

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

Behavioral Health Telehealth Resource

Visit our [website](#)

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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

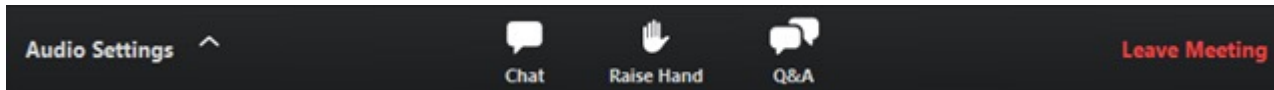
## CHAT Box

- 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)

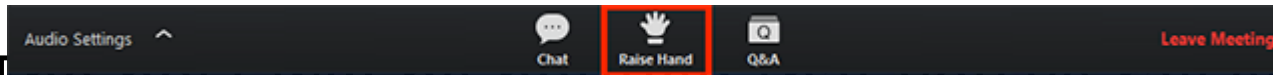
# WEBINAR LOGISTICS

## 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

Melody McKee SUDP MS

Cara Towle MSN RN

Kimbo Smith MA MEd

# DISCLAIMER

Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.

Always consult with legal counsel.

We gratefully acknowledge the support from



and





# Mobile health (mHealth) for schizophrenia-spectrum disorders: Reducing risk, Increasing reach

**Ben Buck, Ph.D.**

Behavioral Research in Technology and  
Engineering (BRiTE) Center

Department of Psychiatry and Behavioral Sciences  
University of Washington

**W** UNIVERSITY of WASHINGTON

 BRiTE

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# Treatment guidelines identify at least **eight evidence-based psychosocial interventions** for schizophrenia

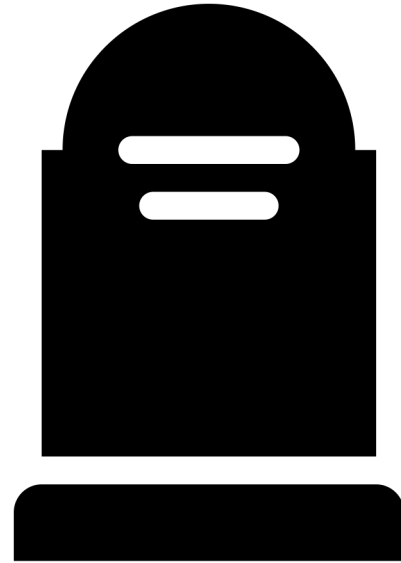
Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., ... & Peer, J. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia bulletin*, 36(1), 48-70.

# But...

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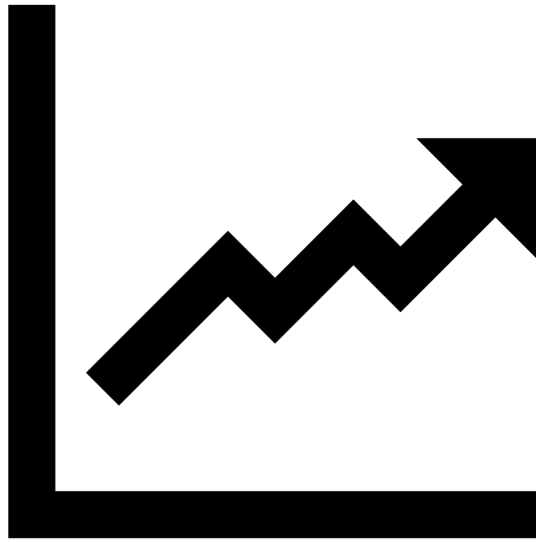
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# Individuals with schizophrenia lose **28.5 years** of **life expectancy** on average

Olson M, Gerhard T, Huang C, Crystal S, Stroup TS. Premature Mortality Among Adults With Schizophrenia in the United States. JAMA Psychiatry. 2015 Dec;72(12):1172-81. PMID: 26509694



# Schizophrenia is a leading cause of global disability

US Burden of Disease Collaborators. The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. *JAMA*, 310(6): 591-608, 2013.

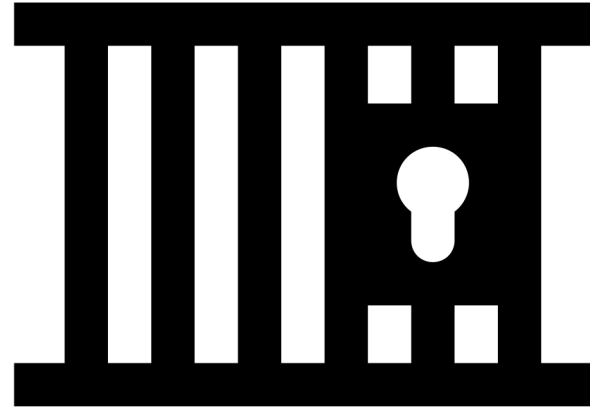
Vos, T., Abajobir, A. A., Abate, K. H., Abbafati, C., Abbas, K. M., Abd-Allah, F., ... & Aboyans, V. (2017). Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *The Lancet*, 390(10100), 1211-1259.





# **Around 1 in 5 individuals experiencing houselessness are affected by psychosis**

Ayano, G., Tesfaw, G., & Shumet, S. (2019). The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis. *BMC psychiatry*, 19(1), 370.



# Overrepresented **three to six times** in the U.S. prison population

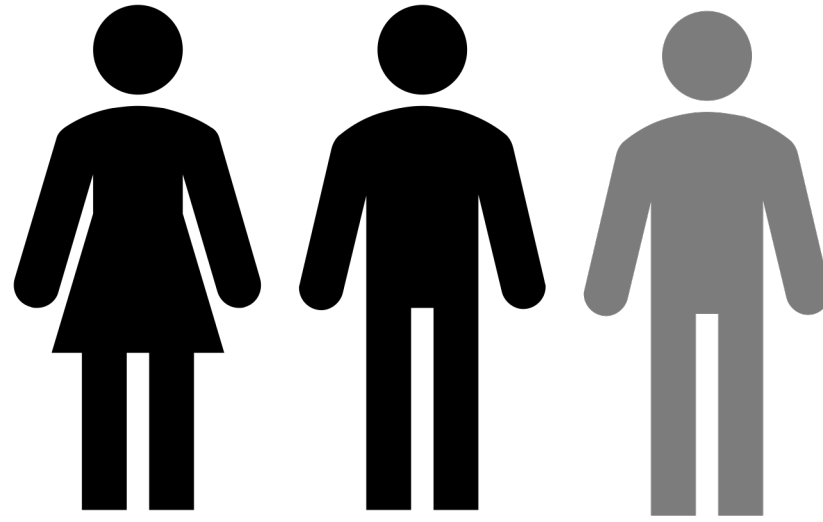
Prins, S. J. (2014). Prevalence of mental illnesses in US state prisons: A systematic review. *Psychiatric Services*, 65(7), 862-872.

# Why?

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About 2 in 3 individuals with schizophrenia are **not receiving treatment** for their condition

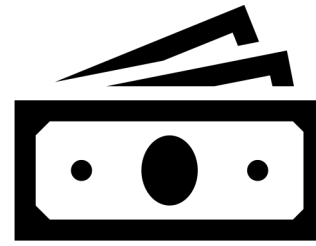
Lora A et al.. Service availability and utilization and treatment gap for schizophrenic disorders: a survey in 50 low- and middle-income countries. Bulletin World Health Organization; 2012: 10.2471/BLT.11.089284.



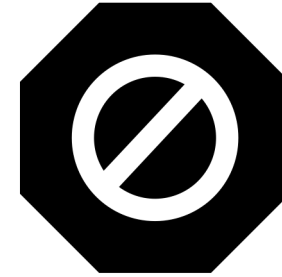
Scarcity



Long distance from  
clinics



High costs



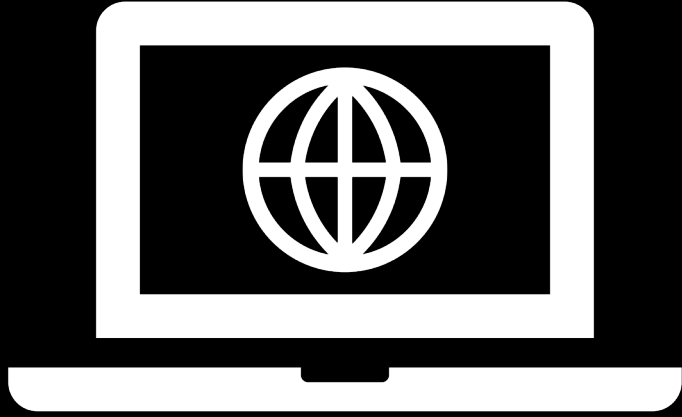
Negative  
beliefs about  
treatment

# Significant **barriers** to treatment for SMI

Drake, R. E., & Essock, S. M. (2009). The science-to-service gap in real-world schizophrenia treatment: the 95% problem. *Schizophrenia Bulletin*, 35(4), 677-678.

MacDonald, K., Fainman-Adelman, N., Anderson, K. K., & Iyer, S. N. (2018). Pathways to mental health services for young people: a systematic review. *Social psychiatry and psychiatric epidemiology*, 53(10), 1005-1038.

Dockery, L., Jeffery, D., Schauman, O., Williams, P., Farrelly, S., Bonnington, O., ... & Clement, S. (2015). Stigma-and non-stigma-related treatment barriers to mental healthcare reported by service users and caregivers. *Psychiatry Research*, 228(3), 612-619.



**Digital health**



**Mobile health  
(mHealth)**



Small reach

Large reach

Clinic based appointment

Enrolled in treatment, outside of clinic

Outside the clinic, relapse prevention

Before initial presentation to clinic

**mHealth as treatment**  
 FOCUS and the mHealth support specialist

**mHealth for prevention**  
 Symptom detection and assessment with ecological momentary assessment and sensors

**mHealth for treatment seeking**  
 mHealth for first episode psychosis and DUP



# I: mHealth for clinical care

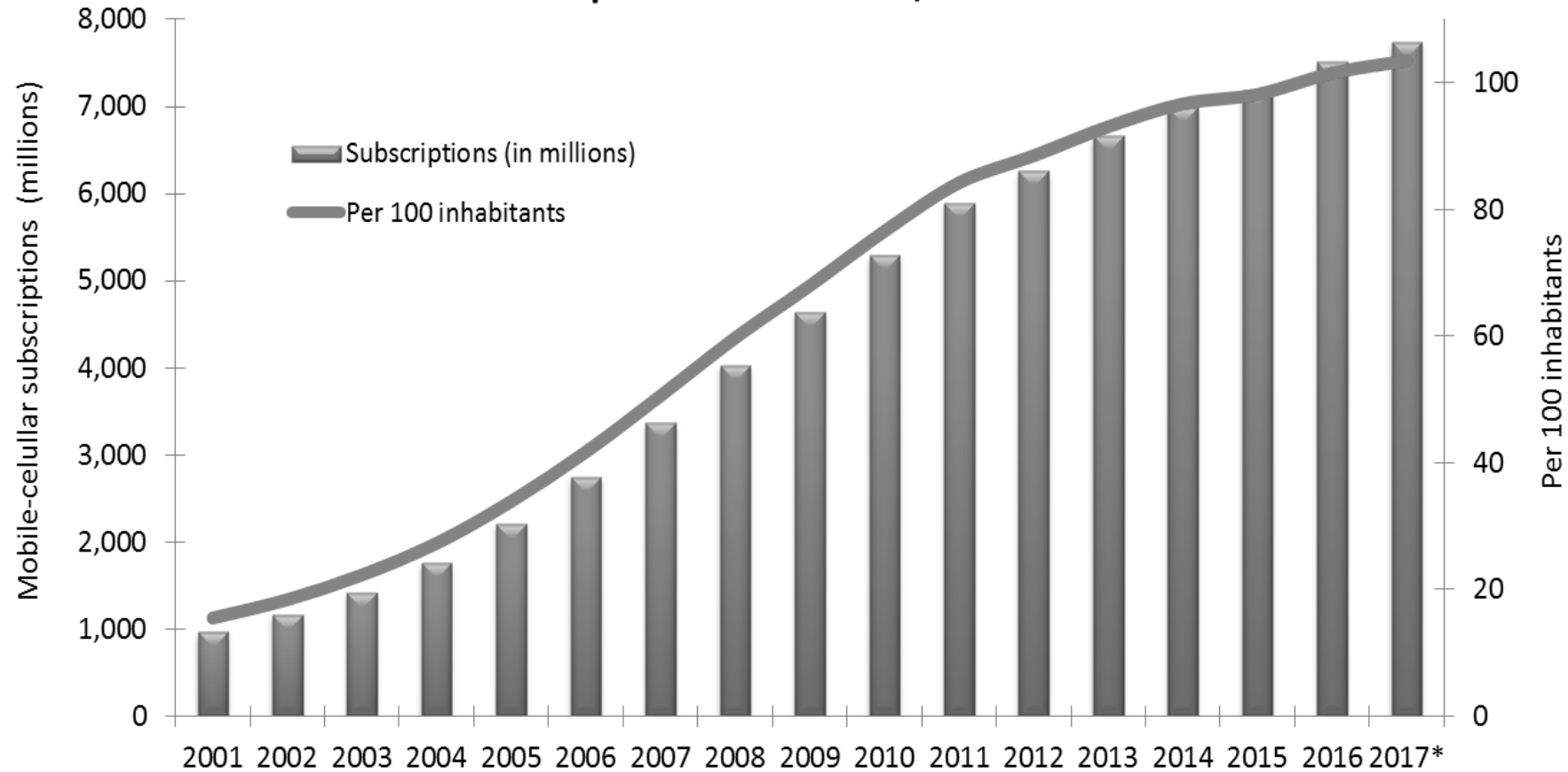
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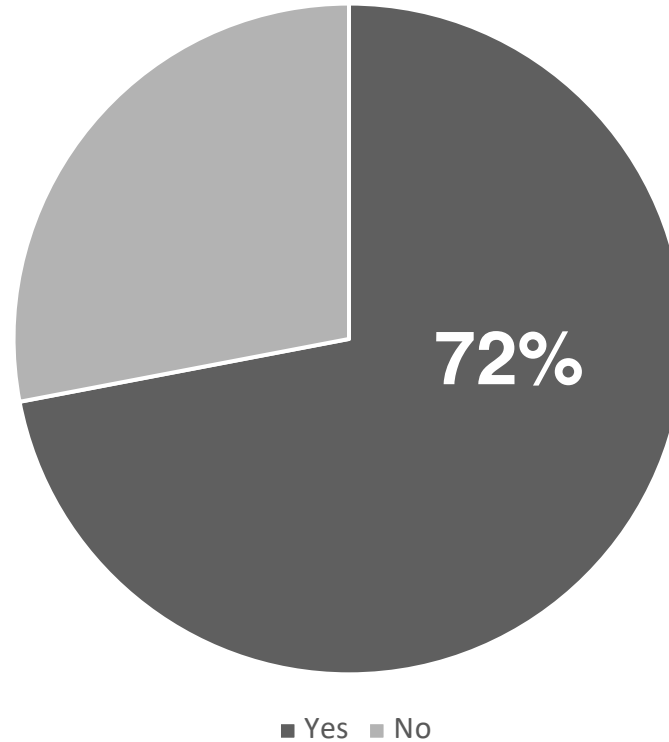
## Global mobile-cellular subscriptions, total and per 100 inhabitants, 2001-2017\*



