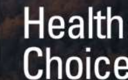
Telepsychiatry Tele-mental Health

Sara Gibson, MD

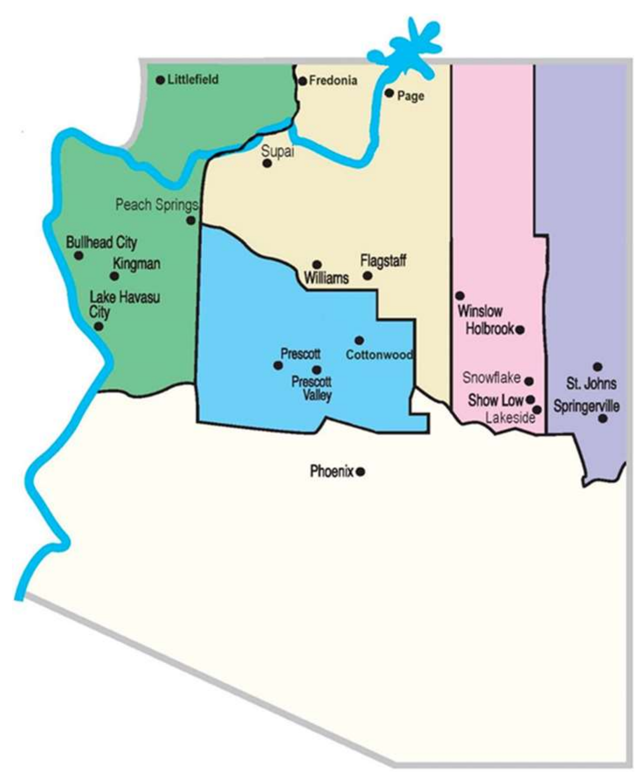
Psychiatrist

Medical Director, Telemedicine

Proprietary & Confidential



• A long time ago in a galaxy far, far away……



ACCESS to CARE!
1996 (29 years)

Northern Arizona Regional Behavioral Health Authority "NARBHA"

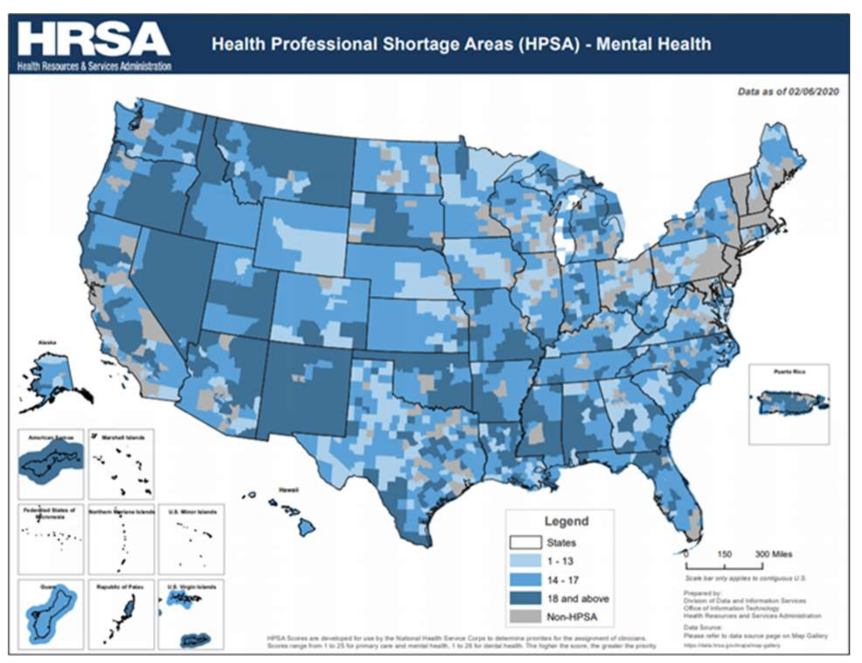
Bridge geographical barriers (remote)

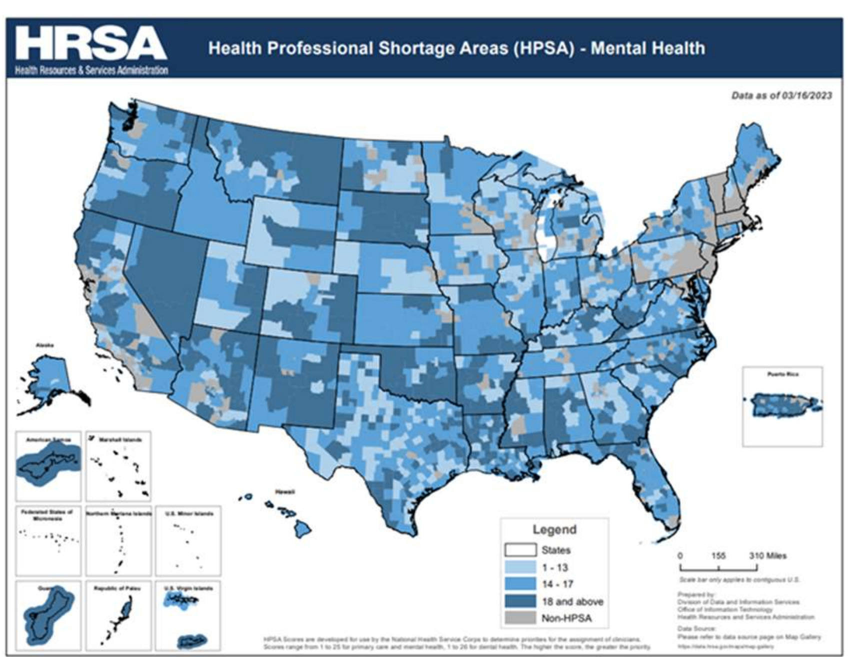
Serve Underserved, Shortage Areas

Vast area, sparse population:

