Live captioning by Ai-Media. ARIA JAVIDAN: Hello, we will get started with the webinar in just a few seconds. SPEAKER: Recording in progress. ARIA JAVIDAN: Hello, my name is Aria Javidan, manager for the national Consortium of telehealth resource centers. Welcome to the latest presentation in our webinar series. Today's session is on the Vermont emergency Tele -- telepsychiartry network: lessons learned from two years of progress. These webinars are designed to provide demonstration and information to support and guide the development of your telehealth programs. Located throughout the country there are 12 resource centers and to national centered on telehealth policy and telehealth technology assessment. Each serve as focal points for advancing the use of telehealth and supporting access to telehealth services in rural and underserved communities. Before we get started today, please use the Q&A function at the bottom of your screen to ask questions. Questions will be answered at the end of the presentation. Please only use the chat for communication issues with technology or communication access issues. Please refrain using chat to ask questions or make comments. Close captioning is available today, located at the bottom of your screen. Today's webinars also being recorded and you will be able to access today's and past webinars on the NCTRC YouTube channel and NCTRC -- our website. REID PLIMPTON: Thanks, ORIA. I am program manager for the Northeast telehealthresourcecenter.org at we are lucky enough to serve seven states throughout New England. Joined by two of my colleagues today to talk about a project near and dear to my heart. With me today I have Allie Johnson, (indiscernible) specialist for quality healthcare and Doctor Martin McGee -- Mark McGee, president of Alpine telehealth. I will let Ali take it away. ALI JOHNSON: Thank you, Reid. So we are a small organization so I will explain briefly that it is a nonprofit organization based in Vermont helping with quality improvement projects related to healthcare services in our state. As we mentioned, I'm quality improvement specialist and project lead for the Vermont Emergency Telepsychiatry Network, which is a project... It focuses on setting up telehealth services in emergency department settings for people with mental health needs. Today, I am really looking forward to sharing with you 10 lessons that we have learned from the past couple of years. ARIA JAVIDAN: Sorry, it looks like your slides are not being shared. ALI JOHNSON: Oh. Well, you didn't miss anything. (Laughs) Is that better? ARIA JAVIDAN: Perfect. We can see them now. ALI JOHNSON: You just missed the logos. So lesson one is subject matter experts play a key role in program guidance, and I am very happy to introduce, again, Doctor Mark McGee from Alpine telehealth. Who is our subject matter expert on the project. Mark, please take it away. DR MARK McGEE: Thanks, Allie. I am Mark McCree, a psychiatrist and president of Alpine telehealth. We are based in beautiful yet chilly Burlington, Vermont. I am delighted and

grateful for the opportunity to work with Reid, Ali and others on this project as it sought to address a persistent need in our system of mental health care in Vermont. Namely, timely access to psychiatric care, particularly in emergency or crisis situations. The reality that we face in Vermont is based in many communities throughout the country, but the issue of results in backlogs in patients awaiting placements at inpatient psychiatric facilities resulting in problems of the (indiscernible) of psychiatric patients, this results in a frequent and persistent delays in needed care and considerable system costs in that patients are often in emergency departments with needs beyond the capacity of their settings to address and this represents significant stress within the broader system. Let me start by presenting a little bit of an overview of telepsychiartry, some research findings in recent years. Evidence-based supporting clinical outcomes. All of the research that has been done has compared telepsychiartry with in person psychiatric encounters. When you compare in person to telepsychiartry, they are more or less equivalent in terms of quality and satisfaction. The ability to form therapeutic relationships is in quick -- equivalent. It is all essentially equivalent peak between telepsychiartry treatment and in person treatment. That being said, I think this is an inaccurate comparison, because really, the real world that we are discussing and considering talking about is a comparison between response to telepsychiartry on the one hand and response to a lack of psychiatric care on the other. That is, I think, the more accurate comparison we are dealing with. Most, if not all of those we are working to support do not have any psychiatric care in emergency settings. Many of these as we will describe in more detail later, are small hospitals in predominantly rural communities. This is a statement on telepsychiartry from the American psychiatric Association from 2018. Telemedicine in psychiatry is a validated and effective practice of medicine that increases access to care.... Obviously we have had four years of activity since then as a result of the COVID pandemic. These are just as true as they were prior to the pandemic. The progress in terms of barriers to successful telepsychiartry implementation, interestingly, this is a site I created as part of some support work I did at the onset of the pandemic in terms of helping to build up capacity. It's just as relevant now as it was then, even despite multiple years of increased experience with telemedicine. Significant barriers are changes that many of us encounter in health systems, clinician supports, unfriendly interfaces, whether it is the videoconferencing, privacy concerns, lack of information, clinician techno phobia. We know that is a real issue among healthcare professionals. Messaging failures, training, and then insufficient support and IT leadership. In terms of principles, for successful telemedicine implementation product -- project, it needs to be clinician driven, users must own the system. It might be providers, nursing staff, other care coordinators. The role is more supportive as opposed to driving

