Use of Telepsychiatry to Improve Access to Care for Rural Populations

State Considerations for Incorporating Telepsychiatry into Behavioral Health and Primary Care Integrated Systems

Presented by ASTHO as part of a HRSA funded project under grant number UD3OA22890 National Organizations for State and Local Officials.

Participant call-in number: 888-504-7949; Required conference ID: 444209
Objectives

• Learn about how telepsychiatry has been used to enhance access to care for rural and underserved communities.
• Describe two state telepsychiatry programs and lessons learned from those activities.
• Share resources on telepsychiatry and telehealth programs from HRSA and other partners.
Speakers

Dr. Jonathan Neufeld, Program Director, Great Plains Telehealth Resource & Assistance Center

Dr. Anna Ratzliff, Associate Professor, Department of Psychiatry & Behavioral Sciences, University of Washington

Brian Cooper, Telepsychiatry & Rural Hospital Specialist, Office of Rural Health, Rural Hospitals, North Carolina Department of Health and Human Services
Statewide Telepsychiatry Programs: Regulatory, Programmatic, and Technical Considerations

Jonathan Neufeld, PhD
Great Plains Telehealth Resource and Assistance Center

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number G22RH30357-01-00 under the Telehealth Resource Center Grant Program for $325,000. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
Outline

• About gpTRAC
• Regulatory Environment
• Reimbursement/Sustainability Environment & Considerations
• Services: Needs, Availability, and Structure
• Procedures and Operations
• Technology
• Examples
• Questions
About gpTRAC and the National Consortium

The National Consortium of Telehealth Resource Centers includes 12 regional centers along with 2 topical centers focused on Policy and Technology.

These Centers provide training, technical assistance, consultation, and a range of written and print resources to assist programs in developing, expanding, or improving telehealth programs of all kinds.

They can be reached at www.telehealthresourcecenters.org.
Four Domains of Telehealth

• Hospital & Specialty Care
  • Specialists see and manage patients remotely

• Integrated Primary Care
  • Specialists (often MH) integrate services into primary care environment

• Monitoring for Transitions and Maintenance
  • Patients access care (or Care accesses patients) at opportune times to maintain best function in least restrictive, least expensive, or most preferred environment

• Direct to Consumer Primary/Urgent Care
  • Popular among younger, busier, and healthier patients
Prerequisite 1 - Conceptual Framework

TELEMEDICINE IS A DELIVERY MECHANISM, NOT A SERVICE

• Providers may need skills or training, but no new certification or credentials
• All regulations regarding healthcare services apply equally to telehealth

ANALOGY

• Providing services in sunlight vs artificial light
• All skills the same, but some things look or feel different, adjustment needed
• Two additional considerations:
  • Competence with equipment
  • Handling emergencies
Prerequisite 2 - The Regulatory Environment

FEDERAL REGULATIONS

- Prescribing Controlled Substances (Ryan Haight Act)
  - In person visit required before prescribing controlled substances (or use consultation)
  - Telemedicine exemption (undefined)
- Medicare (reimbursement)

STATE REGULATIONS

- Provider Licensing Boards (many are silent regarding telehealth)
- Medicaid (reimbursement)
- Commercial payer regulations (reimbursement)
Prerequisite 3 - Regulatory Conventions

Definition of Telemedicine (most common)

- Telemedicine has almost always been defined as “live interactive video”
- Asynchronous (“store and forward”) telemedicine is generally regulated and covered as a separate service (only covered in a few states/plans)
- Telephone, fax, and email are (almost always) excluded

Expanded Applications of Telecommunications in Healthcare (rapid changes)

- Population health - not every service is a “billable encounter”
- Simple, low-cost options are ubiquitous - telephone, text messages, IVR, etc.
- Direct services vs “Force multipliers” (provider consultations, ECHO, etc.)
# State Payer-Services Matrix (example)