- Larger than New York plus New Jersey
- 66,000+ square miles (58% of AZ area)
- Population 836,000+ (11.6% of AZ)

Health Professional Shortage Areas, Mental Health
Need Vastly Exceeds Supply





Courage, Necessity

Telepsych Pioneer 1996

- Psychiatrist in Flagstaff
- LCBHC is the sole mental health clinic for remote, rural Apache County; 2 clinics
  - St. Johns is 165 miles (3 hours)
  - Springerville 200 miles (3 h, 20 mn)
  - 99% of services via telemedicine since 1996, 30,000+ sessions

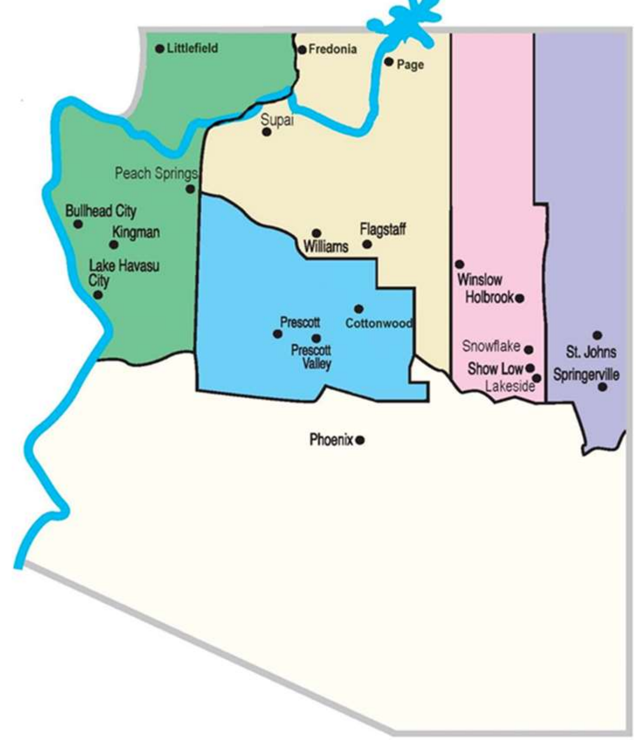
Sparsely populated: <10,000 combined population of three largest towns

>18% have no health insurance

Median household income <$35,000

>28% live in poverty

https://www.census.gov/quickfacts/apachecountyarizona



Telehealth Program Innovation:
28 Years of Nationally Recognized Quality

Program Initiated for Access to Care

Pioneer in direct TH care provision.

Goal to decrease inequalities and improve continuity of care.

Steady Growth & Excellence

-Top 10 TH program of excellence
-10-year satisfaction study
--Presentations & publications

PHE Leadership & Experience

Rapid response to utilization and needs.

New paradigm of in-home services

Continued Focus: Quality of Care

Innovation & education
Tele-mentoring ECHOs
Best practices in ongoing service delivery

1996

2008

2020

How Do We Measure Success?

Improved Access to Care *
Patient Satisfaction
Cost
!!Quality of Care!!

Measuring Success
First, Improve Access to Care

Psychiatric services available to areas of physician shortage

One Provider can "go to" multiple smaller-need locations

BETTER TEAM TREATMENT: Connect multiple distant systems, places, clinicians, families, specialists

More services provided:

Patients seen in their own community, sooner, more frequently, better attendance

Emergency assessments available immediately

Providers caring for people, not driving

Acceptance

- 24+ patient satisfaction studies reviewed in literature; all overwhelmingly positive
- HCAnet acceptance 1998, 2006
  - Client satisfaction surveys
  - Family (of client) satisfaction surveys
  - Staff satisfaction surveys
  - Satisfaction over time

Why Telepsychiatry? Cost

RBHAnet Benefits in 2010

$200,000 savings

1,200 more patient encounters

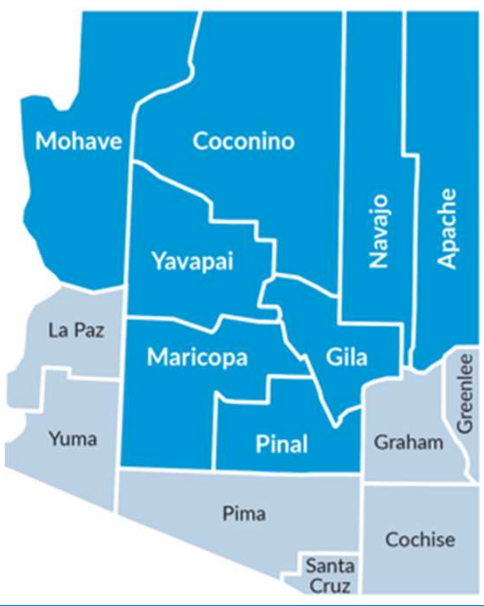
41.2 tons CO_2 saved

Decreased hospitalizations due to increased access to care:

2012: Veteran's Administration VA due to outpatient care

Texas due to emergency room psychiatric consultations

BH Hospitalization length of stay dropped from 11+ to 6.5 days the year after telehealth started in Apache county (1997)



Success in Outcome Measures

✓ **Patient satisfaction**

First 10-year study published

✓ **Cost savings**

Decreased travel, hospitalizations

✓ **Improved access to care**

- Members treated in their community
- Physician recruitment & retention
- Immediate emergency assessments

28+ years of Innovative, Successful Telepsych…NOW to

Improve Outcomes (Quality of Care)