Note: \* Estimate

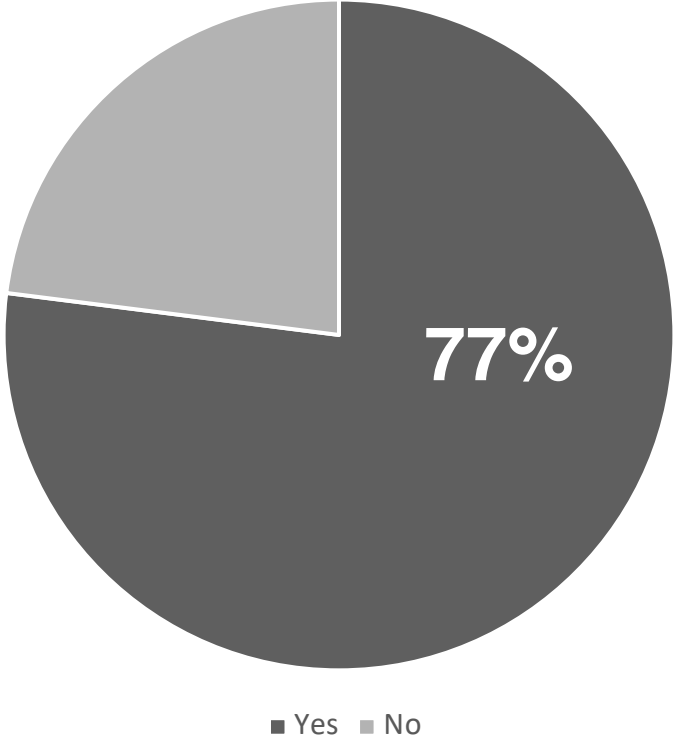
Source: ITU World Telecommunication /ICT Indicators database

# Mobile phone ownership amongst people with SMI



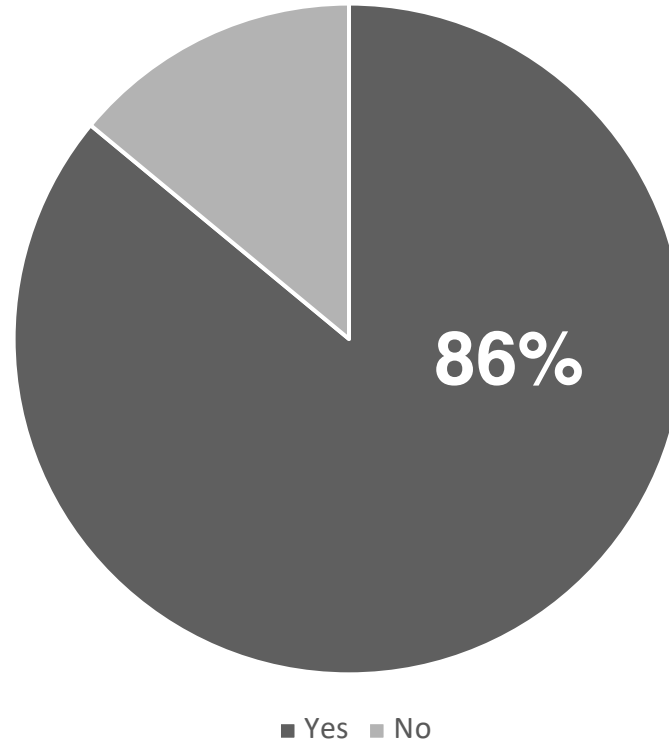
Ben-Zeev, D., Davis, K. E., Kaiser, S., Krzsos, I., & Drake, R. E. (2013). Mobile technologies among people with serious mental illness: opportunities for future services. *Administration and Policy in Mental Health and Mental Health Services Research*, 40(4), 340-343.

# Mobile phone ownership amongst people with SMI



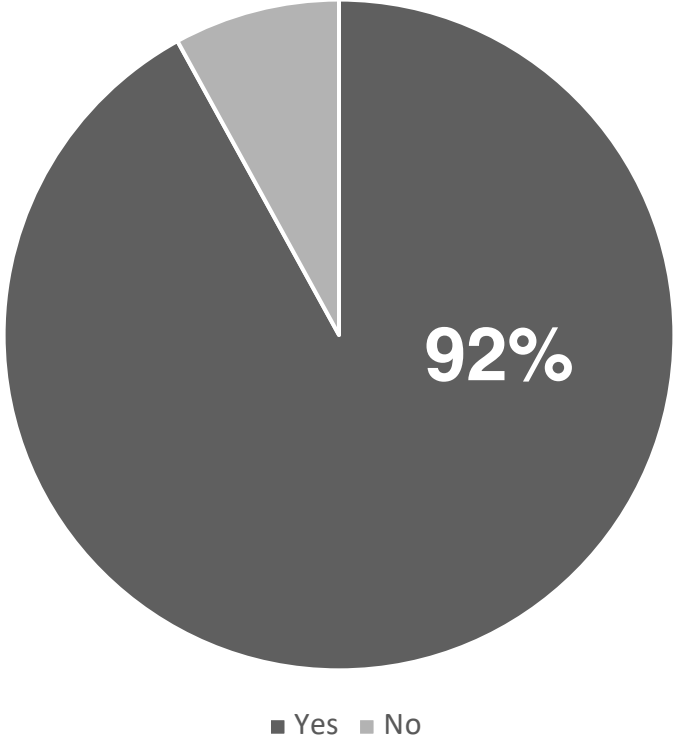
Campbell, B., Caine, K., Connelly, K., Doub, T., & Bragg, A. (2015). Cell phone ownership and use among mental health outpatients in the USA. *Personal and Ubiquitous Computing*, 19(2), 367-378.

# Mobile phone ownership amongst people with SMI

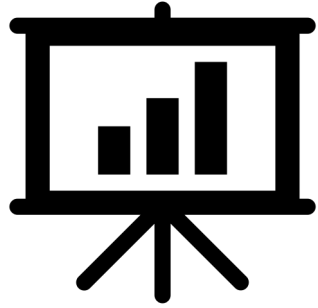


Carras, M. C., Mojtabai, R., Furr-Holden, C. D., Eaton, W., & Cullen, B. A. (2014). Use of mobile phones, computers and internet among clients of an inner-city community psychiatric clinic. *Journal of Psychiatric Practice*, 20(2), 94.

# Mobile phone ownership amongst people with SMI



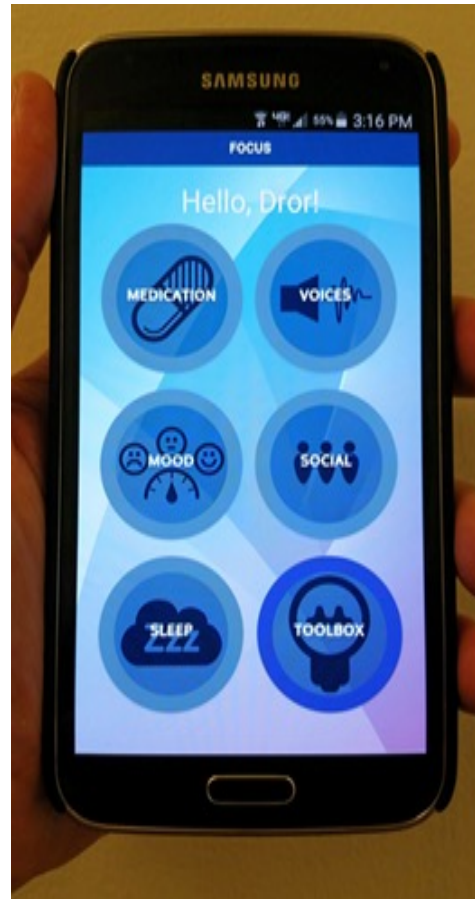
Noel, V. A., Acquilano, S. C., Carpenter-Song, E., & Drake, R. E. (2019). Use of mobile and computer devices to support recovery in people with serious mental illness: survey study. *JMIR mental health*, 6(2), e12255.



