Behavioral Health Institute (BHI)
Training, Workforce and Policy Innovation Center
201 Training Series

Behavioral Health Telehealth Resource
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Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment. BHI established initial priority programs which include:

- **Improving care for youth and young adults with early psychosis**
- **Behavioral Health Urgent Care Walk in Clinic**
- **Expanded Digital and Telehealth Services**
- **Behavioral Health Training, Workforce and Policy Innovation Center**

WEBINAR LOGISTICS

CHAT Box

- We'll share info about logistics
- Let us know if you are having tech issues
- To you: from our training team
- From you: only visible to hosts/panelists
- NOT for content-related questions (see next slide)

WEBINAR LOGISTICS

Q & A

1. Type question into Q&A Window

2. Raise hand *(will be called on/unmuted in order)*

   Click **Raise Hand** in the Webinar Controls.

   The host will be notified that you've raised your hand.

   Click **Lower Hand** to lower it if needed.

Speaker Disclosures

✓ No conflicts of interest

Planner disclosures

The following series planners have no relevant conflicts of interest to disclose:

Brad Felker MD
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DISCLAIMER

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Always consult with legal counsel.

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BUILDING TELEHEALTH CAPACITY for BEHAVIORAL HEALTH:

TeleBehavioral Health 201

SUICIDE RISK ASSESSMENT & MANAGEMENT IN THE AGE OF TELEHEALTH

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BEHAVIORAL HEALTH INSTITUTE
HARBORVIEW MEDICAL CENTER
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Suicide Risk Assessment and Management in the Age of Telehealth

Kate Comtois, PhD, MPH

Professor, Dept of Psychiatry and Behavioral Sciences
University of Washington
Clinical Psychologist, UWMC Outpatient Psychiatry Clinic

BLUF: Pros of Choosing In-Person vs. Telehealth with Suicidal Patients

In-Person

1. Physical access to the patient if they need to be transported to higher level of care
2. Potentially greater engagement
3. Increased behavioral activation in coming to the office
4. Privacy easier to achieve
5. Crisis Response Planning more straightforward

Telehealth

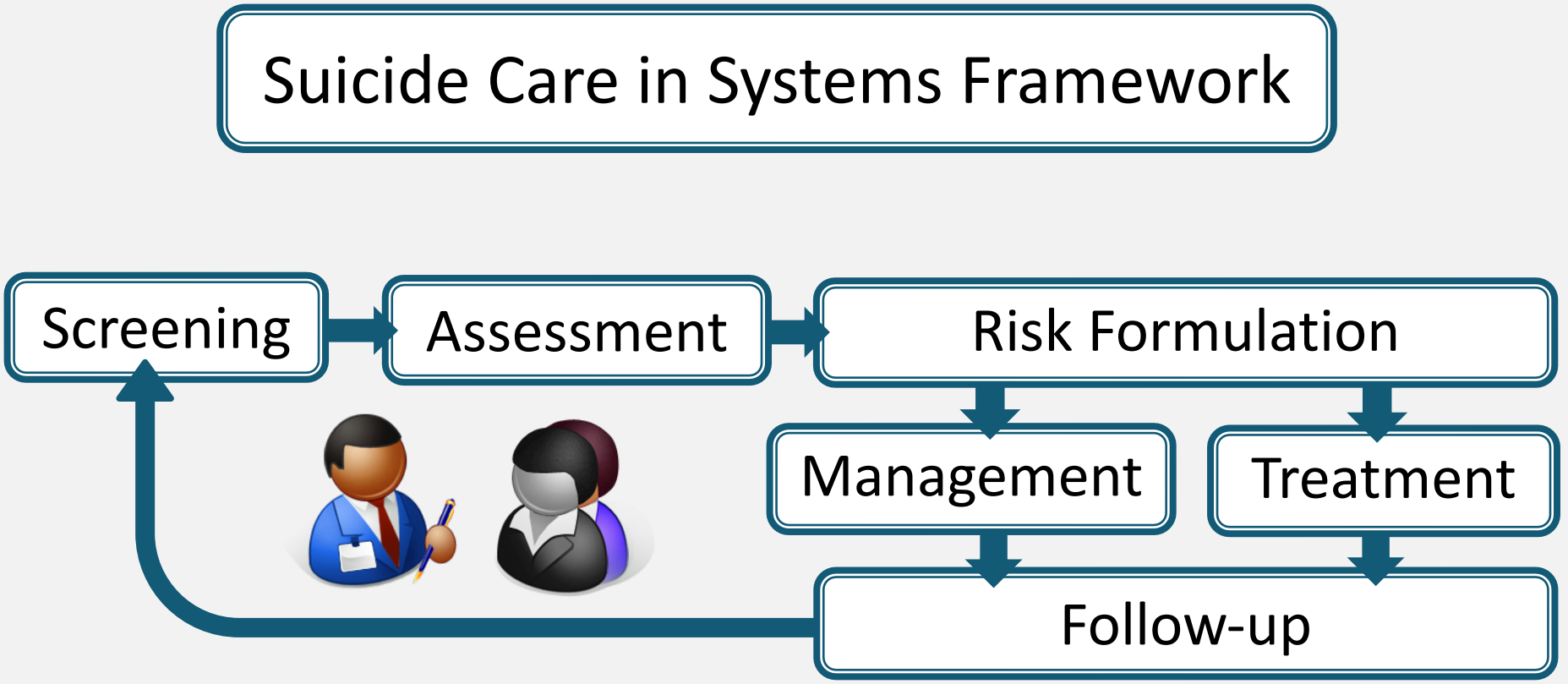
1. Less chance of spreading COVID-19
2. Observe the patients' living situation
3. Opportunity for visual inspection for lethal means counseling
4. Facilitate engagement with patients' family
5. Increase attendance in treatment and ability to reschedule

Overview

- Suicide risk screening
- Suicide risk assessment
- Management vs. Treatment
- Management by Telehealth
  - Technology supports
  - Discussion

Want to acknowledge Jeff Sung, MD, with whom I developed many of these perspectives and slides

Overview of Clinical Interventions for Suicide Risk



Standardized Screening

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen with Triage Points for Emergency Department

Ask questions that are bolded and underlined.	Past month	
Ask Questions 1 and 2	**YES**	**NO**
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
	Past 3 Months	
If YES, ask: *Was this within the past three months?*		

If yes—follow listed recommendation:
Item 1 Behavioral Health Referral at Discharge
Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Continuous Readiness

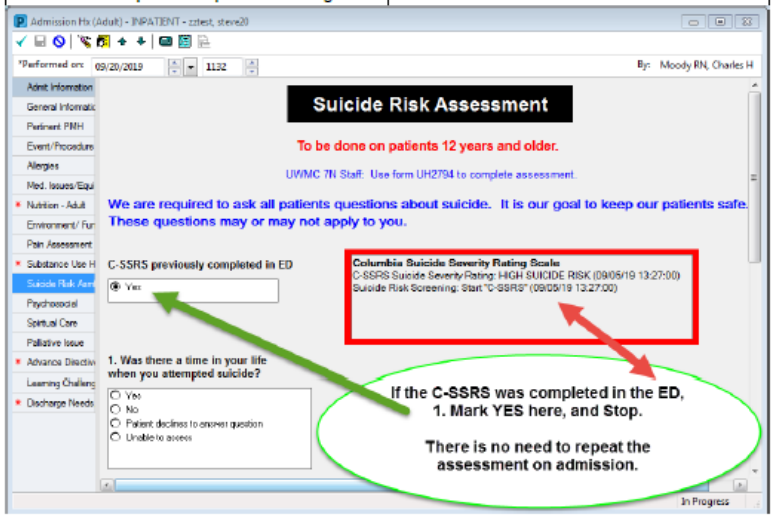
Suicide Risk Assessment – ED to Inpatient

Continuous Readiness for Patient Safety – September 2019

Starting the second week of October 2019, the Emergency Department (ED) will begin using a different, validated screening tool to screen patients for suicide risk. They will be using the *Columbia – Suicide Severity Rating Scale (C-SSRS)*, which will help identify patients who are at Low, Moderate and High risk for suicidal ideation (SI). Here are instructions for inpatient staff:

1. **Confirm risk level when getting report from the ED**
   a. HIGH risk – patient should have a 1:1 patient monitor, and staff should follow the Suicide Prevention Protocol.
   b. Moderate or Low risk – no immediate actions are required. Interventions should be initiated in ED before the patient transfers to inpatient status.
2. **Information from the ED assessment will display on the Suicide Risk Assessment page of the Inpatient Admission History PowerForm:**

If the C-SSRS risk assessment was done in the ED:	If the C-SSRS risk assessment was NOT done in the ED:
a. Select C-SSRS previously completed in ED b. Do NOT complete the 4 question screening	a. Complete the 4 question screening



Questions?

