-mediated communication and distance learning to enhance technology-based care. Develops, consults and teaches a framework inclusive of client/patient populations e.g., age, illness/disorder, who are more apt to have shifts and the ways to approach, adjust and proactively frame the care and its goals.
I.A.6 Identifies and maintains clear professional boundaries in relationships with clients/patients regarding TBH.	I.A.6 Regularly monitors/assesses professional boundaries with clients/patients regarding TBH.	I.A.6 Teaches, trains, and/or consults regarding TBH boundary issues, highlighting differences between in-person and TBH care.
I.A.7 Seeks consultation/supervision if disruptions/confusions in boundaries and other areas occur that could impact therapeutic frame.	I.A.7 Provides synchronous and/or asynchronous supervision of a trainee delivering in-person care at distant site.	I.A.7 Teaches, trains, consults and/or supervises with respect to TBH requirements for clinical care. Consults regarding the peer-reviewed and when possible, evidence-based management of high complexity cases e.g., high-risk populations, legal complications and conflicts e.g., legal/regulatory, jurisdictional mandates, employer/insurer.
	SUBDOMAIN I.B -- Cultural Competence &	SUBDOMAIN I.B -- Cultural Competence &

[CEC1] Client in this case also refers to customer, consumer, patient and other applicable terminology. This may refer to individual, couple, family (immediate and/or extended) and/or group treatment, as applicable.

	Diversity	Diversity
SUBDOMAIN I.B -- Cultural Competence & Diversity I.B.8 Identifies obvious cultural factors; considers this theme if a dilemma arises in care and adjusts assessment and treatment strategies. Explores with an attitude of cultural humility and interest in learning. Seeks appropriate consultation to address cultural considerations/challenges.	I.B.8 Systematically screens for, differentiates between regular and technology-specific cultural factors, e.g., preference for telephone rather than video. Appropriately involves "cultural facilitators" e.g., interpreters and members of the cultural community to assist with assessment and care. Uses culturally sensitive and evidence-based approaches e.g., assessment instruments like the cultural formulation interview.	I.B.8 Researches, trains and teaches peer-reviewed and when possible, evidence-based methods for problem-solving obstacles related to TBH and culture e.g., identifying implicit biases, opting out of a preferred technology if it is not working; obtaining a cultural consultant; researching trends across (and via mixing) technologies; multi-site care of a client/patient.
I.B.9 Assesses primary/native language and client/patient preference for use of interpreter or certified language assistance service, when needed.	I.B.9 Ensures primary and/or preferred language is operational. Explores how language affects the story/narrative and level of intimacy. If an interpreter is used, explores ethnicity, interpersonal communication style and skill i.e., not analyzing, shaping story/narrative. Manages two-site complexities (client/patient site "a" and professional and/or interpreter site "b").	I.B.9 Teaches and consults regarding the therapeutic relationship's cultural issues, comparing similarities and differences between in-person and TBH-based communication. Disseminates evidence-based information about communication trends related to cultural values, practices, preferences and language in TBH.
I.B.10 Contributes to a climate of humility and learning by identifying implicit biases as well as commonalities and differences between the client/patient and professionals.	I.B.10 Promotes a climate of humility and learning by identifying implicit biases and weighing client/patient and professional commonalities and differences as well as how these affect the therapeutic relationship. Facilitates reflection, manages complexities and uses TBH to optimize 'fit' between client/patient and professional based on cultural identity, belief system(s), help-seeking behaviors and preferences for care.	I.B.10 Researches, disseminates and delivers evidence-based training related to public and population health data regarding the impact of these factors on outcomes related to in-person and/or TBH e.g., integrates these factors with data on adoption of technology related to geographic mapping/trending, patterns of technology and resource availability of mobile technologies.
SUBDOMAIN I.C Documentation & **Administrative Procedures** I.C.11 Adheres to operational policies/procedures for TBH care and reviews those for in-person care. For prospective clients/patients, identifies when specific informed consent is required for e-mail, text and other technologies.	**SUBDOMAIN I.C Documentation & Administrative Procedures** I.C.11 Adheres to operational policies/procedures for in-person care and modifications for TBH care. Can demonstrate compliance with proper documentation requirements to ensure the quality and consistency of TBH care and adherence to relevant oversight agencies and their policies/procedures. Can demonstrate adherence and adaptation to best practices for both in-person and TBH care, with awareness of differences in requirements e.g., state/provincial laws and professional standards on informed consent, privacy and billing.	**SUBDOMAIN I.C Documentation & Administrative Procedures** I.C.11 Develops and provides operational policies/procedures by comparing/contrasting information across professions, disciplines and countries. Teaches, trains and consults regarding evidence-based optimal practices and documentation, privacy and billing requirements. Develops and provides systematic prototypes/templates and telesupervision/teleconsultation requirements.
I.C.12 Identifies operational policies/procedures that may need to be reviewed, clarified and/or adapted when a problem arises, even when unspecified in accrediting agency requirements, state/provincial or regulatory code.	I.C.12 Adapts operational policies/procedures for situations in which there is no requirement/ specification to develop new ones.	!.C.12 Identifies and develops new areas of peer-reviewed and when possible, evidence-based documentation and problem-solves difficulties e.g., inconsistencies between states/provinces. Guides TBH adaptations and formulates policy based on innovations in other fields and disciplines.
I.C. 13 Adheres to professional requirements for in-person care e.g., mandated reporting, privacy and others and applies them to TBH. Reviews new TBH standards in advance of implementing. Reviews appropriate reimbursement and billing codes and associated requirements.	I.C.13 Applies accrediting agency requirements, federal, state/provincial and organization policies/procedures and requirements for clinical, legal and ethical TBH practice; adjusts such policies/procedures to applicable care settings. Utilizes appropriate TBH reimbursement and billing codes and associated requirements e.g. use of two-way interactive video for Medicare billing.	I.C. 13 Designs and performs peer-reviewed and when possible, evidence-based evaluation/research of operational policies/procedures, identify best practices. Conducts research and advocates for TBH reimbursement and billing codes.
I.C. 14 Seeks consultation/supervision for amendments or adjustments to regular documentation when deviating from routine care e.g., telephone call instead of video due to technology disruption, emergency/crisis or other travel outside legal jurisdiction.	I.C.14 Documents quality care and adds reasonable components that are clinically, ethically and/or legally indicated; routinely discusses with supervisees I.C.15 Documents with attention to financing,	I.C.14 Develops peer-reviewed and when possible, evidence-based best practices and policies/procedures and documentation for supervision, training and consultation. I.C.15 Develops peer-reviewed and when possible, evidence-based best practices, strategies and

I.C.15 Seeks consultation/supervision for amendments or adjustments to regular documentation regarding financing, service delivery and billing/reimbursement when deviating from routine in-person care e.g. aware there may be laws and policies for health insurance that vary depending on the setting of care, as well as by jurisdiction.	service delivery and billing/reimbursement laws and policies for private, Medicaid and Medicare, which may vary depending on the setting of care, as well as variation state-to-state variation.	policies/procedures related to the financing, service delivery and billing/reimbursement landscape.
	I.C.16 Uses and documents administrative principles to identify if adaptation is routine or non-routine. Seeks professional advice from pertinent authorities and documents adherence to applicable requirements.	I.C.16 Researches, teaches, trains and consults regarding peer-reviewed and when possible, evidence-based standard protocols and procedures for non-routine telepractice e.g., care of refugees or clients/patients on an oil rig and how/when to obtain consultation.
	I.C.17 Ensures that supervisees adhere to all relevant policies/procedures.	I.C.17 Identifies similarities/differences between TBH professions, disciplines and countries. Facilitates interprofessional and international communication. Provides an peer-reviewed and when possible, evidence-based approaches to building and establishing global overarching consensus for administrative procedures and documentation e.g., HL7.

DOMAIN II -- Virtual Environment & Telepresence: TBH professionals can demonstrate how to apply appropriate techniques to maximize therapeutic atmosphere in both physical and virtual environments as well as minimize distraction and interruptions. Professionals can show how to approximate an in-person relationship and foster spontaneity through TBH.

The concept of *telepresence* generally is defined as the use of a video camera, virtual reality and other technologies to create the experience of being, or to have an effect at a place other than their true location, while maintaining the therapeutic environment of care. Professionals should address issues related to an "online environment" in which participants interact. The components of telepresence include: a positive, inviting environment for engagement, a physical plant that provides stability, optimization of technology/media, providing a distraction-free environment and educating other participants to enhance the experience. Particularly when using asynchronous technologies, professionals facilitate patient/client relationship, maintain privacy standards, and manage problems by discussing/documenting mutual expectations for receiving and responding to communications e.g., text or email within a day, viewing social media posts once a week.

Professionals apply appropriate techniques to maximize therapeutic atmosphere for the TBH environment in an attempt to approximate the in-person relationship as much as possible and foster spontaneity. Telepresence is described as both a subjective and objective sense of "being in" TBH environments, with the latter measured by physiological change. Virtual reality is defined as the use of an application that in very near real time allows a user to navigate through and interact with the virtual environment. Augmented reality is defined as adding virtual environment or reality to real world experience.

The *Virtual Environment & Telepresence* **domain** is organized according to **competency level** i.e., novice, proficient or authority. It does not currently have subdomains. In turn, each competency level is categorized into seven discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the TBH professional:

1. Describes aspects of telepresence
2. Adjusts the clinical environment to be conducive for TBH
3. Adjusts technology to facilitate presence
4. Creates an environment free from technological and other distractions
5. Assesses clients'/patients' communication styles and makes adjustments for TBH
6. Reflects and analyzes events longitudinally for TBH adjustments (for Proficient and Authority)
7. Teaches, trains and consults regarding various aspects of TBH virtual environments and telepresence (for Authority)

NOVICE	PROFICIENT	AUTHORITY
II.A.1 Describes the concept of telepresence, can provide an example in the literature and how it applies to care at a distance. This includes creating an inviting environment based on physical, virtual and communication elements. Recognizes that asynchronous technologies e.g., text, email or social media posts may affect telepresence and/or that special effort may be needed with them to create telepresence.	II.A.1 Describes the primary (and alternative) definition(s) of telepresence, is able to educate the client/patient and supervise trainees on skills and other components. Creates an environment that facilitates therapeutic engagement and emotional well being for all participants, including privacy.	II.A.1 Researches, teaches, trains and consults with respect to facilitating telepresence, integrating peer-reviewed and when possible, evidence-based communication, interpersonal and technological factors for the environment (physical and/or virtual) to optimize the TBH therapeutic relationship. Evaluates the impact of new technology on telepresence. Develops a peer-reviewed and when possible, evidence-based approach to assess/evaluate telepresence e.g., checklist, rating scale.
II.A.2 Lists pros/cons of the features of the	II.A.2 Prepares the physical plant so the clinical	II.A.2 Researches, teaches, trains and consults

physical environment for both client/patient and the professional. Before start of treatment and with ongoing service, adjusts to the physical space to the degree possible in terms of lighting, comfort and ambiance; tacitly asks client/patient if comfortable.

II.A.3 Offers alternatives in technology to optimize engagement e.g., larger screen, space selection e.g., library, professional office and adjusts technology e.g., camera and audio.

II.A.4 Creates a distraction-free environment e.g., physical and virtual that assures singular focus on the client/patient and task at hand e.g., not having alarms sounding for texts or emails, not emailing while talking to a client/patient on the telephone or vice-versa, not conducting a session on the telephone while commuting, eliminating distractions by children or pets.

II.A.5 Screens for client/patient communication styles/habits including culture/language (see "Cultural Competence and Diversity" domain) and how technology may alter them. Adapts in-person skills to communicate with clients/patients, families and other healthcare professionals via TBH. Identifies ways in which communication is different, based on technology used. Inquires about use of abbreviations, nouns, emoticons and sentence or thought fragments. Lists potential therapeutic problems related to telepresence failure. Names three ways that technology adds complexity between the client/patient and professional. Works with others to coordinate care.

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environment is private, professional and warm, with a nice tone and ambiance. This includes good seating and work flow e.g., ergonomic support) adequate lighting, secure/private entries and soundproofing, if applicable.

II.A.3 Chooses technology to maximize presence, with near-optimal fit of visual and audio mediums e.g., clarity and visibility, camera angle, spacing/centering of images). Has technical proficiency to meet reasonable client/patient preferences and for non-video engagement e.g., telephone; asynchronous modalities such as social media, text, email).

II.A.4 Practices and helps the client/patient create and maintain a distraction-free environment e.g., prevent/minimize interruptions and intrusions during communication. If interruptions occur, uses clinical and educational experience to reflect and discuss. When applicable, coordinates between sites to avoid disruptions, delays and other problems.

II.A.5 Anticipates differences in client/patient styles/habits related to technology and encourages reflection (see "Mobile Health Technologies Including Applications" domain and "Telepractice Development" domain. Demonstrates and applies in-person skills to communicate with clients/patients, families and other healthcare professionals. Identifies ways in which in-person and technology-based communication are similar/different e.g., use of emoticons, "textese" and abbreviations. Considers flow of conversation and the impact of the medium as well as related to

language and culture e.g., East versus West coast in the U.S. Adjusts communication specifically to modality e.g., engages differently when client/patient is visibly anxious on video.

II.A.6 Manages therapeutic relationship during evaluation and/or care by encouraging reflection and reducing pace if client/patient is moving too quickly via text or manifests "staccato thinking" e.g., heavy use of abbreviations, nouns, emoticons, sentence/thought fragments that may impact comprehension and/or boundaries. If technology disruptions occur, manages negative impact and discusses as a therapeutic issue, if possible. Maintains therapeutic alliance when using asynchronous technologies e.g., uses text selectively, monitors social media posts.

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with respect to conducting peer-reviewed and when possible, evidence-based needs assessments of the plant/ environment of care, e.g, focuses on issues affecting engagement, communication and therapeutic relationship building, workflows for atypical settings such as war zones, oil rigs, disaster areas.

II.A.3 Advises with respect to TBH guidelines for optimizing visual, audio and other relevant components of communication.

II.A.4 Researches peer-reviewed and when possible, evidence-based pros and cons of physical and virtual settings for clinical situations, when to sacrifice ambience for time-urgent responsiveness and when to shift between technologies to promote therapeutic outcomes and manage obstacles to care.

II.A.5 Teaches, trains and/or consults and demonstrates how to evaluate/measure peer-reviewed and when possible, evidence-based impact of discontinuities and optimize a distraction-free environment to assure singular focus on the client/patient or task at hand, by management of discontinuities e.g., interruptions, interferences and suggesting reflection exercises.

II.A. 6 Analyzes the content and process of communication e.g., use of abbreviations, nouns, emoticons and fragments of in-person vs. TBH communication. Researches peer-reviewed and when possible, evidence-based benefits/risks of symbols, shorthand and fragments related to communication, boundaries and relationship to overall outcomes. Develops and teaches peer-reviewed and when possible, evidence-based strategies/approaches to help the professional facilitate/assess communication issues with the client/patient and if applicable, other professionals and systems.

II.A.7 Teaches, trains and consults with respect to peer-reviewed and when possible, evidence-based approaches to the creation, nurturance and maintenance of the therapeutic alliance in light of different therapeutic approaches and/or theories e.g., mindfulness, psychodynamic, cognitive. Encourages professionals to shift communication, technology and therapy approach to better problem-solve. Researches and provides peer-reviewed and when possible, evidence-based ways in which communication style interacts with technology and additional factors to shape the evolution or engagement.

DOMAIN III -- Technology: TBH professionals can demonstrate how to make informed decisions that reflect understanding their own and their clients/patients preferences for and, experience with using technology. Professionals are responsible for understanding how to responsibly use the technology they choose and can demonstrate a functional knowledge of its strengths, applications and limitations e.g., privacy, confidentiality, data integrity and security.

Health technology is defined by the World Health Organization (2011) as the "application of organized knowledge and skills in the form of devices, medicines, vaccines, procedures and systems … to solve a health problem and improve quality of lives." Evidence-based approaches are selected for clinical, educational, supervisory and consultative services.

The *Technology* **domain** is organized according to **competency level** i.e., novice, proficient or authority. It does not currently have subdomains. In turn, each competency level is categorized into five discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the TBH professional:

1. Assesses client's/patient's use of and comfort with technology
2. Adjusts pros and cons of technology to client's/patient's needs/preferences when possible
3. Skillfully operates technologies
4. Educates the client/patient and supervisees
5. Uses and teaches evidence-based technology choices and approaches

NOVICE	PROFICIENT	AUTHORITY
III.A. 1 Inquires about client's/patient's experience with and exposure to clinical care by TBH. Inquires about a client's/patient's level of comfort/openness and trust in technology.	III.A. 1 Assesses client's/patient's preferences, knowledge, skills and attitudes for using technology, in general and specifically care by TBH (see "Clinical Care and Evaluation" and "Telepresence and Environment)). Encourages clients/patients to reflect before taking action e.g., avoid a spontaneous or disinhibited use of email to convey concern to an employer. Assesses client's/patient's concerns, anxiety/phobia and resistance to using technology.	III.A.1 Teaches, trains and consults with respect to peer-reviewed and when possible, evidence-based models for assessing client/patient, populations at large and self-efficacy for knowledge, skills and attitudes regarding technology use. Provides key peer-reviewed and when possible, evidence-based paradigms such as common clinical prototypes of users e.g., early adopter.
III.A. 2 Identifies pros and cons of technologies (and combining them) to meet client/patient goals, preferences and capabilities for agreed therapeutic objective/scope and within technological capabilities.	III.A. 2 Matches client's/patient's need, preference, access and ability to a specific technology (or compares pros/cons of options) e.g., describes the difference between a "native app" with information stored on a mobile device versus mobile/virtual options.	III.A.2 Develops peer-reviewed and when possible, evidence-based strategies for professionals and institutions based on consulting with technology companies regarding appropriate clinical sensitivities and technical needs, administrative authorities e.g., Center for Medicare and Medicaid Services and legal and regulatory bodies. Assesses program needs for set-up, routine use/upkeep, levels of technical assistance e.g., IT, other. Provides levels of service in accordance with budget and other administrative structure.
III.A.3 Demonstrates skill in operating selected technology equipment e.g., hardware, software, microphone, camera and troubleshoots basic technical roadblocks, interferences, interruptions, breakdowns and intrusions. Identifies ways to problem-solve and/or obtain consultation on additional technologies.	III.A.3 Demonstrates skills specific to each technology selected to communicate effectively. Prevents interferences and interruptions with appropriate technology selection for all users. Trouble-shoots problems: makes adjustments to and/or replaces technology e.g., goes from video to telephone; consults with remote information technology (IT) staff and informs technology vendor for repair or to make improvements. Keeps abreast of changing technology and adapts accordingly.	III.A.3 Teaches, trains and consults with respect to technology choices, workflows and adjustments.
III.A. 4 Educates client/patient in how to use selected technology and troubleshoots basic technical roadblocks.	1. III.A.4 Educates client/patient, supervisees, consultees and other systems' professionals to ensure availability and working order of equipment for immediate needs/tasks e.g., the interview, transfer of records, emergency actions, and collateral information.	III.A. 4 Develops and disseminates peer-reviewed and when possible, evidence-based initial and longitudinal models of training and supervision of staff and professionals.
III.A.5 Recognizes the need for evidence-based services when using technology.	2. 3. III.A.5 Employs and adjusts evidence-based approaches to customize service delivery and monitors data on process and outcomes.	III.A5 Researches, disseminates outcomes, consults and teaches by conducting independent reviews of peer-reviewed and when possible, evidence-based approaches to service delivery.

DOMAIN IV -- Legal & Regulatory Issues: TBH professionals are aware of and can demonstrate adherence to relevant federal, state/provincial, and local laws, regulations and policies/procedures regarding TBH practice components e.g., issues such as privacy, confidentiality, data protection/integrity and security. They can also demonstrate adherence to relevant mandated reporting, informed consent and documentation requirements. They are able to demonstrate compliance with legal technology-related mandates, including the appropriate use of business associate agreements.

Legal and regulatory issues affect TBH practice internationally. The term *legal* is defined as allowable or enforceable by being in conformity with the law of

the land and the public policy. *Regulations* are defined as benchmarks promulgated by a regulatory agency, created to enforce the provisions of legislation.

Federal governmental laws and regulations for TBH practice include the following: privacy, confidentiality, Business Associate Agreements (BAAs), data protection/integrity and security[2,LRI1]; inter-jurisdictional practice; communications standards in the U.S and other countries e.g., Federal Communications Standards; prescribing e.g., Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH), Health Information Technology for Economic and Clinical Health (HITECH), Food and Drug Administration issues related to the Ryan Haight Act, Personal Information Protection and Electronic Documents Act (PIPEDA).

State/provincial laws and regulations for TBH practice must also be implemented, enforced and interpreted e.g., interjurisdictional practice. For example, in the U.S., there are a variety of licensing boards that establish practice requirements i.e., medical, nursing, pharmacy, psychology. State/provincial and federal laws and regulations may overlap.

Non-governmental regulatory requirements and recommendations from professional organizations, agencies and other authorities in other countries may also apply to TBH practice in the U.S. and according to other authorities in other countries: Joint Commission, Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), Utilization Review Accreditation Commission (URAC), American National Standards Institute (ANSI) and Healthcare Information and Management Systems Society (HIMSS).

The *Legal and Regulatory Issues* **domain** is organized according to **competency level** i.e., novice, proficient or authority. It does not currently have subdomains. In turn, each competency level is categorized into four discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the TBH professional:

1. Adheres to TBH-relevant laws and regulations
2. Practices in accordance with and educates others on adherence to TBH-relevant legal and regulatory requirements
3. When in doubt, applies/adapts in-person legal/regulatory standards to TBH
4. Attends to TBH contextual and overarching jurisdictional issues in a reasonable fashion. Adaptations are made for atypical practices that facilitate "good enough" care and to attend to TBH-relevant legal and ethical requirements. In addition, professionals discuss and document consideration of routine versus potentially urgent or emergent scenarios to assure that relevant legal and ethical safety requirements are met in a reasonable fashion.

NOVICE	PROFICIENT	AUTHORITY
IV.A.1 Communicates with all relevant authorities to identify and adhere to the relevant laws and regulations in the jurisdiction of client/patient (and the professional's, if different) at the time of contact, including informed consent, even if the authority does not detail updated requirements in "telehealth-related" terminology on public websites.	IV.A.1 Applies and if necessary, adapts clinical care and informed consent to relevant laws and regulations in any/all jurisdiction(s) being served (i.e. federal, state/provincial law). The professional's choice of technology and related risks and benefits must be identified in the informed consent. Professional ensures that the chosen technology, provider networks or other digital employers allow all functions mandated by relevant laws and regulations e.g, full intake, history, informed consent, mandated reporting and continuity of care in relevant jurisdictions.	IV.A.1 Consults, develops and provides potential resolutions for TBH-related legal and regulatory dilemmas or conflicts e.g., references/guidelines, different agencies, provider networks, digital employers and across different disciplines and professions. Advocates for timeliness and clarity in wording of laws and regulations, as well as in all public statements.
IV.A.2 Describes why licensed professionals need to be informed/have training in and have the duty to follow in-person and TBH legal and regulatory standards.	IV.A.2 Educates client/patient about TBH and other technology care options, including their respective pros/cons. Evaluates and improves the service delivery model e.g., interprets existing laws if specific TBH care/telepractice standards cannot be found e.g., privacy rules related to cellular phones.	IV.A.2 Teaches, trains and/or consults on TBH laws and regulations; delineates core issues of combining in-person and TBH care and/or TBH with asynchronous e.g., social media, mobile apps technologies. Develops consensus based on evidence or preliminary research.
IV.A.3 Applies in-person regulatory standards to TBH, and if not explicitly differentiated in regulatory codes, seeks education or consultation regarding use of technologies such as video, telephone, email, social media and others.	IV.A.3 Conforms with in-person regulations and new regulations related to specific technologies. For those not specified, reasonably applies other existing requirements to clinical practice, supervision, consultation and documentation.	IV.A.3 Develops peer-reviewed and when possible, evidence-based strategies for working with legal and regulatory nuances e.g., emergencies or disasters at a distance. Provides an approach to new technology application based on consensus, evidence and/or preliminary research.
IV.A.4 Seeks advice for TBH outside legal jurisdiction in advance e.g., when client/patient travels. Adjusts and documents the process.	IV.A.4 Discusses, describes, adheres to and documents interjurisdictional practice and telesupervision requirements and ethical guidelines when atypical settings are involved e.g., war zone, oil rig, refugee camp; mobile populations e.g., transportation workers, foreign and domestic students; and emergency circumstances e.g., natural disasters or school shootings. Obtains legal advice and supervision/telesupervision or consultation when in doubt. Seeks advice from	IV.A.4 Develops peer-reviewed and when possible, evidence-based clinical telesupervision policies. Updates and consults with regulatory boards and international health authorities on applicable interprofessional requirements and additions based on evidence (or developments). Researches peer-reviewed and when possible, evidence-based optimal methods for providing TBH services to high-risk populations, resolving legal/regulatory complications and conflicts e.g., jurisdictional mandates, employer/insurer.

[LRI1] Health Information Privacy and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), 42 CFR Part 2-Confidentiality of Alcohol and Drug Abuse Patient Records, Personal Information Protection and Electronic Documents Act (PIPEDA), Children's On-line Protection Act (COPA).

	client's/patient's local authorities e.g., ministry of health for a refugee, student or temporary employee in a foreign country. Encourages supervisees to do the same.	

DOMAIN V -- Evidence-Based & Ethical Practice: TBH professionals are aware of and can demonstrate adherence to TBH interprofessional and discipline-based professional standards, guidelines, consensus and evidence-based documents based on domestic and/or international practice. **TBH p**rofessionals can also demonstrate adherence to professional boundaries and other best practice guidelines relevant to a virtual setting when engaging in social media and digital information collection sources. Professionals develop written social media and digital information policies and discuss them with clients/patients as appropriate.

SUBDOMAIN V.A -- Standards & Guidelines: *TBH practice* should be based on evidence, consensus and other professional, discipline-based guidelines. Evidence-based practice is the integration of clinical expertise, client/patient values and the best of research evidence into the decision-making process for client/patient care.

Clinical expertise refers to the professional's cumulative experience, education and clinical skills.

Ethical practice reflects values and principles related to human rights, social justice and professional integrity; followed by practice principles that indicate how the ethical principles should be applied. These practices include interprofessional and discipline-specific professional standards, guidelines and consensus documents.[3EEP1]

Digital ethics is a newer term, referring to managing oneself ethically, professionally and in a clinically sound manner via online and digital mediums.

Within the *Evidence-Based & Ethical Practice* **domain**, the *Standards & Guidelines* **subdomain** is organized according to **competency level** i.e., novice, proficient or authority. In turn, each competency level is categorized into four discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the TBH professional:

1. Identifies, employs and develops relevant documents for ethical TBH service delivery
2. Compares in-person and TBH ethical issues (and potentially information across disciplines)
3. Teaches and supervises TBH ethical issues
4. Engages in discussion, consultation and training of TBH ethical issues across disciplines (for Proficient and Authority levels)

SUBDOMAIN V.B -- Social Media & Digital Information Collection: *Social media* is typically defined as web-based services that allow individuals to construct a public or semi-public profile within a bounded system, share a connection with specific users and traverse their list of connections and those made by others within the system (Boyd and Ellison, 2007). A guiding principle is that professionals need to reflect, be aware of, encourage discussion and respect social versus therapeutic frames of reference and boundaries as clinicians. Professionals also need to explore, educate and adhere to privacy requirements for social media related to clients/patients.

Big data in the context of TBH competencies refers to the use of predictive analytics, user behavior analytics, or other advanced data analytics methods that extract value from data entered at the suggestion of a TBH professional, albeit potentially unwittingly. TBH-competent professional can intelligently discuss how social media and other digital information collection sources can be used by various groups to gather and often re-sell digitized personal information about vulnerable people and/or groups (Mayer-Schönberger & Cukier, 2013). The TBH professional properly vets the technologies they recommend and in turn, educates, guides and protects both their client/patient and themselves from the long-term effects of predatory digitized information gathering sources. Such sources can include technologies that use undisclosed predictive analytics to "scrape" Facebook, Twitter or other social media sites, or by video, email, text-messaging, patient-engagement services chosen by the TBH professional for TBH client/patient interaction.

Within the *Evidence-Based & Ethical Practice* **domain**, this *Social Media and Digital Information* **subdomain** is organized according to **competency level** i.e., novice, proficient or authority. In turn, each competency level is categorized into four discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the TBH professional:

1. Assesses uses of social media and other technologies that may be deleterious to TBH client/patient, and documents such client/patient use of technology
2. Identifies and monitors legal and regulatory privacy issues specifically related to social media and digital information collection as it relates to TBH
   Applies usual in-person legal and regulatory rules to the use of all technology used in professional care in the form of best practices and policies, e.g., informed consent with social media and information collection policies (Proficient)
3. Creates a climate of reflection and discussion, educates the client/patient about issues related to sharing information through social media as well as the collection of clinical information through data gathering sources and documents these exchanges Encourages reflection and discussion about boundary issues related to searching client/patient information online
4. Supervises others regarding social media and digital information collection issues (for Proficient and Authority levels)

NOVICE	PROFICIENT	AUTHORITY
SUBDOMAIN V.A -- Standards & Guidelines	**SUBDOMAIN V.A -- Standards & Guidelines**	**SUBDOMAIN V.A -- Standards & Guidelines**
V.A.1 Identifies documents within own profession for reference and for clinical decisions. Occasionally attends a topical conference, workshop or training related to	V.A.1 Routinely adheres to and integrates consensus and other evidence-based research with ethical principles for TBH clinical work.	V.A.1 Develops/authors/leads consensus statements/processes in TBH by systematically comparing/contrasting information across professions, disciplines and countries.

[EEP1] Interprofessional standards e.g., American Telemedicine Association, as published in Telemedicine Journal e-Health, Journal Telemedicine & Telecare and Journal of Technology in Behavioral Science. In the U.S., there are practice standards, guidelines and consensus statements e.g., American Association of Marriage and Family Therapy, American Counseling Association, American Nurses Association, American Psychiatric Association, American Psychological Association, American Telemedicine Association, National Association of Social Workers. Worldwide e.g., Canadian Psychological and Psychiatric Associations, Australian Psychological Society, British Psychological Society, European Psychiatric Association, Royal College of Australian and New Zealand College of Psychiatrists. Gold standards for guideline development have both an evidence- and a consensus-based approach e.g., Institute of Medicine, 2011,[iii a] American Psychological Association.[iii b]

ethics of TBH.

V.A.2 Demonstrates knowledge of social media and other digitized information gathering services regarding their potential negative impact on client/patient treatment e.g., "scraping" of specific information related to unwitting participants across self-help websites, apps, voice-recognition products on devices and social media to target potential customers for services/products related to identified disorders.

V.A. Can discuss appropriate professional uses of social media for clients/patients as well as within the clinical relationship. Educates clients/patients and answers questions that arise about social media clinical interactions.

V.A.4 Identifies evidence-based TBH research within own profession for reference and for clinical decisions. Identifies similarities/differences between in-person and TBH care.

V.A.5 Discusses difficult and/or unclear ethical TBH topics with colleagues.

V.A.6 Engages a TBH supervisor or consultant for daily decisions and/or to apply ethical TBH practice information.

SUBDOMAIN V.B -- Social Media and Digital Information Collection

V.B.1 Identifies use of social media by clients/patients and documents type and frequency.

V.B.2 Applies usual in-person legal and regulatory rules to social media e.g., HIPAA and when indicated, checks for applicable professional association standards and guidelines. Shares social media and digital information collection policies in informed consent.

V.B.3 Educates oneself about both positive and negative uses of social media and digital information collection services such as predictive analytics, including but not limited to software logs from self-help and educational websites, cameras, wireless sensor networks, voice-activated devices, embedded microphones and radio-frequency identification (RFID) readers when considering technology to be used by clients/patients. Makes clear distinctions between personal and professional use of social media. Identifies digital information about themselves that can be found by clients/patients and addresses appropriately when brought up by clients/patients.

V.B.4 Identifies pros/cons of searching for digital

V.A.2 Identifies similarities/differences between in-person and TBH care. Actively finds, reads and encourages colleagues/supervisees to engage in life-long learning to keep updated. Compares/contrasts requirements of own and other relevant disciplines. Borrows/integrates other professions' clinical expertise with TBH for decision-making.

V.A.3 Teaches and supervises TBH by employing reflection, peer consultation or case discussion. Obtains TBH consultation for complex cases, unanticipated problems and application of new information in accordance with professional standards.

V.A.4 Teaches ethics and supervises interprofessional teams using information and evidence base(s) related to TBH requirements and recommendations for each discipline involved rather than assuming ethical requirements for their own discipline apply to other disciplines.

SUBDOMAIN V.B -- Social Media & Digital Information Collection

V.B.1 Assesses use of social media and digital information for the client's/patient's use with regard to personal needs as well as therapeutic goals. Also assesses the professional's own use(s) of social media and digital information for congruence with professional goals. Remediates incongruities between activities and goals.

V.B.2 Applies usual in-person legal and regulatory rules e.g., licensing laws, HIPAA, PIPEDA and specialized ones e.g., HITECH as it related to social media as well as digital collection of Big Data through TBH and other vendors whom are used for TBH service delivery. Integrates key components of relevant professional association standards and guidelines. Develops/adheres to social media and data collection policies and documents such policies in the informed consent process with client/patient.

V.B.3 Creates a climate wherein the topics of social media and digital information collection issues can be openly discussed. Educates clients/patients about routine use, precautions and common errors/pitfalls in social media e.g., sending suicidal, homicidal comments to social media websites, avoiding negative behavior websites. Educates clients/patients about the judicious use of the Internet when posting personal, behavioral information for education, support or direct care. The THB professional seeks full disclosure from all digital vendors before suggesting technologies to clients/patients.

V.A.2 Designs and performs evidence-based TBH research in own profession. Integrates peer-reviewed and when possible, evidence-based research and practices from other professions as relevant.

V.A.3 Teaches, trains and/or consults how to align peer-reviewed and when possible, evidence-based TBH ethical practice with fundamentals of professional clinical care, evidence-based, and legal/regulatory practices.

V.A.4 Identifies and analyzes TBH information regarding ethical similarities/differences between professions, disciplines and countries; provides peer-reviewed and when possible, evidence-based sources. Facilitates interprofessional and international TBH communication. Builds and establishes global overarching TBH consensus.

SUBDOMAIN V.B -- Social Media and Digital Information Collection

V.B.1 Researches peer reviewed and when possible, evidence-based TBH trends in social media and digital information collection for clinical and other professional uses.

V.B.2 Develops and disseminates peer-reviewed and when possible, evidence-based policies related to similarities/differences of social media and digital information collection technologies to in-person care; researches comparisons between technology social media and digital information collection source options and vendors.

V.B.3 Teaches, trains and consults about peer-reviewed and when possible, evidence-based TBH routine use, cautions with and common errors/pitfalls in social media and digital information use for professionals and clients/patients. Teaches professionals, aides with the development of state and national policies as well as identifies loopholes and solutions for social media and digital information legal and regulatory dilemmas. Develops ideas for fields to move forward with prudence and yet innovation for social media and digital information collection and use.

client/patient information online in any format. Documents Internet searches for information about client/patient and discusses dates, frequencies and rationale with client/patient as appropriate. Does not search client/patient information without proper consent. Seeks appropriate consultation to search without consent in emergent situations	V.B.4 Recognizes that the professional's personal and financial digital information may be found by clients/patients e.g., social media, property ownership, political activism, background searches. Systematically updates professional websites as career progresses, sets corridors to reduce access to private information and discusses such issues in informed consent case-by-case. Routinely monitors privacy settings on social media sites. Takes steps to prevent and manage boundary confusion or violations related to digital information e.g., separate personal versus professional Facebook pages. Inquires if clients/patients have accessed such digital information in any venue. Uses clinical judgment prior to searching for digital client/patient information i.e., does so only for emergent situations, but not just out of curiosity. Fully documents rationale(s). Discloses tracking and evaluation of social media and digital information to the client/patient, as appropriate. V.B.5 Supervises other clinicians in the ethics of choosing social media and digital information collection sources.	V.B.4 Teaches, trains and consults with professionals regarding how to systematically monitor and manage information, avoid boundary confusion/violations and apply critical thinking to decision-making in social media and in choosing analytic technologies. Researches, develops and disseminates peer-reviewed and when possible, evidence-based policies on the pros/cons of searching for client/patient information, as well as exceptions to such policies, including the therapeutic use of data analytic sources in clinical practice. V.B.5 Researches, develops, trains and teaches peer-reviewed and if possible, evidence-based models for TBH supervision related to social media and digital information collection.

DOMAIN VI -- Mobile Health Technologies Including Applications (Apps): TBH professionals choosing to work with mobile health technologies including apps can demonstrate how they are used in accordance with therapeutic goals, how they can have distinct positive and/or negative effects on the therapeutic relationship based on evidence, can demonstrate how they adhere to and apply to relevant professional standards and state/provincial and/or federal law; help clients/patients select options based on evidence; demonstrate an understanding of the privacy limitations of mobile technologies utilized/recommended and discuss these with clients/patients.

Mobile health was first defined as emerging mobile communications and network technologies for healthcare systems (Istepanian & Lacal 2003) and now refers to the application of mobile or wireless communication technologies to health and health care (Steinhubl et al 2013).

Mobile health technology options include behavioral health apps; voice/video calling between professionals and clients/patients; short message service (SMS) and multimedia message services (MMS) with video clips/sound files; multimedia functions for learning; inbuilt touch, motion and global positioning system (GPS) sensors that simplify clinical assessment; and device connectivity. These health communication methods facilitate personalization, tailoring, interactivity and message repetition at a relatively low cost.

Therapeutic use of mobile health should be consistent with therapeutic goals and treatment approaches. The use of the app *becomes TBH when data are transmitted* across distance. Apps have distinct positive and/or negative effects on the therapeutic relationship. Mobile health can have integrative capacity e.g., mobile phone alert identifies client/patient by name when they telephone. Clients/patients may also routinely use an app to log data e.g., mood, rating a child's behavior.

TBH care, may involve asynchronous one and/or two-way communication of clinical information e.g., engagement tools with messages, assignments and treatment reminders. These technologies facilitate ecological momentary assessment (EMA), which is the repeated sampling of naturalistic behaviors and experiences, capturing more accurate accounts of a client's/patient's emotions, functioning and activities related to behavioral health.

The *Mobile Health Technologies Including Applications (Apps)* **domain** is organized according to **competency level** i.e., novice, proficient or authority. It does not currently have subdomains. In turn, each competency level is categorized into five discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the TBH professional:

1. Assesses client/patient use of mobile health technologies
2. Selects a technology with client/patient for a purpose, documents and monitors
3. Practices and educates with evidence-based technology and approach
4. Attends to legal, regulatory and ethical issues, and develops new ones if indicated
5. Researches, teaches and consults to professionals (for Proficient and Authority)

NOVICE	PROFICIENT	AUTHORITY
VI.A.1 Screens for/inquires about clients'/patients' rationale for using a specific app. VI.A.2 Screens, assesses, selects and documents	VI.A.1 Assesses use of mobile health technologies and educates client/patients about options e.g., "native," pre-installed, TBH as well as appropriate installation and effective use.	VI.A.1 Consults and teaches professionals about the peer-reviewed and when possible, evidence-based personal and clinical uses of apps by clients/patients and how to systematically check for appropriate use. Teaches professionals to help clients/patients identify and engage with beneficial vs. harmful uses of mobile technologies.

apps with a specific clinical goal in mind. Understands the privacy limitations of apps recommended and discusses with patient/client.	VI.A.2 Prioritizes selection of options for clinical care, understands the privacy monitors implementation, process and outcomes of it. Links the option with a specific purpose to complement clinical care e.g., integrating information in an electronic health record versus client/patient interaction. Helps clients/patients avoid extraneous or duplicative apps, which may create confusion or diffuse therapeutic goals. Helps users reflect on important clinical issues such as privacy related to who else has access to the information e.g., family, other professionals, pharmacists, insurance companies, and technology repair shop.	VI.A.2 Researches/evaluates the use of mobile health technologies including apps by clients/patients and professionals to build, maintain and enhance therapeutic care. Teaches professionals how to select and use peer-reviewed and when possible, evidence-based technologies both initially and longitudinally.
VI.A.3 Educates clients/patients that TBH apps should be evidence-based. Engages in discussion about diary, data logging, symptom reporting and other uses of apps.	VI.A.3 Utilizes evidence-based apps. Outlines an evidence-based approach to app use that reflects technical e.g., installation, trouble-shooting, selecting features and safety concerns e.g., toggling off the option to send "bugs" to app developer. Documents rationale related to therapeutic goals.	VI.A.3 Researches and develops peer-reviewed and when possible, evidence-based apps as well as their evidence-based review criteria and app uses. Identifies whether one or more apps used concurrently is therapeutic for the individual client/patient. Identifies client/patient factors that indicate mobile technologies may not be advisable or should be de-emphasized.
VI.A.4 Identifies and is compliant with basic legal, regulatory and ethical requirements for using text, email and apps e.g., informed consent, privacy/HIPAA compliance in the U.S., practice over state/provincial lines.	VI.A.4 Maintains legal, regulatory and ethical standards i.e., maintains confidentiality by ensuring privacy. Anticipates, prevents and responds to potential problems related to using apps.	VI.A.4 Develops peer-reviewed and when possible, evidence-based quality improvement strategies to adhere to and consider adaptation of legal, regulatory and ethical standards related to use of apps e.g., privacy settings, who has access to device.
	VI.A.5 Develops sound administrative practices e.g., documentation, use of a linkage with EHR, calendar functions, communication with clients/patients on progress/feedback and reminders of healthy behaviors, scheduled appointments and medications	VI.A.5 Researches, consults and teaches professionals how to adapt appropriate peer-reviewed and when possible, evidence-based administrative procedures.

DOMAIN VII -- Teleplractice Development: TBH professionals can demonstrate how to use TBH and other forms of telecommunication technology to create and maintain one's professional identity and to engage the community at large e.g., soliciting testimonials from current or former patients/clients, in accordance with local, state/provincial and federal regulations and professional association standards. Professionals can show how to ensure the accuracy and validity of information disseminated.

Teleplractice, as part of TBH care, focuses on the creation and maintenance of one's professional identity and how this identity is digitally presented/projected to others, including networking and marketing practices to augment local practice development strategies. Marketing technology needs to be chosen according to the client/patient sensitivities, legal and ethical requirements. Professionals should be aware of legal and ethical considerations and requirements regarding digital practice development and maintenance e.g., Federal Trade Commission substantiation rule.[4TD1 5TD2] In addition, engaging with prospective clients/patients in a text or e-mail-based format is not advisable without informed consent as per privacy standards e.g. U.S. HIPAA. Professionals need to understand the workings of social media websites, how these sites evolve (i.e., change privacy settings), and how they aid/thwart the therapeutic process. Professionals using social media to expand their practices, services, products and/or reputations must clearly delineate between personal and professional communications so as to prevent harm to past, current and future clients/patients.

The *Teleplractice Development* **domain** is organized according to **competency level** i.e., novice, proficient or authority. It does not currently have subdomains. In turn, each competency level is categorized into three discrete **telebehavioral objectives**, which are then distinguished by cumulative and measurable **telebehavioral practices**. Within his or her competency level then, the TBH professional:

1. Develops a professional digital identity and integrates this identity with their offline professional identity, as applicable
2. Adheres to local, state/provincial, and federal regulations and professional standards for practice development
3. Tailors the digital identity to the clinical care, culture and business standards of the communities accessed and served

NOVICE	PROFICIENT	AUTHORITY
VII.A.1 Identifies basic differences between marketing online vs. offline e.g., impact of social media on interactions with clients/patients. Identifies need for extra caution about providing personal information about oneself or family and handling negative social comments on review sites and avoiding boundary confusion. Identifies how social media information needs to be adjusted to be congruent with professional identity, privacy and boundary considerations and specific personal as well as societal roles over time.	VII.A. 1 Develops a well-designed offline and/or online teleplractice marketing plan. Accurately describes professional services, technologies used and how services meet participants' needs e.g., clients/patients, providers, administrators.	VII.A.1 Teaches, trains and/or consults regarding peer-reviewed and when possible, evidence-based issues related to pros/cons of how technology can more broadly disseminate one's professional and personal identities vs. traditional practice promotion strategies e.g., social media vs. business cards.
VII.A.2 Follows legal and ethical requirements with regard to testimonials, paid endorsements, confidentiality, scope of practice, offering services only where licensed, avoiding fraudulent statements, etc. e.g., FTC substantiation rule.	VII.A.2 Identifies and adheres to the relevant local, state/provincial, and/or federal laws e.g., Federal Trade Commission, HIPAA, HITECH in the U.S. Follows professional association standards and guidelines e.g., making false or fraudulent statements, exerting undue influence over a client/patient when employing technology-based services.	VII.A.2 Teaches, trains and/or consults regarding issues related to pros/cons different marketing dissemination strategies related to additional services offered by the professional, including etiquette and legal requirements. They advise regarding the value of independent review of technology to determine appropriateness e.g., marketing through websites and social media blogs, search engine advertising campaigns, webinars, eBooks, podcasts.
VII.A.3 Includes components of cultural differences above and beyond demographic, gender and ethnicity e.g., sexual orientation, sizes, class, ages, abilities in published marketing materials e.g., words and images.	VII.A.3 Develops and uses a community outreach and/or a marketing plan to promote teleplractice services in a culturally competent manner.	VII.A.3 Consults, trains, teaches and researches the evolution of developing and using community outreach and/or a marketing plans to promote TBH services in an peer-reviewed and when possible, evidence-based, culturally-competent manner.

[TD1] FTC Substantiation rule reference: https://www.ftc.gov/public-statements/1983/03/ftc-policy-statement-regarding-advertising-substantiation.

[TD2] Requiring advertising to be based on analysis of a service or program, its procedures, community standards and relative costs and benefits.

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