initiatives, that type of thing. Management practices have to follow best practices, which we will talk about as well. Users need training, they need to be supported, they need the right equipment, they need quality equipment that is reliable, easy to use. Then we need to evaluate the effectiveness of programs on an ongoing basis. As we develop new strategies, I think it is important to share with colleagues so we can really enhance the pace at which innovation can be developed and implemented in important areas of need. Other barriers relevant art licensing, these issues persist, and I think have, in many ways, reverted back to pre-pandemic. The pandemic created a great deal more electability around licensing of healthcare professionals in response to the public health crisis. Many of those accommodations have since reverted back or expired, so these remain significant issues around onboarding, recruitment of providers. There is a great deal more flexibility with licensing compacts. Some states, including Vermont, have begun issuing telemedicine only licenses, which I think rightly streamlines the process of developing and implementing products -- project such as the one we have been trying to support. In terms of Vermont telemedicine law, this is obviously relevant to our projects. Vermont has really taken an important and I would say gold stepped from a legislative standpoint as it relates to telemedicine. And they have effectively placed telemedicine on essentially equal footing to other forms of healthcare that are provided in person. So in terms of prescribing, they were clear that prescribers and providers may issue soups -- prescriptions without the need for an in person exam and prescriptions delivered are held to the same standards of appropriate practice as those in person settings. I think that is a fairly bold and exciting legislative development that Vermont has done in terms of really creating an equivalency in the telemedicine space which enhances what care can be effectively and safely delivered through this platform. Informed consent is required. At the initiation, treatment and it can be done verbally or in writing. And then a note that Vermont's law prohibits the recording of any telemedicine encounters out of privacy concerns. In terms of the need for telepsychiartry, emergency department boarding of patients with mental health needs has an impact on the system of care as well as patient experience. Patients in crisis need timely access to treatment and emergency department boarding often does a great job of keeping individuals safe and caring for their basic needs but often, because of a lack of access to specialized mental health care, that aspect of their care is often missing. Telepsychiartry's is -- telepsychiartry in those systems can help. If they need to wait for care, it can be initiated in the emergency department with potentially aggressive pharmacological interventions offered in that setting. So this enables emergency departments to offer meaningful treatment, psychiatric treatment, for patients who might be in their care in the emergency department as

they await disposition to a more appropriate level of care. In terms of some of the information we have gathered, survey in October 2023 in Vermont averaged 28 patients of all ages on any given day. And these were folks presenting with psychiatric issues requiring a higher level of care. They were even awaiting transfer or discharge to mental health care. On any given day approximately 15% or one in seven patients in emergency department setting are waiting for mental health care. So this is a significant scope and a significant issue that our friends who are providing emergency department healthcare are contending with on a daily basis. Surveys of the type of work, work for survey of psychiatry in Vermont indicate that an exceptionally small portion of psychiatrists are actively practicing delivering psychiatric care in emergency department settings. Barely more than half of a full-time equivalent was tasked with providing care in that particular setting, so an exceedingly small proportion of psychiatrists are delivering psychiatric care in emergency department settings to these patients. Based on the background on the context, I want to pass things up too Ali to talk a little bit more about the work that she has done in support of this project. ALI JOHNSON: Lesson two is about a needs assessment in worth the time and expense. We were fortunate to have seed funding from a philanthropic organization in Vermont, the Vermont community foundation. We were able to collaborate with Alpine telehealth and metric and MCD global to conduct these six activities. We did a literature review, a national environmental scan looking at Beck's -- best practices. We services all 14 emergency departments in the state and received surveys from 89 different stakeholders about the need for Telus I -- telepsychiartry and what a network might look like. And then, there were a number of key informant interviews conducted and the report has some recommendation. It is available on our website. What we learned was that emergency departments want help with mental health needs. The hospitals were specific in identifying needs of funding. It meant software, training and technical assistance and reasons for having a network would include timeliness of care, and improving the workforce capacity, access to better training, graphic access to people needing care, you will see that one of the critical access hospitals that Mark mentioned, financial access to services and prevention of readmission, for example. Some four, collaborators should be engaged early and often. I am really proud of the work that we do as a big group. We have an advisory board and it has representatives from all of these key sectors and the system that we are working on, including peopled with the lived experience, including telehealth experts and others. Lesson five, a project should be evidence-based and limited in scope. I am still learning the limited in scope part of the lesson. On the one hand, we have a big charge, and on the other hand, a limited scope in terms of the setting, the mental health patient population we are trying to help on the psychiatry service specialty that