<table>
<thead>
<tr>
<th>Payer</th>
<th>Providers</th>
<th>Services</th>
<th>Other Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>MD/DO</td>
<td>Consult (G040x,G042x)</td>
<td>CCM (9949x)</td>
</tr>
<tr>
<td></td>
<td>PA/APN</td>
<td>E&amp;M (9921x)</td>
<td>Intro/Annual (9949x)</td>
</tr>
<tr>
<td></td>
<td>Psychologists</td>
<td>Psych Evals (9079x)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Workers</td>
<td>Psychotherapy (9084x)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dietitians</td>
<td>Nutrition Therapy (9079x)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening &amp; Education</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>Any Credentialed</td>
<td>Any covered service</td>
<td>Store/Fwd, Remote Monitoring</td>
</tr>
<tr>
<td>Commercial</td>
<td>Any Credentialed</td>
<td>Any covered service</td>
<td>As Medicare; Contracts</td>
</tr>
</tbody>
</table>


Setting Up a Telehealth Service

FOUR COMPONENTS

• Services (Defining, Finding, Developing, Structuring)
• Reimbursement & Sustainability
• Policies & Procedures
• Technology
Services - Need, Availability, and Structure

“Getting the services you want in a format you can use.”

- Formal Needs Assessments
- Informal Assessments

Main Challenge - Reimbursement/Sustainability:

- Who owns the billing (remote vs on site)?
- No-shows are very often a major challenge
- Most programs experience under-utilization in first months/years
Operations, Procedures, and Readiness

Clinical Flow

- Procedures vary widely and are based on program needs and current practice.

Best Practice: Integrate telehealth services into normal clinic procedures as much as possible.

- Check-in, insurance auth/check
- Rooming the patient and vitals
- Introduction to provider
- Nurse/MA provides support as needed, either in room or by phone

Best Practice: Open the video link and keep it open throughout the day/clinic; mute camera and microphone as necessary.
Operations, Procedures, and Readiness

Documentation

• Evidence of Informed Consent

• Standard medical record of encounter

  Provider notes in same chart

  -OR-

  Referral/Consult notes as for other consults

• Additional items

  • Start/stop time

  • Provider’s location or other special procedures per policy

  • Coordination with primary provider
Operations, Procedures, and Readiness

Integration

Best Practice:

- Telemedicine providers are integrated into the on-site medical staff
- Both treatment and records are integrated as much as possible
- Some payers require coordination/reporting to PCP (always a good idea)

Example: “Mini-huddles” at the beginning of telemedicine clinics to review scheduled patients and status, and relay messages between local providers and remote specialists regarding updates in the care process and goals.
Operations, Procedures, and Readiness

Policies

• Rely on “usual” policies as much as possible
• Add/modify: Informed Consent (requirements vary by state)
• Add: Staff training commensurate with role
• Add: Screening procedures, selection of appropriate cases
• Add: Emergency procedures - returning care to local control when necessary
Technology

- Network or Partner Requirements
- Use Cases and Form Factors Needed
- Video Architecture
- Peripherals
First rule of video:

HIGH QUALITY BANDWIDTH!

• Minimum bandwidth: 1-3 Mbps (same as a good Netflix experience)

• Realistic approach: Test and upgrade as needed
Technology

Network or Partner Requirements

• Platform or Technology they require or support

• Support Services/Help Desk
Technology

Use Cases and Form Factors Needed

• Everything is possible from phones to multi-monitor conference room systems
Technology

“Families” of Video Architectures:

Appliances

• Standard (interoperable) video formats (H.323)
• Limited form factors (rooms, desktops, or carts - NOT phones or tablets)
• Operated via a remote control
• Generally more expensive (both hardware and support)

Software Systems (run on any hardware or form factor)

• Computer or mobile operating system (Windows, Mac, Android)
• Proprietary video with standard (interoperable) add-on services
  • Proprietary video is often better quality, but only connects with itself
Technology

Peripherals

- Otolaryngoscope and Stethoscope are most common
Clinical Processes Should Drive Design
Summary

• Regulatory considerations are important, but not overly restrictive.
• State policies affect local reimbursement and may vary.
• A plan that details services and sustainability is critical.
• Procedures should mirror “usual” processes, with some important additions.
• Partners/programs/service providers can help make technology decisions that meet current needs and support future possibilities.
• gpTRAC and the Telehealth Resource Centers can provide objective information, peer contacts, and individualized consultation.
Contact Information