Decrease Health Inequalities

Quality of Care

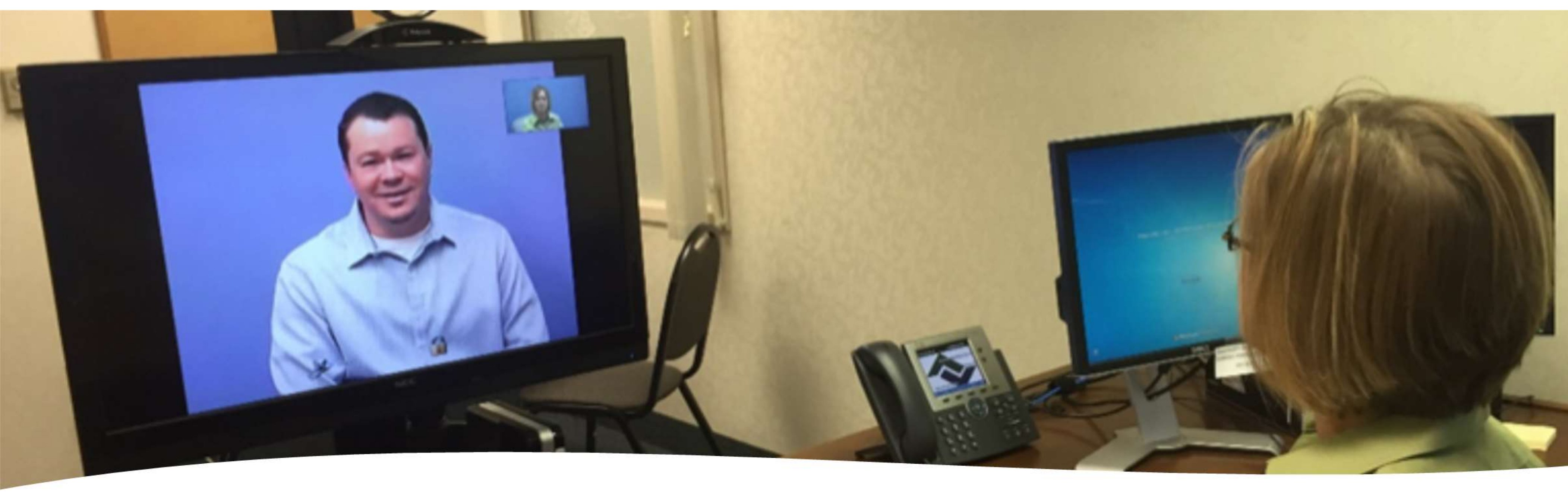
"Expertise, ability, and therapeutic alliance are more important than proximity. "
Tara Sklar, JD, MPH

Competence + Connection= Extraordinary Outcomes

Telehealth is an Evidence Based Practice for Treatment (Quality of Care)

•HHS has recently released research regarding the efficacy of telehealth around Medicaid, Medicare, Maternal Health, Equity, Emergency Care, BH Care, and QOC; finding:

- No significant differences between the quality of care delivered remotely and care delivered in person for various conditions
- Telehealth can reduce barriers like transportation challenges and time constraints
- Patients attending remotely had an increase in appointment completion rates



Telehealth Quality of Care

Telemedicine is an Evidence-Based Practice

- Studies demonstrate that telepsychiatry is equivalent to in-person for:
  - Assessment
  - Diagnoses
  - Therapeutic alliance
  - Treatment adherence
  - Clinical outcomes

- **Telepsychiatry versus face-to-face treatment: systematic review and meta-analysis of randomised controlled trials**
- Cambridge University Press: **01 September 2023**

- **Conclusions:** Telepsychiatry achieved a symptom improvement effect for various psychiatric disorders similar to that of face-to-face treatment..
- No significant difference was seen [symptom improvement] between telepsychiatry and face-to-face treatment when all the studies/diagnoses were combined (k = 26, n = 2290; P = 0.248).
- No significant difference regarding all-cause discontinuation was seen between telepsychiatry and face-to-face treatment when all the studies/diagnoses were combined (k = 27, n = 3341; P = 0.564).

Telehealth has the *Same Standard of Care* as seeing a patient in person!

Medical Professionals are responsible for obtaining the information they need for a medical decision, such as appropriate physical exam, blood pressure, lab work, weight, etc

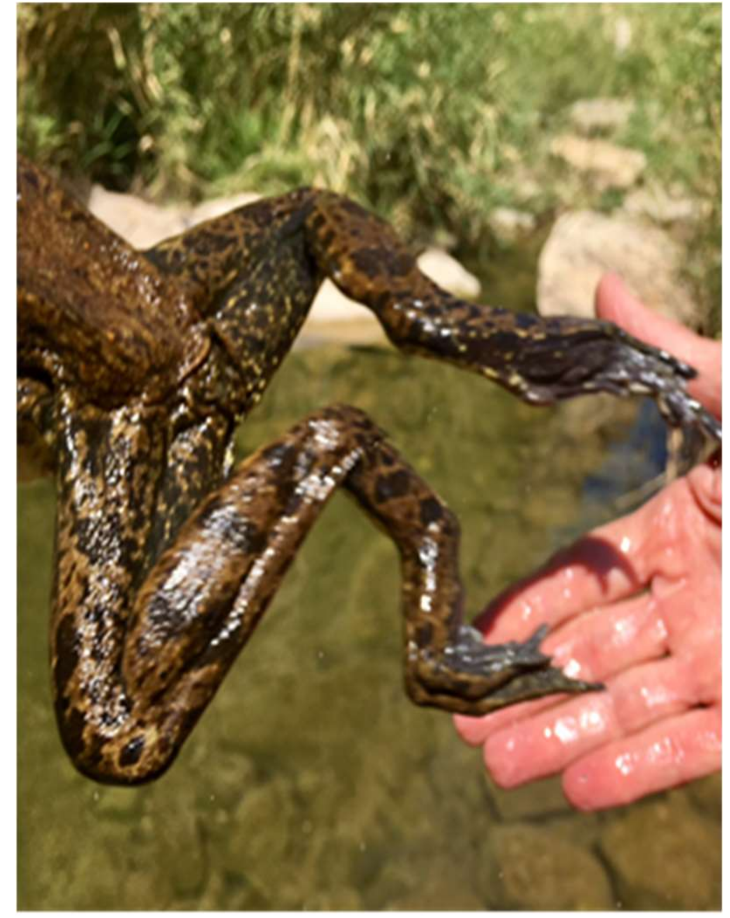
Must be clinically appropriate and medically necessary