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Assessment: Standardized Assessments

Standard Measures

- Columbia Suicide Severity Rating Scale (full interview)
- Suicide and Self-Injury Interview
- Self-Harm Behavior Questionnaire
- Suicide Status Form (from CAMS)
- Reasons for Living Scale

Assessment: Standardized Assessments

TABLE 3. Response patterns for all suicide attempt measures

Pattern	*Self-Report Measures*			*Clinician Interview Measures*		*n*	%
	BSS	SBQ-R	MSRC CDEs	C-SSRS	SHBQ		
1						439	44.6%
2	■	■	■	■	■	197	20.0%
3	■		■	■	■	77	7.8%
4		■	■	■	■	48	4.9%
5			■			39	4.0%
6			■	■	■	35	3.6%
7	■		■			26	2.6%
8	■	■	■		■	20	2.0%
9	■					12	1.2%
10				■	■	12	1.2%
11	■	■	■			11	1.1%
12		■	■			9	0.9%
13	■			■	■	8	0.8%
14	■		■		■	8	0.8%
15				■		7	0.7%
16			■		■	7	0.7%
17		■	■		■	7	0.7%
18					■	5	0.5%
19		■				4	0.4%
20	■	■				4	0.4%
21			■	■		3	0.3%
22	■	■		■	■	3	0.3%
23	■		■	■		2	0.2%
24	■				■	1	0.1%
25	■	■			■	1	0.1%
26		■		■	■	1	0.1%
27	■	■	■	■		1	0.1%
n (%) reported SA	371 (37.7%)	306 (31.1%)	487 (49.5%)	394 (40.0%)	430 (43.7%)		

Note. Black tile: reported a suicide attempt; BSS: Beck Scale for Suicide Ideation; C-SSRS: Columbia-Suicide Severity Rating Scale; MSRC CDEs: Military Suicide Research Consortium Common Data Elements; SA: suicide attempt; SBQ-R: Suicidal Behaviors Questionnaire-Revised; SHBQ: Self-Harm Behavior Questionnaire (SHBQ); White tile: denied a suicide attempt.

994 active duty service members referred as being at some suicide risk:

- 45% denied any suicide attempt across all measures
- 20% reported a suicide attempt across all measures
- 35% responded inconsistently

Hom et al, 2019

Assessment: Risk Assessment

UNCERTAINTIES

Can we usefully stratify patients according to suicide risk?

Matthew Michael Large *conjoint professor*[1], Christopher James Ryan *clinical associate professor*[2], Gregory Carter *conjoint professor*[3], Nav Kapur *professor*[4]

[1]School of Psychiatry, University of New South Wales, NSW, Australia; [2]Discipline of Psychiatry, Westmead Clinical School and Sydney Health Ethics, University of Sydney, Australia; [3]Centre for Brain and Mental Health, Faculty of Health and Medicine, University of Newcastle,; [4]Centre for Suicide Prevention, Manchester Academic Health. Science Centre, University of Manchester, & Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK

What you need to know

- Despite the ubiquity of advice to use suicide risk assessment in clinical practice, there is no evidence that these assessments can usefully guide decision making
- All patients presenting with a mental health problem require a thorough and sympathetic assessment with the aim of negotiating an individualised treatment plan
- All patients with suicidal thoughts or behaviours should be offered evidence based therapies for the treatable problems associated with suicide, such as substance misuse disorder and depression
- The overwhelming majority of people who might be viewed as at high risk of suicide will not die by suicide, and about half of all suicides will occur among people who would be viewed as low risk

Assessment: Risk Assessments

Box 2: How to approach a patient who you think might be suicidal

- Conduct a respectful, thorough, and sympathetic assessment using active listening
- Keep a focus on the content and nature of the doctor-patient interaction
- Try to understand and address the individual circumstances that are distressing the patient
- Identify the patient's current treatment needs, including common modifiable social and clinical factors for suicide
- Do not attempt to stratify patients into high and low risk categories
- Do not simply rely on the patient's expression or non-expression of suicide plans and ideas
- Never dismiss any patient who raises your concern about suicide as low risk
- Talk with the patient's family or friends
- Ask about firearms and other lethal methods of methods of suicide
- Involuntary hospitalisation should be used sparingly and with great care
- Negotiate a management plan with every patient
- Document your assessment, reasoning, and treatment plan

Large et al, 2017, British Medical Journal

Assessment: Culturally Based Assessment

Cultural Assessment of Risk for Suicide (CARS) Scale

Family conflict

- There is conflict between myself and members of my family

Social support

- I am accepted and valued by others†
- I feel connected to, like I am a part of, a community†

Sexual minority stress

- The decision to hide or reveal my sexual or gender orientation to others causes me significant distress
- Because of my sexual or gender orientation, no one understands my pain or distress

Acculturative stress

- Adjusting to America has been difficult for me

† indicates scored in reverse

Chu et al, 2013, Psychological Assessment

Assessment: Culturally Based Assessment

Cultural Assessment of Risk for Suicide (CARS) Scale (continued)

Non-specific minority stress

- People treat me unfairly because of my ethnicity, sexual, or gender identity

Idioms of distress (emotional/somatic)

- When I get angry at something or someone, it takes me a long time to get over it
- Sometimes I feel so tired I do not want to get up/wake up
- There is something in my life I feel ashamed about

Idioms of distress (suicidal actions)

- I have access to a method of suicide other than a gun that I have previously thought to use (like a weapon, a rope, poison, or medication overdose)
- I have, without anyone's knowledge, thought of suicide in the past

Cultural sanctions

- Suicide would bring shame to my family†
- I consider suicide to be morally wrong†

† indicates scored in reverse

Chu et al, 2013, Psychological Assessment

Assessment: Culturally Based Assessment

Reason for Life – A Strengths Based Assessment of Protective Factors

Efficacy Over Life Problems

1. I believed I can help others fix their problems.
2. I believed I can make things work out for the best even when life gets difficult.
7. I believed I can fix my problems.
11. I had the courage to face life's hardest moments.

Cultural and Spiritual Beliefs

4. No matter how hard things got, I believed God wanted me to live.
6. My Yup'ik Elders taught me that my life is valuable.
8. I believed I must live to be an Elder.
9. My religion taught me that my life is valuable.

Others Assessment

3. People saw me do good things to help others.
5. People saw that I am strong and care about others.
10. People saw I live my life in a good way.

Allen et al, 2019, Assessment

MIRECC / CoE

MIRECC/CoE
More Health Care

QUICK LINKS

Hospital Locator
Zip Code
Go

Health Programs
Protect Your Health
A-Z Health Topics

Veterans Crisis Line
1-800-273-8255 PRESS 1

Rocky Mountain MIRECC for Suicide Prevention

ROCKY MOUNTAIN MIRECC

Updated: 13 February 2019

Therapeutic Risk Management of the Suicidal Patient

About TRM | Risk Tool | Presentations | Resources | Join

About TRM

The Rocky Mountain MIRECC model of Therapeutic Risk Management of the Suicidal Patient is a clinically and medicolegally informed model for the assessment and management of suicide risk. It involves three main components:

- Augmentation of clinical risk assessment with structured instruments
- Risk stratification with respect to both severity and temporality
- Collaborative development of a safety plan

