

Behavioral Health Series

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Hello, everyone. Welcome to the webinar action steps on virtual care access, focus on behavioral health, brought to you by United States of care and wellbeing trust. I'm Jen de Yong, Senior Director at United States of care. I'll be your host for today. Before I introduce you to our panelists, I'd like to start by sharing a bit about United States of care and what brought us here. United States of care is a nonpartisan nonprofit organization, we work to ensure that everyone has access to quality, affordable health care, regardless of health status, social need or income. The health care system isn't working for millions of people in the United States, and our research shows that people want a better health care system in the wake of the pandemic. In fact, we believe there may be an opening for reforms that weren't possible before. We do our work in a unique way, we go around the country listening to people's needs and experiences to center health care reform efforts around those needs. And we're tackling these challenges on two tracks. First, we're working in states to expand access to quality affordable health care right now, because people can't wait for a perfect solution from Washington DC. We're also working to create the conditions for long term change. We know we need a new national conversation and new innovative solutions to build momentum to federal change that people can rely on and that won't be overturned at every election. And we do all our work in partnership with policymakers, advocates, leaders, entrepreneurs and everyday people. Over the past year and a half, we have seen the COVID 19 pandemic response unleash a revolutionary expansion in virtual care, whether it be telehealth remote monitoring, or other remote forms of communication. virtual care tools have been shiny and new to many. But at use of care, we're looking beyond the present to the potential it has for being a long term lasting solution to close gaps, address barriers, and get more people access to the care they need. As part of our work, we've been looking at populations who historically have faced challenges accessing the care they need to understand what's working well for them in their virtual care experience, what hasn't, and what do providers and policymakers need to know to make using virtual care a more equitable option. We've issued a set of considerations for policy makers and health system leaders among other reports. And you can find all of our virtual care related resources on our website at [United States of care.org](https://www.unitedstatesofcare.org). And today, I'm excited to share that we just published this week our latest suite of products looking at the experiences of using virtual care to access behavioral health services, including treatment for mental health and substance use disorder. We conducted this research with third horizon strategies in partnership with wellbeing trust. I'm glad to bring you this webinar today to share with you an overview of our learnings from this research, and also give you a chance to hear from some experts in the field on the role of virtual care has played and helping people get access to

behavioral healthcare services. This couldn't be a more timely topic, there has long existed a behavioral health care crisis in the United States, and the COVID 19 pandemic has made it exponentially worse. Today, demand for mental health services remains high and untreated substance use disorders are rising. In fact, the most common use of virtual care services during the pandemic has been for mental health conditions. As we started out on our research, we wanted to first establish a foundation by understanding the barriers people experience accessing behavioral health services in general. As you can see from the list on this slide, these barriers range from experiencing the social stigma associated with various behavioral health conditions and seeking treatment to simply have long wait times to get an appointment. Similarly, we also looked at the research on challenges providers face and providing people with the behavioral health services they need.

04:35

We then took a look at virtual care. We wanted to understand the ways in which virtual care helps to address these barriers that people and providers experience but also we wanted to better understand what were the new challenges that virtual care presented to people. To do this, we looked at a range of modalities that are used with behavioral health services. This includes the digital front door, synchronized telemedicine AC telemedicine, remote patient monitoring and contingency management. We catalogued which barriers to care each addressed, and also identified the new challenges that needed to be overcome in order to effectively use these tools, for example, to start making sure patients and providers have access to the right technology and broadband. We also found instances where using these virtual care modalities was just not clinically appropriate. To complement our research, we went out into the field and conducted a series of case studies with behavioral health centers across the country to understand the extent to which virtual care has helped the people they care for access the behavioral health services they need. You'll hear from a panelist today who was part of one of the organizations we spoke with. Overall, we found that although virtual care has helped, in some cases to get people to care they need there's still work to be done if we want it to be an effective tool in helping all people access personalized, understandable, and equitable behavioral health care. As part of our research published this week, we identify several critical policy solutions and implementation actions needed to overcome the barriers to accessing virtual care and maximize its tools. on the policy front, these solutions range from those related to insurance coverage, including establishing sustainable Provider Reimbursement and coverage parity. Those related to technology, including expanding access to broadband, ensuring people and providers have the appropriate technology, ensuring coverage for a variety of modalities, including audio only, and virtual care messaging, and supporting patient education and provider training efforts around digital literacy. We also identified solutions related to addressing legacy policies, including making permanent flexibilities allowed during the pandemic, such as those that waive prior relationship, or established patient requirements and allow for virtual care to be delivered in home and community settings. We also identified solutions related to workforce availability, such as taking down barriers to allow providers to practice across state lines, and expand primary care and behavioral health integration programs to support care coordination, while also ensuring connections to local communities based providers in case there's a need for higher levels of care. And lastly, we identified solutions related to treatment tools, including allowing for contingency management, and utilization tools across state lines, and updating regulations to allow for greater access to medication assisted treatment for treating substance