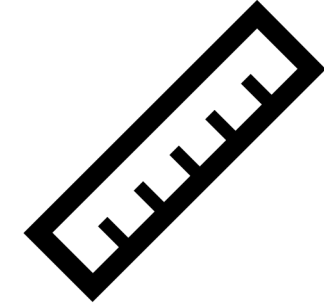
**Evidence-based**



**Intervention**



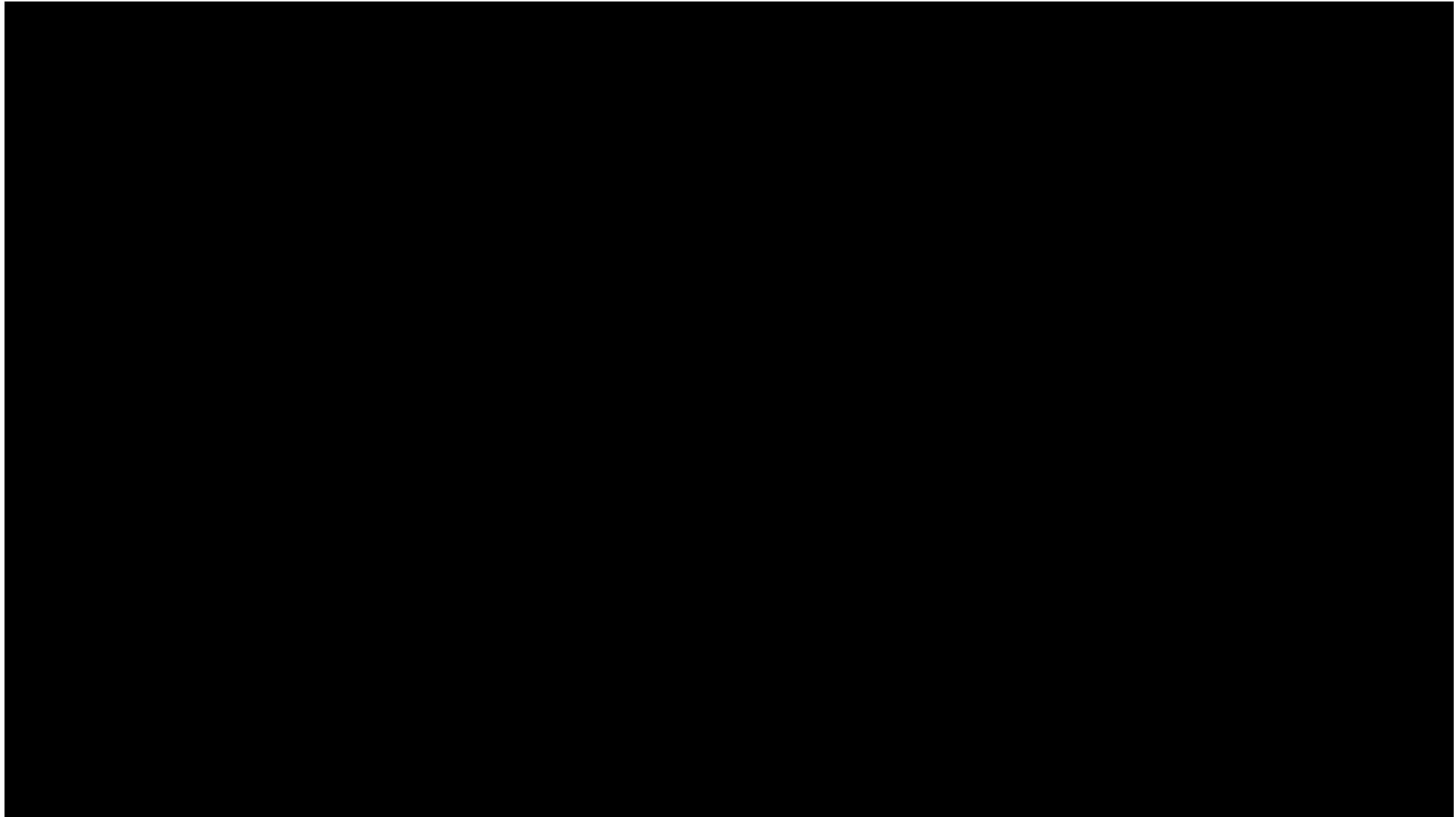
**FOCUS**



**Measurement and outreach**



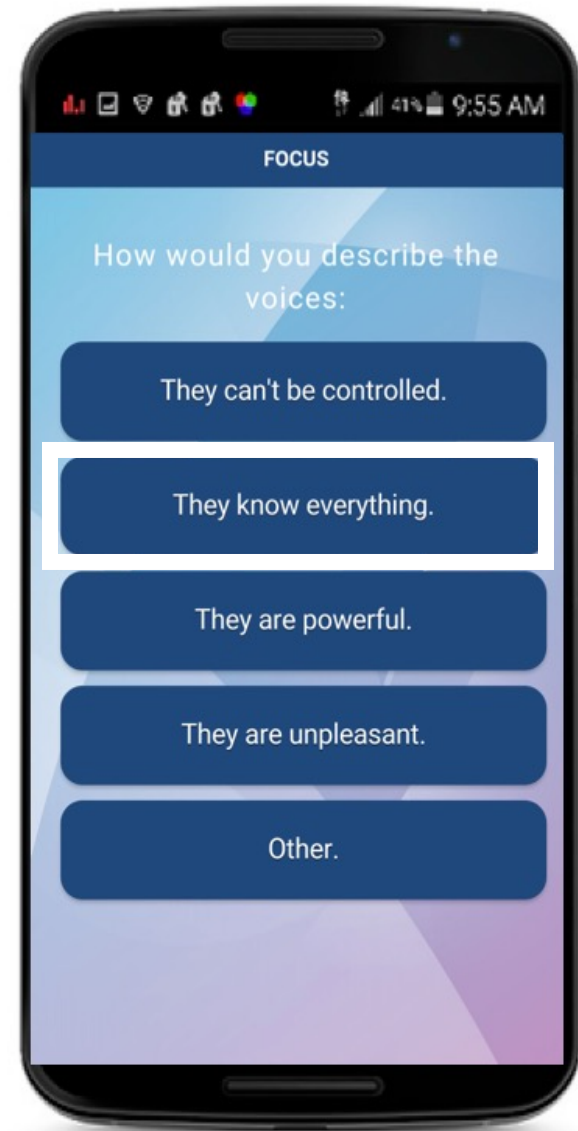
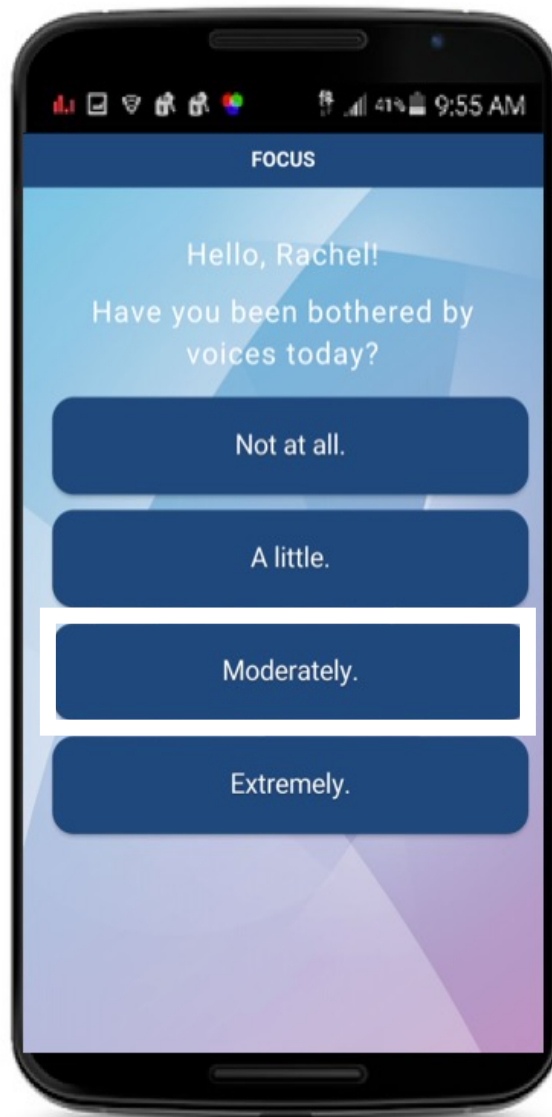
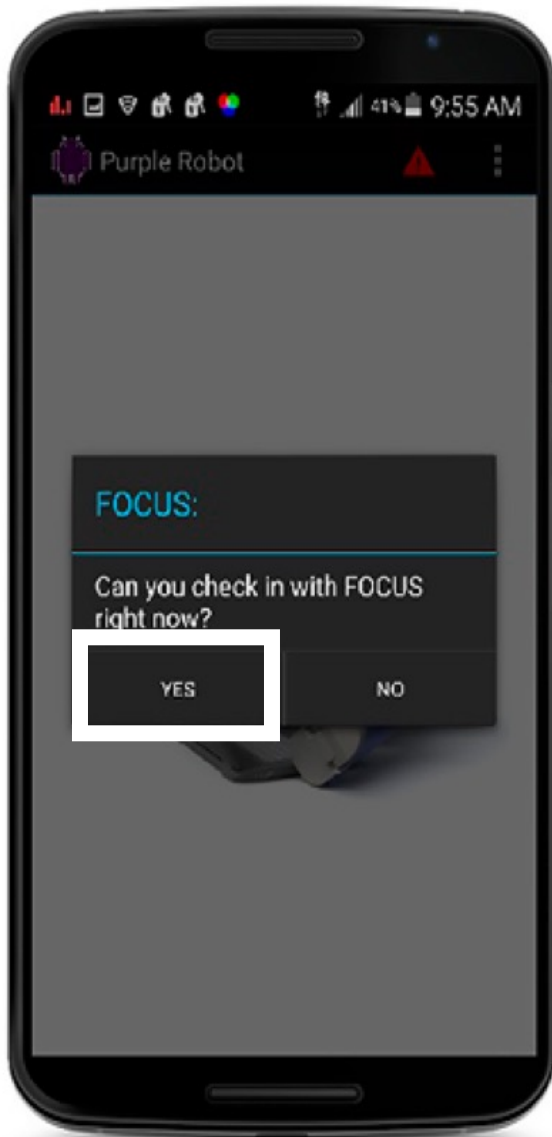
**Human supported coaching**



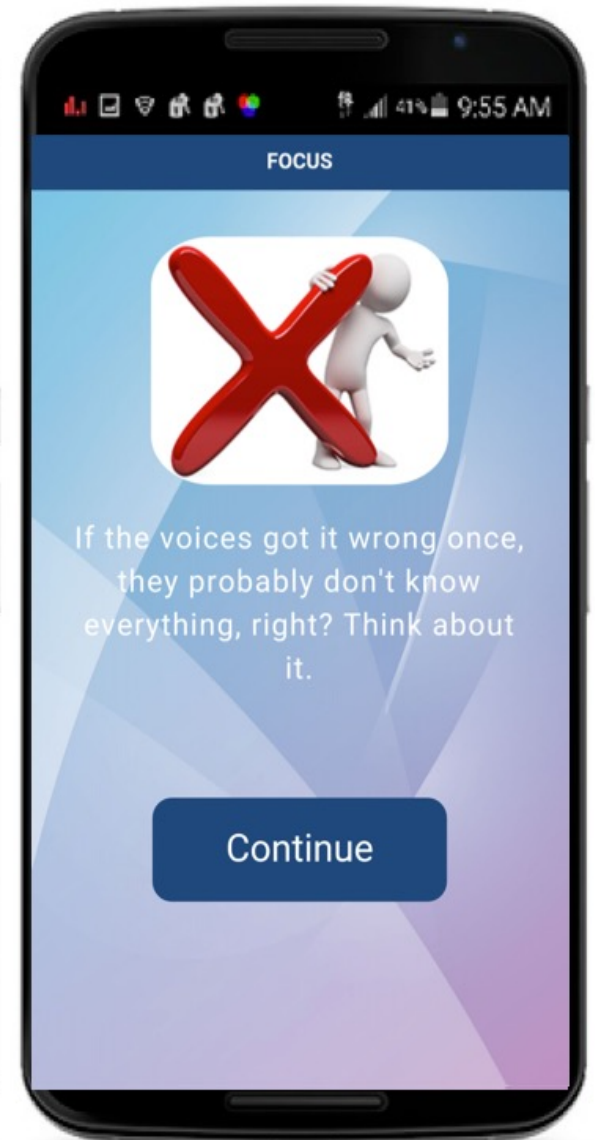
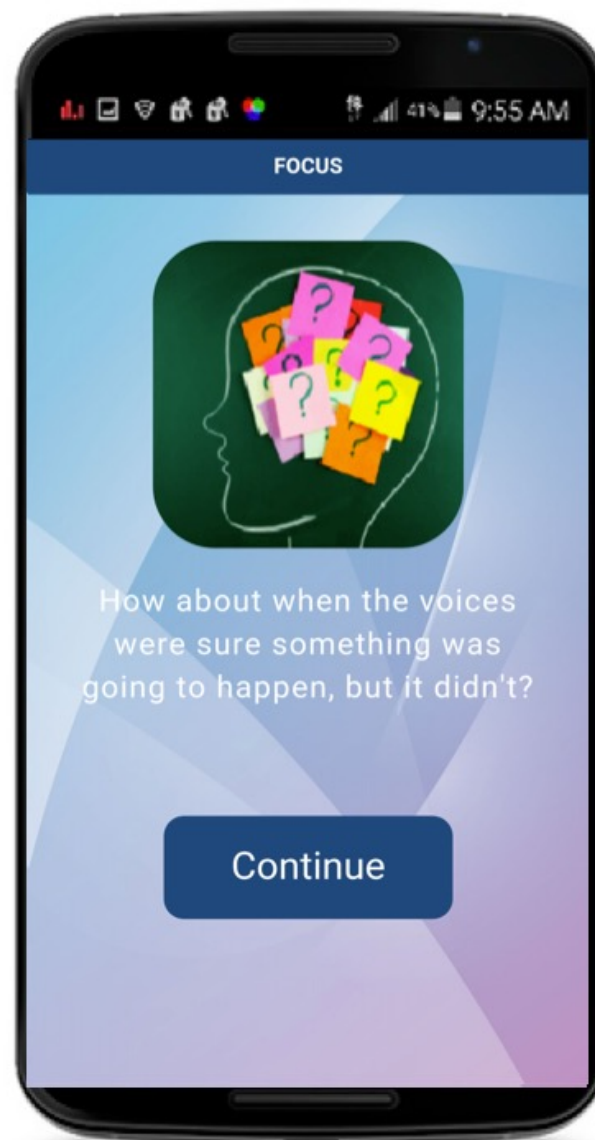
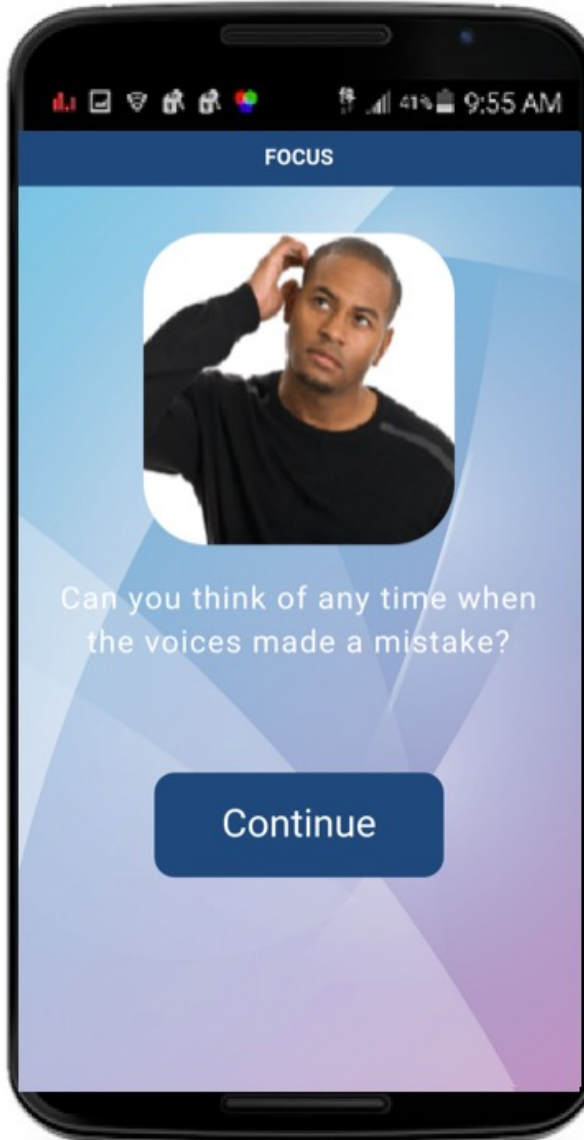
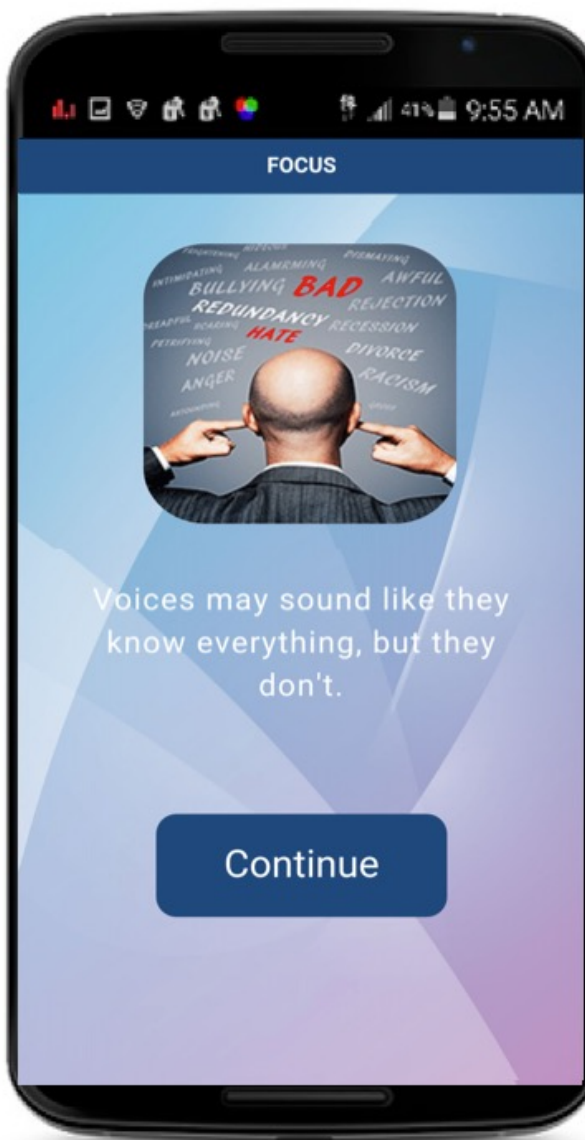
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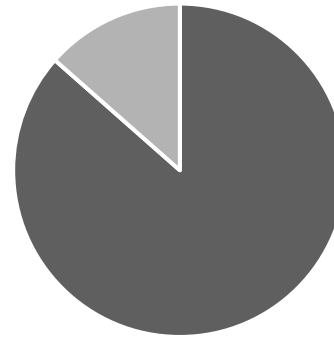