All standards, regulations, rules, and quality performance measures must apply

Quality of Care: Documentation of Examination

- Psychiatric telemedicine eval documents physical features:
  - alertness, distress, grooming, dysmorphic features, speech fluency & speed, neurologic findings such as tics/ tremors/ altered gait/ nystagmus, flushed or pale skin, rashes, review of vital signs, motor gait, muscle appearance
- AIMS (can do all except cogwheel)
- Mental Status Exam
- The Telehealth Ten: A Guide for a Patient-Assisted Virtual Physical Exam :

  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7368154/



Documentation Requirements

AZ Statue requires informed consent to be obtained prior to providing care via telehealth.

Document in medical record that the services were "provided via audio/video telehealth" and that there is a "need for, effectiveness, and appropriateness of the telehealth medium"

If audio only (phone), document that patient is unable to achieve video

Fraud, Abuse, Diversion

- IDENTITY VERIFICATION
- Document
- High profile investigations-fraud was by the provider and not due to the modality of telehealth
- Not yet published: no increase in diversion of controlled substances via TH vs in-person

Child's drawing of the "TV doctor"

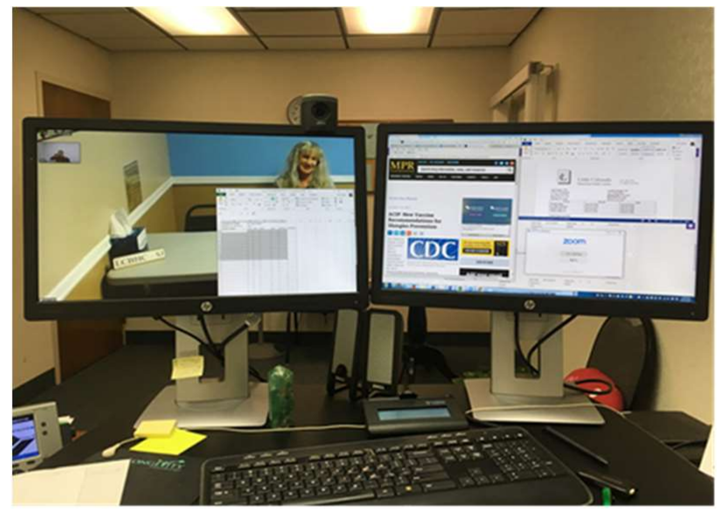
Provider Type, Patient Location

Defined by Federal (CMS), State, Payor, Licensure

Patient Location is Broadening:

- Outpatient
- Inpatient (subsequent care)
- Nursing Homes
- Prison
- Legal (T36/commitment evaluations, testimony)
- Schools
- Public libraries
- Chapter Houses

Consistent Providers for Frequent Moves



Vulnerable populations who are frequently moved:

- Children (eg DCS custody foster placements)
- Residential treatment facilities, group homes

New Client Location: HOME

- Pandemic, disaster response= rapid evolution to an
- IN HOME REVOLUTION!
- Brings mental health care directly into people's homes
- New in-home standards and guidelines

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Telehealth In-Home Standards and Guidelines

- **The standard of care via telehealth is the same as it is in person**
- You **can** establish a provider-patient relationship via telehealth
- You must have proof of identity (POI). Staff or Clinic can verify.
  - Previous contact counts as POI
  - Patients can show a picture ID
  - Providers can show their name badge
  - If the session is audio, patient can verify their date of birth
  - Biometrics for telehealth POI are newly available
- Patient attests to privacy
  - Ask the patient if they are in a private, safe space to conduct the session
- Provider **MUST** know the location of the patient during the session ICE (In Case of Emergency)

  Having the patient's medical record available is a telehealth standard of care, and will include the patient address ICE

Accessing Emergency Services

911 will not work remotely!

Clinicians **MUST** know what the emergency services are available for the patient.

- Call E911 267-908-6605 and ask to be connected to the emergency services for the location of the emergency
- Behavioral Health Crisis Line- 877-756-4090
- Have the patient identify a support person to be contacted ICE (In Case of Emergency)
- Know if there is a firearm in the home
- Have a safety plan in place (who to call, what to do)

- Initially hesitant, patients are generally appreciative of in-home care, and when video is successful, there is much excitement.
- Some members actively avoid video and there is a sense that they do not want their privacy invaded or home seen.
- Find a Kind Human to help people navigate technology.
- Providers report greater insight into their members' lives when "visiting" but must find a way to obtain medically necessary vitals, drug screens, labs

Technological Barriers in the Home: "The Digital Divide"

Patients may not have access to equipment (phone with video, tablet or computer) or internet (none or slow) or knowledge (how to use the technology).

Ideas:

- Have a staff member meet with the patient ahead of time, virtually, to demonstrate how to connect
- Provide a tablet or phone with data
- Direct to Connect AZ for assistance with digital literacy
- Federal programs: LifeLine, the Broadband Connectivity Fund

Increased Access to Care with Audio-only?

Audio-only telehealth services continue to be evaluated by Federal and State regulators, including AHCCCS and CMS, with particular interest in the following areas:

- Quality and efficacy of care
- Cost of care
- Access to care

We continue to see members that would either be **unable** or **unwilling** to access care in person or via video…who will seek out care when given an audio only option.

The "Digital Divide" is a technologic (internet, equipment, knowledge) barrier to visual tech, and rural remote locations are difficult for patients to access in-person care.