Jonathan Neufeld, PhD

jneufeld@umn.edu

(574) 606-5038

http://gptrac.org

http://telehealthresourcecenters.org
Washington State: Mental Health Integration Program

Anna Ratzliff, MD, PhD
Associate Professor
Depression Therapy Research Endowed Professorship
Associate Director for Education, AIMS Center
Director, UW Integrated Care Training Program
MHIP Co-Occurring Diagnoses

Disease Conditions
- Chronic Physical: 71%
- Mental Illness: 66%
- Substance Abuse: 38%

72 percent had substance abuse or mental illness identified
15 percent had a chronic physical condition only

Co-occurring diagnosis among DL-U clients

- Mental Illness
- Chronic Physical Condition
- Alcohol/Drug Problem

SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2006-07. Chronic physical and mental illness diagnosis groups derived from CDPS grouper. Mental illness also indicated by receipt of mental health medications.
The Challenge:
Mental Health Improvement Program (MHIP)

- Funded by State of Washington and Public Health Seattle & King County (PHSKC)
- Administered by Community Health Plan of Washington and PHSKC in partnership with the University of Washington AIMS Center (http://aims.uw.edu/)

2008
Pilot initiated in King & Pierce Counties

2009
Expanded state-wide to over 100 CHCs and 30 CMHCs
Collaborative Care Model (CoCM)

- Primary care patient-centered team-based care
- Registry to track population
- Systematic case review with psychiatric consultant (focus on patients not improved)
- Active treatment with evidence-based approaches
- Validated outcome measures tracked over time

Slide used with permission from AIMS Center
Strong Evidence Base for CoCM

- Now over 80 Randomized Controlled Trials (RCTs)
  - Meta analysis of Collaborative Care (CC) for depression in primary care (US and Europe)
  - Consistently more effective than usual care

- Since 2006, several additional RCTs in new populations and for other common mental disorders
  - Including anxiety disorders, PTSD
  - Emerging evidence for ADHD, alcohol and substance use disorders
**Population Based Care - Using Registry**

### Caseload Overview

<table>
<thead>
<tr>
<th>View</th>
<th>Treatment Status</th>
<th>Name</th>
<th>Date of Initial Assessment</th>
<th>Date of Most Recent Contact</th>
<th>Number of Follow-up Contacts</th>
<th>Weeks In Treatment</th>
<th>Initial PHQ-9 Score</th>
<th>Last Available PHQ-9 Score</th>
<th>% Change in PHQ-9 Score</th>
<th>Date of Last PHQ-9 Score</th>
<th>Initial GAD-7 Score</th>
<th>Last Available GAD-7 Score</th>
<th>% Change in GAD-7 Score</th>
<th>Date of Last GAD-7 Score</th>
<th>Psychiatric Consultation</th>
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<tbody>
<tr>
<td>Year</td>
<td>Active</td>
<td>Susan Test</td>
<td>9/5/2015</td>
<td>2/23/2016</td>
<td>10</td>
<td>26</td>
<td>22</td>
<td>14</td>
<td>-36%</td>
<td>2/13/2016</td>
<td>18</td>
<td>17</td>
<td>-6%</td>
<td>?</td>
<td>Flag for极端 &amp; safety risk</td>
</tr>
<tr>
<td>Year</td>
<td>Active</td>
<td>Albert Smith</td>
<td>8/13/2015</td>
<td>12/2/2015</td>
<td>7</td>
<td>29</td>
<td>18</td>
<td>17</td>
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<td>?</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>?</td>
<td>Flag for极端</td>
</tr>
<tr>
<td>Year</td>
<td>Active</td>
<td>Joe Smith</td>
<td>11/30/2015</td>
<td>2/28/2016</td>
<td>6</td>
<td>14</td>
<td>14</td>
<td>10</td>
<td>-29%</td>
<td>2/28/2016</td>
<td>10</td>
<td>6</td>
<td>-40%</td>
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<tr>
<td>Year</td>
<td>Active</td>
<td>Bob Dolittle</td>
<td>1/5/2016</td>
<td>3/1/2016</td>
<td>3</td>
<td>9</td>
<td>21</td>
<td>19</td>
<td>-10%</td>
<td>3/1/2016</td>
<td>12</td>
<td>10</td>
<td>-17%</td>
<td>3/1/2016</td>
<td>Flag for极端</td>
</tr>
</tbody>
</table>