**N = 33**  
Individuals with  
schizophrenia or  
schizoaffective disorder  
recruited from community-  
based treatment programs

**30 days**  
**1/week**  
Study staff  
address technical  
difficulties

**45.9 years,**  
**61% male, 76%**  
**African**  
**American**

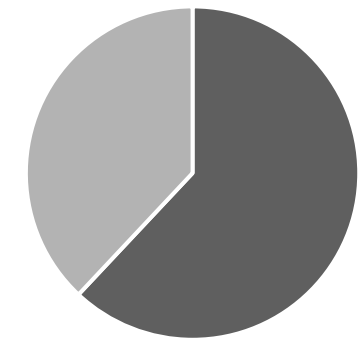
Frequent use (**86.5%**)



■ Yes ■ No

An average of **5.2**  
**times per day**

Most (**62%**) self-initiated



■ Self-initiated ■ Prompted

**90.6%** “satisfied”  
**87.5%** “would  
recommend”

# FOCUS is feasible and acceptable

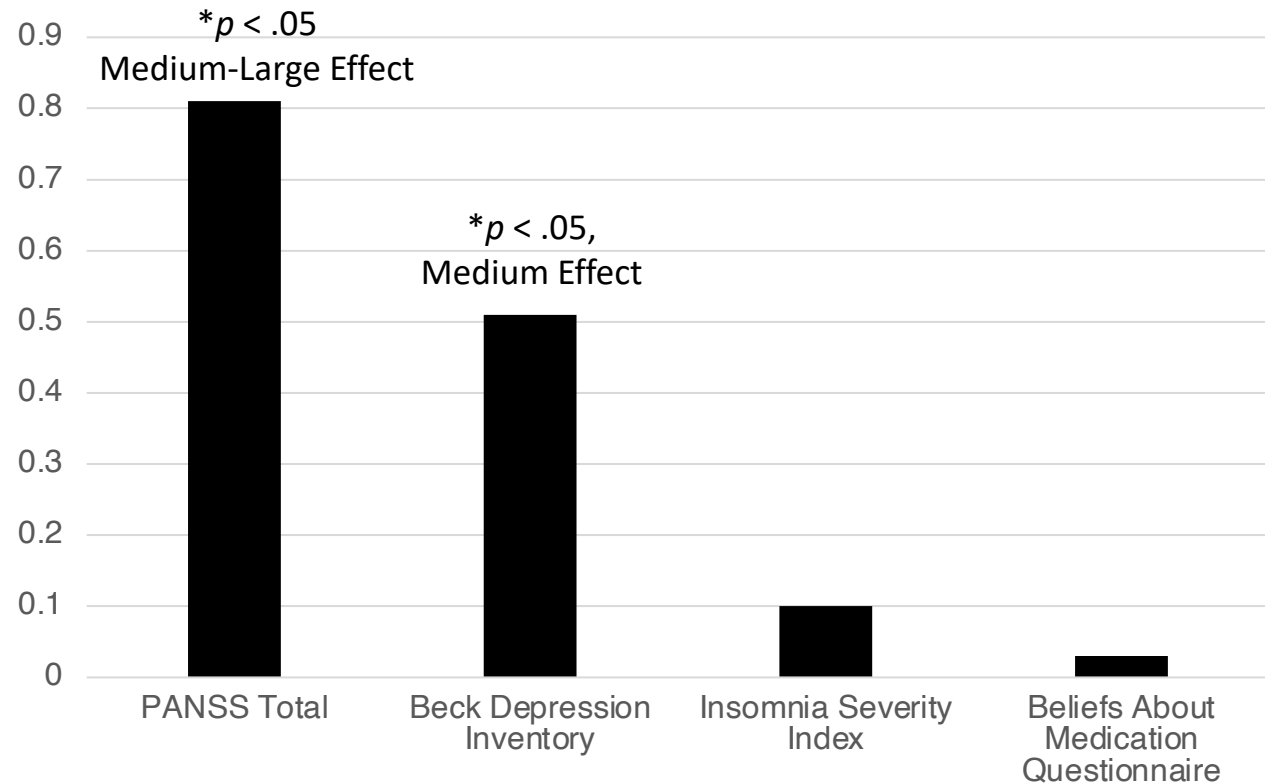
Ben-Zeev, D., Brenner, C. J., Begale, M., Duffecy, J., Mohr, D. C., & Mueser, K. T. (2014). Feasibility, acceptability, and preliminary efficacy of a smartphone intervention for schizophrenia. *Schizophrenia bulletin*, 40(6), 1244-1253.

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Individuals with schizophrenia or schizoaffective disorder recruited from community-based treatment programs

**30 days**  
**1/week**  
Study staff address technical difficulties

**45.9 years,**  
**61% male, 76%**  
**African American**

### Clinical improvements (Effect size, Cohen's d)



# FOCUS is feasible and acceptable

Ben-Zeev, D., Brenner, C. J., Begale, M., Duffecy, J., Mohr, D. C., & Mueser, K. T. (2014). Feasibility, acceptability, and preliminary efficacy of a smartphone intervention for schizophrenia. *Schizophrenia bulletin*, 40(6), 1244-1253.



**N = 163**

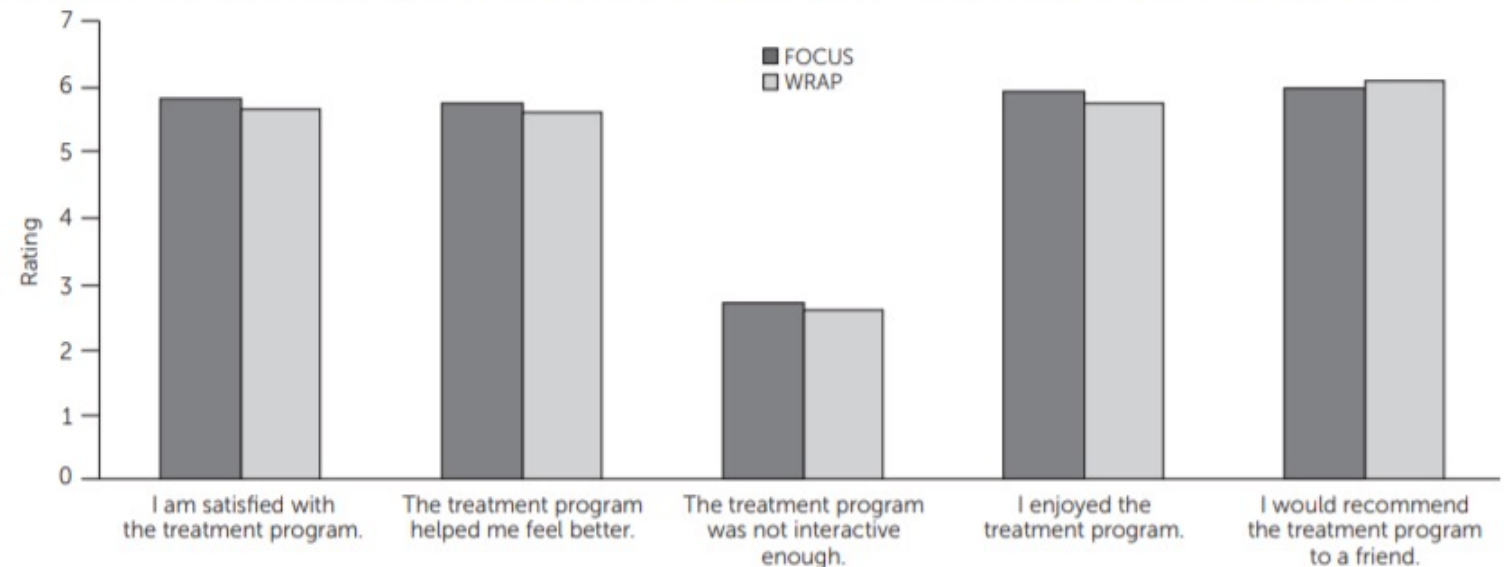
Individuals with serious mental illnesses (i.e. schizophrenia, bipolar disorder or severe major depressive disorder)

## Equal levels of client-reported satisfaction

**Randomized**  
**90 days FOCUS**  
**vs.**  
**90 days WRAP**

**49 years, 52% female, 53% African American, around 40% SCZ/SCZA**

**1/week**  
Study staff address technical difficulties



<sup>a</sup> Responses range from 1, strongly disagree, to 7, strongly agree.