use disorders. The last thing I wanted to share are the key themes we found because I think it sums up our research quite well. First, we found out barriers to virtual care do not impact all populations the same way and vary greatly based on race, ethnicity, age, gender, geographical region and socio economic factors. underserved populations, including people of color and people living in rural areas are disproportionately impacted by barriers to behavioral health care. barriers may also be heightened by clinical condition. Second, virtual care is not a panacea, and will not resolve all the challenges to behavioral health care. Third, virtual care should augment not fully replace other services. Specifically, virtual tools should supplement or complement approaches to behavioral health care. Fourth, federal and state policy changes are needed to maximize the effectiveness of virtual care treatment for mental health and substance use disorders. And last, any virtual care policies and implementation of those policies must be inclusive and designed with patient, family and provider needs in mind. All of these things are not unique to behavioral health. In fact, they are consistent with what we have found and written about so far as we have looked at virtual care use and other care settings as well.

09:06

So with that, I'd like to now turn to our panelists and get their perspectives on how virtual care has been used to access behavioral health services, and what more is needed to maximize it as a tool for closing gaps and access. With us today is Mindy clouded, Senior Director at third horizon strategies, and one of the lead researchers on United States of care's recent research on virtual care and behavioral health services. Mindy's a national consultant leader and strategist and behavioral health and integrated care and has more than 25 years of experience in behavioral health and healthcare policy. Previously, Mindy held leadership positions with Colorado Behavioral Health Care Council, National Council for Behavioral Health and Jefferson Center for Mental Health. She was also the chair of the practice transformation committee and served on the steering committee for the Colorado State Innovation Model. We also I'm Ben Miller, president of wellbeing trust, a national foundation dedicated to advancing the mental, social and spiritual health of the nation. And his role as president, Dr. Miller oversees the implementation of the foundation strategies and full portfolio of investments and partnerships. These responsibilities build on those and Dr. Miller's prior role as Chief Strategy Officer of wellbeing trust, through which he ensured alignment across the foundation's grants, research partnerships and policy recommendations. A clinical psychologist by training Dr. Miller is a nationally recognized mental health and policy expert. And we have Anya Zimbra Behavioral Health Consultant at HealthPoint, which is a federally qualified health center in the Seattle Tacoma Washington area that offers integrated behavioral health. HealthPoint is a group of 10 clinics plus for smaller school based health centers and an urgent care facility. It is one of the healthcare organizations we profiled in our recent research report. Dr. Zimbra as a healthcare consultant as a behavioral health consultant. Apologies, works in primary care and has been with HealthPoint for the last 14 years. She is interested in a holistic mind body approach to care, trauma informed care and serving the underserved and immigrant populations. And lastly, we had planned to have Brian Turner, CEO of sobhita Health join us on our panel today. But unfortunately, he had a last minute personal conflicts that needed to be at. I welcome you all to read more about Silvija Health's experience using virtual care and our recently published case studies on our website at United States of care.org. And in Brian's place, we are excited to welcome Amanda Weissman, Executive Director of clarity health care, a federally qualified health center with multiple clinics located throughout the Hannibal Missouri area. Amanda has spent the last

20 years working in the healthcare field. She joined preferred family healthcare in 2019, working in the Quality Management Department. And shortly after she accepted the position of program director of clarity healthcare, and then became executive director in 21. She promotes community partnerships and well being by leading and participating in a wide range of local community based and regional organizations. And coalition's Welcome, everyone. So glad to have you here. For our audience members throughout the rest of the webinar, you're welcome to submit questions you have for the panel using the q&a function, which you'll find in the lower part of your screen. And we'll turn to those questions towards the end of the program. So welcome to kick us off. I think Mindy, I'll start with you, Mindy. This is such a rapidly evolving area of research. And as you know, we published some considerations this past week and but wanted to have you share with how the virtual care and behavioral health care space has changed since we conducted the research behind those considerations earlier this year in the spring and summer. Thank you, Jen. And thank you, everyone for joining us today. Yes, it is a very rapidly evolving field. And you know, when we began our research, there was a very high level of uncertainty among the provider community and among clients, patients around what was going to happen with telehealth folks had built up their infrastructure very rapidly. It's not the telehealth didn't exist before the pandemic but in behavioral health, it was used in very limited circumstances, mostly for psychiatry. There were limitations in terms of rural communities, being able to to utilize telehealth. And so folks were rapidly trying to bring up broadband disseminate devices so that people could actually participate in telehealth and there was just a lot of uncertainty about if that investment was going to pay off in the long term. If the flexibilities were going to remain.