**FREE UW AIMS Excel® Registry** ([https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data](https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data))
# Measurement-Based Treatment-to-Target

<table>
<thead>
<tr>
<th>DATE OF CONTACT</th>
<th>CONTACT TYPE</th>
<th>WEEKS IN Tx</th>
<th>VISIT TYPE</th>
<th>PHQ-9</th>
<th>GAD-7</th>
<th>BIPOLAR SCREEN</th>
<th>PTSD SCREEN</th>
<th>CURRENT MEDICATIONS</th>
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</thead>
<tbody>
<tr>
<td>1/19/2016</td>
<td>Clinical Assessment</td>
<td>0</td>
<td>Clinic</td>
<td>15</td>
<td>13</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>1/29/2016</td>
<td>Psychiatric Consultation Note</td>
<td>1</td>
<td>Phone w/ CC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/2/2016</td>
<td>Follow Up Contact</td>
<td>2</td>
<td>Clinic</td>
<td>12</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/5/2016</td>
<td>Follow Up Contact</td>
<td>2</td>
<td>Phone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/10/2016</td>
<td>Psychiatric Consultation Note</td>
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<td>Phone w/ CC</td>
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<td></td>
</tr>
<tr>
<td>2/10/2016</td>
<td>Psychiatric Consultation Note</td>
<td>3</td>
<td>Phone w/ CC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/23/2016</td>
<td>Follow Up Contact</td>
<td>5</td>
<td>Clinic</td>
<td>17</td>
<td>13</td>
<td></td>
<td></td>
<td>Fluoxetine HCl (Prozac) 10mg</td>
</tr>
<tr>
<td>3/9/2016</td>
<td>Follow Up Contact</td>
<td>7</td>
<td>Clinic</td>
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<td>11</td>
<td></td>
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<td>Fluoxetine HCl (Prozac) 20mg</td>
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<tr>
<td>3/18/2016</td>
<td>Follow Up Contact</td>
<td>8</td>
<td>Phone</td>
<td></td>
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<td></td>
<td>↑Fluoxetine HCl (Prozac) 20mg</td>
</tr>
<tr>
<td>4/26/2016</td>
<td>Follow Up Contact</td>
<td>14</td>
<td>Clinic</td>
<td>4</td>
<td>6</td>
<td></td>
<td></td>
<td>↑Fluoxetine HCl (Prozac) 20mg</td>
</tr>
</tbody>
</table>

## Collateral Contacts

<table>
<thead>
<tr>
<th>DATE OF CONTACT</th>
<th>NAME</th>
<th>ROLE</th>
<th>AGENCY</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No Records Found</td>
</tr>
</tbody>
</table>

## Patient Progress

![Graph showing patient progress over weeks in treatment. The graph compares PHQ-9 Depression Scale and GAD-7 Anxiety Scale scores.](image-url)
MHIP: Pay for Performance initiative
cuts median time to depression treatment response in half

Mental Health Integration Program (MHIP)
Since 2008: More than 50,000 clients served in > 150 primary care clinics

In 2016:
- Over 5,000 Psychiatric Consultations
- 92% of those were phone or tele communications
Solution: Leverage Scarce Psychiatric Over Population

Over Population ➔ Through a Team

Care Manager 1
50-80 patients

Psychiatric Consultant
8 hours

Care Manager 2
50-80 patients

Care Manager 3
50-80 patients

50-80 patients/caseload
~3 hrs psych/week/care manager
= a lot of patients getting care

Over Distance ➔ Through Telepsychiatry

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Rural Adaptation: Centralized Care Manger
Supporting Multiple Small Practices
2017: CoCM is Reimbursable!

Medicare Codes: G0205/G0206/G0207

1. Active treatment and care management using established protocols for an identified patient population;

2. Use of a **patient tracking tool** to promote regular, proactive **outcome monitoring** and treatment-to-target using validated and quantifiable clinical rating scales; and

3. Regular (typically weekly) systematic psychiatric caseload reviews and consultation by a psychiatric consultant, working in collaboration with the behavioral health care manager and primary care team. These primarily focus on patients who are new to the caseload or not showing expected clinical improvement.