# FOCUS is effective and engaging

Ben-Zeev, D., Brian, R. M., Jonathan, G., Razzano, L., Pashka, N.,... & Scherer, E. A. (2018). Mobile health (mHealth) versus clinic-based group intervention for people with serious mental illness: a randomized controlled trial. *Psychiatric Services*, 69(9), 978-985.

# Equivalent clinical effects

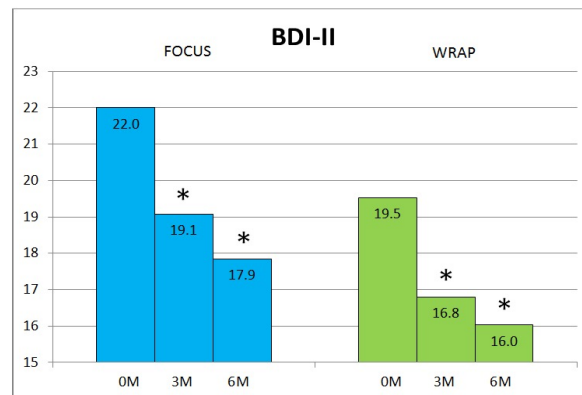
**N = 163**

Individuals with serious mental illnesses (i.e. schizophrenia, bipolar disorder or severe major depressive disorder)

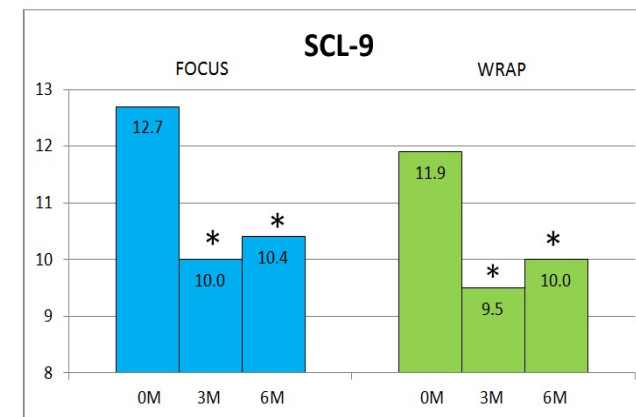
**Randomized**  
**90 days FOCUS**  
**vs.**  
**90 days WRAP**

**1/week**  
Study staff address technical difficulties

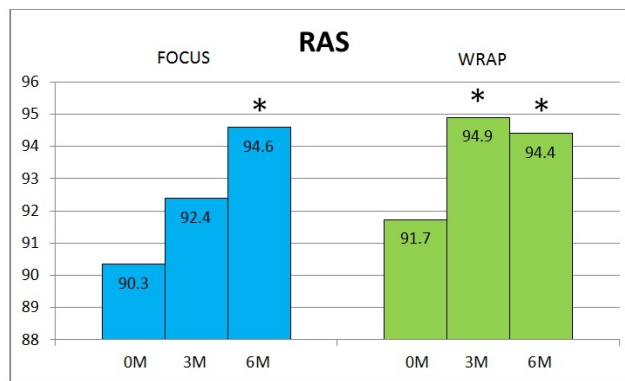
**49 years, 52% female, 53% African American, around 40% SCZ/SCZA**



Depression



General Psychopathology



Self-reported Recovery

## FOCUS is effective and engaging

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# Higher engagement in FOCUS

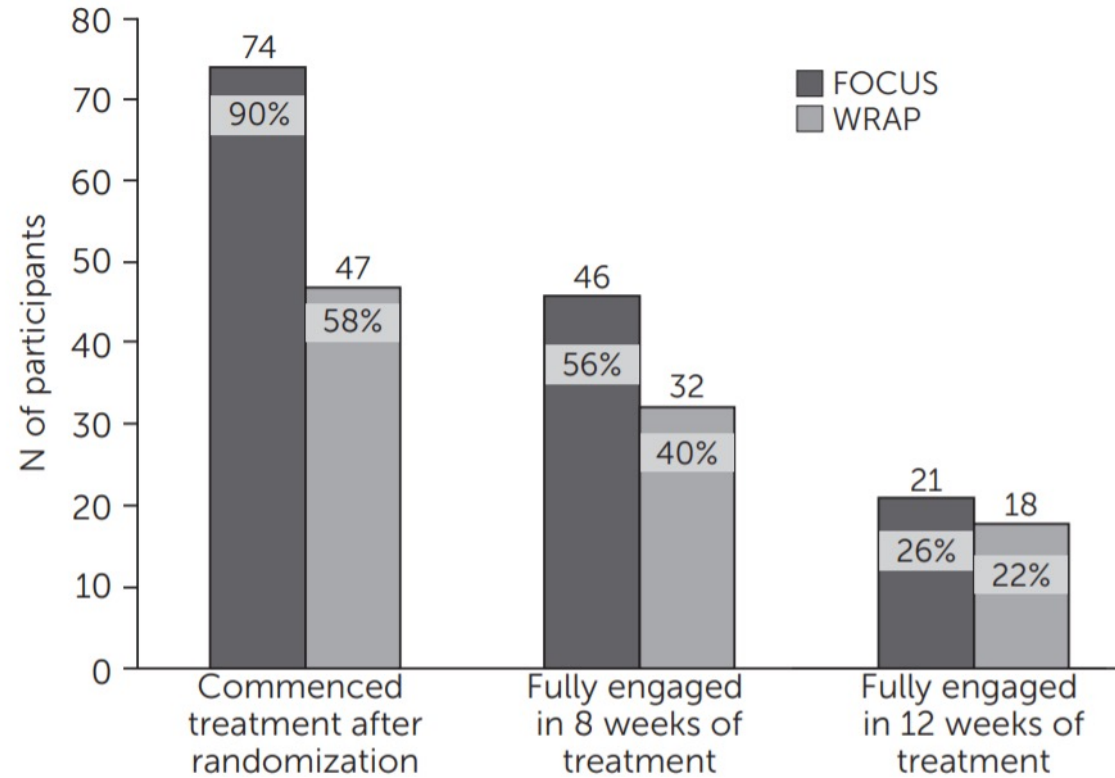
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**1/week**  
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## FOCUS is effective and engaging

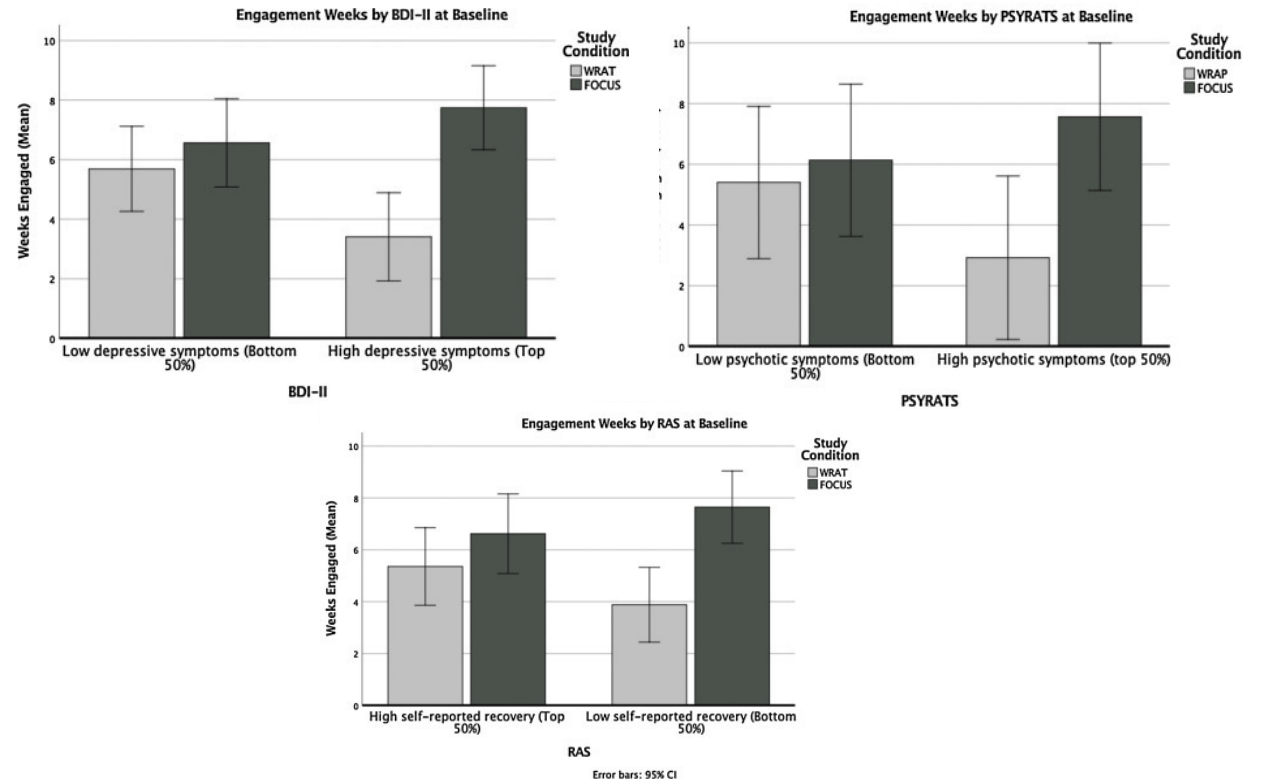
Ben-Zeev, D., Brian, R. M., Jonathan, G., Razzano, L., Pashka, N.,... & Scherer, E. A. (2018). Mobile health (mHealth) versus clinic-based group intervention for people with serious mental illness: a randomized controlled trial. *Psychiatric Services*, 69(9), 978-985.

# Elevated symptoms not a predictor of dropout in FOCUS

**N = 163**  
 Individuals with serious mental illnesses (i.e. schizophrenia, bipolar disorder or severe major depressive disorder)

**49 years, 52% female, 53% African American, around 40% SCZ/SCZA**

**Randomized 90 days FOCUS vs. 90 days WRAP**  
**1/week**  
 Study staff address technical difficulties



# FOCUS is effective and engaging

Buck, B., Chander, A., & Ben-Zeev, D. (2020). Clinical and demographic predictors of engagement in mobile health vs. clinic-based interventions for serious mental illness. *Journal of Behavioral and Cognitive Therapy*.



**N = 163**

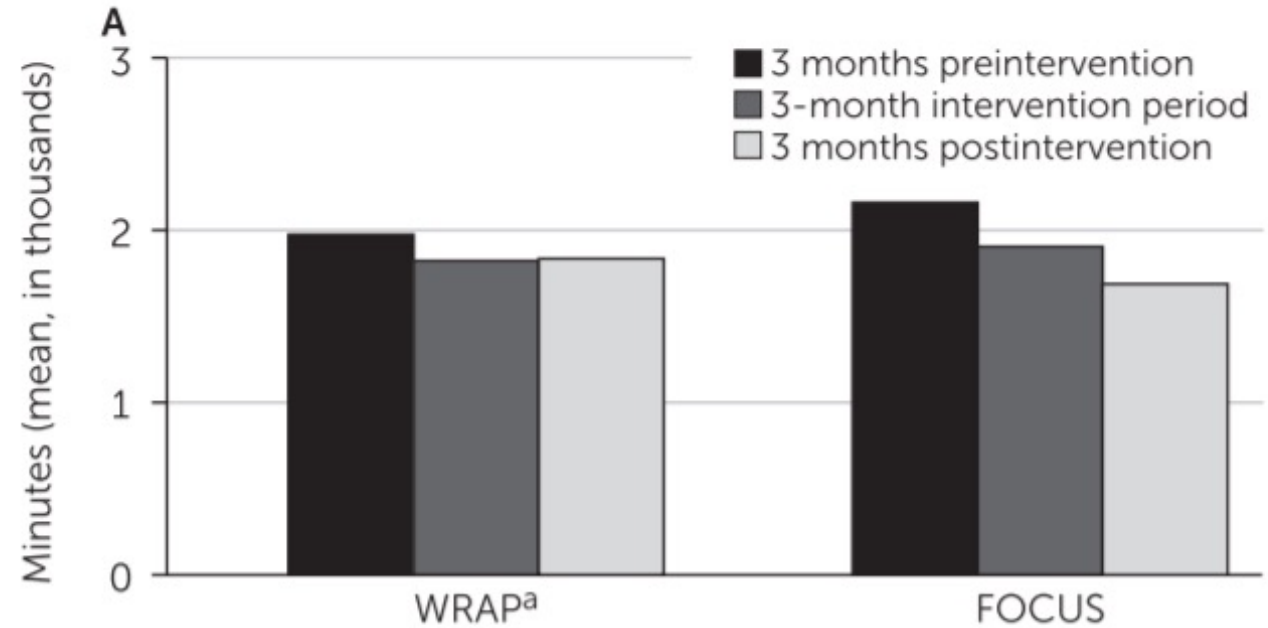
Individuals with serious mental illnesses (i.e. schizophrenia, bipolar disorder or severe major depressive disorder)

**Randomized**  
**90 days FOCUS**  
**vs.**  
**90 days WRAP**

**49 years, 52% female, 53% African American, around 40% SCZ/SCZA**

**1/week**  
Study staff address technical difficulties

Among treatment responders, those with FOCUS use less in-person services



# FOCUS reduces use of other services

Ben-Zeev, D., Buck, B., Hallgren, K., & Drake, R. E. (2019). Effect of mobile health on in-person service use among people with serious mental illness. *Psychiatric Services*, 70(6), 507-510.