14:00

Since that time, there has been considerable movement both in the policy space in the clinical space. So you know a couple of things that just happened in this last month. In November CMS final finalized a rule saying that within Medicare for behavioral health telehealth would be able to continue indefinitely with the elimination of originating site provisions meaning that people could access telehealth from their home. They eliminate a geographic restriction so any community of any size of any populace. People living in any size geography could access telehealth for behavioral health services. And they also continued to affirm that audio only services would be provided the Biden infrastructure plan which also passed, you know, very recently, and since that research was conducted and the paper was written, invested \$65 billion in broadband. So there's a lot happening in the policy space to sustain telehealth in the clinical space, I think that folks are in somewhat of a different place than they were six months ago when we were doing the research in that, you know, at that time, people were very focused on what they will be able to sustain telehealth. And now I think people are beginning to ask different questions that beginning to ask when and how is it most appropriate to use telehealth? And how do we augment in person services with telehealth? And you know, some of the questions that are that folks are beginning to ask is what is the impact of telehealth on social isolation and loneliness? Right, like how do we as behavioral health providers, or as primary care providers working to address behavioral health issues deal with social social isolation, which is such a big part of recovery? There's also questions around the efficacy and the impact on telehealth in terms of outcomes. When we did our research, none of the providers that we interviewed for the case studies were able to look at, is there any difference in outcomes between folks receiving care in person and folks receiving care via telehealth? And so I think, you know, the questions are shifting to like when and how is it most

appropriate to use telehealth? Thanks, Mindy. That's a really helpful overview of what we've been seeing over the past many weeks. I wanted to turn to Ben to talk a little bit about integration. One of the policy considerations that we put in our report was about care integration. Could you talk a little bit about how virtual care can support behavioral health integration and why this is important?

16:41

Yeah, thanks, Jen. And thanks, everybody, for being here. This is a wonderful partnership that we've got with the United States of care. And such a timely topic for us to be discussing today. And thanks to my colleagues for speaking into this. So let's just start with why integration. And what it is because I think that's actually important. A lot of times we use this language, we don't always know what it means. We know that care for individuals that are seeking mental health services is really fragmented. And based on your own experience, and experience of others, friends, colleagues, much of those contributing factors have to do with unnecessary care limitations, the fact that you gotta jump around between provider and provider, you got to figure out which clinics going to see you what day you got to look at prior authorizations, there's a whole slew of things. And they always lead back usually to frustration, and people not necessarily getting care in a timely manner. Integration brings mental health services or primary care services together. And it makes it more seamless for the individual that seeking that care. And I can give you 1000 examples of what this looks like. But let's just say at a high level, let's just say that it means that you put people together in the same location. So it could be a primary care office, it could be a school, you know, and you want to make sure that the resources are there so that the mental health professional or the primary care professional are able to do things in partnership with one another. We published a paper a few years ago that looked at how, when you bring teams together, you coordinate, you consult and you collaborate simultaneously. These are three amazing functions that good teams have. It's something that decades of evidence support. So let's talk about telehealth now for saying so telehealth and primary care specifically, it really can enhance a lot of the services that can be offered and expands the reaches the reach of physicians to to patients that otherwise wouldn't be able to access mental health services. And this can vary down in a couple of different ways. There's, there's the immediate assistance that can be provided, if I need to have a consultation with a psychiatrist. There's the more consultative assistance that might be provided if the clinician or physician wants to talk to another clinician or physician and say, Hey, listen, I have this patient, I don't know what to do. All of those things are a major value add but then the the most brilliant piece is what happens when the patient can ultimately engage with a new clinician, and then take that clinician home with them, when they're on their couch talking to them the next day or whatever that might be. There's a lot of great resources that have come out in this space. And actually one that was just published about a month ago was done by a good friend and colleague of mine, Dr. Sandy blonde, who published this wonderful website called Team telemedicine dotnet. And I give you this as another resource aside from the amazing thing the United States of Canada and because they actually provide these video vignette real life examples of what it looks like to have telehealth integrated within that practice. So as my colleagues today will probably give you more examples of this is a major value add for our teams. It's not without some controversy and not without some additional questions that need to be answered. But the bottom line is that technology and specifically, telehealth can further enhance our ability to integrate care. It brings together these dots that have been disconnected for too long. And now of course we really do want to focus in on how we can continue to maximise on this and

learn from it. But for now, I think we're really starting to see some of that integration play out in much more healthy and effective ways.

19:55

And yeah, I know you live and breathe integration that's part of your Practice is anything you would want to add on your personal experience of providing care and into integrated format and how virtual cares played out in that?

20:14

Are you asking me next?

20:16

Yeah. Ania just curious as someone who actually practices in it, you probably provide services in an integrated healthcare setting. I'm, I'm curious about how how it's been played out of some of the comments that have been that Ben just made.

