MENTAL HEALTH SERVICES VIA SKYPE: MEETING THE MENTAL HEALTH NEEDS OF COMMUNITY COLLEGE STUDENTS THROUGH TELEMEDICINE

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ABSTRACT

There is a pressing need to examine the mental health needs of community college students due to the high prevalence of mental health issues among college-aged students and the large increase in community college enrollment. Research must be done to evaluate the best, new methods of providing mental health services to such a growing population of students. Community college students are at an increased risk for mental health disorders compared to students at traditional four-year colleges and universities due to unique stressors for community college students, such as having to balance school with work or children. However, compared to 58 percent of four-year institutions that offer on-campus psychiatric services, fewer than one out of ten community colleges provide psychiatric services for students. Given the needs of community college students, barriers to access, and lack of resources at community colleges, telemedicine should be considered as a way to

increase the accessibility of mental health services for community college students. Telemedicine is the use of technology to provide health services from remote locations through interactive audio- and video-conferencing technology. This Note examines the promising benefits of telemedicine, such as increasing access to medical services and reducing costs, and the legal barriers to implementing telemedicine. These legal barriers include privacy, licensing, professional liability, and reimbursement. This Note explores several proposals to address the unique issues surrounding telemedicine, and argues for a legal framework that facilitates the increased use of technology to provide quality health care. Addressing these legal impediments will allow community colleges to take advantage of the potential benefits of telemedicine as a way to increase access to mental health care for community college students.

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I. INTRODUCTION

Educating about half of all undergraduate students, community colleges play a key role in the postsecondary education system in the United States.[1] Community colleges provide open access to higher

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[1] *2014 Fact Sheet*, AM. ASS'N OF COMMUNITY CS. (2014), http://www.aacc.nche.edu/AboutCC/Documents/Facts14_Data_R3.pdf (stating that community college students represent 45 percent of all U.S. undergraduates).

education by offering flexibility and low tuition rates to a diverse population of students.[2] For example, the average cost of annual tuition and fees for community college students is $3131—almost one-third less than the cost of annual tuition at a public four-year institution.[3] At less than half the cost of a public four-year college and about one-tenth of the cost of a private four-year college, community colleges offer students an affordable way to complete many of the core requirements of a bachelor's degree before transferring to a four-year institution.[4] These students also tend to have varying needs and obligations outside of school.[5] Community colleges offer accommodations for the 60 percent of community college students who attend school part-time and also must balance school with family, jobs, and other responsibilities.[6] Forty-one percent of part-time community college students are full-time employees, while 32 percent are part-time employees.[7] Twenty-two percent of full-time students are employed full-time, while 40 percent of them are employed part-time.[8] The advantages of community college for students include cost, flexible scheduling, and smaller class sizes.[9]

Additionally, online enrollment in community colleges has increased, demonstrating a reliance on technology to meet students' needs and to provide access to postsecondary education.[10] Although the success rates of online courses are lower than those for traditional courses, a study of California's 112 community colleges found that students who took at least some online courses were "more likely to earn an associate's degree, a vocational certificate, or transfer to a four-year college."[11] As one of the

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[2] *Id.*

[3] Cristina Couch, *Two-Year vs. Four-Year Colleges: Which One is Right for You*, COLLEGEVIEW, http://www.collegeview.com/articles/article/two-year-vs-four-year-colleges-which-one-is-right-for-you (last visited Feb. 21, 2016).

[4] *See id.*

[5] *Id.*

[6] *2014 Fact Sheet, supra* note 1, at 1.

[7] *Id.*

[8] *Id.*

[9] *The Pros and Cons of Community Colleges*, SCHOLARSHIPS.COM, https://www.scholarships.com/resources/college-prep/choosing-the-right-school/the-pros-and-cons-of-community-colleges/ (last visited Feb. 21, 2016).

[10] *Online Courses at Community Colleges See Major Growth – But Student Success Rates Lag*, PUB. POLICY INST. OF CAL. (May 14, 2014), http://www.ppic.org/main/pressrelease.asp?i=1526 [hereinafter *Online Courses at Community Colleges*]; Scott Jaschik, *Online at Community Colleges*, INSIDE HIGHER ED. (Apr. 7, 2014), https://www.insidehighered.com/news/2014/04/07/study-finds-slower-online-growth-community-colleges-growth-nonetheless.

[11] *Online Courses at Community Colleges, supra* note 10.

main sources of enrollment growth in higher education during the past decade, online learning at community colleges reflects the historic role of community colleges in providing the availability and flexibility that many students need as they pursue their higher education goals.[12]

In addition, there has been a marked growth in mental health issues among high school and college-aged students, as well as a rise in the use of college counseling centers for those issues.[13] Mental wellbeing is essential to successful learning, as mental health difficulties have been shown to adversely affect academic performance.[14] Students suffering from depression, anxiety, and stress reported lower grades on exams and incomplete or dropped courses in a 2007 survey of California community college students.[15] Still, community college counseling centers have "proportionally fewer resources than do their counterparts at four-year institutions," despite educating more than half of all undergraduates.[16] Commuter or online students are also "particularly vulnerable to having their problems go unnoticed on campus," given that community colleges lack residence halls and a corresponding residence life staff to watch over students.[17] The growth of mental health issues among college students emphasizes the critical need to examine the mental health resources available at community colleges, as well as best practices to assist community college students who are struggling with mental health disorders.[18]

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[12] *Trends in eLearning: Tracking the Impact of eLearning at Community Colleges*, INSTITUTIONAL TECH. COUNCIL (Apr. 2015), http://www.itcnetwork.org/membership/itc-distance-education-survey-results.html.

[13] Nicole Evangelista et al., *Supporting Mental Health Needs of Community College Students*, CTR. FOR SCH. MENTAL HEALTH 1 (Jul. 2011), https://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/Resources/ Briefs/CCIssueBrief.pdf.

[14] Louise A. Douce & Richard P. Keeling, *A Strategic Primer on College Student Mental Health*, AM. COUNCIL ON EDUC. 2 (2014), https://www.apa.org/pubs/newsletters/access/2014/10-14/college-mental-health.pdf.

[15] Sang Leng Trieu et al., *Examining Mental Health Data in California Community Colleges*, IJOURNAL INSIGHT INTO STUDENT HEALTH SERVICES 2 (2007); Amy Novotney, *APA Partners to Review College Student Mental Health*, 45 AM. PSYCHOL. ASS'N MONITOR ON PSYCHOL. 40 (2014), http://www.apa.org/monitor/2014/09/cover-partners.aspx.