**FOCUS is an acceptable,  
feasible, effective and  
engaging intervention for  
SMI that reduces burden on  
community MH clinics**

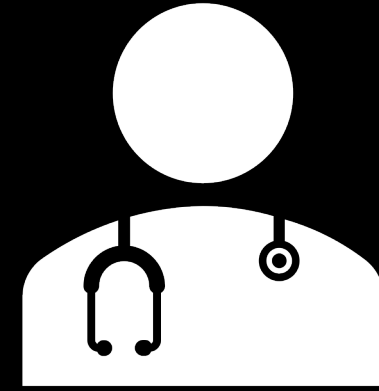


# Next: Implementing FOCUS statewide

Ben-Zeev, D. (PI), Implementing mHealth for Schizophrenia in Community Mental Health Settings (R01MH116057). Co-Is: Buck, B., Kopelovich, S., Jones, N., Leviin, C., Lyon, A., Marcus, S. et al.

**How to  
formalize the  
clinical support  
role?**

**“Supportive  
Accountability”**



**mHealth  
Support  
Specialist**





**FOCUS**

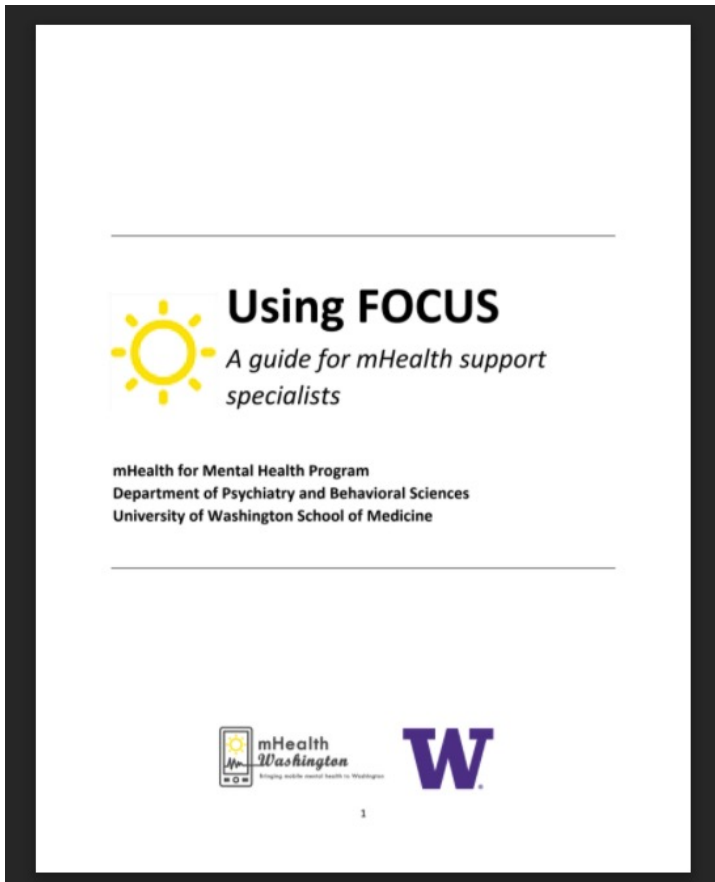


**mHealth support  
specialist**

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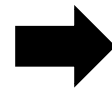


## Goals:

**1. Preparing Your Clinic**

**2. Getting Clients Started**

**3. Reviewing and Sharing Client Data**



**4. mHealth Coaching**

# FOCUS mHealth Support Specialist Training

Ben-Zeev, D. (PI), Implementing mHealth for Schizophrenia in Community Mental Health Settings (R01MH116057). Co-Is: Buck, B., Kopelovich, S., Jones, N., Leviin, C., Lyon, A., Marcus, S. et al.

**Remote**

**Weekly**

**15 minutes**

**Informed by the dashboard**



# Dashboard







**GAINS**



**GUIDED  
CHECKLIST**

1. **Greeting and assessment**
2. **Agenda setting and pacing**
3. **Interventions** ←
4. **Next steps**
5. **Scheduling**



**TAPS**

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1. Technology Troubleshooting

2. Activate Motivation

3. Personalize FOCUS Skills

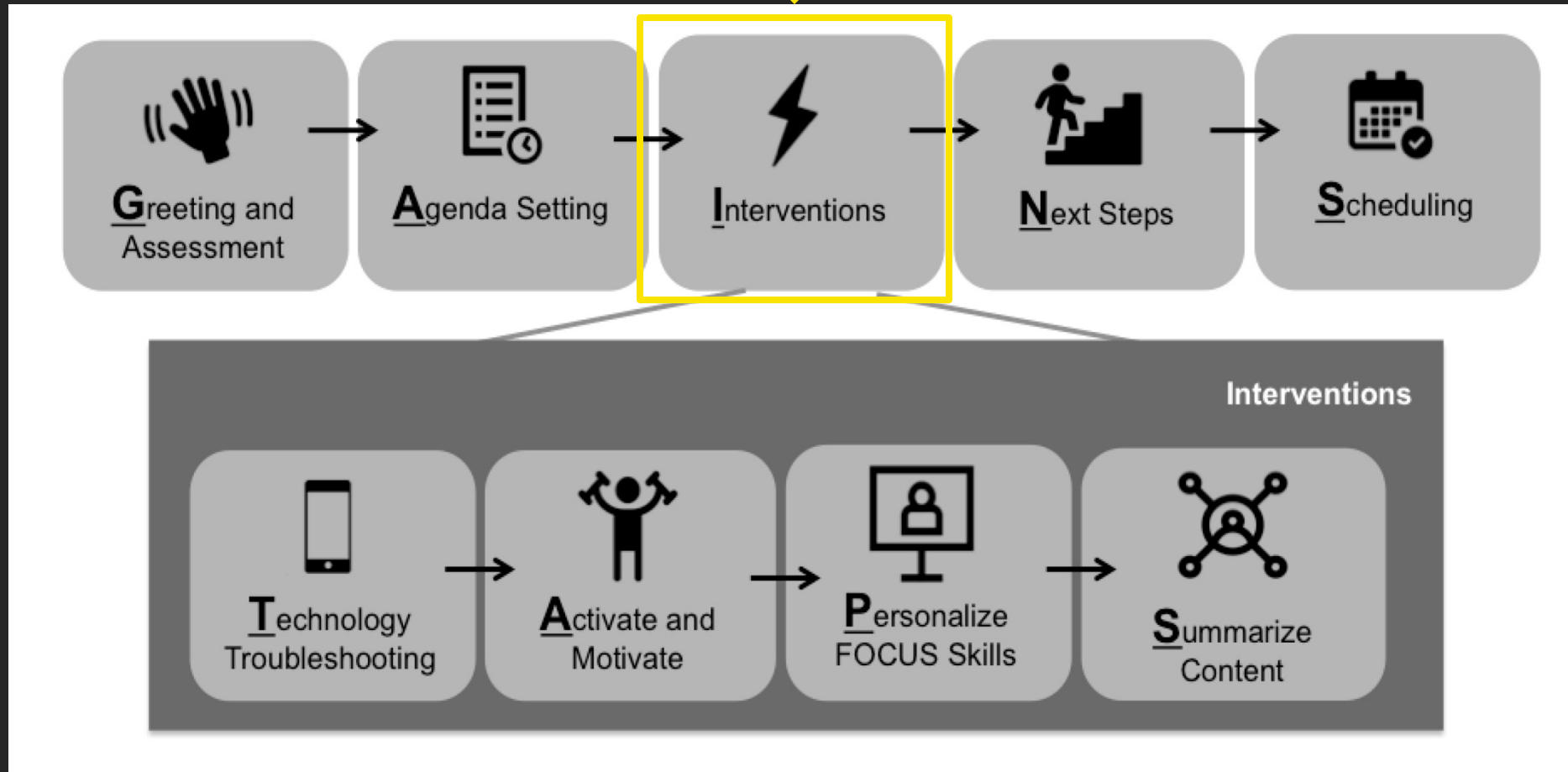
4. Summarize Content

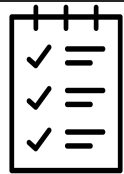


**GUIDED  
CHECKLIST**

# COACHING & INTERVENTIONS

**MATERIALS:**  
Phone  
Manual

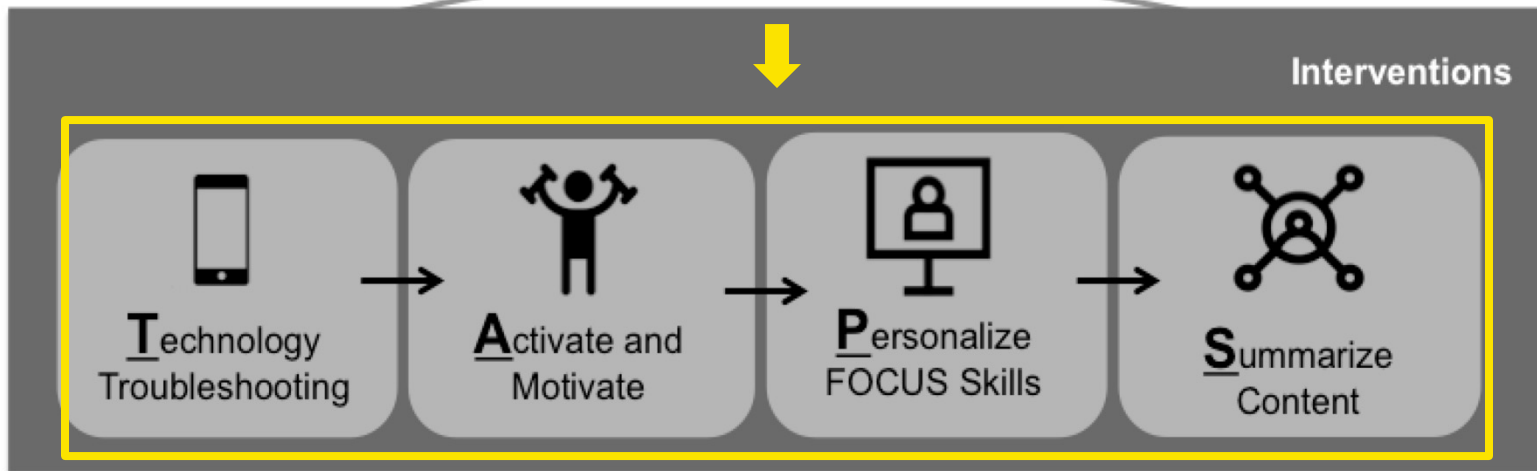
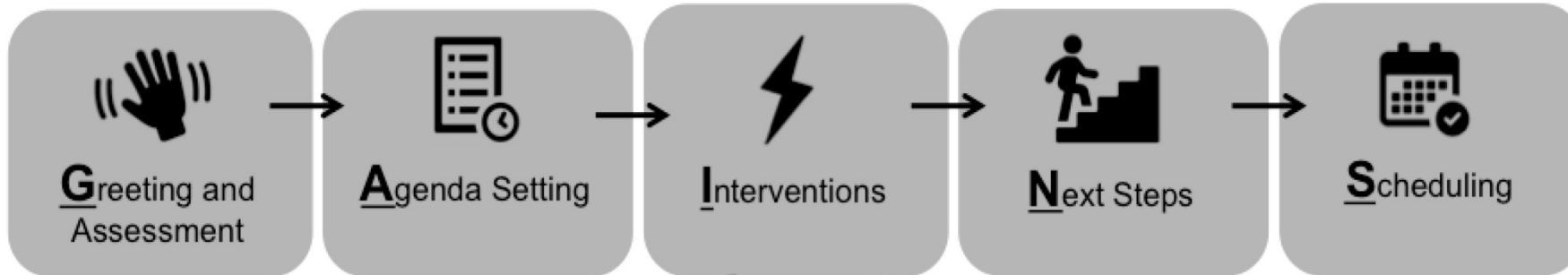




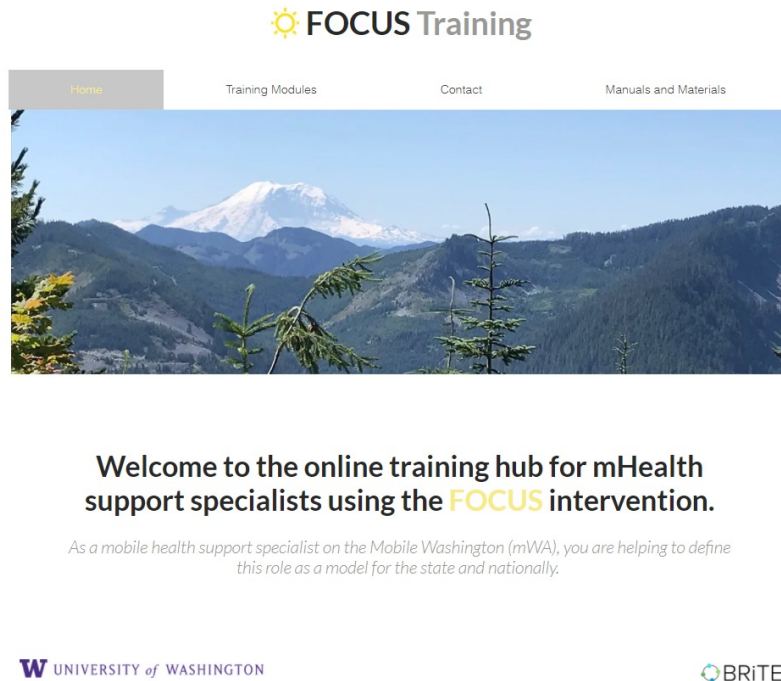
**GUIDED  
CHECKLIST**

# COACHING & INTERVENTIONS

**MATERIALS:**  
Phone  
Manual



# “Flipped Training” with Online Community




## FOCUS mHealth Support Specialist Training

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Small reach

Large reach

Clinic based appointment

Enrolled in treatment, outside of clinic

Outside the clinic, relapse prevention

Before initial presentation to clinic

**mHealth as treatment**  
 FOCUS and the mHealth support specialist

**mHealth for prevention**  
 Symptom detection and assessment with ecological momentary assessment and sensors

**mHealth for treatment seeking**  
 mHealth for first episode psychosis and DUP





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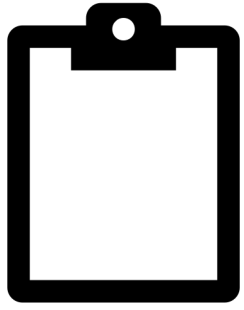


# II: mHealth for prevention

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**Ecological Momentary  
Assessment**



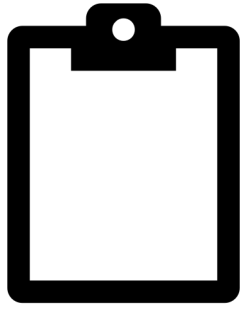
**GPS**



**Accelerometer, Light,  
Noise**



**Phone use  
(SMS, calls)**



**Ecological Momentary Assessment**



**GPS**



**CrossCheck**



**Accelerometer, Light, Noise**



**Phone use (SMS, calls)**

**#1. Identify risk  
signals**

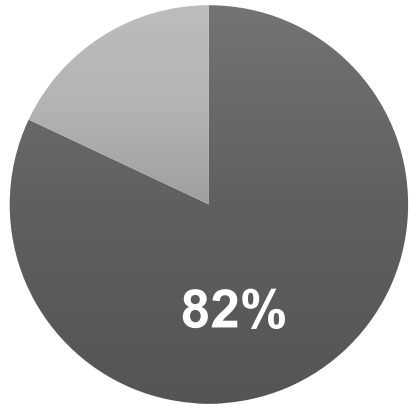
**#2. Identify treatment  
targets**

N = 61

Installed integrated mHealth system (1 year data collection)

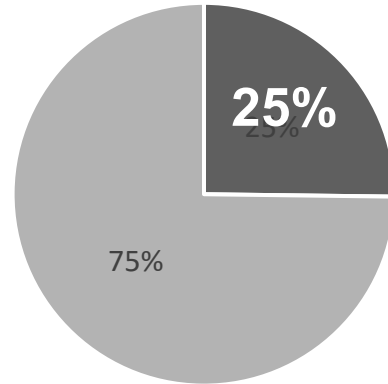
1x/day assessments

Individuals



■ Any Level of PI ■ No PI

Assessments



■ Any level of PI ■ No PI

## Persecutory ideation (PI) days



Stress, Depression, Hallucinations



1.20 fewer kilometers traveled



4.15 fewer minutes in a moving vehicle



6.26 fewer minutes spent near speech



0.79 fewer minutes spent on phone calls



4.04 more minutes sitting still

## Detecting digital traces of paranoia

Buck, B., Scherer, E., Brian, R., Wang, R., Wang, W., Campbell, A., ... & Ben-Zeev, D. (2019). Relationships between smartphone social behavior and relapse in schizophrenia: a preliminary report. *Schizophrenia research*, 208, 167-172.

N = 465

Installed integrated  
mHealth system (1 month  
data collection with audio  
diaries)

4x/day assessments

Digital traces of clinical (i.e. treatment history)  
vs. non-clinical voice hearing

More **frequent**

**Louder**

Appraised as **more powerful**, **More negative content**

In the moment experiences/behaviors

Associated with **increased negative affect**

Increased **social withdrawal**

(less time spent with others,  
more time spent at home)

# Detecting factors associated with disruptive voices

Ben-Zeev, D., Buck, B., Chander, A., Brian, R., Wang, W., Atkins, D., Brenner, C., Cohen, T., Campbell, A., Munson, J., (Under review). Mobile RDoC: Using Smartphones to Understand the Relationship Between Auditory Verbal Hallucinations and Need for Care.



# The vision:

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**Detect**  
social  
withdrawal in  
person at risk



**Deliver**  
Intervention  
challenging  
beliefs about  
power of voices

# Vision for **preventive interventions** for the **schizophrenia spectrum**



Small reach

Large reach

Clinic based appointment

Enrolled in treatment, outside of clinic

Outside the clinic, relapse prevention

Before initial presentation to clinic

**mHealth as treatment**  
FOCUS and the mHealth support specialist

**mHealth for prevention**  
Symptom detection and assessment with ecological momentary assessment and sensors

**mHealth for treatment seeking**  
mHealth for first episode psychosis and DUP





**Clinic based  
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**Before initial  
presentation to  
clinic**

**mHealth for  
treatment  
seeking**  
mHealth for first  
episode psychosis  
and DUP

# III: mHealth for treatment-seeking

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# RA1SE

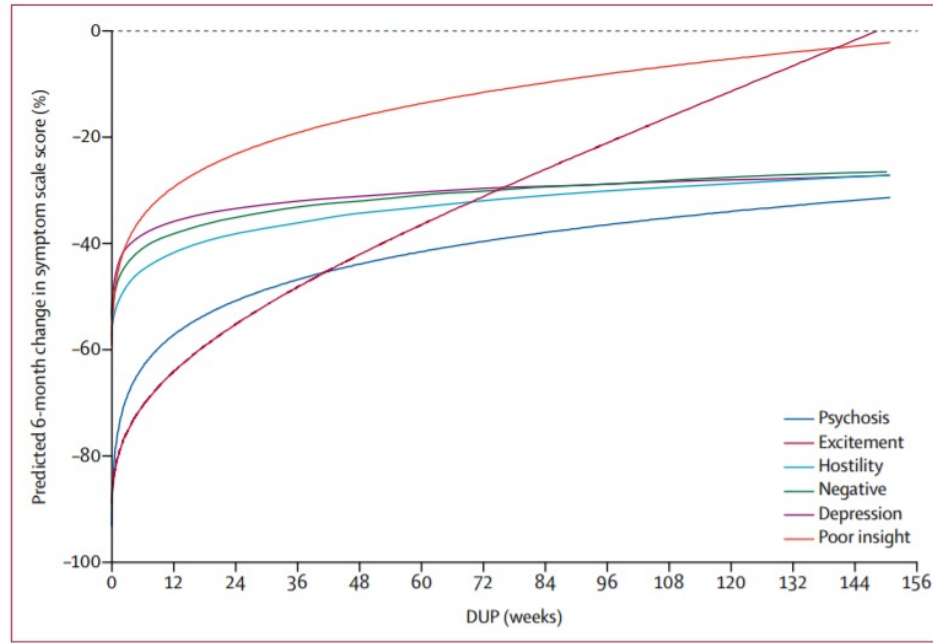
Recovery After an Initial  
Schizophrenia Episode

## Coordinated specialty care improves outcomes for young adults with early psychosis

Nossel, I., Wall, M. M., Scodes, J., Marino, L. A., Zilkha, S., Bello, I., ... & Sederer, L. (2018). Results of a coordinated specialty care program for early psychosis and predictors of outcomes. *Psychiatric Services*, 69(8), 863-870.

Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Rosenheck, R. A., ... & Marcy, P. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, 173(4), 362-372.

**Recommendation:**  
No more than 12 weeks



**Figure 2: Predicted change in untransformed symptom scale scores over 6 months as a proportion of baseline, against DUP**  
Symptom change was calculated from natural log-transformed scores adjusted for centre, drug use, and demographics. Only the first 3 years of DUP are shown. DUP=duration of untreated psychosis.

**Reality:**  
Typically 1-3 years

# Duration of untreated psychosis is a critical determinant of outcome in early psychosis

Drake, R. J., Husain, N., Marshall, M., Lewis, S. W., Tomenson, B., Chaudhry, I. B., ... & Jones, P. B. (2020). Effect of delaying treatment of first-episode psychosis on symptoms and social outcomes: a longitudinal analysis and modelling study. *The Lancet Psychiatry*, 7(7), 602-610.

**94%**

**18-24 year-olds  
have sought  
health-related  
information on  
the Internet**

**75%**

**Have used a  
health-related  
mobile app**



**4.5x**

**More time on  
mobile phones  
than on Internet-  
connected  
computers**

# Young adults with early psychosis are **digital natives**

Gowen, L. K., & Rafferty, M. (2012). How the Internet Supports the Lives of Young Adults with Mental Health Challenges.  
Rideout, V., & Fox, S. (2018). Digital health practices, social media use, and mental well-being among teens and young adults in the US.



# Could mHealth support help-seeking in early psychosis?

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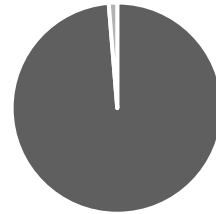
**N = 76**  
Young adults at risk for early psychosis, recruited online through Google Ads

**24 years, 78% female, 75% white**

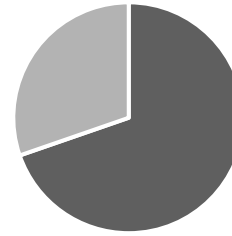
**Survey of interest in mobile health features**

Previous use of health related apps **(69.7%)**

Smartphone ownership **(98.7%)**

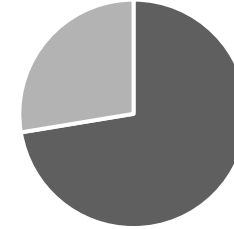


■ Yes ■ No



■ Yes ■ No

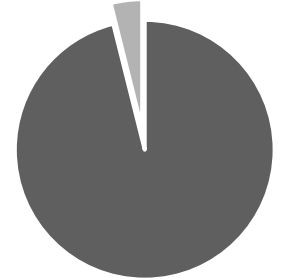
Log in to social media platform every day? **(72.4%)**



■ Yes ■ No

Mode = **2 hours/day**  
40% > 3 hours

Use smartphone for texting? **(96.1%)**



■ Yes ■ No

82.9% talking

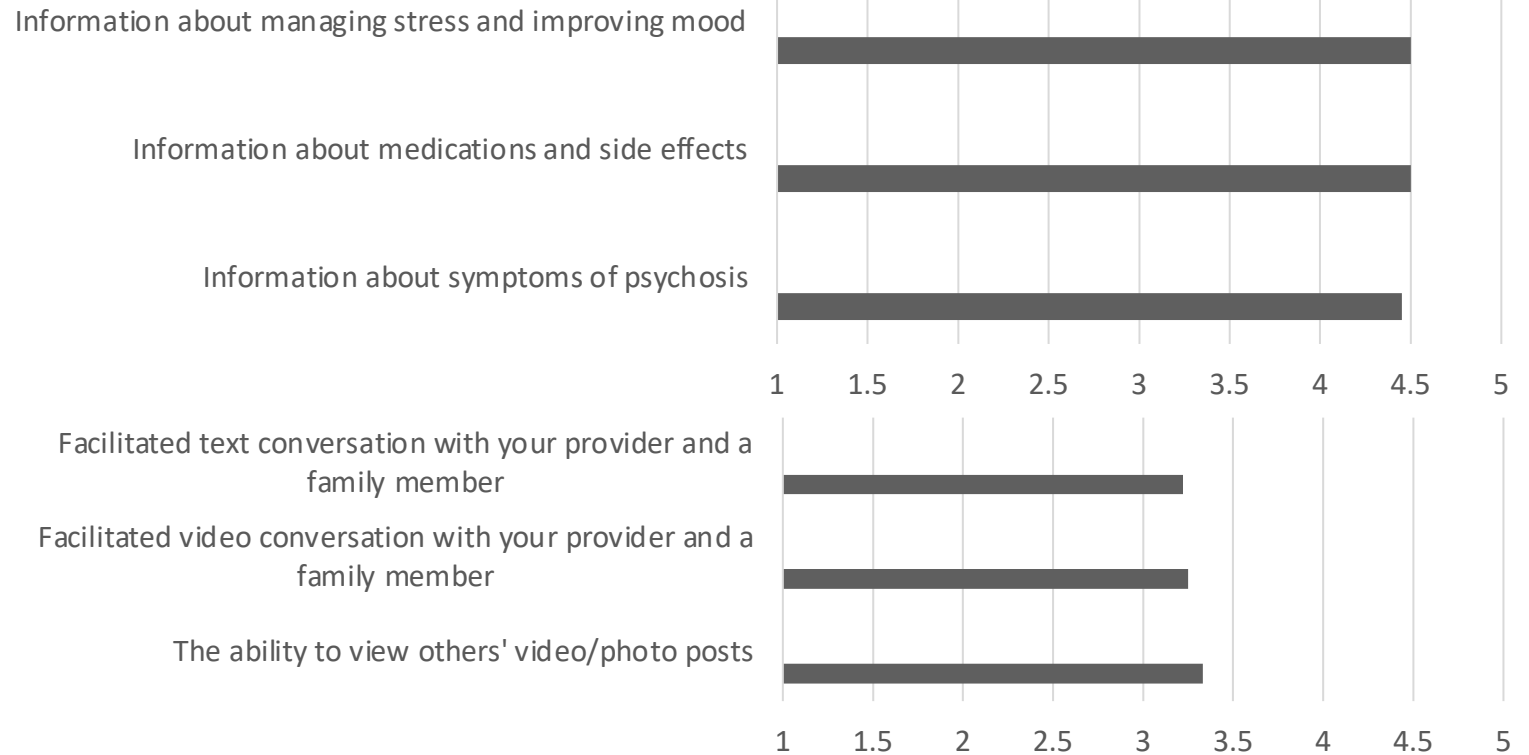
# Young adults with early psychosis are interested in mHealth

Buck, B., Chander, A., Nguyen, T., Monroe-Devita, M., Ben-Zeev, D. (In preparation). Remote mHealth for early psychosis: A survey study examining user needs, preferences, beliefs, and barriers

**N = 76**  
Young adults at risk  
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through Google Ads

**24 years, 78%  
female, 75%  
white**

**Survey of  
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mobile health  
features**

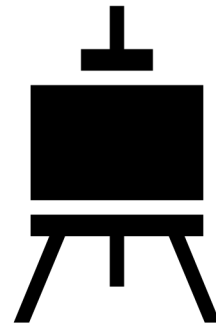


# Young adults with early psychosis are interested in mHealth

Buck, B., Chander, A., Nguyen, T., Monroe-Devita, M., Ben-Zeev, D. (In preparation). Remote mHealth for early psychosis: A survey study examining user needs, preferences, beliefs, and barriers

# NORTH

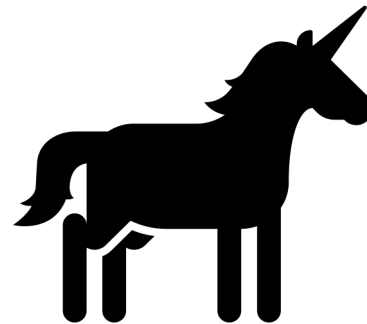
Normalizing  
Orientation to  
Treatment and  
Help-seeking



**Iterative user-  
centered design**



**Remote  
interviews**



Imagine for a minute that you have a magic wand, but you can only use this magic wand to gain support for your mental health. The rules are like this: your magic wand can't make any symptoms go away, but they can change things that are available to you to help you manage them or feel better.

What would you use the magic wand to do?

Buck, B. (PI) User-centered design of a mobile health intervention to promote help-seeking and reduce duration of untreated illness among young adults with early psychosis (K23MH122504)

# More to come!

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**Clinic based  
appointment**

Small reach

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# Implications and future directions

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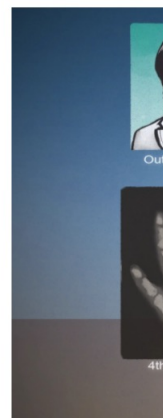


Image Credits: f

## FORTUNE

RANKINGS ▾

MAGAZINE

NEWSLETTERS

VIDEO

PODCASTS

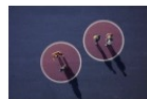
CONFERENCES

COVID-19

### Most Popular



A second lockdown proposed by Trump would get more support from Americans than one proposed by Biden



This elite college is building a COVID 'bubble'—where students are tested 3 times per week, and can't leave campus



MacKenzie Scott is now the wealthiest woman in the world



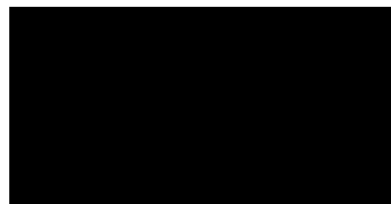
### HEALTH • DIGITAL HEALTH

# Prepare for the Digital Health Revolution

THE LANCET  
Digital Health

BY **SY MUKHERJEE**

April 20, 2017 3:30 AM PDT



April 20, 2017

COMMENT | VOLUME 1, ISSUE 6, E252-E254, OCTOBER 01, 2019

## Big data and health

Michael Snyder • Wenyu Zhou

Open Access • Published: August 29, 2019 • DOI: [https://doi.org/10.1016/S2589-7500\(19\)30109-8](https://doi.org/10.1016/S2589-7500(19)30109-8)

Check for updates

References

Article Info

Figures

**The digital health revolution is here.** Innovations include not only the collection and analysis of electronic health records and personal genomes, but also diverse physiological and molecular measurements in individuals at a level that has not previously been possible. Our recent studies,<sup>1, 2</sup> in which we deep-profiled 109 people for a median of nearly 3 years and made 49 major health discoveries (67 if hypertension is included) affecting 53 people, shows the value of big data and active monitoring. Many health discoveries involved disease risk prediction from genome sequencing, but most involved early detection of disease before symptom onset. Many of these findings were highly impactful, such as early detection of cardiomyopathy, lymphoma, and two precancerous conditions (monoclonal gammopathy of undetermined significance and smoldering myeloma).<sup>2</sup> However, the health data revolution is just beginning as more direct-to-consumer devices that measure health information become available (eg,

PDF [487 KB] Figures S

# “The digital health revolution”

## August 2019

## *Washington State Declares Emergency Amid Coronavirus Death and Illnesses at Nursing Home*

A person in the Seattle area died. Two others tested positive for the virus in a long term care center where dozens of people have reported feeling ill.



**February 29, 2020**

**1. Increase in need for mental health services**

**2. Increase in willingness to use digital health**

**3. Development of infrastructure for digital health**



David Atkins, PhD  
Research Professor



Dror Ben-Zeev, PhD  
Professor, BRITE Center Director



Rachel Brian, MPH  
Research Project Director



Benjamin Buck, PhD  
Instructor, Clinical Training Lead



Ayesha Chander, MRes  
Research Coordinator



Trevor Cohen, PhD  
Professor



Jordan Graff, MPH  
Center Coordinator/Research  
Coordinator



Kevin Hallgren, PhD  
Assistant Professor



Angela Klipsch, MS  
Research Coordinator



Suzanne Meller, MPH,  
MSW, LSWAIC



Justin Tauscher, PhD, MS  
Post Doctoral Research Fellow



Oleg Zaslavsky, PhD, RN  
Assistant Professor



Cornell University



Dartmouth



Northwell  
Health

NIMH K23MH122504 (PI: Buck)  
NIH Loan Repayment Program Award (PI: Buck)  
BBF NARSAD YI Award (PI: Buck)  
NIMH R01MH112641 (PI: Ben-Zeev, PD: Buck)

NIMH R01MH103148 (PI: Ben-Zeev)  
NIMH R01MH116057 (PI: Ben-Zeev)  
PCORI CER-1403-11403 (PI: Ben-Zeev)  
NIMH R34MH100195 (PI: Ben-Zeev)



**Thank you!**

**Questions?**

**W** UNIVERSITY of WASHINGTON



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# **Slides & resources will be posted after the session**

<https://bhi-telehealthresource.uwmedicine.org/>

## **Please complete the evaluation survey:**

- To obtain Certificate of Completion
- To access CME information

**LINK will be in the chat box & also emailed out**

# Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

Behavioral Health Telehealth Resource

Visit our [website](#)

Email: [melmckee@uw.edu](mailto:melmckee@uw.edu)

# TELEBEHAVIORAL HEALTH 101

- **6-module Online Self-Study\***  
**Or...**

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

- **6-session Interactive Webinar**

Register at: [https://uw-phi.zoom.us/webinar/register/WN\\_64sfo7hrT-6TOibLXQUxIQ](https://uw-phi.zoom.us/webinar/register/WN_64sfo7hrT-6TOibLXQUxIQ)

- Introduction to TeleBehavioral Health and Policy Overview\* (webinar 11am-12pm on 1/8/21)
- Getting started: Facts & Myths, and Security & Privacy (webinar 11am-12pm on 1/22/21)
- Digital Health Do's & Don't's, Workflows, and Safety planning (webinar 11am-12pm on 1/29/21)
- Billing and Reimbursement for TeleBehavioral Health (webinar 11am-12pm on 2/5/21)
- Clinical Engagement over Telehealth (webinar 11am-12pm on 2/12/21)
- Clinical Supervision in Telehealth (webinar 11am-12pm on 2/26/21)

**\*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....

# TELEBEHAVIORAL HEALTH 101

## CME Information

### ▪ **6-module Online Self-Study\***

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

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 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**

Register at: [https://uw-phi.zoom.us/webinar/register/WN\\_64sfo7hrT-6TOibLXQUxIQ](https://uw-phi.zoom.us/webinar/register/WN_64sfo7hrT-6TOibLXQUxIQ)

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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 201 SERIES

**Monthly series: 3<sup>rd</sup> 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 – (tent) SUICIDE RISK ASSESSMENT over TELEHEALTH**
- **07/16/21 – APPLYING TELEHEALTH to MEASUREMENT-BASED CARE**
- **08/20/21 – (tent) CULTURAL COMPETENCE & HUMILITY in TELEBEHAVIORAL HEALTH**
- **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\\_fRlJ\\_A](https://uw-phi.zoom.us/webinar/register/WN_6GBzJWGXRE6yNM9N_fRlJ_A)

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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)

# CME-accredited Case Conference Series for Washington State Healthcare Providers

## Psychiatry & Addictions Case Conferences (UW PACC-ECHO)

Didactic presentations and case consultations

12:00-1:30 pm, Thursdays

[uwpacc@uw.edu](mailto:uwpacc@uw.edu) [ictp.uw.edu/programs/uw-pacc](http://ictp.uw.edu/programs/uw-pacc)

## UW TelePain

Didactic presentations and case consultations

12:00-1:30 pm, Wednesdays

[telepain@uw.edu](mailto: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 Washington State Healthcare Providers

## Psychiatry Consultation Line (PCL)

for prescribing providers with adult psychiatry and/or addictions questions

Staffed 24/7

877-WA-PSYCH (877-927-7924) | [pclwa@uw.edu](mailto:pclwa@uw.edu) | <https://pcl.psychiatry.uw.edu/>

## Partnership Access Line (PAL)

for primary care prescribers with child and adolescent psychiatry questions

8am - 5pm, Monday - Friday (excluding holidays)

866-599-7257 | [paladmin@seattlechildrens.org](mailto:paladmin@seattlechildrens.org)

| [www.seattlechildrens.org/PAL](http://www.seattlechildrens.org/PAL)

## PAL for Moms

for providers with behavioral health questions related to pregnancy and postpartum

9am - 5pm, Monday - Friday (excluding holidays)

877-PAL4MOM (877-725-4666) | [ppcl@uw.edu](mailto:ppcl@uw.edu) | [www.mcmh.uw.edu/ppcl](http://www.mcmh.uw.edu/ppcl)

## UW TelePain Hotline

for providers caring for patients with complex pain medication regimens, particularly high dose opioids

8.30am – 4.30pm, Monday - Friday (excluding holidays)

**1-844-520-PAIN (7246)** | Staffed by UW Division of Pain Medicine pharmacists and physicians