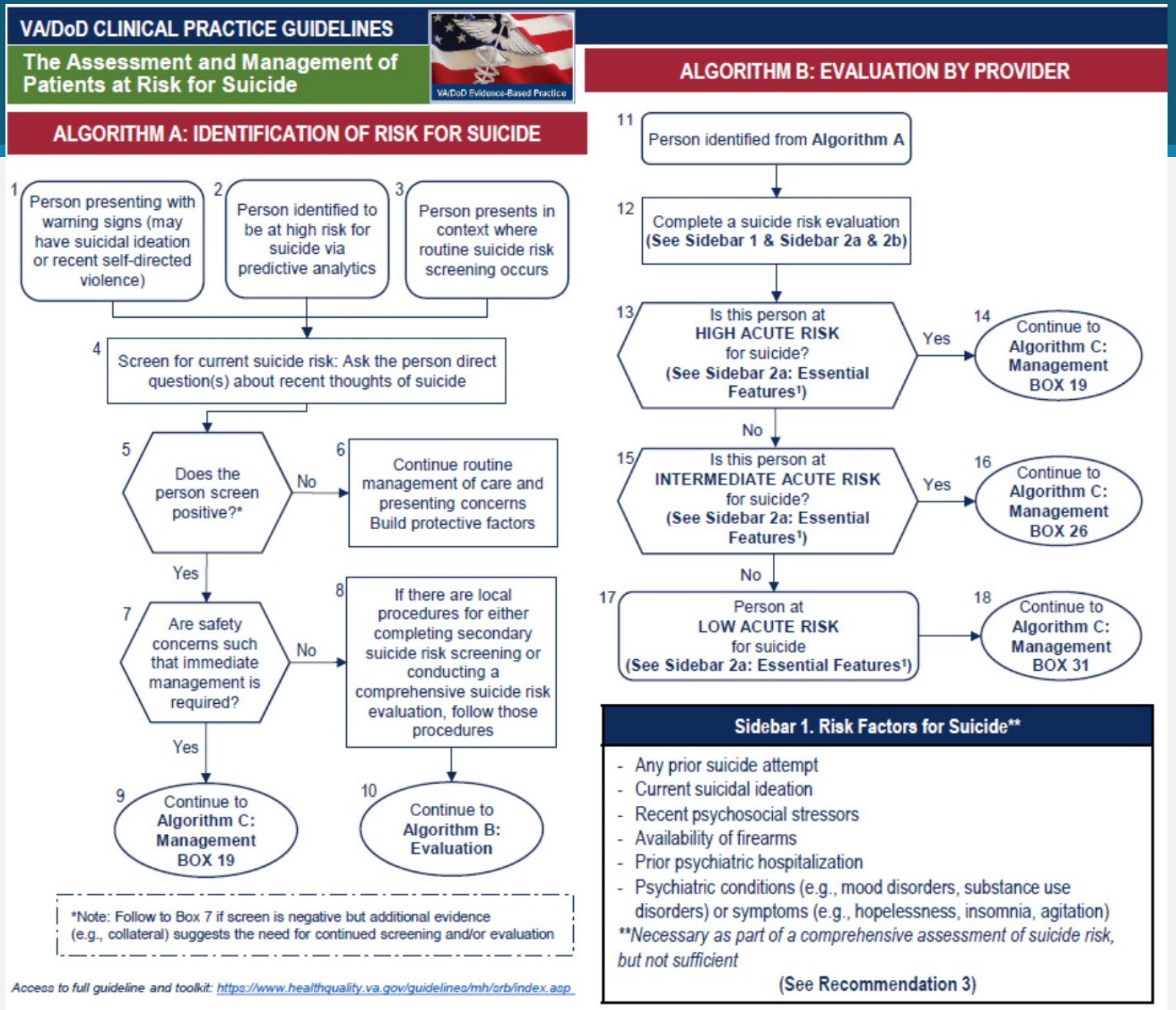
The model and its components are fully described in a series of four articles published in the Journal of Psychiatric Practice (see below under resources).

Rocky Mountain MIRECC

Home
Research
Education
Clinical
VA Suicide Risk Management Consultation Program
Resources for Clinicians
SDV Nomenclature
Assessment Tools
Therapeutic Risk Management
Lethal Means Safety
Fellowships
TBI Toolkit
Talking to Kids ab/ Suicide
About Us

Order Educational

VA/DoD Clinical Practice Guidelines



VA/DoD Clinical Practice Guidelines

Sidebar 2a. Essential Features from Risk Stratification Table – Acute Risk[1]

Level of Risk	Essential Features	Action
High Acute Risk	- Suicidal ideation with intent to die by suicide - Inability to maintain safety, independent of external support/help Common warning signs: - A plan for suicide - Recent attempt and/or ongoing preparatory behaviors - Acute major mental illness (e.g., major depressive episode, acute mania, acute psychosis, recent/ current drug relapse) - Exacerbation of personality disorder (e.g., increased borderline symptomatology)	- Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors - These individuals may need to be directly observed until they are transferred to a secure unit and kept in an environment with limited access to lethal means (e.g., keep away from sharps, cords or tubing, toxic substances) - During hospitalization co-occurring conditions should also be addressed
Intermediate Acute Risk	- Suicidal ideation to die by suicide - Ability to maintain safety, independent of external support/help These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g., children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.	- Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g., acute psychosis) - Outpatient management of suicidal thoughts and/or behaviors should be intensive and include: frequent contact, regular re-assessment of risk, and a well-articulated safety plan - Mental health treatment should also address co-occurring conditions
Low Acute Risk	- No current suicidal intent AND - No specific and current suicidal plan AND - No recent preparatory behaviors AND - Collective high confidence (e.g., patient, care provider, family member) in the ability of the person to independently maintain safety Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.	- Can be managed in primary care - Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and co-occurring conditions exist

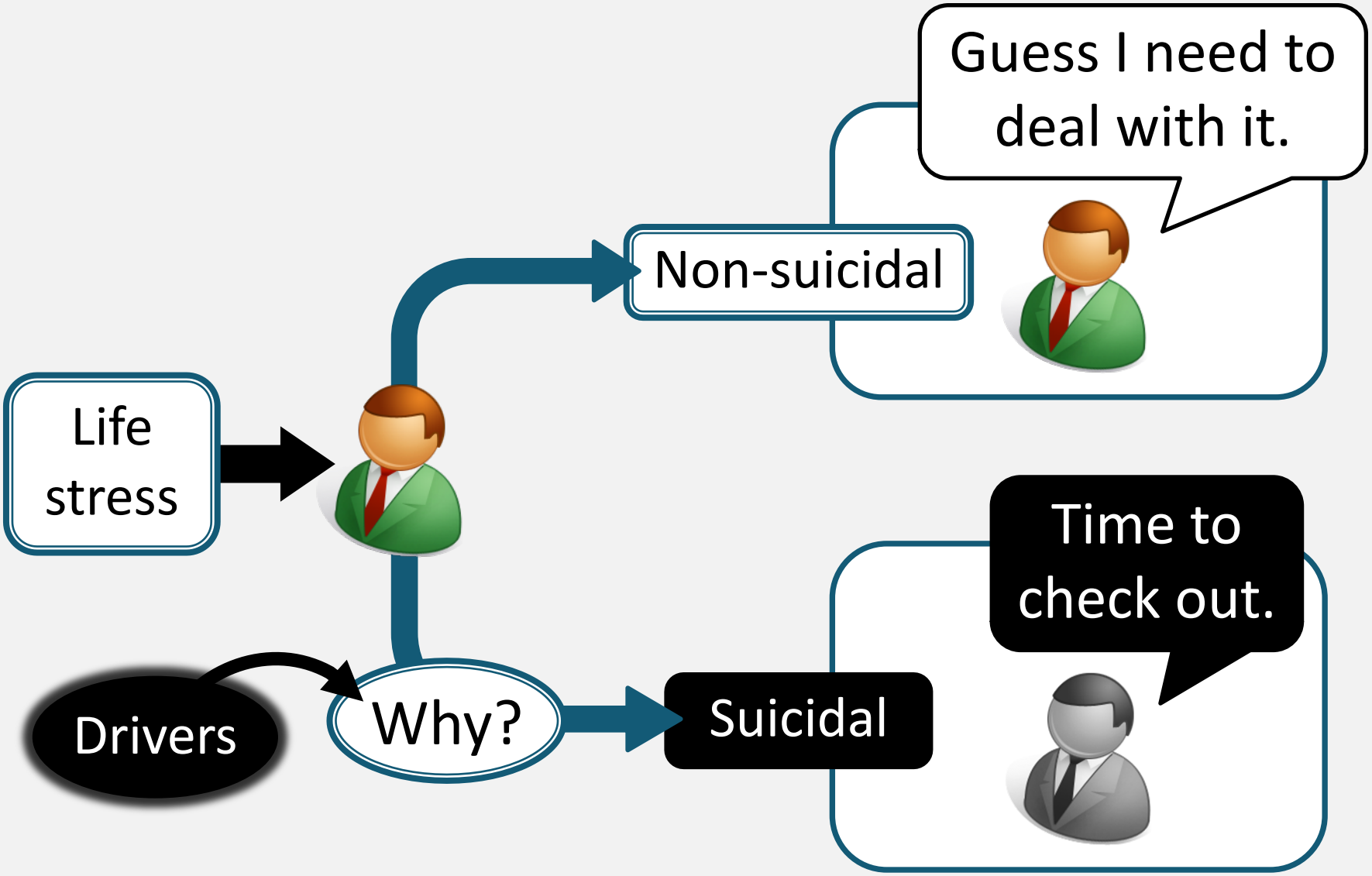
VA/DoD Clinical Practice Guidelines

Sidebar 2b. Essential Features from Risk Stratification Table – Chronic Risk[1]