20:29

Yeah. So it's, it's played out really well. I mean, we, as an FQHC, that serves 93%, low income people, 70%, Medicaid, insured 19%, uninsured and 74% persons of color, we really have always had a demand for telephone visits with our population. And I'd like to remind you that it takes more time to live when you are poor, you shop more often you need access to different places for services, and different parts of your food supply your car, if you have one breaks down, you can't afford babysitters as readily. So with access to more phone visits, we are able to reduce some of those barriers, you know, when patients have transportation, childcare work schedule barriers. So it's has been so helpful, it's been a game changer that phone visits have been able to be billable. And this lead time. And virtual visits are so helpful. And when those are accessible, depending on technology, because unfortunately, not every patient has access to virtual technology. But when it's available, it's very helpful to have patients be able to see us and for us to see them and to sort of approximate and in clinic visit more closely. And we generally do 30 minute visits anyway. So being able to not have to commute to clinic for 30 minute visit and then leave again Park and leave, it just takes a lot less of a bite out of a busy day for people. And then with greater demand during COVID. It's also enabled us to step up our care. So to provide actually more behavioral health services with less office space. So we're able to, you know, right now, we still have some vacancies we'd like to fill. But theoretically, we could increase our FTE our capacity for behavioral health work with having some of it be remote. So where we get into disadvantages is that and I'm sure Ben will have things to share about that. And Amanda as well, is that some patients with anxiety, depression, PTSD tend to be avoidant already have crowded places and leaving the house. And so virtual visits are easier for them to attend. But there's sort of the nudge and the exposure therapy possibility is is also missed. So, but with virtual visits, there are fewer no shows, you know, people are reachable and the visits happen. So on the whole you more visits are happening and more care is being delivered. Sometimes some problems we've had are that people can be more casual about double booking themselves, or they might forget the appointment, or they might not have privacy or be attending to other duties while they're in the visit. Another issue is assessments. So a lot of testing really needs to happen in clinic with the person observed and engaging in the test modality. And

then with pediatric patients, they tend to already spend a lot of time online or school during COVID. And I find that they're harder to engage with and to read in virtual visits. In addition to privacy concerns for pediatric patients we have right we don't we can't always tell if there's a parent in the background, sort of monitoring their visit and interfering with their for their level of privacy. Then there are some modalities that we do use even though we are a brief PC, BH model, behavioral health outfit, we do engage in EMDR kind of therapies and those kinds of therapies work better in person. So some of the work we do is better in person. And then this one is sort of harder to really put our hand on but there are you know the relationship factors that have been researched too much about 70% of the active ingredient in successful behavioral health work and some of that relationship factor is done involve nonverbal cueing and helping people reregulate in your room. I don't know how much how many of you are familiar with polyvagal theory, but it involves kind of creating a safe container, and the person's body actually relaxes and is able to, to relate to you better. There's an attachment process that's part of healing. And some of those things do function better in person.

25:28

The case can be made that people who are well established with you who've met you in clinic then have an easier time transitioning and maintaining that relational connection and benefit when they're in a virtual visit or even on a phone visit. So then one other thing that I thought of is that for patients for whom the clinic is a refuge, and a place of healing and privacy, which there are patients like that, if you live in a crowded situation, then access to the clinic is your place for healing. So that, you know, that makes us think like, Wait, if some patients really need to get away out of their homes or their situations to come to clinic, might we maybe have rooms in clinic where people can do virtual visits, but where they have that privacy? Anyway, just some thoughts.

26:24

Thanks, Sonia, that was great. And a lot to just hear the benefits and the challenges that you're seeing, I wanted to circle back on one of the technical things that you raised, you spoke about EMDR. For those of us who are non clinicians, can you just describe what that is a little bit.

26:41

So EMDR is part of a group of therapies that involve by bilateral stimulation. And it originally was discovered involving AI movements where you have sort of eye movements moving back and forth, and it helps the brain process. And we we don't fully understand it, it's a little bit of a black box, why it works. But it's a trauma treatment. And it can also be used for general anxiety reduction, Peak Performance Training and many other advantages. It can be done also with touch. And you can do like a bilateral tapping, like this kind of tapping around your thighs. And it has kind of grown and utility, with it being used beyond the traditional EMDR modality, which is sort of a CBT integrated exposure therapy, which traditionally is delivered in longer visits in the 90 minutes. So there can be what we call resource installation and development with bilateral tapping done in our work. And it's easiest done in person to really demonstrate and have the person experience it. But once it's taught, it can also be delivered virtually it continued virtually.