[16] Doug Lederman, *Community College Counseling Gains*, INSIDE HIGHER ED. (Jun. 18, 2013), https://www.insidehighered.com/news/2013/06/18/survey-shows-growth-counseling-services-2-year-colleges.

[17] J. Chamberlin, *Mental Health Services Remain Scarce at Community Colleges*, 43 AM. PSYCHOL. ASS'N MONITOR ON PSYCHOL. 11 (2012), http://www.apa.org/monitor/2012/04/community-colleges.aspx.

[18] Martha Anne Kitzrow, *The Mental Health Needs of Today's College Students: Challenges and Recommendations*, 41 NAPSA J. 165, 167 (2003).

There is a lack of data on two-year community colleges, and more research must be done to determine whether best practices to address the mental health needs of students in community colleges differ from best practices for four-year colleges.[19] It is unclear why research on mental health services for community college students, as well as the provision of mental health resources itself, are so lacking.[20] But, it may be connected to the presumption that because community college students are older, as 57 percent of students range from twenty-two to thirty-nine, they do not require the same supervision and care as younger students who traditionally attend a four-year institution directly after high school.[21] Due to this belief, the *in loco parentis* ("in the place of the parent") concept in higher education might possibly be weaker in the case of two-year institutions as opposed to four-year institutions, with on-campus mental health support falling lower on the list of priorities for community colleges.[22] However, 30 percent of community college students are younger than twenty-one and the average age of community college students is twenty-eight.[23]

Community college students, no matter their age, require more than the mental health resources currently available. The benchmark studies conducted by the American College Counseling Association's Community College Task Force confirm the high demand for mental health services in community college students, as well as various financial and institutional barriers that prevent many community college students from receiving the mental health support they need.[24] In 2009–2010, the American College Counseling Association's Community College Task Force conducted its first survey of sixty-seven counselors from fifty-four community colleges from twenty-eight different states to gather benchmark data on personal counseling in community colleges.[25] The study highlighted that 95 percent of community colleges had no on-site psychiatric resource.[26] It also found that the ratio of counselors to students was about 1 to 2000–

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[19] Evangelista et al., *supra* note 13, at 3.

[20] *Id.*

[21] *2014 Fact Sheet, supra* note 1.

[22] Joseph Storch, *In Loco Parentis, Post-Juicy Campus*, INSIDE HIGHER ED. (Sep. 17, 2009) https://www.insidehighered.com/views/2009/09/17/loco-parentis-post-juicy-campus.

[23] *2014 Fact Sheet, supra* note 1.

[24] Am. Coll. Counseling Ass'n: Community Coll. Task Force, *2009-2010 Community College Counselors Survey Results*, AM. C. COUNSELING ASS'N (June 24, 2010), http://www.college counseling.org/community-college-survey-09-10.

[25] *Id.*

[26] *Id.* at 1.

2500 students, despite the International Association of Counseling Services recommendation of a 1 to 1000–1500 ratio.[27]

In 2011, the survey was expanded to 294 community colleges from forty-four states, and this larger sample found that only 13 percent of community colleges provide on-site psychiatric services for students, compared to the 56 percent of four-year institutions that do so.[28] However, the survey noted that 68 percent of community colleges did provide mental health counseling services.[29]

The 2012–2013 version of the study, which represented 198 community colleges in forty-three states, reflected many of the same themes that were seen in the 2011 study.[30] For example, most community college counselors wear many hats and suffer from role overload, as they are responsible for providing career and academic services, as well as mental health services.[31] Common themes among the responses from the community college counselors included fiscal pressure that affected the quality and availability of services, as well as competing job demands.[32] Given that many counseling centers are unavailable and counselors over-extended, referrals to off-campus mental health services could serve to meet the demands of community college students. However, even if off-site mental health resources may be available to students in less remote areas, many counselors reported that referring students to off-campus services tends to be challenging due to college policies and student health insurance.[33]

The most recent study, from 2013–2014, represented 179 counselors from community colleges in thirty-nine states.[34] There was a marked

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[27] *Id.*; Evangelista et al., *supra* note 13, at 5; *Statement Regarding Recommended Staff to Student Ratios*, INT'L ASS'N OF COUNSELING SERVS., INC., http://www.iacsinc.org/staff-to-student-ratios.html (last visited Mar. 23, 2016).

[28] Chamberlin, *supra* note 17; Jon Edwards, *Survey of Community/2year College Counseling Services*, AM. C. COUNSELING ASS'N (2011), http://www.collegecounseling.org/docs/ACCA-CCTF-2011SurveyBooklet.pdf [hereinafter Edwards, *Survey 2011*].

[29] Edwards, *Survey 2011*, *supra* note 28.

[30] Lederman, *supra* note 16.

[31] *Id.*

[32] Am. Coll. Counseling Ass'n – Cmty. Coll. Task Force, *Survey of Community/2 Year College Counseling Services 2012–2013*, AM. C. COUNSELING ASS'N 3, http://www.college counseling.org/wp-content/uploads/ACCA-CCTF-2013-Survey.pdf (last visited Mar. 15, 2016).

[33] *Id.*

[34] Jon Edwards, *Survey of Community/2 Year College Counseling Services 2013–2014*, AM. C. COUNSELING ASS'N, 1, http://www.collegecounseling.org/wp-content/uploads/ACCA-community-survey-2013-14.pdf (last visited Mar. 18, 2016) [hereinafter Edwards, *Survey 2013–2014*].

decrease to only 8 percent of community colleges with an on-site psychiatry resource.[35] By contrast, 58 percent of four-year schools reported on-campus psychiatry.[36] Further, the survey found that 84 percent of community college counselors have a caseload size of up to twenty clients per week, and 99 percent have regular roles in addition to personal counseling.[37]

These studies reflect an increasing awareness of the need for mental health resources on community college campuses, and community colleges should explore innovative approaches to improving such services for their students. The field of telemedicine, or more specifically telepsychiatry or telemental health, offers a promising medium for providing more accessible mental health resources and support to community college students, whose needs and barriers to service are at once both similar to and very different from those of students at four-year institutions.[38]

As technology has advanced, the practice of telemedicine, or the use of electronic communication and technology to provide or support clinical health care at a distance, has also increased.[39] Telemedicine has improved access to and decreased the costs of quality health care services for underserved populations, particularly in rural areas.[40] Community colleges could gain from the benefits of telemedicine, which expand accessibility to medical services by allowing medical providers to reach beyond their geographic limits. Community college counseling centers could rely on and refer students to off-site resources accessible through on-campus or personal technology such as smart phones and computers. This could accommodate the busy schedules of students who may have otherwise sacrificed mental health support due to logistical and financial barriers. However, the practice of telemedicine brings its own unique legal obstacles that challenge the expanded adoption of telemedicine, particularly on a nationwide scale.[41]

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[35] *Id.* at 2.