Level of Risk	Essential Features	Action
High Chronic Risk	Common warning sign: - Chronic suicidal ideation Common risk factors: - Chronic major mental illness and/or personality disorder - History of prior suicide attempt(s) - History of substance use disorders - Chronic pain - Chronic medical condition - Limited coping skills - Unstable or turbulent psychosocial status (e.g., unstable housing, erratic relationships, marginal employment) - Limited ability to identify reasons for living	These individuals are considered to be at chronic risk for becoming acutely suicidal, often in the context of unpredictable situational contingencies (e.g., job loss, loss of relationships, relapse on drugs). These individuals typically require: - Routine mental health follow-up - A well-articulated safety plan, including lethal means safety (e.g., no access to guns, limited medication supply) - Routine suicide risk screening - Coping skills building - Management of co-occurring conditions
Intermediate Chronic Risk	- These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance use, medical and pain disorders - Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without engaging in self-directed violence	These individuals typically require: - Routine mental health care to optimize psychiatric conditions and maintain/enhance coping skills and protective factors - A well-articulated safety plan, including lethal means safety (e.g., safe storage of lethal means, medication disposal, blister packaging) - Management of co-occurring conditions

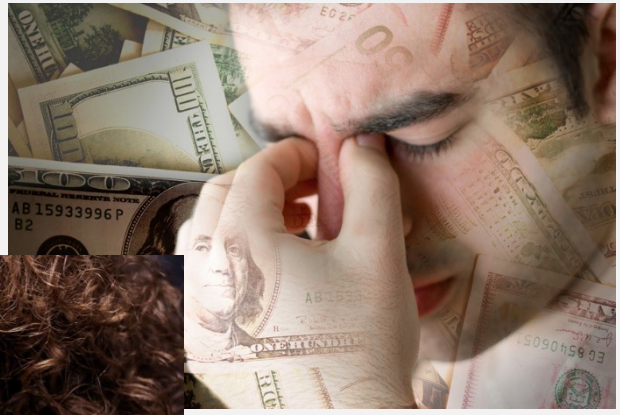
Low Chronic Risk	- These individuals may range from persons with no or little in the way of mental health or substance use problems, to persons with significant mental illness that is associated with relatively abundant strengths/ resources
	- Stressors historically have typically been endured absent suicidal ideation
	- The following factors will generally be missing:
	  - History of self-directed violence
	  - Chronic suicidal ideation
	  - Tendency towards being highly impulsive
	  - Risky behaviors
	  - Marginal psychosocial functioning
		- Appropriate for mental health care on an as needed basis, some may be managed in primary care settings
		- Others may require mental health follow-up to continue successful treatments

The Experience of Suicidality
What are the drivers of suicide?



There are many stressors, including psychiatric diagnosis, experienced by suicidal and non-suicidal individuals alike.

"Indirect drivers" of suicidality



Financial problems

Depression

Homelessness

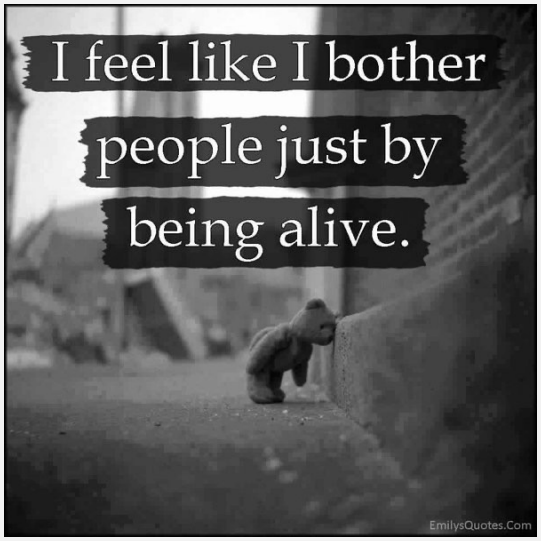
Relationship problems

The most effective treatments focus on the *unique problems of suicidal people* that prevent them from solving secondary drivers.