27:56

Great, thank you. Thanks for that edit at a detail there. Amanda, I'd love to hear from you your perspective of a provider of behavioral health services in a rural region, I guess what is your experience have been like with virtual care, and how has it impacted the communities that you're seeing? Yeah, um, so obviously, thank you for having us. We're excited to be part of this. Thankfully, telehealth was not new to clarity, healthcare or preferred family before 2020. Right when COVID kind of got to the Midwest region, we are in Hannibal, Missouri. So we're a very small rural community. However, what we found was from 2019 to 2020, our encounters our patient encounters stayed virtually the same. But we went from 3% in virtual visits to about 39% virtual visits. So we had a lot more availability, and we were able to continue the continuity of care with people who I'm wondering, you know, like if we weren't able to do the telehealth visits, if those I think we had something like 13,000 telehealth visits last year, so would those have not happened at all? Would they have would some of them come into the office? So I think just having that option available and ready to slide right into it, there wasn't a lot of training, not a lot of a big training curve or anything like that for our staff, because like I said, we were using it, like Mindy had mentioned, you know, here and there. You know if weather was bad and that kind of thing and patients didn't want to drive in, we would use it for that. But we went at the beginning of the pandemic we did go to just right at the beginning kind of an all virtual platform there for a while so we could get our feet underneath us and see. And then now we have mostly gone back to a hybrid model and some patients are coming back into into office and some are remaining telehealth and they kind of play it on a case by case basis and what's best for that for that patient but we do record hire them to come in office, you know about every third or fourth appointment just so that we do get that face to face, I will say, I understand, you know, contributing to the loneliness and, and keeping them at home. However, I do feel like some people that have, you know, they feel like there's the stigma attached to behavioral health treatment are a little more likely sometimes to engage in that treatment when they're doing that from their home. So I have found that that is something that we've had people kind of reach out, we've had people show for appointments much more for behavioral health, we have 8%, higher kept rate, I believe, since pre pandemic for just our behavioral health appointments. So we have people that we have outreach, and that we have, you know, done everything we could possibly do to get them to appointments, we've provided transportation that we just couldn't get to engage that as soon as we offer, you know, a telehealth appointment to them, they were right on the phone. So wow, that's interesting. It's just a great a great data point, observation and, and, and practice to think about kind of the future. It's very interesting, thanks for sharing that. You all have touched on this in different ways. But I'm just would love to hear a little bit more specifically about the extent you see virtual care tools addressing health disparities and behavioral health, I can open it up to any of the panelists who want to jump in.

31:32

Well, anytime you make accessing care easier, it helps mitigate some of the potential impacts around disparities. And so I think that when we bring care to where people are, whether that's through their phone, their computer in a clinic through a phone or computer, it does help. Now, there's a lot of, of butts here. And some of those are well, do people have the devices? Do people have access to broadband, like Mindy was alluding to earlier? Those things I feel like are major policy debates that are still happening, because the downside of doing so what I just said is that you can actually further disparities, you can have people that do not have access to these technologies can afford these

technologies actually get worse because they are not having the ability to expose themselves to these things as other people might, which is on us to make sure that we are tracking them, you know, so I think it actually is kind of a it's a booth interior, there's a lot of good that could come from this. But if we do not pay attention to some of the other issues that I think have been alluded to by our panelists here, I think we do run the risk of furthering increasing disparities.

32:41

I would agree, I also, like in our case, because of the limitations for broadband and devices, we did work with our local university, and we had hotspots available with one year of service, we're to the point now where that service is ending that one year time period is over. And so we're kind of back to the drawing board a little bit with, so the service ended, but the person still does not have access then to, you know, to internet, where they live or where they work. So we're kind of back to the drawing board on that. But that did help for the first the first year.

33:21

Very good points on internet and technology access. But on the whole, I do feel that virtual and fallen visit availability really helps reach underserved communities. Now people who are too busy or also maybe ambivalent about behavioral health care, our it lowers the barrier, it makes it less stigmatizing. Somehow, they just feel like they can do it in this format more easily. And it takes less of their time.

33:53

What about workforce challenges? I'd love to hear your perspectives on the impact that virtual care has had on workforce challenges in the behavioral health space.

34:06

I'll start, which is the there is a huge shortage of behavioral health worker workers, right, we can't fill our positions. And a lot of mental health professionals tend to be more comfortable with working virtually exclusively given the choice. And so some people have exited the workforce out of the agency job market out of safety concerns at first and then now possibly also for convenience reasons. And so this has added to the provider shortage in our agencies and clinic settings. So to counter that a little bit, I think offering a hybrid model can help so that behavioral health workers and employees can do some remote work and some in clinic work and that can help attract people or or retain people nationals in this line of work, I think. Yeah. So, you know, it'd be nice if there was more flexibility and sort of making it work for different providers and trying, because there's need for everybody to work. So if we can, that way, you don't have to have more people doing the work of providing care than that is a good thing, if virtual helps the providers as well.