→ Anticipate open to FQHC and RHC in 2018
Resources

• University of Washington AIMS Center
  http://aims.uw.edu/

• American Psychiatric Association

  Telepsychiatry Toolkit
  https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/telepsychiatry-toolkit-home

  Telepsychiatry Blog
  https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog

Collaborative Care Training – APA SAN TCPi
  https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care
Improving Behavioral Health Care in the ED: North Carolina Statewide Telepsychiatry Program (NC-STeP)

Brian P. Cooper, Jr., MHA
August 2017
First, I would like to acknowledge the funders of this program:

NCGA
North Carolina General Assembly

James B. Duke
THE DUKE ENDOWMENT
MISSION

- The North Carolina Office of Rural Health assists underserved communities and populations to develop innovative strategies for equal access, quality, and cost-effectiveness of health care for all.

PRINCIPALS

- Work with communities to meet the health needs of all residents.
- Seek to eliminate health disparities.
- Foster state and local partnerships with ownership vested in communities.
- Provide in-depth and ongoing technical assistance.
- Ensure clear and measurable accountability.
- Rural and Critical Access Hospitals (CAHs)
- Rural Health Centers
- Health Professional Shortage Area Designations
- Recruitment Services
- Community Health Grants
- Farmworker Health
- Medication Assistance
- Integrated Health Systems
- Telepsychiatry through NC-STeP
Most counties in North Carolina do not have a sufficient number of mental health professionals.
Background
External Environment in 2013

• Nationwide
  • Patients present to emergency departments with behavioral health crises and require an assessment from a trained individual.
  • However, many ED physicians do not have adequate training to conduct a proper assessment, so patients are boarded in the ED, awaiting transfer to an appropriate level of care (often another facility).
  • According to a 2008 nationwide survey of ED physicians, 79% reported that their ED boarded behavioral health patients.¹

• North Carolina
  • In North Carolina, patients placed under involuntary commitment (IVC) are taken to emergency departments for an assessment.
  • Due to lack of behavioral health professionals and inpatient psychiatric beds, hospitals reported an average length of stay (LOS) for IVC patients between 48 and 72 hours.

• Solutions
  • Among the various possible solutions, telepsychiatry arose after successful programs were initiated by the South Carolina Department of Mental Health (2010) and the Albemarle Hospital Foundation (2011).

Background
Telepsychiatry as a Solution

• The Albemarle Hospital Foundation’s telepsychiatry program, initiated in 2011, was successful in reducing the average LOS for IVC patients.

• The program used a hub-and-spoke model, connecting nine hospitals with one provider hub. This model was adopted for the statewide program.
A network of stakeholders came together to prepare a proposal to the state legislature:
- The North Carolina Hospital Association
- Large Health Systems
- Behavioral Health Local Management Entities
- American College of Emergency Physicians
- Etc… (an estimated 22 stakeholders in total)

Bipartisan support was emphasized

Program created in July 2013 under Session Law 2013-360

When the funding was granted, the legislature instructed ORH to prepare a plan to implement the statewide program. ORH continued to engage stakeholders in the creation of the initial implementation plan and in a quarterly advisory group.
Background
Program Inception

• July 2013 – NC General Assembly created the statewide initiative

• Partners
  • NC Office of Rural Health
  • East Carolina University Center for Telepsychiatry and e-Behavioral Health

• Funding – $2 million in recurring state appropriations
  • Additional one-time $1.5 million awarded by The Duke Endowment*

Program Funding as of June 30, 2017

*Funding reflects amounts budgeted, not amounts expended. The NC General Assembly has allocated a total of $8 million since the program began.
Program Challenges

• Broadband Availability
• Creation of the Web Portal/HIE
• Provider Credentialing
• Workforce Recruitment and Turnover
• Reimbursement/Sustainability (e.g. 31% Self-Pay)
• Spending Rates/Carryover
• Limited Program Scope
Program Outcomes  
Measuring the Impact