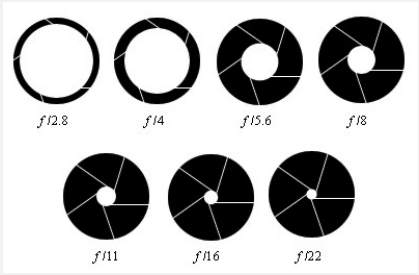
"Direct drivers" of suicidality

Stress & Agitation

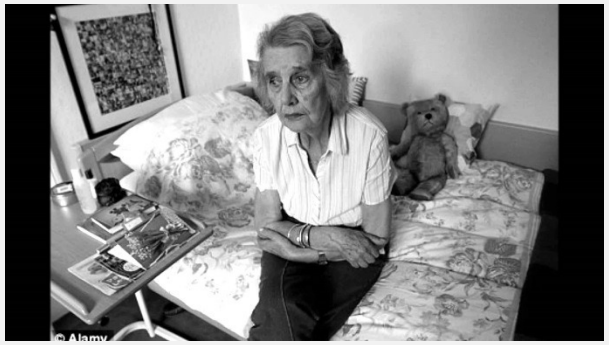
Intense emotion dysregulation or pain



Burdensomeness

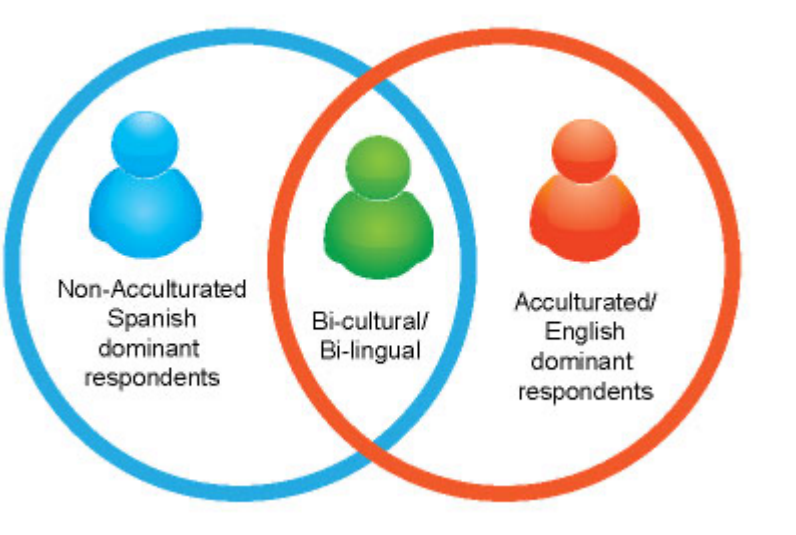


Attentional fixation on suicide



Lack of social connection

Minority and Cultural Drivers to Consider



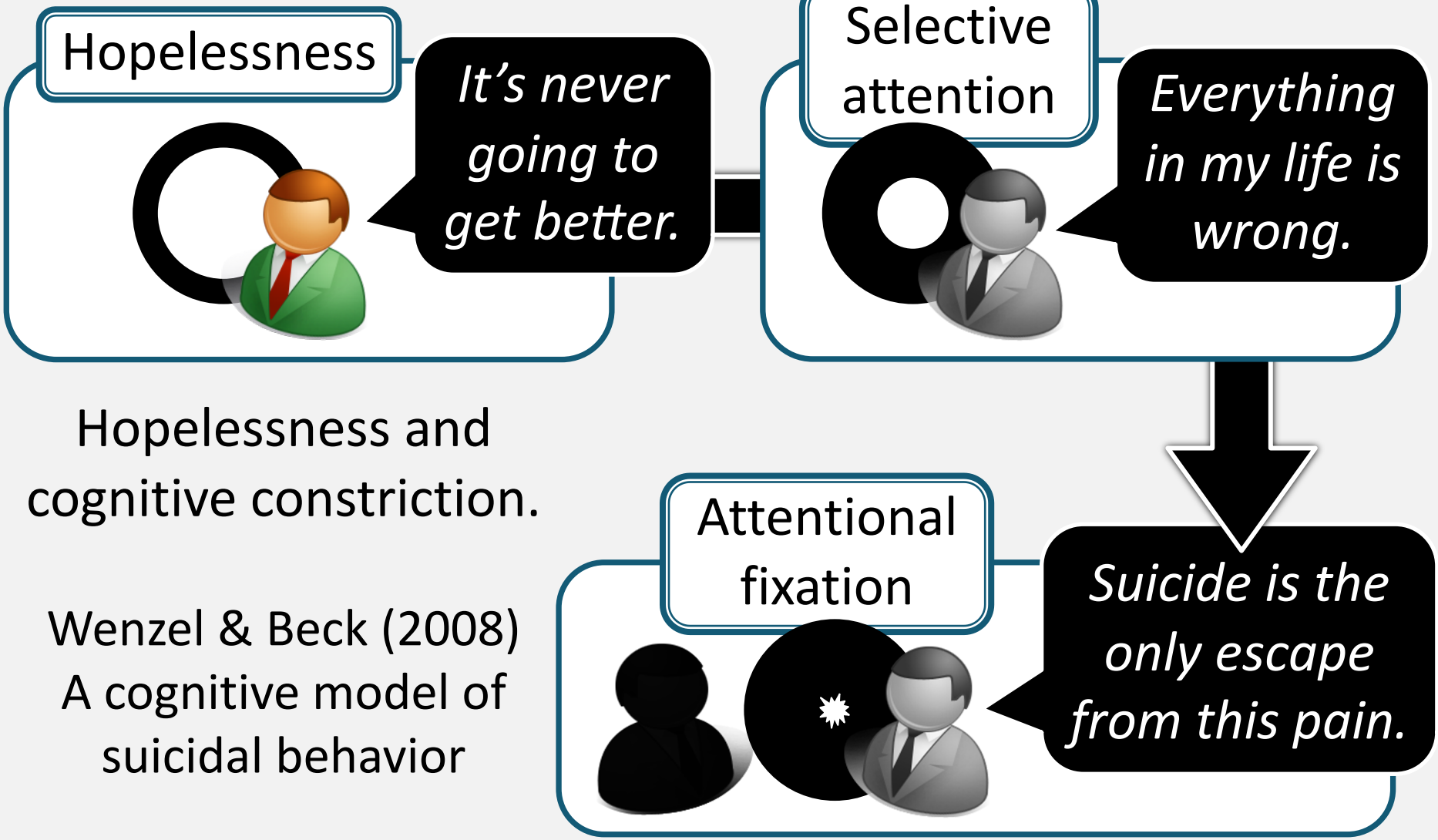
Acculturation

Historical Trauma

Familism

Religiosity

Wenzel & Beck's Cognitive Model of Suicidal Behavior
Hopelessness, Selective Attention, Attentional Fixation



Hopelessness and cognitive constriction.

Wenzel & Beck (2008)
A cognitive model of suicidal behavior

Assessment: Narrative Interviewing

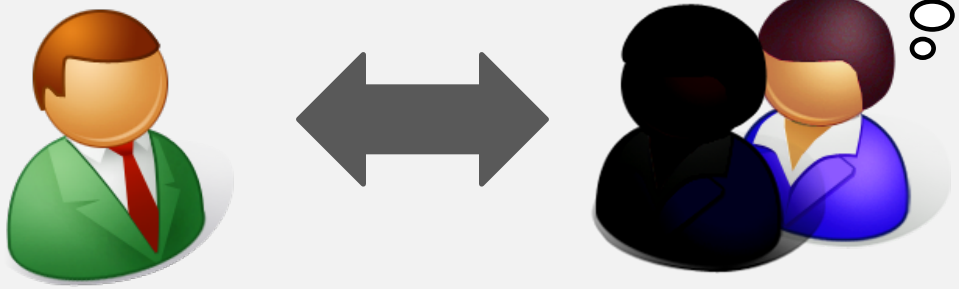
Narrative Interviewing

Please *tell* me the *story* of what led to the suicidal crisis. Just let me listen to you.

Themes

Self-esteem
Separation and Loss
Rejection
Restrained or Dependent

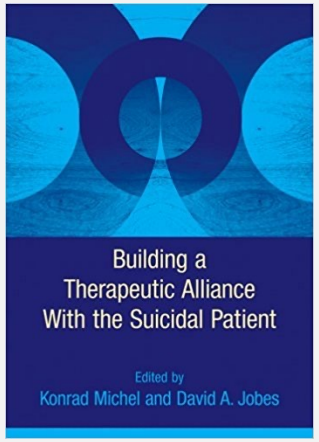
Aeschi group



Narrative interviewing: An effort find a story so that actions make sense. "*Tell*" and "*story*" correlated with alliance (Michel et al., 2004).

Aeschi Model – Collaboration and the Suicidal Narrative

1. The clinician's task is to reach, together with the patient, a shared understanding of the patient's suicidality.
2. The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect.
3. The interviewer's attitude should be non-judgmental and supportive.
4. The interview should start with the patient's narrative.
5. The ultimate goal must be to engage the patient in a therapeutic relationship.



Management vs. Treatment

Client

Nothing is working. I should just kill myself.

1

What do you think about a short hospitalization?

Therapist

Client

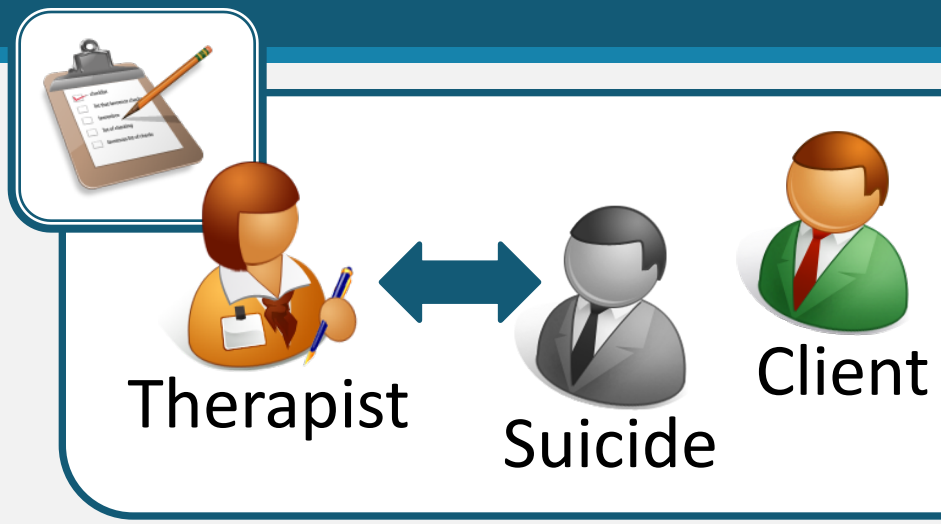
Nothing is working. I should just kill myself.

2

Can we take a closer at that way of thinking?

Therapist

Management of Suicide Risk

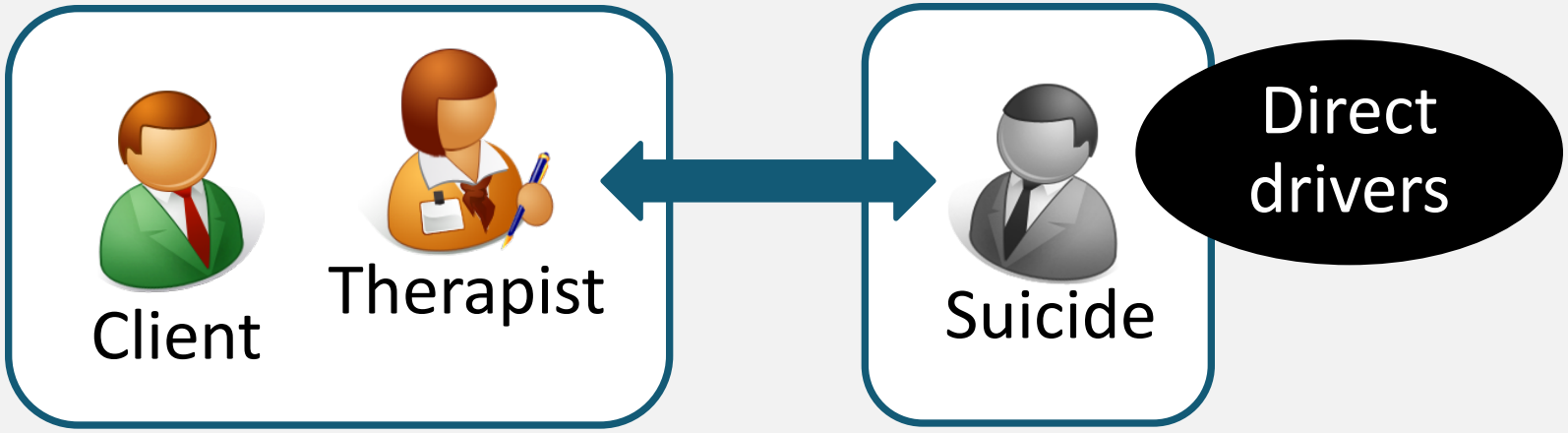


Continuity of care
(managing transitions, discharge & referral)
Psychiatric treatment
Safety planning, including means safety

Management

Therapist engages in interventions that seek to *reduce risk* by modifying risk factors related to suicide. Management is *optimally*, but *not necessarily*, collaborative.