35:29

I would add that I think there's, there's a myriad of reasons that the behavioral health workforce crisis exists in our country today. And digital and telehealth are not necessarily addressing all of those issues. Right. Like, like, as you said, it's not a panacea. And, you know, our understanding of what's driving the behavioral health workforce shortage is one, there's inadequate reimbursement, you know, and and reimbursement models that continue to reimburse on a fee for service basis, don't allow the flexibility for

people to address needs of all people that are not tied to diagnoses that allow folks to address social determinants of health and recovery aspects. There's also continues to be a excess of paperwork requirements, on safety net providers, so much so that you know, that I think that really drives one of the reasons that you see so many people that are behavioral health practitioners operating independent practices and not taking insurance, right, only taking self pay or Sliding Fee Scales, because they don't want to deal with the with the paperwork. And then there's also just this question of, you know, how do we maximize non licensed clinicians? Right? How do we continue to drive the use of community health workers and peer supports, and make sure that all of those services are both reimbursable and really valued in the clinical setting? So telehealth, you know, doesn't address those things. The end, and we as a nation are going to have to continue to, to wrestle with them. That was exactly what I was going to say as well, not only the workforce force shortage is obviously an issue for all of us, we have increased our number of community health workers and outreach workers. But the strain on the staff that we currently have, I'm getting a patient ready for a telehealth appointment is completely different than getting a patient ready for an in person appointment. And our nurses, you know, you're calling a patient, they didn't answer your calling back in five minutes. And, and just it's a constant on the phone all day long, getting patients ready for the next telehealth appointment. Whereas if they just came in the office, you do your thing, you put them in the room, you move on to the next patient. There's never like a downtime in between the appointments like they're sometimes are when they come in office. And so just watching kind of the transition of how even the appointment flows is just very stressful. For the staff that we do have.

38:13

I could spend six days talking about workforce. And I won't do that. I think my colleagues have summarized it nicely. I just say one thing that I think was embedded here, which is that sometimes it's a different set of skills or competencies, to use virtual platforms to deliver interventions. And Amanda, I think he just said this beautifully. You know, I think about the different type of workflows that have to be established within clinics, and how that can be so disruptive. But then I think about like what clinicians themselves have to do on you said this earlier, when you're used to sitting in the room with a patient and reading the nonverbals. And seeing the foot tapping and seeing how their, you know, their body expresses change. When you talk about a particular topic, sometimes that's really hard to see in virtual land. And you don't need to be a clinician to understand this, because we've all been living in these kind of two by two squares for the last two years. And so we know the challenges of trying to engage someone interpersonally just do through our own work. So I think the clinicians, you know, in graduate school, we're not always taught like what it's like to intervene through a camera. Okay, were very much taught to read those nonverbals and pick up on those cues. And I think that as we began to enter into this next phase of wherever we're going, within healthcare, that competencies around virtual care should be something that are prioritized. You know, just as we have standards for care delivery, we should be thinking about standards for, you know, telehealth delivery, and some of that stuff is still a little bit wild, wild west out there where everybody's doing whatever they think is best, but I think we could strengthen this quite substantially and benefit a lot of folks.

39:43

And to add to that, also, you have nurses who have been nurses for 40 years and are wonderful, and then we throw in this, you know, curveball, and you know, it's kind of hard to switch up what you've done for so long and kind of get on board with that so. So it's a different learning curve, I think for everyone. I also want to go back to something that Anya mentioned earlier around, you know, now there are behavioral health providers that are so comfortable delivering tele, like there's some that don't like it, right, there's some that want to be in person. And then there are some that are so comfortable with it now that they don't want to come in. And so for community based providers that do offer hybrid services, or that offer, you know, a very, like robust array of services and not just talk therapy, right? It, the workforce challenges are more complex. And there's a lot of almost competition now, like it's created more competition with telehealth only companies that are delivering, you know, a confined set of services for community based providers, FQHCs community mental health centers, CCBHC. Yes. They're now competing for that same pool of clinicians. So so that is also complicated the situation. Thanks, Mindy. I guess I've related on those on that note as well, you know, I think, Amanda and I know you both have talked about the values of hybrid models, and I guess you see a hybrid in person and virtual care model as being something that's sustainable for providers over the long term.

41:27

I think so and I think providers do appreciate the flexibility to have some time in clinic and some time not, and to have a little bit less commute time. So I think it helps to prevent provider burnout. And then, I think, you know, like virtual work is also a good alternative, even when we're in clinic, when a certain patient can't make it in. You know, for example, just last week, I had a patient who was supposed to come in and to see me, and she developed respiratory symptoms. So she would have actually been screened out at the gate of our clinic and sent back and sent home. So instead, she thought of this and and called me and said, Hey, I have respiratory symptoms, and we switched it to a virtual visit, right, so we're able to just be more flexible and still provide the care in those circumstances. So and that's, it's actually pleasant, I find when I'm in clinic to occasionally have a virtual visit between my in person visits, even though I'm sitting at my desk in clinic, so that I think, also can improve work satisfaction to be able to do that.