we are focusing on. We have these different aspects of the network, and I will go a clock face and cover each of the six aspects very briefly. I mentioned that we have an advisory board and a clinical subject matter expert. We have the project lead, that is me. I do a lot of work in keeping the grants going and so forth, the operations. And, of course, our partners at metric. We have a training component to increase knowledge and experience of ED stats supporting telepsychiartry services and we will say more about that in a little bit. We have two demonstration projects. One is a midsize hospital focusing on the child adolescent population and the other is a critical access hospital getting after hours support in the emergency department. Four the midsize general -- demonstration project, Rutland Medical Center is a 144 bed acute care hospital and their project has had about one year of effort so far. The Masters level clinicians from the designated agency to the original evaluation to people (indiscernible) they make recommendations. If that recommendation includes admission to an inpatient service, these... Because Rutland doesn't have a child and adolescent psychiatrist on staff, they partner with the nearby inpatient setting and basically, patients are able to talk with their provider before going over to (unknown name). I will show you some data. Please keep in mind that the consults are limited to occurring two afternoons per week. That has to do with the availability of the providers. There is a nice benefit that they have worked out that the (unknown name) providers can enter data directly into the RMC electronic health record. The other project is newer. We went through a longer process that Reid might touch on on selecting this hospital and the vendor that they are going with. Northeastern Vermont regional Hospital is in the Northeast kingdom. It is a 25 bed critical access hospital. Their emergency department has the highest number of until health visits per capita in Vermont. They are in a psychiatry desert in the Northeast Kingdom. And so, while they work closely with their regional designated agency, they still wanted access to psychiatrists for patients with higher acuity. Hospital assistance is on the newer side. The hope here is that through our experience and the demonstration projects, we will generalize that to Vermont and have it cost information about what the service costs and the nonreimbursed part of that so we can try to lobby or request funding, hopefully through general funds ultimately but we are still working on that part period We want to establish a statewide telepsychiartry program and statutes based on our mentor state, North Carolina. And evaluation has been a big component so far. We have had the opportunity to evaluate patient provider satisfaction, quality and cost of the demonstration projects and the level of engagement with our collaborators. Speaking of valuation, lesson six. Evaluation should be rigorous. We have invested quite significantly in this part of our program and the hope is that it will provide the evidence needed to support future funding and just future support in