Treatment of Suicide Risk



Treatment

Therapist and client engage in a *collaborative relationship* to *resolve risk* by targeting internal factors that are unique/intrinsic to suicide risk. Treatment is *necessarily* collaborative.

Treatment of Suicide Risk

Consultative & Collaborative

Therapist

Client

Suicide

Self-Management

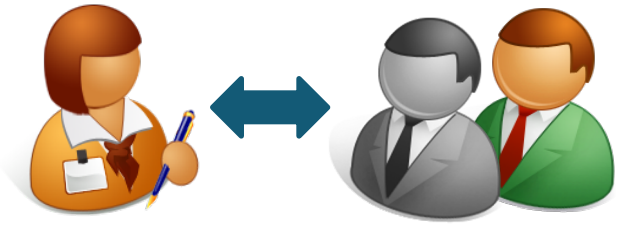
Treatment to Promote Self-Management

Over time, the patient grows in confidence and responsibility in self-management of suicide risk.

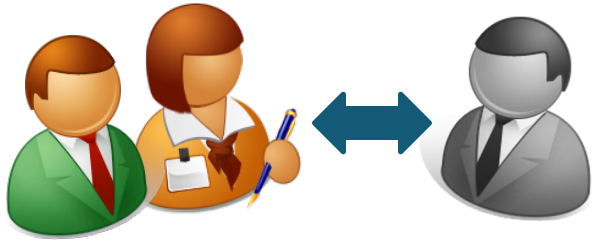
Ellis. (2004). *Collaboration and a self-help orientation in therapy with suicidal clients.*

Treatment for Suicidality

Management

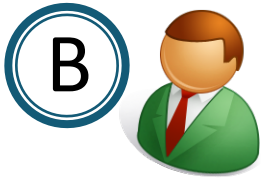


Treatment

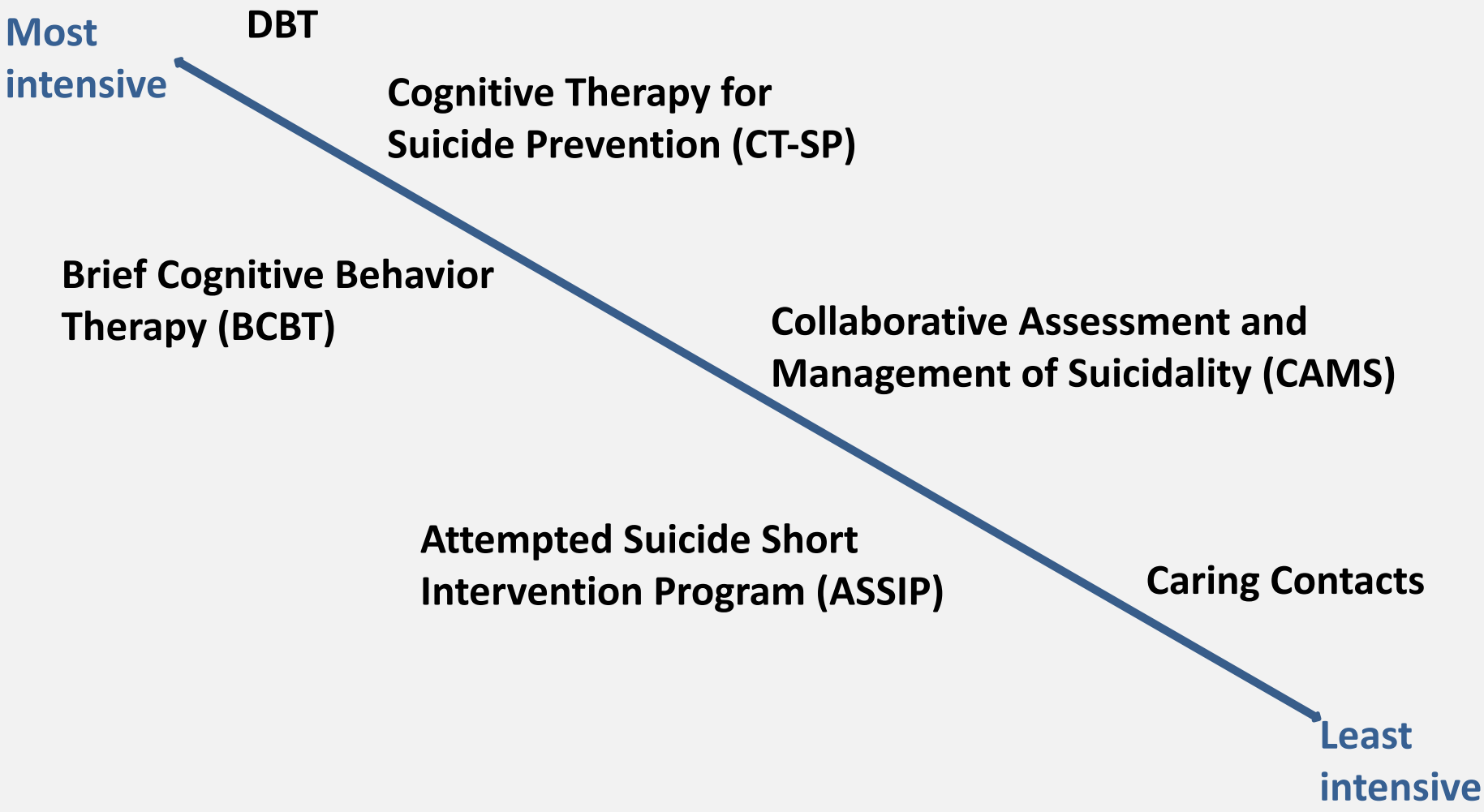


	Collaboration	Goal	Target
Management	Optimal when collaborative	Reduce risk	External factors related to suicide risk
Treatment	Necessarily collaborative	Resolve risk	Internal factors intrinsic to suicide risk

Goal of Psychotherapy is the Resolution of Suicidality

Suicidal 	Non-suicidal 
Interpersonal Theory of Suicide	
Thwarted belongingness	Connection and belonging
Perceived burdensomeness	Value, purpose and self-worth
Hopelessness, helplessness	Hope, agency
Cognitive Theory of Suicide	
Selective attention, attn. fixation	Mindfulness and perspective
Emotion Dysregulation	
Emotion dysregulation and skills deficits in emotion-regulation, problem-solving, communication	Mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, problem-solving

Evidence Based Treatments for Suicidality: A Story for Another Day



Telehealth Practice/Agency Plans

Lead Telehealth Sessions with Contact Information

- Where is the person located for your call/session?
- At what phone number can you reach them?