Healthcare is CARE

CONNECTION

Lacking social connection=15 cigarettes/day
Mental Health, Opioid epidemics

PHYSICAL DISTANCING

+

TELEHEALTH

=

SOCIAL CONNECTION

Provider-Patient Relationship

- Must be established for any medical service
- Arizona statute states: establishment of a Provider-Patient relationship IS achieved via interactive video-audio.

Make Tech Invisible!

- There is evidence that patients quickly adapt and establish rapport with their teleprovider.
- Minimize technological interface to improve rapport
  - ***High quality technology***
  - User-friendly
  - Zoom to life-size
  - Use solid blue background (affect recognition)
  - Eye contact - camera angle or alternate gaze
  - Live, interactive
  - Avoid picture-in-picture at patient end
  - Another human present at clinical site

Therapeutic Alliance

Provider-Patient Relationship + Good Rapport =

Therapeutic working alliance= Improves patient outcomes.

Tele-Therapy (Virtual Psychotherapy) WORKS! (even audio-only)

Evidence-based efficacy

Improves treatment access disparities in vulnerable populations

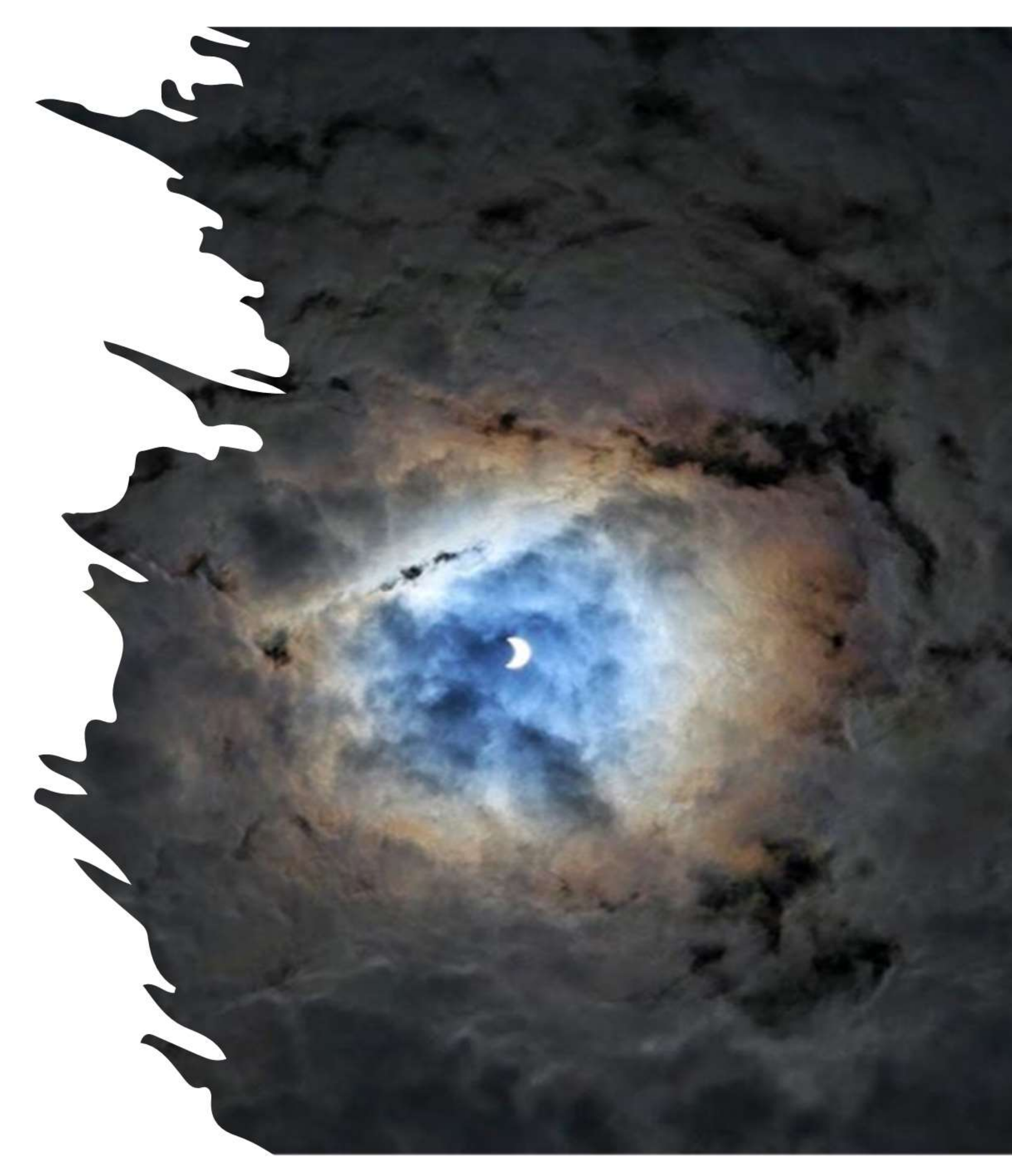
- Dennis CL, Grigoriadis S, Zupancic J, et al. Telephone-based nurse-delivered interpersonal psychotherapy for postpartum (IPT) depression: Br J Psychiatry. 2020 Apr;216(4):189-196. doi: 10.1192/bjp.2019.275
  - At 12 weeks, 10.6% of women in the IPT group and 35% in the control group remained depressed with the IPT group 4.5 times less likely to be clinically depressed
  - Nurse-delivered telephone IPT is an effective treatment for diverse urban and rural women with postpartum depression and anxiety that can improve treatment access disparities.