general and teaches lessons about process improvement. That is what our organization is all about. These are the four main components of the activities. We have an evaluation committee that is part of the ETN advisory board, a logic model which I will show you an example of, a planning matrix and report outs. Here is our logic model. We worked with the evaluation committee and the advisory board and our contractor, RTI International. They have been really excellent partners in this. We have a set of evaluation questions and we plan for how we are going to get those data, who is responsible for collecting it, is it qualitative? Quantitative? Is it a survey? Is it a key informant interview? Is it information from an electronic health record? It keeps us organized. And we evaluate all aspects of the program. Our 2023 evaluation report is available on the webpage and I have linked to it on this slide. Lesson seven was a big one to learn. Significant administrative effort is required to plan, implement and evaluate. I am referring strict is -- specifically to the demonstration project. In the case of Rome, they had already done a lot of the groundwork for preparing the program and, in the case of Northeastern, they just had a slower start and needed more support and they realize, we all realized along the way that this working of a care pathway along with a vendor and all the different offices within the hospital, making sure the coding, billing and IT was all in sync and conventionally, this was a big one, enrolling a large number of providers because they went with a national vendor relative to the small hospital site. Remember, it is a 25 bed critical access hospital in the Northeast Kingdom of Vermont. A very rural area. This was a mismatch of quite a lot of administrative time. Because of the evaluation component, a lot of effort is needed to gather and report the data, not to mention the number of meetings that we have, because we are a program. So there are some recommendations we are considering about streamlining credential by proxy. This is something we would want to share with a hospital who doesn't have this service yet who is considering adopting it. Lesson eight, the congressionally directed spending funding is fleeting. It is so bittersweet. We were awarded over $900,000 of congressional directive spending from the senator, Patrick Lahey's office. I got to see the senator after his retirement. He and his wife were working on Church Street and I ran and I stopped him and I thanked him for this funding and I let him know that the program is working and that the money is being well spent. He was so happy and extends his very best to people who work on this project period so the fleeting part is we received this award and it was a one year, one time award. So... But it is all worth it. Lesson nine, it is all worth it. Here is some data about the Rutland project surveying children and adolescents and we see that 93% of them are on Medicaid and there are patients of different ages, under 10, 11-14, 15-17. They are all being served by this project period I mentioned in the study design, the project design, that

the service is only provided two afternoons a week. So we are hoping that with telepsychiartry, there might be a shorter length of stay. Mark set it up really well explaining how these people are languishing in emergency departments, waiting for specialized care. We find that the length and stay is in fact longer. But these numbers are not adjusted for acuity so factors that lead to the longer length of stay have to do with the higher acuity and the more intense treatment and then just the artefact of only having the service available a couple of times per week. But you can see that off the 28 patients who were... Who had in patient treatment plan, six got discharged home safely as a result of these consults. Our evaluators conducted a number of key informant interviews with hospital staff of the two demonstration sites and they are very happy with the service. It is perceived as beneficial. It is helping with transfers and referrals and, anecdotally, shorter inpatient stays. Some feedback from the Rutland staff, specifically increased satisfaction because of the proactive management being offered to the patients, creating this therapeutic relationship with a provider ahead of time has convinced some reluctant families to agree to that transfer to the inpatient setting. And yes, Rutland was able to expand their project to patients who are going to be referred to other locations for treatment. So we are excited for that expansion. From the retreat side, this is their local telepsychiartry vendor. They are finding that patients... Excuse me, providers are reporting a positive experience and they are getting nice technical support from the Rutland team. This team to team connection has been really valuable. Our evaluation found that advisory board members are satisfied and engaged and here you can see that they are happy with their accomplishments, they are happy with their ability to recruit diverse people who represent different sectors being helped are affected. And fostering respect, inclusiveness and trust. I will end here and leave you with my 10th lesson, which is a telehealth resource Center is a valuable resource. Reid, please take it away. REID PLIMPTON: Thanks, Ali. (indiscernible) involved in this effort. One thing I will highlight is, as I mentioned at the start of the webinar, I am the program manager for the Northeast telehealth resource center. However, I am also a program manager for a number of virtual health technology efforts within my parent organization and so combined with some of my colleagues underneath that team and the Northeast telehealth resource Center, my team aimed at producing generalized free resources for those interested in telehealth. We were able to find some great ways to intertwine with this project and develop resources both for the project themselves and our larger stakeholder area. Hopefully from each. Here on the list you see six or seven different ways that we intertwined within the project between the global health team, the metric team and it does go as far back as Allie referenced with the needs assessment, which I think was really powerful as well to be part of it all the way through and