- If you are going to have an ongoing relationship with the patient, establish who their emergency contact is and explain you will reach out to that person *if*
  - You are concerned they are at imminent risk and
  - ____What____? (conditions where you would act against the patient's confidentiality and autonomy)

REMEMBER – you cannot control their behavior and are responsible for your behavior not theirs

Telehealth Practice/Agency Plans

Agree on Policy and Procedures

- Up front, when no one patient is at risk, decide on how you want to approach high risk situations on telehealth
- Include the right players from clinicians up through leadership and risk management (or a colleague, attorney, or ethics consult with your professional organization, if solo practice)

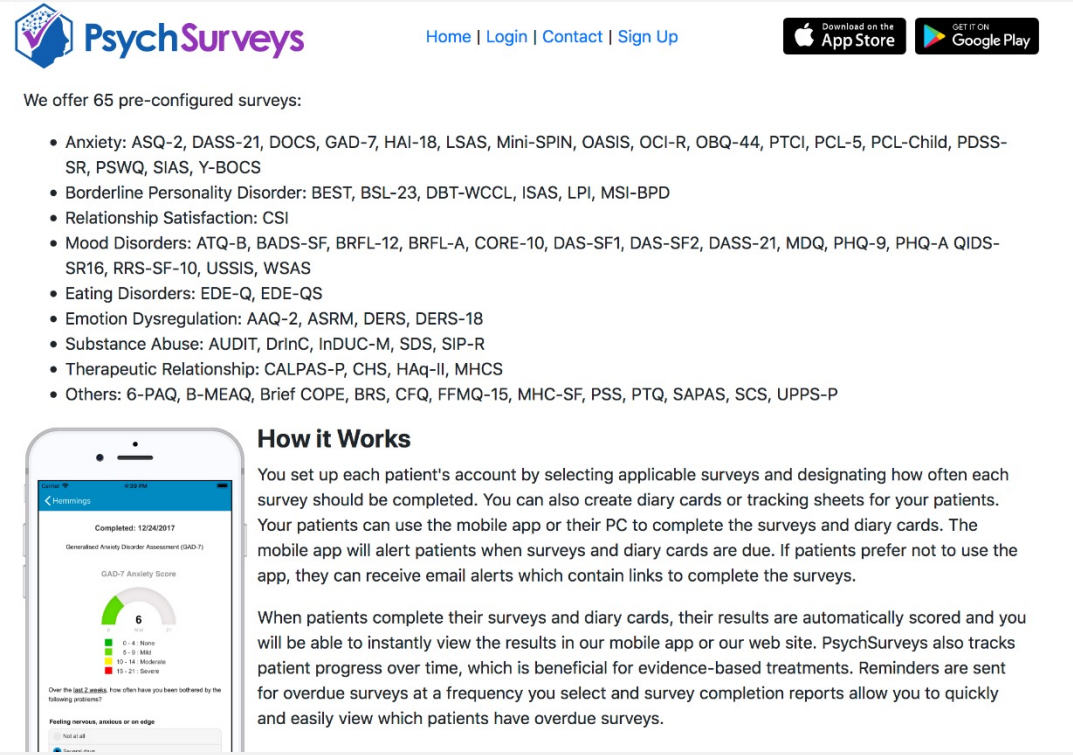
- Have written P&P ready to share with any attorney or reviewer who request records after a bad outcome
- Adapt informed consent documents, as needed

REMEMBER – you cannot control patient's behavior and are responsible for your behavior not theirs

Telehealth Options for Risk Assessment

Online Surveys

- PHQ-9 in EPIC can be conducted online ahead of session
- PsychSurveys



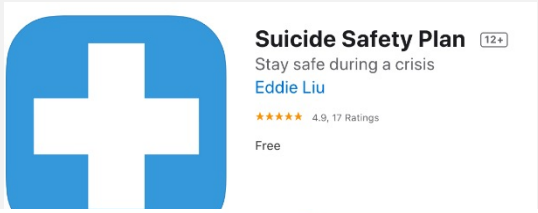
- Other self-monitoring apps

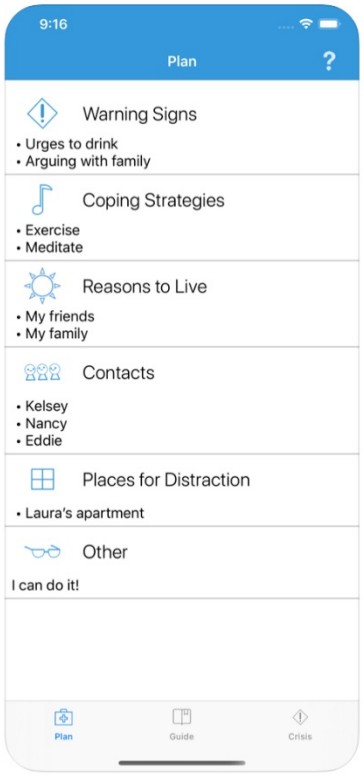
ONE MIND PsyberGuide

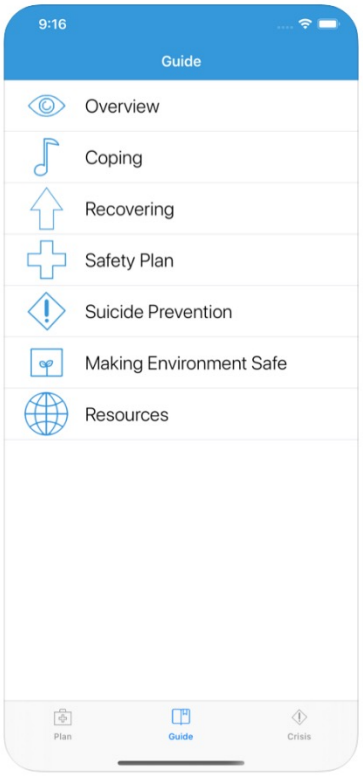
Non-profit company that rates apps for safety, data privacy and user ratings

Telehealth Options for Risk Management

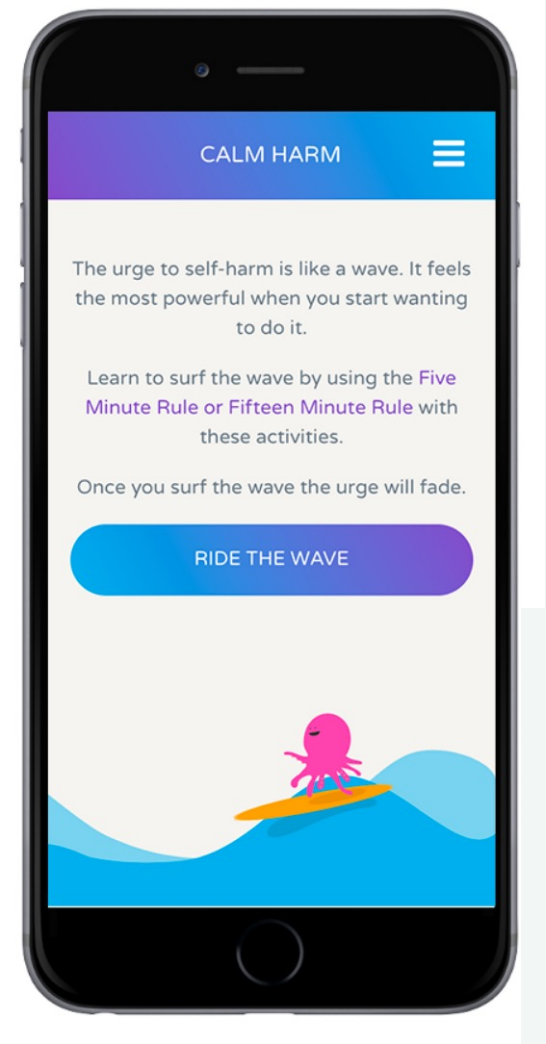
Safety Plan and Crisis Management Apps





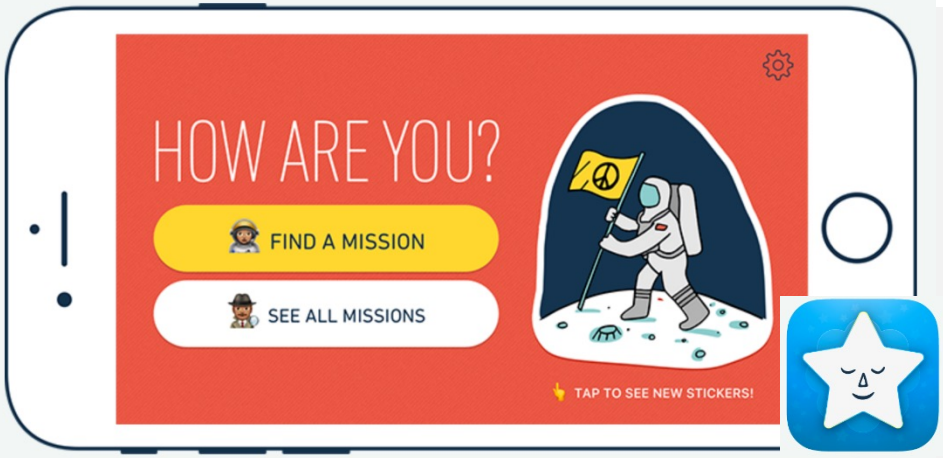


Telehealth Options for Coping Skills



ONE MIND PsyberGuide

Woebot® Health



STOP, BREATHE & THINK KIDS

VA Free Telehealth and Suicide Resources

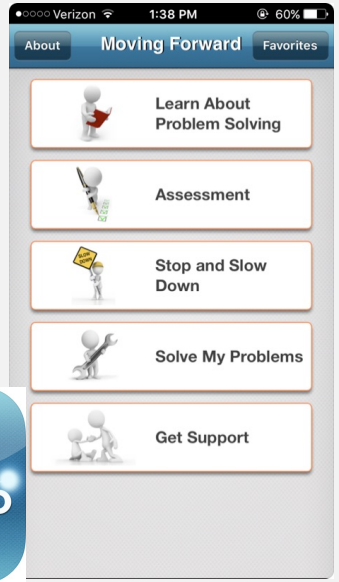
ROCKY MOUNTAIN MIRECC FOR SUICIDE PREVENTION