[36] *Id.*

[37] *Id.* at 4.

[38] Evangelista, et al., *supra* note 13, at 5; Brian J. Grady et al., *Telepsychiatry and School Mental Health*, CHILD ADOLESCENT PSYCHIATRIC CLINIC N. AM. (2011), https://www.e-psychiatry.com/Telepsychiatry-and-School-Mental-Health.pdf.

[39] Susan E. Volkert, *Telemedicine: RX for the Future of Health Care*, 6 MICH. TELECOMM. TECH. L. REV. 147, 151 (1999/2000); Diane Hoffman & Virginia Rowthorn, *Legal Impediments to the Diffusion of Telemedicine*, 14 J. HEALTH CARE L. & POL'Y 1, 1–2 (2011).

[40] Volkert, *supra* note 39, at 150.

[41] Hoffman & Rowthorn, *supra* note 39, at 5.

The development of telemedicine must be facilitated and encouraged by a legal regulatory system that supports its growth.[42] Part II of this Note examines the background of telemedicine, focusing on the uses and benefits of telemedicine to deliver health care and how these advantages can be used to overcome the unique barriers to mental health services for community college students. Part III lays out some of the legal and regulatory barriers, such as licensing, professional liability, reimbursement, and privacy, which prevent the expansion of telemedicine and explores proposed solutions to these problems. Finally, the conclusion argues for further research and collaborative efforts toward legal reform in the field of telemedicine in order to take advantage of its many benefits. It also addresses the need for additional research on the specific mental health needs of community college students to facilitate the advancement and improvement of mental health supports for students in community colleges.

II. BACKGROUND OF TELEMEDICINE

A. DEVELOPMENT OF TELEMEDICINE

The powerful ability of technology to connect people across the globe has resulted in the growing use of telemedicine to improve access to health care, particularly to geographically isolated and underserved populations, including rural communities, Native Americans, and prison inmates.[43] Telemedicine replaces traditional "in-person" encounters and involves the use of "remote transmissions of video, audio, and text data to individuals involved in a patient's care."[44] It is distinguishable from cybermedicine, which is the distribution of health information on a website without a prior or current doctor-patient relationship.[45] Telemedicine is broad and can take various forms, such as telephone consultations, interactive video conferencing, electronic patient records, and telepresence surgery.[46]

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[42] Gilbert Eric Deleon, *Telemedicine in Texas: Solving the Problems of Licensure, Privacy, and Reimbursement*, 34 ST. MARY'S L. J. 651, 683–85 (2003); Grady et al., *supra* note 38, at 82; Evangelista, *supra* note 13, at 5.

[43] Kathleen M. Vyborny, *Legal and Political Issues Facing Telemedicine*, 5 ANNALS HEALTH L. 61, 62 (1996).

[44] Shannon S. Venable, *Call to Action: Georgia Must Adopt New Standard of Care, Licensure, Reimbursement, and Privacy Laws for Telemedicine*, 54 EMORY L. J. 1183, 1185 (2005).

[45] *Id.*

[46] *Id.* at 1186–87; Dean R. Batson, *Pennsylvania's Abortive Attempts to Regulate Telemedicine Through Restrictive Licensure Requirements: Protecting the Patient or Protecting the*

Telemedicine is also used for many different purposes in health care, including "diagnosis, patient monitoring, treatment, and storage of patient data."[47] Telemedicine services have been provided to patients for many decades.[48] It began in the 1950s with the development of telepsychiatry, when the National Institute of Mental Health connected seven state hospitals in four states through a telephone system for teleconferencing lectures.[49] Since then, advancements in technology systems, equipment, and availability have heightened interest in the practice of telemedicine.[50] Present-day applications of telemedicine include:

> ". . . sharing of patient information and records to save time and administrative costs; kiosks set up in urban areas allowing people access to basic health care; use in prisons to insure physician safety when treating inmates; use by the military to treat personnel at sea and in distant locations; home monitoring of the elderly and disabled; education and training; and providing health care to residents of rural areas."[51]

Telemedicine allows patients to see specialists more easily, addresses medical professional shortages, and reduces travel time and expenses for medical professionals and patients.[52] This makes telemedicine an appealing option to tackle the many challenges to delivering health services to underserved populations.[53] Further, the widespread use of communication technology, such as laptops and smart phones, lends itself well to the incorporation of telemedicine into the practices of medical professionals.[54]

Profession?, 106 DICK L. REV. 591, 592 (2002).

[47] Sarah E. Born, *Telemedicine in Massachusetts: A Better Way to Regulate*, 42 NEW ENG. L. REV. 195, 200 (2007).

[48] Venable, *supra* note 44, at 1185.

[49] *Id.* ("By the 1960s, psychiatrists were using the telephone to conduct group telepsychiatry consultations with remote patients"); Christina M. Rackett, *Telemedicine Today and Tomorrow: Why "Virtual" Privacy is Not Enough*, 25 FORDHAM URB. L.J. 167, 170 & n.28 (1997).

[50] Helen M. Farrell, *Practicing Psychiatry via Skype: Medicolegal Considerations*, 10 CURRENT PSYCHIATRY (Dec. 2011), http://www.currentpsychiatry.com/home/article/practicing-psychiatry-via-skype-medicolegal-considerations/640db4be624be48e08cce0a8c041f7f0.html.

[51] Ann K. Schooley, *Allowing FDA Regulation of Communications Software Used in Telemedicine: A Potentially Fatal Misdiagnosis?*, 50 FED. COMM. L.J. 731, 735–36 (1998).

[52] Farrell, *supra* note 50.