Virtual Psychotherapy= Decreased Therapy Disruptions

- US adults with psychiatric illness experienced fewer disruptions in receiving psychotherapy following the transition to virtual psychiatric care that accompanied the onset of the COVID-19 pandemic. NIMH study of 110,000 persons with mental health disorders receiving therapy.
- Prior to the pandemic, the median time between visits was 27 days and after the pandemic it dropped to 14 days, suggesting individuals were more likely to return for additional psychotherapy after the widespread shift to virtual care.
  - 10/11/23 Psychiatric Services

Patient Dynamics by Diagnosis

- PSYCHODYNAMIC ADVANTAGE!
- Basic Principle: Distance increases sense of safety, decreases olfactory flooding, prevents touch
    - Social anxiety
    - Agoraphobia
    - PTSD
    - Other anxiety (panic)
    - Psychosis



- Data from www.azdhs.gov/opioid/

WHY MAT/MOUD? OVERDOSE!! DEATH!!

- Arizona 2024 final stats:
  - 4,029 Verified non-fatal opioid overdose events
  - 1,485 Opioid deaths
  - Heroin 2.2%
  - Rx/synthetic 97.8%
  - Polydrug 88.8%

Waves of Opioid Overdose Deaths

- The 107,000 number of overdose deaths in the United States in 2021 was more than six times that in 1999, and 75% involved opioids
- “Third wave" of increasing opioid overdose deaths fueled by the increase of synthetic opioids in the drug supply. The third wave started in 2013 with the rise in use of fentanyl and tramadol.

- “Fourth Wave”…2023. Increased methamphetamine and cocaine among people who use fentanyl. Half the fentanyl + contained 3+, Xylazine was in 14% of fentanyl + specimens. Also increased smoking>injection.

Top five drugs listed for AZ annual threat assessment

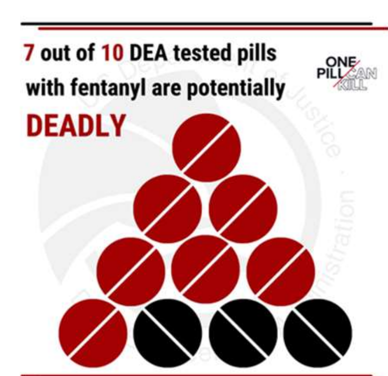
- Fentanyl
- Methamphetamine
- Cocaine
- Heroin
- Marijuana

Randy Moffitt, Drug Intelligence Officer, presented 02/05/2024

Public Safety Alert

Laboratory testing indicates 7 out of every 10 pills seized by DEA contain a lethal dose of fentanyl.

DEA has seized a record 74.5 million fentanyl pills to date in 2023, which already exceeds last year's totals of 58 million pills.



Multi-colored fentanyl pills. 95% of overdose deaths in AZ children 17 and under caused by fentanyl poisoning.

Telehealth is an Evidence Based Practice for SUD Treatment (Quality of Care)

- Best outcomes when RETAINED IN TREATMENT.
  - **Study 92,000 adults: Telehealth Linked to Better Opioid Treatment Retention**
    Starting treatment with buprenorphine for opioid use disorder (OUD) via telehealth is associated with longer retention in treatment compared with starting treatment in-person. JAMA Network Open, 10/18/23
  - **Retention in Telehealth Treatment for Opioid Use Disorder Among Rural Populations: A Retrospective Cohort Study.** 1,816 rural patients across 14 states attended an initial telemedicine visit and received a clinical diagnosis of OUD. ***Conclusions:*** Telemedicine is an effective approach for treating OUD in rural populations, with retention comparable to in-person treatment. Telemedicine and e-Health 15May 2023
  - **Increased Use of Telehealth Services and Medications for Opioid Use Disorder During the COVID-19 Pandemic Associated with Reduced Risk for Fatal Overdose** (33% lower with telehealth). Nationwide CDC, CMS, and NIH. JAMA Psychiatry
- Tipsheet: treating Opioid Use Disorder via TH: In home Induction TH
  https://custom.cvent.com/10D3BAE39269457884C1D96DE1DF8D8D/files/c0f35116b188481b80df828b226e90c1.docx

MAT Definitions, SAMHSA

MAT=Medication-Assisted Treatment

- Medication-assisted treatment (MAT) is the use of medications with counseling and behavioral therapies to provide a "whole-patient" approach to the treatment of substance use disorders.
- Medications used are approved by the FDA and are clinically driven and tailored to meet each patient's needs.

MOUD=Medications for Opioid Use Disorder

MAUD=Medications for Alcohol Use Disorder

OUD=Opioid Use Disorder

- Misuse of
  - pharmaceutical opioids,
  - heroin,
  - other opioids such as fentanyl and its analogues.
- OUD is typically a chronic, relapsing illness, associated with significantly increased rates of morbidity and mortality.
- MOUD (Medication for OUD) is first-line treatment for most patients with an OUD.
- OUD is CHRONIC so treat INDEFINITELY, unless patient requests

Why MOUD? Improved outcomes.

PROVEN EFFICACY FOR OUD TREATMENT:

- TREATMENT RETENTION

  People on medication stay in treatment longer.

- HARM REDUCTION

WHY TELEHEALTH?
CDC 6/27/24: Only ¼ of Americans who needed MOUD in 2022 got meds

- US Centers for Disease Control and Prevention 6/27/24 in CDC's "Morbidity and Mortality Weekly Report"
- 2022 National Survey on Drug Use and Health….56,610 adults

  3.7% of 9.3 million American adults needed OUD treatment (met criteria for OUD DSM-V)

- TREATMENT DISPARITIES

  Non-Hispanic White adults and men received MOUD more frequently 60%

  Black 44% and Hispanic 46% individuals less likely to receive medication.

  Women 40% vs Men 51%

  MOUD recipients more likely to be employed, have arrest hx, MJ and other drugs and stimulants, and aged 35-49

Those most in need of treatment did not attend college, were unemployed, had ever been arrested and booked, had any mental illness, used illicit drugs other than opioids, or misused stimulants or opioids.