42:39

I would agree. I have a little anecdotal, we had a provider who went 100% virtual, and then we talked her in now she's a hybrid, she has two days in office, and three days at home. And we actually were needing the office space, because that's our problem is now we have too many providers to all come back into office because there's not enough office space. So they're sharing offices on certain days. And we had given her kind of the option to go back to 100% virtual and she was like, no, no, there are some patients that I need to see. In person, they're doing much better now that I'm back. So we gave her that option, she chose to say hybrid, I think most of them would probably prefer a couple of days in office, just to see, I know our addiction medicine program, where we're scheduling those patients on days when the provider is in the office so that they can, you know, touch base with him more often and face to face. But yeah, I would agree with I think I think the hybrid model is kind of here to stay. So Jen, one of the things that it raises from a policy lens is, you know, both Anya and Amanda are describing the need to maintain capacity to do both right, to offer services virtually and offer services in person based on clinical need based on provider and patient. Patient first and provider preference, right. But in

order to do that, it it raises questions around payment parity, you know, will will telehealth drive down rates? Will services be paid the same? If they are provided via telehealth or if they are provided in person? How does that impact sustainability for community based providers?

44:27

Can I just tee off on that? Because I know we want to talk about policy just a bit but I think Mindy's very astute in pointing this out. Because, you know, we've even seen the trends now of Payers asking patients to go through the virtual door first. And that while that might be good for some people, it's not good for all people and that element that Mindy just described, his choice just gets left out to dry. So that is a major policy discussion. There's also policy discussions that are happening right now. Do you need to establish care face to face before the virtual visit? It becomes, you know, something that will be paid for. And I know there's been a lot of conversations in Congress about this the thing about policy in this space, which makes it so cumbersome and complicated, it's a federal, state and local issue. It's, it's just, it's not an easy, well, let's just break this glass and push this button, you know, the public health emergency, which expires January, I mean, that's been a boon for a lot of folks. And we've seen telemedicine companies just surge, and the number of companies that are out there, which has led to challenges around regulation, you know, how do you regulate all these new companies and make sure that they're delivering good quality care? You know, and that that's a state issue? That's a federal issue. You know, how do we think about licensure, which I know is something that we've talked briefly about today, but I mean, guys, if you haven't spent time looking at the complexities of licensing, just like Do yourself a favor, unless you want to write your dissertation on it, don't do it, because it's it gives you a headache. It is absolutely one of the most problematic things that limits our workforce from diversifying outside of the confines arbitrary confines of a state. So if I'm in California, I can't do a lot to help somebody in Alabama. Now, thankfully, Congress is doing a lot to embrace this. And and I could give you the names of the various pieces of legislation that are out there. But I think the bottom line is that there's progress here, that we're seeing our Congress move to enact legislation that might make some of these telehealth provisions permanent, we're seeing Congress began to look at address issues around parity, which I think, you know, Mindy already pointed out that are going to be so essential, do we have payment parity? Do we have delivery parity, but then most importantly, how do we get to this really, really tricky issue around licensing, and that's something that I feel like, you know, is going to be the next big hurdle that we have to embrace. And remember, folks, we don't have a lot of time for this. So if we're going to embrace this hybrid model, which, you know, go for it, I do think that we've got to figure out the policy sooner rather than later. I think it's like 29 states have telemedicine parity provisions, which means that they're paying, you know, at the same rate as they would in person visit, which also means that we've got, you know, 20 plus, that aren't. And that means that you as a clinician might have a reimbursement rate, going back to our workforce issue that's substantially lower because you're delivering it through virtual versus in person. And that is not a sustainable model, it means that we're going to have those disparities that we touched on already increase some of the states that we know, don't have this parity provision, and probably going to see some of those disparities increase, especially as people are more reluctant to come back to face to face care.

47:34

These are such great points, then, you know, parity policy work is so important right now. And then on the licensure front, you know, we've lost a lot of income from patients going out of state because they perhaps lost their housing or they were going to care for a loved one second, with COVID out of state. And then sometime halfway into the visit, we might find out oh, the person is actually not in our state right now. And then we can't build their insurance because we're not licensed to practice in the state where they currently are. So you have a clash between our ethics, you know, of non non patient abandonment, we can't abandon these patients in need, versus the policy, which is that they have to be in the state where we are licensed. So it'd be so amazing to arrive at more nationwide licensure for all behavioral health practitioners and licensing, you know, if all the states could just agree and make it one big license, that would be amazing.