Uniting for Suicide Postvention USPV

SUICIDE RISK MANAGEMENT Consultation Program

FOR PROVIDERS WHO SERVE VETERANS

BROADCASTING @rmirecc



MOVING FORWARD

National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

itabase

Self-Help

These apps provide support and guidance in living with PTSD.

PTSD Coach | PTSD Family Coach | Mindfulness Coach | VetChange

Treatment Companions

These apps offer additional help for PTSD treatments.

CPT Coach | PE Coach | CBT-i Coach | ACT Coach

Related

These apps help with related issues affecting people with PTSD.

COVID Coach | Insomnia Coach | Mood Coach | Concussion Coach

Let's come back now with a discussion: In-Person vs. Telehealth with Suicidal Patients

In-Person

1. Physical access to the patient if they need to be transported to higher level of care
2. Potentially greater engagement
3. Increased behavioral activation in coming to the office
4. Privacy easier to achieve
5. Crisis Response Planning more straightforward

Telehealth

1. Less chance of spreading COVID-19
2. Observe the patients' living situation
3. Opportunity for visual inspection for lethal means counseling
4. Facilitate engagement with patients' family
5. Increase attendance in treatment and ability to reschedule

Questions? Thoughts? Concerns?

I still don't see how…

Well, what about when…

I had a patient once who…

I'm not sure this would work with…

This would help so much with…

So are you saying that…

How would this work with…

Behavioral Health Institute (BHI)
Training, Workforce and Policy Innovation Center

BEHAVIORAL HEALTH TELEHEALTH RESOURCE

For more information including upcoming training & additional resources:

Visit us online:
https://bhi-telehealthresource.uwmedicine.org/

Email us:
melmckee@uw.edu

Slides & resources will be posted after the session
https://bhi-telehealthresource.uwmedicine.org/

After today's session:

- **Registration at Pre-Registration (iths.org)**
- **Post-webinar email:**
  - **Evaluation – required for each session to obtain a Certificate of Completion.**
  - **Certificate of Completion – no cost.**
    - **May be able to use Certificate of Completion to meet CE requirements.**
  - **CME information – nominal cost.**

April 8

BEHAVIORAL HEALTH INSTITUTE

HARBORVIEW MEDICAL CENTER

UW Medicine | King County

TELEBEHAVIORAL HEALTH 201 SERIES

Monthly series: 3rd Friday of each month, 11am-12pm PST:

- **10/23/20 – TELEHEALTH POLICY – THE CHANGING FEDERAL AND STATE LANDSCAPE**
- **11/20/20 – PREPARING PATIENTS & TECHNOLOGY for TELEHEALTH**
- **12/18/20 – DOING GROUPS over TELEHEALTH**
- **01/15/21 – MOBILE HEALTH (mHEALTH) FOR SERIOUS MENTAL ILLNESS**
- **02/19/21 – PROVIDER SELF-CARE & WELLNESS in the ERA of TELEHEALTH and COVID**
- **03/19/21 – BEHAVIORAL HEALTH APPS**
- **04/16/21 – CHILDREN and TELEBEHAVIORAL HEALTH**
- **05/21/21 – APPLYING TELEHEALTH to SUD TREATMENT in COMMUNITY-BASED SETTINGS**
- **06/18/21 – CULTURAL COMPETENCE & HUMILITY in TELEBEHAVIORAL HEALTH**
- **07/16/21 – APPLYING TELEHEALTH to MEASUREMENT-BASED CARE**
- **08/20/21 – SUICIDE RISK ASSESSMENT over TELEHEALTH**
- **09/17/21 – COUPLES & FAMILY THERAPY over TELEHEALTH**

A CERTIFICATE OF COMPLETION WILL BE ISSUED FOR EACH SESSION ATTENDED

CME Accreditation Register at: https://uw-phi.zoom.us/webinar/register/WN_6GBzJWGXRE6yNM9N_fRIjA

The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of Washington School of Medicine designates this live activity for a maximum of ***12*** *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity. (Each session is 1.0 credits)

TELEBEHAVIORAL HEALTH 101

- **6-module Online Self-Study***

https://NRTRC.catalog.instructure.com/programs/telebehavioral-health-101-series

- Introduction to TeleBehavioral Health and Policy Overview*
- Getting started: Facts & Myths, and Security & Privacy
- Digital Health Do's & Don't's, Workflows, and Safety planning
- Billing and Reimbursement for TeleBehavioral Health
- Clinical Engagement over Telehealth
- Clinical Supervision in Telehealth

***Session 1 will meet the requirements for telehealth training as established by Washington SB6061, effective January 2021. A certificate will be issued for each module completed.**

Please see next slide for CME information….

BEHAVIORAL HEALTH INSTITUTE

HARBORVIEW MEDICAL CENTER

UW Medicine | King County

TELEBEHAVIORAL HEALTH 101

CME Information

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The University of Washington School of Medicine designates this enduring material for a maximum 1 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Learners have the opportunity to complete up to 6 modules, with each module accredited for 1 *AMA PRA Category 1 Credit™.*

- **6-session Interactive Webinar**

The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of Washington School of Medicine designates this live activity for a maximum of ***6*** *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity. (Each session is 1.0 credits)

Learners may obtain CME credits from the online self-study module OR the webinar series, but not both.

TELEBEHAVIORAL HEALTH
101 and 201 SERIES

Continuing Education for Social Workers

This series has been approved for CEUs by the Washington Chapter, National Association of Social Workers (NASW) for Licensed Social Workers, Licensed Marriage & Family Therapists and Licensed Mental Health Counselors. Our Provider number is #1975-433. (Each session is 1 credit)

Seeking your input regarding continued support.

Additional Resources…

CME-accredited Case Conference Series for Washington State Healthcare Providers

Psychiatry & Addictions Case Conference (UW PACC-ECHO)

Didactic presentations and case consultations

12:00-1:30 pm, Thursdays

uwpacc@uw.edu ictp.uw.edu/programs/uw-pacc

UW TelePain

Didactic presentations and case consultations

12:00-1:30 pm, Wednesdays

telepain@uw.edu

https://depts.Washington.edu/anesth/care/pain/telepain

CME Accreditation

The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of Washington School of Medicine designates this live activity for a maximum of ***72*** *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity. (Each session is 1.5 credits)

Telephone Consultation Services for WA Healthcare Providers

Psychiatry Consultation

Psychiatry Consultation Line (PCL) - prescribing providers with adult psychiatry and/or addictions questions
877-WA-PSYCH (877-927-7924) | pclwa@uw.edu | https://pcl.psychiatry.uw.edu/

Partnership Access Line (PAL) - PCPs with child/adolescent psychiatry questions
866-599-7257 | paladmin@seattlechildrens.org | www.seattlechildrens.org/PAL

PAL for Moms - behavioral health questions related to pregnancy & postpartum
877-PAL4MOM (877-725-4666) | ppcl@uw.edu | www.mcmh.uw.edu/ppcl

Pain & Opioid Consultation

Pain & Opioid Provider Consultation Hotline - for providers caring for patients with complex pain medication regimens, particularly high dose opioids
1-844-520-PAIN (7246) | Staffed by UW Division of Pain Medicine pharmacists and physicians

UW Medicine
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Washington State Health Care Authority

Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION