

# Fallbrook Regional HEALTH DISTRICT

To: Board of Directors  
Fallbrook Regional Health District  
From: Bobbi Arleen Palmer, MBA, MSW  
Chief Executive Officer  
Date: October 10, 2018

Status Report Based on Phase 2: Organize For Impact Month 1

Organize For Impact : Establishes common goals and requires stakeholders to work together to establish common goals and shared measures, creating a deeper level of outcomes and shared vision.

## Wellness Advisory Committee Process- Community Involvement

1. October 10, 5-6 PM and prior to the Board Meeting
2. November 14, 5-6 PM and prior to the Board Meeting

Advisory Committee format with prescribed structure:

1. I agree wholeheartedly
2. Will accept proposal as an option
3. Can live with it but not enthused
4. Do not fully agree and want to register a different view however; don't want to block the decision so will stand aside
5. Needs more work before consensus
6. Lastly, I'd like to honor the process and defer to the group

Based on the Conceptual Framework from Stanford Social Innovation the following is:

- Knowledge based
- Articulated
- Shared
- Coherent
- Consistent with the group and District's mission
- Continually evaluated



# TeleMental Health and Its Promise

By Jessica Thackaberry, MD

IN MY INTERACTIONS with physicians of various specialties here in San Diego, when I tell them I am a psychiatrist, almost invariably they complain that patients cannot get appointments with a psychiatrist, and they request the ability to send referrals. As physicians, we know this is not an isolated issue in San Diego County, but rather a global issue of a shortage of psychiatrists as well as the inadequate geographic and socioeconomic distribution of specialty services. This is especially prominent in our most rural areas of Southern California — Imperial County, for example.

TeleMental health, also known as tele-psychiatry or teletherapy, is a tool to provide care to patients who otherwise would have minimal access to psychiatric treatment, and is revolutionizing the way patients receive mental healthcare today. Models of care for TeleMental health consist of a wide range of services, including, but not limited to, fee-for-service or direct care to patients through a telemedicine platform, consultative services to other physicians through a technological means (either directly seeing the patient via webcam or after reviewing the medical record through a secure link), or asynchronous technology, in which a standardized

interview is performed and recorded, to be reviewed later by a psychiatrist.

Today, TeleMental health has been shown to be effective in terms of increasing access to psychiatric care, providing treatment for a wide range of diagnoses and disorders, and is well accepted by both patients and providers who have utilized it. In some settings, such as federally qualified health centers, team-based care including TeleMental health has shown better mental health treatment outcomes than care as usual.

The origins of telemedicine date back to the 1950s, when Cecil Wittson of the Nebraska Psychiatric Institute began using closed-circuit television technology to provide training to students in the Nebraska State Hospital in Norfolk, and in the 1960s, when patients were being seen miles away from Massachusetts General Hospital at Logan International Airport for direct care without travel times. With further advancement in the technological field, more recently patients are able to be seen in real time both in clinic and from home by a psychiatrist or a therapist via videoconferencing technology, and in some instances can facilitate a visit from their mobile devices. Feasibility studies have indicated that it is effective and possible to conduct TeleMental health visits in just about any circumstance, from consult/liaison visits in the emergency room or the medical floor to psychiatric visits in a primary care setting, to mobile visits

to patients who are home-bound or disabled and unable to make it to clinic.

With a multitude of barriers to care for underserved patients, TeleMental health offers access to many people who previously have been unreachable either due to geographic distances, appointment availability and scheduling issues, or due to the level of disorganization of the patient. Recent evidence indicates that 97% of patients with mental health conditions own a smart device, and some studies have even shown increased pa-

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tient satisfaction in the younger generations when seeing a provider through TeleMental health, thought to be largely due to comfort with the technology and the convenience of being able to see a provider anywhere. It has also been suggested that patients who live in small rural communities where physicians and patients have a higher likelihood of knowing each other personally may be more likely to accept mental health services from a distant provider, offering more of a sense of anonymity and reducing stigma.

As telepsychiatrists, our goal is not only to treat patients with mental illnesses over a distance, but also to provide support and tools to primary care providers and other specialists over those distances. Particularly imperative to address access to care issues in Southern California, TeleMental health can be used as a tool in collaborative care to work with primary care and other specialties in bringing the best psychiatric care to patients regardless of their ability to access a psychiatrist directly. Virtual connections can be made between specialists via shared electronic health records, which can allow e-consult services and better access to specialist support for many primary care providers. Through video communication, a psychiatrist can see patients in a primary care office, inpatient hospital or emergency room setting, providing psychiatric consultative support. This is especially important; as per Wang et. al in 2005, only 22% of patients with mental illness see a behavioral health

provider, and only 12% of patients actually see a psychiatrist, leaving our primary care colleagues to treat the remainder of patients with mental illness in the U.S. In circumstances such as these, collaboration becomes essential, and TeleMental health is one avenue in which this collaboration is possible.

Outside of primary care and specialty offices, patients are becoming increasingly able to access mental healthcare in the palm of their hands through video visits with providers as well as through various mental

health apps and therapy tools. While the evidence is very limited regarding the use of these apps and tools, it is thought that they may be specifically helpful in substance use disorders, and some have used various mobile apps to track daily moods and medication adherence.

There is further research being conducted – and definitely needed – regarding the ethical use of mobile apps, especially when data is being recorded and transferred, but with the speed at which technology develops, this is a highly anticipated area of expansion of TeleMental health.

Technology in today's climate grows at a rapid pace, and in a time when our psychiatric resources are so few and not readily growing, it is important to use these technologies to the best of our ability to reach out to patients where they are. I have highlighted just some of the uses that have been more recently studied, and with hope new research in the future can lead to even better and more innovative uses for technologies that have now become daily staples in our lives and those of our patients. I am anxiously waiting for the use of these technologies to become more of a reality in our day-to-day lives, and look forward to contributing to their development moving forward. **SDP**

*Dr. Thackaberry is assistant clinical professor of Psychiatry, clinical lead for the TeleMental-Health Program, and psychiatric*

*attending for the Community Psychiatry Program and the Psychiatric Mental Health Nurse Practice Clinical Training Program at UC San Diego.*

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