[53] *Id.*

[54] *Id.*

B. OVERCOMING BARRIERS TO MENTAL HEALTH CARE IN COMMUNITY
COLLEGES THROUGH THE BENEFITS OF TELEMEDICINE

1. Increased Access

One of telemedicine's initial and primary advantages is its ability to provide health care to rural areas, where it is difficult to provide services due to remoteness or a lack of specialists, by bringing the physician to the patient.[55] Telemedicine also addresses other access barriers including financial issues, logistical considerations, and can assist in removing the stigma and confidentiality issues that worry some recipients of mental health care.[56]

The use of telemedicine eliminates long trips and the cost of travel for patients seeking access to a specialist, without sacrificing the quality of care.[57] Considering that a large portion of community college students attend school part time and are juggling jobs and other obligations, linking mental health professionals to students via telemedicine expands access to care by accommodating these logistical constraints. [58] Potential applications of telepsychiatry in community colleges include interactive video-conferencing for "evaluations, ongoing sessions with students and families, medication management, enhanced mental health staffing, continuing education, and classroom teacher consultations." [59] The majority of community colleges that lack on-site psychiatric resources could benefit from the combination of school-based health care and technology. [60] Telemedicine could assist under-resourced community colleges provide quality psychiatric care, including multilingual psychiatrists or mental health professionals, through one of the primary advantages of telemedicine: "accessing care in the right place, at the right time, with the right provider in a culturally sensitive context."[61]

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[55] Volkert, *supra* note 39, at 151.

[56] Evangelista, et al., *supra* note 13, at 5.

[57] Batson, *supra* note 46, at 595; Volkert, *supra* note 39, at 158.

[58] *2014 Fact Sheet, supra* note 1.

[59] Grady et al., *supra* note 38 (highlighting similar issues as those found in community colleges, such as shortages in psychiatrists and barriers to care).

[60] *Id.*; Edwards, *Survey 2013–2014, supra* note 34.

[61] Grady et al., *supra* note 38, at 83–84 (quoting "In 1998, a young Latino boy was treated remotely at school via telepsychiatry by a Spanish-speaking psychiatrist at the Lincoln Hospital Telepsychiatry Network in New York City. The psychiatrist and the student were able to interact via real-time videoconferencing, as well as share the computer desktop for drawing and writing. Upon completion of 16 sessions of cognitive behavioral therapy, the child reported that he

Further, expanding access to important school-based or on-site health care remains an important concern in assessing the most effective ways to meet the needs of community college students.[62] Telemedicine can help remedy this, as it allows for convenient on-campus access to off-site mental health resources. This is demonstrated by the use of telemedicine for children and adolescents in the case of the Central Greene School District in a rural county in Pennsylvania, which started a telepsychiatry pilot program in October 2005.[63] The program allowed child psychiatrists to provide medication management by teleconferencing with students who were located in the private offices of the school nurses.[64] The county's human services director reported a concern that "student[s] with depression or [attention deficit hyperactivity disorder] already have issues affecting their school work and that the situation is only compounded by missing additional time in school."[65] District data showed an increase in the students' school attendance, as well as an increase in the students' ability to keep scheduled mental health appointments, from 75 percent before the program's inception to 96 percent since the program started.[66]

Further, studies suggest that school-based health centers can be more effective in treating students.[67] School-based health centers are an important system through which health care services are provided to "enable children with acute or chronic illnesses to attend school, but also improve their overall health and wellness through health screenings, health promotion, and disease prevention activities."[68] These centers often operate as a partnership between the school and a community health organization, and the success of these centers in accommodating the academic needs of children as well as the logistical challenges of parents should be considered in light of the similar barriers to service and needs of

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looked forward to sessions and was no longer disruptive.").

[62] Am. Coll. Counseling Ass'n – Cmty. Coll. Task Force, *supra* note 32 (community college counselors report that "[r]eferring students to off-campus services tends to be problematic due to college policies, student health insurance, and lack of community resources.").

[63] Grady et al., *supra* note 38, at 85–86.

[64] *Id.*

[65] *Id.* at 85.

[66] *Id.*

[67] Jamie Chamberlin, *Schools Expand Mental Health Care*, 40 AM. PSYCHOL. ASS'N MONITOR ON PSYCHOL. 64 (2009), http://www.apa.org/monitor/2009/01/school-clinics.aspx.

[68] *HHS Announces Availability of $100 Million For School-based Health Centers*, HEALTH RES.   &   SERVS.   ADMIN., http://www.hrsa.gov/about/news/pressreleases/2010/101004schoolbased healthcenters.html (last visited Feb. 23, 2016).

community college students.[69] A 2007 study found that low-income and uninsured adolescents who used school-based health centers were more likely to keep regular check ups and less likely to visit emergency rooms than adolescents who used community clinics.[70] Another study found that adolescent "students were [twenty-one] times more likely to make mental-health related visits to school-based health centers than to community health clinics."[71]

Mental health professionals agree that school-based health programs are the most effective way to reach children because on-campus resources "reduce the stigma of the traditional mental health setting and the barrier of having to get there."[72] Thus, the use of telepsychiatry to provide community college students with convenient, local access to quality mental health services offers a promising opportunity to address specific barriers to accessing mental health care and potentially improve academic performance through increased school attendance.[73]

2. Cost-Effectiveness

Community colleges require cost-effective mental health services in order to efficiently support their students in the face of fiscal constraints.[74] As technology has advanced, telemedicine has become more widespread and affordable.[75] However, insufficient research on telemedicine's cost-effectiveness and potentially high equipment costs limit its broader implementation and growth.[76] Although the equipment required can be purchased and maintained for a relatively low cost, start-up costs for "training personnel and integrating telemedicine into existing health care frameworks can be substantial."[77] Costs include equipment, installation of lines, maintenance, rental costs of lines, administrative expenses, data transmission costs, and upgrades of equipment.[78] Advancements in

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[69] *Id.*

[70] Chamberlin, *supra* note 67.

[71] *Id.*

[72] *Id.*

[73] Grady et al., *supra* note 38, at 85–86.

[74] *See* Edwards, *Survey 2013–2014, supra* note 34.

[75] Rural Health Advisory Comm., *Telemental Health in Rural Minnesota*, MINN. DEP'T HEALTH OFF. RURAL HEALTH & PRIMARY CARE 27 (Jul. 2010), http://www.health.state. mn.us/divs/orhpc/pubs/rhac/tmh.pdf.

[76] *Id.*

[77] Deleon, *supra* note 42, at 652 n.5.

[78] Donald M. Hilty et al., *The Effectiveness of Telemental Health: A 2013 Review*, 19 TELEMED.

technology can decrease costs; however, more research must be done to determine the cost-effectiveness of telemedicine, as differing types of cost analyses result in differences in data collection and analysis.[79]

3. Clinical Efficacy

Although there is currently insufficient research on the clinical efficacy of telemental health, studies generally demonstrate a positive trend in clinical outcomes.[80] Factors in evaluating the effectiveness of telemental health, when compared to in-person care, include access to care, quality of care, reliability of diagnosis and assessment, satisfaction, costs, technology reliability, and feasibility of administration.[81] Results as to the clinical efficacy of this emerging field tend to be encouraging, and clinical studies of mental illnesses such as depression, post-traumatic stress disorder, substance use, and development disabilities have found that video-conferencing appears to be just as effective as in-person care.[82]

In comparison to in-person care, telemental health yields "reduced length of hospitalization, better medication adherence, symptom reduction of disorders, and effective therapy."[83] For example, in 2011, "146 hospitals provided 55,000 patients in 531 community-based outpatient clinics with 140,000 telemental health visits . . . . A review of more than 98,600 patients who received clinic-based telemental health care between 2006 and 2010 showed a 25 percent reduction in hospitalization."[84] Further, a review of 1041 mental health patients before and after using telemental health services in 2011 demonstrated a 30 percent reduction in hospital admissions as compared to a similar period of time before

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J. & E-HEALTH 444, 451 (June 2013); Vyborny, *supra* note 43, at 63–64.

[79] For example, cost-offset models, which suggest that treating mental conditions can reduce other health costs, differ from cost-benefit analysis, which translates all outcomes, such as quality of life, into economic terms. *See* Hilty, et al., *supra* note 78, at 450–51; *see* Deleon, *supra* note 42, at 9 (citing studies).

[80] *See* Gil Siegal, *Enabling Globalization of Health Care in the Information Technology Era: Telemedicine and the Medical World Wide Web*, 17 VA. J.L. & TECH. 1, 8–9 (2012); David Chorney, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMED. L. 215, 223, 248 (2014).

[81] Hilty, et al., *supra* note 78, *at* 446.

[82] *Id.*

[83] *Id.* at 445; *see id.* at 447–49.

[84] TRACY A. LUSTIG, THE ROLE OF TELEHEALTH IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY 103 (2012), http://www.nap.edu/openbook.php?record_id=13466&page=103.

enrollment in the telemental health program.[85] A study of telemental health in rural Minnesota reflected some of the same benefits, noting that the telemental health services increased early diagnosis and provided easier access to treatment, which ultimately yielded better outcomes.[86]

However, there are potential disadvantages to using telemedicine.[87] For example, current technology lacks the ability to provide psychiatrists with "the rich multidimensional aspects of a person-to-person encounter," and remote sessions may affect what patients tell their doctors and how they feel when they communicate.[88] Although psychiatrists tend to have limited physical contact with patients, in-person examinations may be required in certain situations, such as when prescribing certain medications.[89] The clinical benefits of telemedicine are promising, but as this field continues to expand and change, additional research should be conducted to more clearly demonstrate and evaluate the efficacy of remote mental health treatment.[90]

III. LEGAL AND REGULATORY BARRIERS

The potential benefits and effectiveness of telemedicine are promising. Telemedicine could serve as a solution to many of the issues challenging community college mental health service providers.[91] However, federal and state governments and medical professionals must work to remove barriers to telemedicine.[92] Both state and federal governments have power to legislate in the areas of telemedical practice, and states should collaborate to create schemes that are more consistent in their approaches.[93] The development of telemedicine and its widespread use is affected by the significant barriers of licensing, professional

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[85] Chorney, *supra* note 80, at 233 n.100; Lustig, *supra* note 84.

[86] *See* Rural Health Advisory Comm., *supra* note 75 (evaluating the barriers to accessing mental health services in rural areas of Minnesota and recommending enhanced and expanded use of telemental health services as a solution).

[87] Farrell, *supra* note 50.

[88] *Id.*

[89] *Id.*

[90] Lustig, *supra* note 84; *see* Siegal, *supra* note 80, at 8–9.

[91] Hilty et al., *supra* note 78, at 451.

[92] Volkert, *supra* note 39, at 160.

[93] Vyborny, *supra* note 43, at 92–95 (discussing justifications for these powers); Born, *supra* note 47, at 205–12 (describing the state's Tenth Amendment powers and the federal government's power to pre-empt state regulation through the Commerce Clause or Spending Power).

liability, reimbursement, and privacy.[94]

A. LICENSURE

Medical licensure serves as the greatest hurdle to the interstate practice of telemedicine, as states reserve the ability to regulate the practice of medicine within their borders.[95] States have a constitutional police power that allows for "regulations to protect the health and safety of their citizens."[96] State licensure statutes exist primarily to protect patients from being treated by unlicensed and unqualified physicians.[97] Under state law, physicians who want to practice medicine within a state must be licensed to do so.[98] Most states have full licensure laws, under which physicians who practice telemedicine must be fully licensed within that state.[99] Thus, physicians "must apply, fulfill the requirements, and receive a license to practice medicine in their patient's state before they can legally provide care to that patient."[100]

One of the arguments for strict licensure standards is the fear of substandard care; however, this problem has proven to be mainly a hypothetical concern.[101] Relatively uniform national standards, upon which state laws are based, render "state-by-state licensure obsolete."[102] Strict full licensure laws are burdensome for physicians and patients who seek to practice and obtain telemedicine across state lines, and should be revised and reconsidered to find a "balance between quality assurance and patient access."[103] By limiting telemedical practice across state lines, state-by-state licensure requirements "hinder[] access to care, especially

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[94] Batson, *supra* note 46, at 592; Vyborny, *supra* note 43, at 65–66; Rackett, *supra* note 49, at 168–69; *see* Hoffman & Rowthorn, *supra* note 39, at 1 (summarizing roundtable on the legal impediments to telemedicine).

[95] Batson, *supra* note 46, at 596–97.

[96] Deleon, *supra* note 42, at 668.

[97] Batson, *supra* note 46, at 597; Hoffman & Rowthorn, *supra* note 39, at 89.

[98] Deleon, *supra* note 42, at 668.

[99] *Id.* at 669.

[100] *Id.*

[101] Batson, *supra* note 46, at 601.

[102] Vyborny, *supra* note 43, at 78; *see also* Batson, *supra* note 46, at 601; Hoffman & Rowthorn, *supra* note 39, at 23; The Ctr. for Telemedicine Law, *Telemedicine and Interstate Licensure: Findings and Recommendations of the CTL Licensure Task Force*, 73 N. D. L. REV. 109, 113 (1997) (noting that licensure standards among states are relatively uniform).

[103] Deleon, *supra* note 42, at 684–85; *see also* Hoffman & Rowthorn, *supra* note 39, at 10 (noting that telemedicine practitioners who seek to practice across states find strict licensure laws burdensome).

for residents of states that do not have needed expertise in-state."[104] A less restrictive licensing requirement for out-of-state physicians would encourage more flexibility in the expansion of telemedicine.[105]

States have chosen different ways to regulate telemedicine. Several solutions to the obstacle of state-by-state licensure have been suggested, including a national licensing statute for telemedicine that is similar to the structure used in the United States military.[106] The military allows for a physician "to practice medicine for the armed forces, regardless of location, so long as the physician is legally licensed to practice in any state."[107] A "limited" or "abbreviated" license is another proposal, which would only allow the practice of telemedical services across state lines.[108] Some states have a "consulting exception," under which out-of-state physicians may practice medicine in consultation with a referring in-state physician, and the scope of the exception varies from state to state.[109]

There are also two models for a national licensure system, which "could apply to all aspects of licensing or could be limited to the practice of telemedicine."[110] Under a "federalization of licensure model," a license would be issued based on national, standardized criteria, and would grant a national organization or agency authority to administer care at the national level.[111] Another national licensure option is a hybrid model, under which physicians would still be required to obtain licenses in each jurisdiction but a standardized set of criteria would "facilitate the administrative process."[112]

Medical license portability requires significant collaboration. Another potential solution is the mutual recognition model, under which state licensing boards "enter into a compact to legally accept the policies and processes (licensure) of a licensee's home state."[113] States in the compact

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[104] Hoffman & Rowthorn, *supra* note 39, at 10 (quoting FED. COMMC'N COMM'N, CONNECTING AMERICA: THE NAT'L BROADBAND PLAN 200–08, 206 (2010), http://download.broadband.gov/plan/national-broadband-plan.pdf).

[105] Born, *supra* note 47, at 214–15.

[106] Vyborny, *supra* note 43, at 78; *see also* The Ctr. for Telemedicine Law, *supra* note 102, at 119–21 (describing laws adopted by several states regarding telemedicine services).

[107] Vyborny, *supra* note 43, at 80.

[108] *Id.* at 80.

[109] Hoffmann & Rowthorn, *supra* note 39, at 11.

[110] *Id.* at 15.

[111] *Id.*

[112] *Id.* at 16.

[113] Batson, *supra* note 46, at 608–09; Hoffman & Rowthorn, *supra* note 39, at 13–14; Born, *supra* note 47, at 219.

agree to a common set of standards for qualification, conduct, and discipline, and the compact acts as a waiver to licensure in the signatory states.[114] Regional or nationwide compacts would allow physicians to use telemedicine without having to go through the full licensure process for each state.[115] The regulation of the practice of nursing could serve as a model toward developing a more flexible interstate licensure model. The National Council of State Boards of Nursing ("NCSBN") developed a multi-state licensure plan to address the practice of nursing across states.[116] Signatory states to the Nurse Licensure Compact agree to waive certain standards for licensees in other compact states.[117] Thus, under this form of mutual license recognition, nurses who practice telemedicine can easily deliver their services in multiple states with only one license.[118] And if a similar model were adopted, physicians could service patients across state lines as well.

However, state cooperation remains a significant obstacle to the licensure of telemedicine across state lines.[119] A mutual recognition compact licensure structure could offer a more flexible approach that encourages medical professionals to engage in telemedicine while also maintaining patient safety.[120] But the challenges of developing common standards must be overcome for states to take advantage of mutual recognition compacts as an option for the expanded use of telemedicine.[121]

B. PROFESSIONAL LIABILITY

Issues of medical malpractice and professional liability are important to the discussion of telemedicine, but the lack of telemedicine malpractice cases makes it difficult to draw rules regarding the legal risks of telemedicine.[122] Most of the legal actions associated with telemedicine are not cases regarding negligent telemedical care, but instead have mainly centered on internet pharmaceutical prescriptions.[123] In evaluating and

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[114] Batson, *supra* note 46, at 609.

[115] *Id.*

[116] *Id.*

[117] *Id.*

[118] Deleon, *supra* note 42, at 673–74.

[119] Batson, *supra* note 46, at 610; The Ctr. for Telemedicine Law, *supra* note 102, at 128.

[120] Batson, *supra* note 46, at 674.

[121] Batson, *supra* note 46, at 610; The Ctr. for Telemedicine Law, *supra* note 102, at 128.

[122] Hoffmann & Rowthorn, *supra* note 39, at 32.

[123] *Id.* at n.163 (noting that there is little case law addressing liability issues in telemedicine).

identifying how medical malpractice law should be changed to "better protect patients and reduce liability risk for physicians," there are several important issues that telemedicine brings forth, such as jurisdiction and choice of law (whether it is the law of the patient's or physician's residence that applies); which standard of care applies; whether the requirements for informed consent should differ for telemedicine; and who is responsible for failure of equipment or connections.[124]

As for choice of law questions, there is general agreement that the plaintiff should be able to sue in his or her home state, and most courts would give deference to the plaintiff's choice of jurisdiction.[125] If jurisdiction is found, the court could then "apply general choice of law principles to determine the law as to standard of care."[126]

There is some debate over "[w]hether telemedicine practitioners should be held to the same standard as others in their field or to a separate 'telemedicine standard.'"[127] In reviews of literature on the issue of standard of care, in most cases, the standard for physicians who practice telemedicine would be "the standard of a reasonably prudent practitioner of the same or similar background acting under the same or similar circumstances," the same as traditional practitioners.[128] Courts will establish limits to the applicable standard of care as they interpret "same or similar circumstances" in the context of telemedicine.[129]

Related to the issues of malpractice and liability is the question of informed consent, with professionals generally agreeing that patients should "be provided with information specific to telemedicine in the process of obtaining informed consent."[130] The source and scope of informed consent must be explicitly laid out, and patients should be informed of the particular risks in using telemedical services.[131] California, for example, has enacted a statute that lists the information patients must be told in the context of informed consent for telemedicine.[132] Such information includes a description of potential risks,

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[124] *Id.* at 32–34.
[125] *Id.* at 34.
[126] *Id.*
[127] *Id.*
[128] *Id.* at 34–35.
[129] *Id.* at 35.
[130] *Id.* at 35–36.
[131] *Id.* at 37.
[132] *Id.* at 37 & n. 187 (citing Cal. Bus. & Prof. Code § 2290.5(c) (West Supp. 2010)).

consequences, and benefits of telemedicine.[133] Patients must be informed that all existing patient access and confidentiality protections apply, and that dissemination of any personally identifiable information or images requires the consent of the patient.[134]

C. REIMBURSEMENT

Lack of consistent reimbursement policies for telemedicine services has been a major obstacle to the expanded use of telemedicine, as physicians are generally not interested in practicing telemedicine with little prospect of payment.[135] Reimbursement rates differ depending on the type of insurance—Medicare, Medicaid, or private insurance—as well as on the type of service provided. [136] Congress required Medicare reimbursement for telemedicine services to begin in 1999 under the Balanced Budget Act of 1997.[137] However, the narrow scope of the Balanced Budget Act limited its implementation. Reimbursement was only offered to patients in Health Professional Shortage Areas ("HPSA"), which were designated as areas with a shortage of primary care medical professionals.[138] The Balanced Budget Act was later amended by the Medicare, Medicaid, and the State Children's Health Insurance Program ("SCHIP") Benefits Improvement and Protection Act of 2000, which expanded reimbursements beyond HPSAs to also include patients in rural areas.[139]

While states differ in their approach to reimbursement, California was one of the first states to enact laws regarding telemedicine reimbursement. [140] The Telemedicine Development Act of 1996, a California law, sought to assist underserved populations who could not

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[133] *Id.*

[134] *Id.*

[135] Deleon, *supra* note 42, at 680.

[136] Rural Health Advisory Comm., *supra* note 75, at 30 (providing tables that compare reimbursement for mental and behavioral health services as contrasted with the other primary care services delivered via telemedicine).

[137] Deleon, *supra* note 42, at 680 (citing Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4206, 111 Stat. 251, 377 (1997)).

[138] *Id.* at 681.

[139] *Id.* at 682.

[140] Rural Health Advisory Comm., *supra* note 75, at 31 (showing variations in coverage in several Midwestern states); Catherine Atkins, *A 2011 Recap of the 1996 Telemedicine Development Act*, THE THERAPIST (Nov./Dec. 2011), https://www.camft.org/ias/COS/ Resources/Attorney_Articles/Cathy/A_2011_Recap_of_the_1996_Telemedicine_Development_ Act.aspx.

access health care due to geographic and/or economic barriers. [141] California law requires insurance plans to cover services that can be provided through telemedicine. [142] The legislature enacted the reimbursement statute in order to take advantage of telemedicine's benefits, which included "expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs, and the ability to remain with support networks."[143] California lawmakers recognized that "without the assurance of payment and the resolution of legal and policy barriers, the full potential of telemedicine will not be realized."[144]

The context of providing telemedicine to adolescents and children in school-based health centers offers a helpful comparison to the challenges involved with providing community college counseling services. The American Telemedicine Association ("ATA") evaluated state telemedicine coverage policies and highlighted best practices to encourage school-based telemedicine providers to take advantage of the capabilities of telemedicine via Medicaid. [145] The ATA noted that over twenty-five million children are eligible for Medicaid services, and telemedicine via school-based health centers serve as "a recognized model for quality and cost-effective healthcare delivery."[146] In its evaluation of best practices, the ATA identified states with model policies based on specific criteria including: "inclusive definitions of technology with little to no restrictions on the types of technology approved for use in a clinical service," "geographic area served," "applicable health services and conditions," "provider eligibility," "reimbursement methodology," and "level of coverage and affected health care plans."[147] The ATA suggests that policymakers begin with the provision: "Medicaid will provide coverage for telemedicine services at a school-based health center to the same extent that the services would be covered if they were provided through in-person consultation."[148] Further research on telemedicine's efficacy

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[141] Atkins, *supra* note 140.

[142] *Id.* (citing Cal. Health and Safety Code § 1374.13, Cal. Welf. & Inst. Code § 14132.72, and Cal. Ins. Code §§ 10123.13 and 10123.85).

[143] *Id.*

[144] *Id.*

[145] *State Medicaid Best Practice: School-Based Telehealth,* AM. TELEMEDICINE ASS'N (2013), http://www.americantelemed.org/docs/default-source/policy/state-medicaid-best-practice---school-based-telehealth.pdf.

[146] *Id.* at 1.

[147] *Id.* at 2.

[148] *Id.* at 6.

and cost-effectiveness would likely assist lawmakers in determining how to address these reimbursement issues in order to fully realize the promising potential of telemedicine.

D. PRIVACY

Patient privacy concerns serve as another barrier to fully realizing telemedicine's benefits.[149] Through the digitalizing of medical records, telemedicine has been able to improve patient care, accuracy, and decrease costs; however, unauthorized access to patient medical records is a risk that is tied to the computer technology and transfer of data, both of which are central to telemedicine services.[150] Because telemedicine introduces unique privacy issues, legislation should incorporate appropriate privacy measures and requirements within the specific context of telemedicine and in light of technological advancements, such as regulations that impose stiffer penalties for noncompliance with procedural security measures to prevent breaches in health-related information.[151] Currently, without such regulations in place, confidential patient data could easily be intercepted and misused, and "patients are not adequately protected against such invasions of privacy because states' medical confidentiality requirements are not uniform," resulting in varying levels of recourse based on where they reside or where their doctor is licensed.[152]

Maintaining the privacy and confidentiality of patient information is important because the potential for security breaches of private medical information causes complex ethical, social, and legal concerns.[153] For example, the fear of security breaches may dissuade patients from disclosing sensitive or stigmatizing information to their physicians.[154] Considering the stigma surrounding mental health treatment, the need to protect medical information in today's age of rapidly advancing technology remains vital to the expanding use of telepsychiatry and telemental health services.[155] Patient privacy is crucial to effective health care services, as medical professionals need maximum information "to

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[149] Rackett, *supra* note 49, at 168–69.

[150] Venable, *supra* note 44, at 1212.

[151] *See* Deleon, *supra* note 42, at 678–79 (discussing Texas laws that seek to ensure medical privacy).

[152] Rackett, *supra* note 49, at 169.

[153] Keith A. Bauer, *Privacy and Confidentiality in the Age of E-Medicine*, 12 J. HEALTH CARE L. & POL'Y 47, 50 (2009).

[154] *Id.*

[155] *Id.*; Rackett, *supra* note 49, at 190.

obtain adequate patient histories, make correct diagnoses, and provide patients with appropriate treatments."[156]

In 1996, Congress enacted the Health Insurance Portability and Accountability Act ("HIPAA") to enhance patient privacy as health care technology advanced.[157] Under HIPAA, the National Committee on Vital and Health Statistics recommends a uniform national standard for the electronic maintenance of patient medical records. [158] HIPAA protects "individually identifiable health information," and generally this information cannot be disseminated without the patient's consent. [159] Each state has its own patient privacy laws, as HIPAA serves as a "national floor of privacy standards" without preempting individual state laws.[160]

Federal and state legislation should be sufficiently comprehensive and explicit in creating and describing the standards for the transmission of information during telemedicine sessions. [161] Legislators must specifically address the confidentiality of patient records and information within the unique context of telemedicine, and ensure that confidentiality issues such as easy access to electronic information and possible loss of control over transmission are addressed and protected.[162] To actualize the benefits of telemedicine, future privacy regulations should limit the number of entities that have access to personal health information and implement adequate security measures.[163] Further, the "human factor" in medical treatment is important in the expansion of telemedicine. As such, the ethical justifications and implications for maintaining patient confidentiality should be emphasized in trainings for medical professionals practicing telemedicine, particularly given the greater potential for breach of patient data.[164]

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[156] Bauer, *supra* note 153, 156.

[157] Venable, *supra* note 44, at 1212.

[158] Deleon, *supra* note 42, at 676.

[159] Venable, *supra* note 44, at 1212–14.

[160] *Id.* at 1214.

[161] *Id.*

[162] *Id.* at 1215.

[163] Bauer, *supra* note 53, at 59–62 (describing particular principles in medical information privacy, such as openness and transparency, purpose specification, collection limitation, individual participation and control, data quality and security safeguards, accountability and oversight, and remedies and sanctions).

[164] *Id.* at 62; Rackett, *supra* note 49, at 188.

IV. CONCLUSION

Telemedicine could be a promising solution to some of the barriers that prevent the use of mental health services, such as high costs, time constraints, logistical hassles, and stigma. For community college students, these barriers can be even more pronounced and compounded, since many of these students are at an increased risk for mental health disorders.[165] There is currently a lack of research on the mental health needs of community college students, and the low amount of resources that community colleges have in comparison to those at four-year institutions is troubling, especially given that "[r]ecognizing and treating anxiety and depression, effectively managing stress and behavioral health problems, and improving the quality of the learning environment can all be expected to strengthen learning outcomes for students of any age and in any context." [166] Studies also demonstrate "an increase in student persistence and retention associated with counseling services," as those "who participate in counseling report improvements in their satisfaction with their quality of life."[167] But campus counseling centers face a high demand and lack the resources to meet the clinical needs of students, and the current research on community college counseling centers demonstrates that many community colleges either do not have or lack sufficient campus mental health resources.[168] The critical need to support this vulnerable and significant portion of the nation's undergraduate population is clear, and innovative uses of technological tools to deliver quality mental health care services should be further explored and facilitated.[169]

The use of technology to expand the reach of mental health services continues to grow. Technology now allows for the use of websites, videos, email, and mobile device applications in suicide prevention and outreach, as well as the use of counseling and monitoring services aimed at teens and young adults suffering from mental health issues such as eating disorders, depression, and anxiety.[170] Technology-based applications and

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[165] Chamberlin, *supra* note 67.

[166] Douce & Keeling, *supra* note 14, at 3.

[167] *Id.*

[168] *Id.*; Edwards, *Survey 2013–2014*, *supra* note 34.

[169] Evangelista, *supra* note 13, at 5.

[170] *See* David D. Luxton et al., *Technology-Based Suicide Prevention: Current Applications and Future Directions*, 17 TELEMED. J. & E-HEALTH 50, 50 (2011) (exploring existing technologies used in suicide outreach and prevention); Lorraine Sanders, *The Uber Version of Therapy*, THE OZY (Jan. 10, 2015), http://www.ozy.com/fast-forward/the-uber-version-oftherapy/38045.

programs can assist in overcoming barriers to care, including increasing the geographical reach of services and providing nearly instantaneous access to resources that is not limited by conventional hours or availability.[171]

Despite these benefits, it is important to carefully research and evaluate the clinical effectiveness of technology-based programs in order to "identify best practices, determine cost-benefit, and provide empirical support for their use."[172] Further, technology can assist in expanding access to health care in more efficient and innovative ways, but ultimately the technology itself "cannot replace careful clinical case management and use of empirically supported interventions."[173] Rather, telemedicine must be used to enhance and improve the reach and quality of health care.[174]

Legislators must address the unique barriers to telemedicine's growth for the field's promising applications and implications to materialize and for telemedicine to become an efficient and reliable treatment alternative.[175] Federal and state governments and medical professionals must work together to adopt flexible regulatory schemes that facilitate the flow of telemedicine while also protecting the patient.[176] Regulatory frameworks that offer the most adaptability of telemedical services will allow the most opportunities for improvements and growth in the field.[177] As more students continue to rely on community colleges to achieve their higher education goals and as technology becomes more accessible and affordable, the promises of telemedicine should be seriously considered as an effective solution to providing quality mental health services and support to an important population within the higher education system.[178]

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[171] Luxton et al., *supra* note 170, at 52.

[172] *Id.* at 53.

[173] *Id.*

[174] *Id.*

[175] Venable, *supra* note 44, at 1216–17.

[176] Born, *supra* note 47, at 220.

[177] Hilty et al., *supra* note 78, at 451.

[178] President Obama's proposal to offer two years of free community college shows on increased focus and reliance on community colleges. Kyla Calvert, Obama: *Community College Should Be 'as free and universal in America as high school'*, PUB. BROADCASTING STATION NEWSHOUR (Jan. 20, 2015), http://www.pbs.org/newshour/rundown/community-college-tuition-top-theme-state-union-speech/. In California, the recent approval to approve bachelor's degrees at certain community colleges also reflects on growing reliance on the community college system. Alexei Koseff, *California Community Colleges Board Approves 15 Pilot Bachelor's Degrees*, SACRAMENTO BEE (Jan. 20, 2015), http://www.sacbee.com/news/politics-government/capitol-alert/article7780146.html.