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Baseline (2013)</th>
<th>Target for 2017</th>
<th>Actual Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reports of Involuntary Commitments (IVCs) admitted to hospitals</td>
<td>147 per month</td>
<td>12,264</td>
<td>9,412</td>
</tr>
<tr>
<td>Number of IVCs Overturned</td>
<td>42 per month (28.6%)</td>
<td>3,160 (25.8%)</td>
<td>2,459 (26.1%)</td>
</tr>
<tr>
<td>Number of telepsychiatry assessments conducted</td>
<td>450 per month</td>
<td>33,950</td>
<td>25,372</td>
</tr>
<tr>
<td>Average LOS (in hours) for behavioral health patients</td>
<td>Between 48 and 72</td>
<td>Mean: 43</td>
<td>Mean: 53.2 Median: 29.8</td>
</tr>
</tbody>
</table>

- 2013 baseline values were reported by the Albemarle Hospital Program.
- The difference between the mean LOS (53.2 hours) and the median LOS (29.8 hours) is due to extreme outliers.
- Due to 2,459 overturned IVCs, NC-STeP estimates a cumulative cost savings of $13,278,600 to state psychiatric facilities
Lessons Learned/Discussion
If You Were to Duplicate This Program…

If you were to replicate this program in your state…

- Don’t depend too strongly on a single provider/person/champion
- Navigate the intricacies of public funding
  - Large capital expenses (IT system, equipment) often have delays in billing
  - State legislatures and private grantors like to avoid carryover
  - You’ll have to demonstrate your (a) self-sustainability or (b) cost savings
- Develop and fund the number of psychiatric beds your state actually needs
  - If possible, distribute beds across the state
  - New bed conversion program for rural hospitals in NC
- Work clinicians to the top of their licenses first before referring patients to a more expensive level of care (utilize LCSWs, LPCs, etc.)
  - Keep in mind workforce shortages. Look for programs to foster growth.
  - NC has expanded loan repayment to benefits to include telehealth
- Keep in mind the barriers that affect all forms of telehealth/telemedicine
  - Broadband infrastructure, provider credentialing, Medicaid reimbursement, payment parity across payers
It’s been a pleasure!

Brian P. Cooper, Jr., MHA
Telepsychiatry Specialist
NC Office of Rural Health
(919) 527-6494
brian.cooper@dhhs.nc.gov
http://www.ncdhhs.gov/divisions/orh
LinkedIn:
https://www.linkedin.com/in/bcooperjr
For additional information...

East Carolina University Center for Telepsychiatry and e-Behavioral Health:  
http://www.ecu.edu/cs-dhs/telepsychiatry/

North Carolina Office of Rural Health:  
http://www.ncdhhs.gov/divisions/orh
Q&A

If you have a question, you may type it into the chat box now or press the phone commands to have the operator unmute your line.
Resources

• Washington State’s Mental Health Integration Program: https://aims.uw.edu/washington-states-mental-health-integration-program-mhip
• North Carolina’s Statewide Telepsychiatry Program: https://www.ncdhhs.gov/statewide-telepsychiatry-program
Resources (Cont.)

• Telehealth Resource Centers: [http://www.telehealthresourcecenter.org/](http://www.telehealthresourcecenter.org/)
• SAMHSA-HRSA Center for Integrated Health Solutions: [http://www.integration.samhsa.gov/operations-administration/telebehavioral-health](http://www.integration.samhsa.gov/operations-administration/telebehavioral-health)
• ASTHO Telehealth Webinar: Lessons Learned from States Using Telehealth to Expand Access to Care for Rural and Underserved Communities: [http://www.astho.org/Programs/Health-Systems-Transformation/Webinars/](http://www.astho.org/Programs/Health-Systems-Transformation/Webinars/)
• American Psychiatry Association: [Telepsychiatry Toolkit](http://www.astho.org/Programs/Health-Systems-Transformation/Webinars/)
Thank you for joining us!

Please complete our webinar evaluation survey:
http://astho.az1.qualtrics.com/jfe/form/SV_7NyAvoR2

HWxHBs1

Visit ASTHO’s website for additional resources:
http://www.astho.org/Programs/Health-Systems-Transformation/

ASTHO contacts:
Megan Miller mmiller@astho.org
Emily Moore emoore@astho.org