48:35

You all these are such great points. I just want to again, welcome our audience. If you have any questions, you want to ask our panelists, in these final few moments that we have together, please feel free to submit them at the q&a function at the bottom of the zoom. Callin our zoom appointment screen here. Amanda, I wanted to just continue on that policy discussion a little bit more. And also, you know, hear from you are there is there anything else that policymakers should be considering as we think about sustainability of virtual care and overall behavioral health systems of delivery? I think that we've pretty much covered the the, the major points, obviously, broadband is big for us where we're located. Just the reimbursement rates, the licensing issue, we've had the same thing, you know, someone loses their job, goes to live with mom or dad and a different state, and the same exact thing has happened to us, you know, you're halfway through the appointment. They're like, Oh, by the way, I'm, you know, in Florida or something, and we're in Missouri. So those same issues have happened with us, but I would say those just, you know, continuing to make sure we're reimbursed at the highest level possible, continuing to make sure we have, you know, somebody working on broadband to make sure everyone has access. I think those are the biggest points for us as well. Um, I don't think there's really anything standing out there that that we haven't touched on already, at least in my opinion. Thanks, Mindy, from your perspective, what are some of the things that that we should be considering or thinking about in terms of policy solutions specifically regarding provision of substance use disorder treatment for via virtual care? Well, I think one of you know, to go back to Ben's point about it being complex, because there's federal decisions, state decisions, Local Decisions, one of the things that we're seeing is there's kind of this patchwork now of provisions at the state level around telehealth prescription allowance, particularly for opioid use disorder. And so if we want to continue to promote medication assisted treatment, and, you know, make that more fully accessible, I think there needs to be more reckoning around, how do we have more uniformity and in the approach to what's allowed for MIT. And another consideration on the substance use side is to go back to something I said in the very beginning, which is, you know, what, what is the if we're using digital and telehealth to help people with substance use, were such a big aspect of recovery is community building and social, you know, addressing social isolation, what's the way? Right? How do we help people to continue to have that engagement with others? If if they're only accessing care via telehealth

51:34

for tool groups?

51:36

Well, that's a good one that we that we did at first, you know, instant because they wouldn't come in, obviously, for individual appointments, much less group. So we were canceling groups just at the beginning. And so we got them online and had them do a virtual group, which is not the same thing by any means as being in the same room as someone but it was better than nothing at that point. Thanks, Amanda, could you describe a little bit what your virtual groups were, like? Just say that for those of us who aren't familiar with them, yeah, and I did, I wasn't the one that set them up. But I believe they use just a like a Google platform, and the people who would normally come to the group in our residential Sud or not residential, using our outpatient Sud, then had the option to log on at a certain time. And then it was a secure, like chat room, basically. And they would have their group virtually.

52:26

That's great, thank you. Feedback on the group idea. Also, video interpreters would be really beneficial to you know, instead of just having an audio interpretation as part of a video visit, so if there could be a fully visible virtual interpreter, that would be great. And we need, you know, part of the wish list is to kind of add more texting or other smart ways to communicate, so that we can also push screeners back and forth between patients and providers, and that should be confidential and HIPAA compliant. So that is one of the issues is we can't capture screeners unless we administer them interview style, which eats too much time out of the visit. So yeah, and then, as we said before, part of the wish list, as well as to have a way to issue smartphones, tablets, and laptops to patients who need them. And you know, Wi Fi really shouldn't be subsidized public utility available to all.

53:23

In that same vein, I think that and Dennis just nailed this. For those of you that are watching the webinar real time, please look at Genesis chatter here because it's just brilliant. And speaking to so much of the problems that I think undergird much of what we described here today, but what you were just saying Ania, which I think Dennis alludes to this is all reactive, right? Everything telehealth, these interventions are all reactive, you know, we need to be thinking about how do we really position ourselves to be more proactive upstream, looking at prevention? And and while yes, undoubtedly that there can be some elements of telehealth that can be around secondary prevention, we still need to make sure that people have a job, they've got affordable housing, they've got transportation to dress. I mean, all of these things I'll never forget, a couple of three years ago, before COVID, I was in New Mexico talking to a group of folks. And I remember very vividly I was on stage and I was describing why, you know, Mexico's got some of the highest rates of drug overdose in the country. And in the back of the room, this guy raised his hand. And he said, You know, I've been a psychiatrist, addiction psychiatrist for, you know, 50 years, I can tell you, if you want to help give people hope and keep them alive, you give him a job, you give them a sense of purpose and meaning you connect them to others. And and I've always found that to be such a beautiful sentiment and true but also fundamentally one of the most challenging propositions for us as a nation to embrace. Does it have to do with mental health? Absolutely. Does it have to do with ways that we access care and provide affordable coverage? Absolutely. But it's almost a different conversation. And that's why I feel like those things have to come together, which I think Dennis alluded to, amongst many other brilliant points that he made.

55:01

expend. And I think that seems like a great note for us to wrap up our webinar. Since we're starting to come up towards the end of our time here. I just want to say a huge thank you to everyone who joined us today, especially our experts, as our panelists here, Mindy cloud. And Ben Miller, Amanda Weissman and Anya SOBOROFF. Thank you to each of you for sharing your time and your insights. I learned so much today and just really enjoy this conversation with all of you. I encourage you all to go to our website at United States of care.org to access a deep body of work available to support your efforts, including a recording of today's conversation, as well as links to the recently published resources looking at virtual care and behavioral health services. And I hope you'll consider joining us at a future us of care event virtual and one day hopefully in the not too distant future in person again, as we continue to navigate this pandemic that we're in, we really look forward to working with all of you, policymakers, advocates, and concerned citizens, as we strive in the midst of a public health crisis to build a healthcare system that can withstand the next one. Thanks again, everyone. Have a great afternoon. Goodbye. Thank you