Why Telehealth? Medical Treatment of Opioid Use Disorders Falls Short

Availability of Medications for Opioid Use Disorder in Community Mental Health Facilities, JAMA June 18, 2024 Cantor, Griffin, Levitan et al, *JAMA Netw Open.* 2024;7(6):e2417545. doi:10.1001/jamanetworkopen.2024.17545

Cross-sectional study of 450 community outpatient mental health treatment facilities in 20 states (incl AZ), 34% of clinics offered MOUD.

Despite high rates of opioid use disorder among people with co-occurring mental health disorders, only a third of community outpatient mental health treatment facilities in high-need states offer MOUD, indicating the need for improved scaling efforts.

SAMHSA/HHS Final Rule 2/2/24 on Regulations for Opioid Treatment: Barriers Reduced

Medications for the Treatment of Opioid Use Disorder 42CFR Part 8 Final Rule

Removes unnecessary barriers to medication access by focusing on individual patient needs and adds protections for vulnerable groups.

- -Eliminates the 1-year opioid addiction history requirement
- -Promotes priority treatment for pregnant individuals.
- -Removes the requirement for two documented instances of unsuccessful treatment for people under age 18.
- - Allows consent to be obtained electronically.
- -Medication access is no longer contingent on receipt of counseling.

Of note, the term medication assisted treatment (MAT) has been updated to medications for opioid use disorder (MOUD), and the term treatment program has been changed to opioid treatment program throughout the final rule. Pursuant to proposed changes set forth in the SNPRM entitled `Medications for the Treatment of Opioid Use Disorder:

Existing definitions updated include: comprehensive treatment; medication for opioid use disorder; and practitioner. The term detoxification treatment is removed and replaced with withdrawal management.

Medication First

Modeled after Housing First, a homeless assistance program

1. Get persons with opioid use disorder onto MAT (meds) quickly

Persons with OUD should receive medical stabilization [=meds] prior to undergoing lengthy assessment processes or psychosocial interventions.

2. THEN provide voluntary supportive services as needed

Individualized psychosocial treatment should be offered to patients but not required as a condition of medical treatment.

3. Continue meds as long as they are helping.

Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits.

Why Telehealth? Buprenorphine Induction UNOBSERVED

- **Office-based induction:** Observed all day in office
- **Home-based induction:** Community Standard Care

- ASAM's National Practice Guideline Committee Consensus opinion supported the use of home-based induction (Kampman 2015). Good studies back to 2009=safe.
- Opiate Withdrawal is NOT dangerous to adults
- Biggest risk is precipitated withdrawal. Confirming of baseline withdrawal symptoms is the most difficult aspect of unobserved/home induction: Patient must be already in withdrawal before their first dose.
- Provide education on induction protocol
- Give prescription for initiation of buprenorphine, unobserved, at home

Telehealth Improves Outcomes

- Competence
  - Be a proud professional, in a community of practice
- Connection, Trust
  - Tech as a healing modality, strengthens and supports.
  - Chronic diseases require a relationship.
  - Connection, Kindness, and Warmth proven to improve medical outcomes and "Healthspan" (over lifespan)
  - Integrate medical with ancillary therapies (care and case management).

Systems and Models: Tele-Education

- Medical education (1987 Minnesota Medical School)
- Project Echo Tele-mentoring BCBSAz-HC:
  - ✓ Substance Use Disorder
  - ✓ Trauma in Children
  - ✓ Social Determinates of Health

Policies, Legislation, Federal

- **DEA**: extended the PHE flexibilities around prescribing controlled substances to 12/31/25 without requiring an in-person exam.
- **CMS**: PHE Flexibilities expire 3/31/25 but the new 2025 Physicians Fee Schedule does have more telehealth allowable services than pre-pandemic.
- SAMSHA's 42 CFR Part 8 Final Rule states allows for **OTPs (Opioid Treatment Programs)** to initiate buprenorphine via telehealth, both audio-visual, and audio only modalities

DEA: Controlled Substance Prescribing Jan 2025 published in Federal Registrar (only impacts if no prior in-person medical eval)

Final Rule – Expansion of Buprenorphine Treatment via Telemedicine Encounter

OK for Telemedicine prescribing of buprenorphine when an in-person visit has not been conducted. Must meet these conditions:

Prescription Drug Monitoring Program PDMP Reviewed for the patient prior
Initial Prescription Limitation of 6 months supply, additional requires in-person
Pharmacist Identity Verification of patient before filling prescriptions.

Final Rule – Continuity of Care via Telemedicine for Veterans Affairs Patients

OK provided another VA practitioner has conducted an in-person eval at any time. Must review VA EHR and the State PDMP

IN-PERSON VISIT REQUIREMENTS CONTINUE TO BE WAIVED THROUGH 12/31/25

DEA Proposed Telehealth Prescribing Rule
!!Comment until 3/18/25, burdensome!!

Special Telehealth Registration 3 Categories

- Telemedicine Prescribing Registration
- Advanced Telemedicine Prescribing Registration
- Telemedicine Platform Registration

Must have a DEA registration in each state they intend to prescribe in

Audio only rule

Practitioners would be permitted to prescribe Schedule III-V controlled substances approved by the U.S. Food & Drug Administration to treat opioid use disorder via telemedicine (currently limited to buprenorphine) through an audio-only visit. Audio-only visits would only be permitted if the practitioner has the capability to use audio-video, but the patient is either unable to use video or does not consent to it. However, unlike the final buprenorphine rule, treatment would need to be initiated through an audio-video visit, and the practitioner would need to have conducted at least one medical exam of the patient via audio-video. Prescriptions not meeting the criteria described above would only be able to be issued through an audio-video visit.

Schedule II Controlled Substances only if located in same state and must be less than 50% of total Schedule II prescriptions

Must check PDMP for the last year for the state the patient is in, the provider is in, any U.S jurisdiction with PDMP reciprocity agreements with either of the states above

Proposed Rule
Related Article

Submit Comments

CMS Medicare

Contact congressional representatives and participate in coalitions advocating for a telehealth extension before March 31.

- **CMS**: PHE Flexibilities expire 3/31/25. Exception: The CMS PFS-based policies specific to FQHCs/RHCs that have an end date of December 31, 2025.

- The ARA (American Relief Act 2025) extended the following items until 3/31, 2025

- Geographic restrictions and originating sites like the patient's home
- Eligible practitioners including therapists, physical therapists speech language pathologists and audiologists
- Audio only telehealth services
- Extended telehealth services for FQHCs and RHCs
- Delayed in person requirements for mental health services
- Acute Hospital Care at Homes
- Telehealth flexibility allowing the home or temporary residence of an individual to serve as an originating site
- Telehealth Flexibility allowing a hospital to use remote clinician services in combination with in-home nursing services to provide inpatient level care in patient's home
- Resource

CMS Medicare

Contact congressional representatives and participate in coalitions advocating for a telehealth extension before March 31.

- CMS (Medicare) Without Congressional action, key Medicare telehealth flexibilities will expire on March 31, 2025, and Medicare telehealth reimbursement policies will revert to pre-pandemic standards. (geographic restrictions, home services) (reinstating geographic and originating site restrictions). [Continuing Resolution set to expire March 14, 2025 which is 1.funding the federal government and 2.extending telemedicine flexibilities].

- Non-rural hospitals
- Originating site from hospital or clinic, in-person or unpaid virtual care
- Behavioral health (mental health or substance use treatment) TH services require in-person visit within 6 months.
- Urban areas lose Medicare telehealth access entirely
- Rural patients must travel to an originating site (no in-home)

AHCCCS (Arizona State Medicaid) Coding 2025

- AHCCCS has removed E/M codes 99201-99215 and replaced them with 98000-98015 which includes the type of technology used in the session description, no modifier GT or FQ is needed
- Virtual Check in code 98016 has been added “Brief communication technology-based service (eg, virtual check-in)” no GT, GQ, or FQ modifier needed
- 98966-98968 codes added for a telephone assessment related to services provided within the previous 7 days and uses the FQ modifier;
  - [ended 99441-99442 Telephone Medical Discussion with Physician]

Audio-only telehealth services continue to be evaluated by Federal and State regulators, including AHCCCS and CMS, with particular interest in the following areas:

- Quality and efficacy of care
- Cost of care
- Access to care

We continue to see members that would either be **unable** or **unwilling** to access care in person or via video will seek out care when given an audio only option. The "Digital Divide" is a technologic (internet, equipment, knowledge) barrier to visual tech, and rural remote locations are difficult for patients to access in-person care.

AHCCCS Telehealth Service Page

Innovate!! Create!! Connect!!

WE ARE JUST BEGINNING!

Great example: school bus technology center on the Navajo Nation for kids to attend school in their car during COVID-19.

What Can We Do to Help?

- Enhance regulatory support
- Mitigate fraud, abuse, IDENTITY VERIFICATION
- Improve our care quality

Technology needs to support healing rather than being a distraction.

- Development of "community of practice" and mentorship enhanced with technology
- Integrate care, clinically integrated networks, care management, enhance ancillary services.
- Telehealth is a "Home visit, house call" =Diversion from urgent care and ED
- Outreach to patients have not seen a PCP and offer in-home immediate telehealth.

Competence

&

Connection

=EXTRAORDINARY PATIENT OUTCOMES

=SATISFIED CLINICIANS

Guidelines

“Best Practices in Videoconferencing-Based Telemental Health” The American Telemedicine Association (ATA) and The American Psychiatric Association (APA) guideline update on the development, implementation, administration, and provision of telemental health services. TELEMEDICINE and e-HEALTH, 2018 Nov;24(11):827-832. doi: 10.1089/tmj.2018.0237. Epub 2018 Oct24

Patient Resource, US Dept Health and Human Svs, 2023:
HHS Office for Civil Rights Issues Resources for Health Care Providers and Patients to Help Educate Patients about Telehealth and the Privacy and Security of Protected Health Information | HHS.gov

SAMSHA:Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.
https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf

Guidelines

American Telemedicine Association (ATA)

American Association of Child & Adolescent Psychiatry (AACAP) Practice Parameter for Telepsychiatry with Children and Adolescents

Emergency Guidelines for Telepsychiatry: Shore, JH, Hilty, DM, Yellowlees, P; General Hospital Psychiatry, 2007:29, 199-206

American Psychiatric Association

Resources

- Telehealth Resource Centers http://www.telehealthresourcecenter.org/
- Southwest Telehealth Resource Center
  - https://southwesttrc.org/
- CTEL Center for Telehealth and e-Health Law
  - http://ctel.org/
- Center for Connected Health Policy
  - https://www.cchpca.org/
- Centers for Medicare & Medicaid Services: www.cms.hhs.gov
- Arizona AHCCCS Coding Policy and Allowable codes https://azahcccs.gov/PlansProviders/MedicalCodingResources.html

Resources from Southwest Telehealth Resource Center

- Consortium of Telehealth Resource Centers: https://telehealthresourcecenter.org/
- TTAC (National Technology Center): https://telehealthtechnology.org/
- Southwest Telehealth Resource Center: https://southwesttrc.org/
- Arizona Telemedicine Program: https://telemedicine.arizona.edu/
- Service Provider Directory: https://telemedicine.arizona.edu/servicedirectory
- Previous Webinars: https://telemedicine.arizona.edu/webinars/previous
- The Telehealth Ten: A Guide for a Patient-Assisted Virtual Physical Exam: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7368154/
- Patient Experience Toolkit: https://rhntc.org/resources/patient-experience-improvement-toolkit