be that well informed on the local community needs as we went through the vendor bedding and some of the other developmental projects during the one-year pilot. On the next slide, I didn't want -- I wanted to break down the best practice inventory that we have alluded to a few times. What it is and what it is not. I think (indiscernible) or they never end, so throughout the two years of this effort so far, we have, you know, reached out to individuals throughout the state of Vermont such as their traffic on workflows and telepsychiartry, the technology they have deployed, what type it is a, how they are being used, how many, the availability of it, how they are interacting with community members and what is the breakdown by various different demographic considerations, insurance considerations, so on and so forth to understand the health equity aspects of it. Is the serving everybody we hope it will and could? How they coordinate with community partners. I will call this out as an interesting one. I think each of our seven states have a little bit of a different sort of mental health community health network outside of the hospitals and the large health systems in Vermont. They have something that is called a designated agency, and there are multiple of them throughout the state and they have their own staff that are tasked with coordinating with the health system and the patient has to leave the health system. So learning a little bit more about what that looked like in practice was, in my opinion, into what was pragmatically a (indiscernible) in any of the health systems. You need to understand what each of them was doing in terms of providing care after that crisis. And then quality improvement. Vermont and a lot of states in our region are lucky enough to have been embarking on these telehealth networks and specifically in Vermont Tele psych. What benchmarks have they established to ensure that they are striving for the best and what benchmarks have they established to ensure that they are aware of any roadblocks that are happening, whether due to broadband issue or something else human and logistics based within the facility. We did a lot of sort of qualitative interviews and quantitative surveys around aspects of that. On the next slide, I am excited. This is one of the fruits of my labor, if you will. At and by hour, I mean the entire team along with (indiscernible) As part of the outcomes of the pilot projects and the effort so far, the team worked closely with those involved to curate a custom, unique toolkit that we are calling the (unknown term) toolkit that will be available on our telehealth classroom website sometime within the next week. Just a brief explanation, as I mentioned, (indiscernible) are charged with developing free accessible resources for any individual interested in improving telehealth access and access to healthcare. One of the ways that magic does that is through what we call telehealth classroom, which is a free self-paced hub of training resources. I think at last count there were double digits. Don't quote me on this. Maybe 12 different trainings you can take on there, and that is not including the (unknown term) one we are

extremely excited to release in the near future. I am happy to let you know as soon as this is available. On the next slide, a little bit more of what that entails. As I alluded, it is self-paced. When you first visit the website, you create an account and that will allow you to save where you are at. You can take any of these modules as fast or slow as you need to. But these are some of the different buckets that we are covering in online modules. Some we touched on today. The background and the need, the demonstration projects within Vermont, some of the workflow considerations, the evaluation. And some we didn't necessarily dive into today but would be valuable to anybody that is considering emulating this effort. The literature review that we did looking at telepsychiartry you say -- usage across the United States, a review of what other states are doing. As was mentioned, North Carolina has great stuff happening there but there are other states of the US that have found a way to have some sort of stage telepsychiartry model. Technology and billing and reimbursement are two other pieces that we dive into here. And then, the last piece, other web-based trainings. Going as far as, you know, trainings for the healthcare providers within your system and as high-level as considerations for a health system looking at sustainable implementation. It is pretty in-depth. Again, we are excited to release it. With that, my next two slides are exciting, rolling it out and releasing of two unique deliverables, ways that we wanted to share information within this toolkit, starting with a short animated video. (Video plays) REID PLIMPTON: We are not hearing sound. ALI JOHNSON: I am going to re-share. REID PLIMPTON: I will acknowledge that... I will explain more about it. The toolkit is really aimed at helping anybody wherever they are at, if they are healthcare professional that is interested in exploring telepsychiartry implementation within their emergency departments. The first thing in this video is to vignettes, walking through what telepsychiartry deployment might look like. (Video plays) (Music plays) SPEAKER: During a medical emergency, patients go to the emergency department or ED for care. But for patients experiencing a mental health crisis, the ED often cannot provide the specialized care they need. Gaining access to a psychiatrist in the ED can take hours, days or even weeks. Patients needing psychiatric medication may not have access to it in the ED and the length of time these patients may need to wait in the ED limits the availability of resources for medical emergencies. Fortunately, having a telepsychiartry service in place and address these issues. Telepsychiartry removes the need of a provider's physical presence. Hospitals can set up their local psychiatrist with telehealth or they can partner with external vendors to reach a greater number of providers. The technology is as simple as using HEPA compliant software on an iPad connected to the hospital's secure Wi-Fi, laptops and telehealth cards can also be used if preferred. If needed, a phone can be used. Here is an example of the hospital workflow using local providers. Jamie, an

adolescent presenting with thoughts of suicide is presented to the ED. An ED nurse offers a telepsychiartry consult to Jamie. Jamie's mom signed informed consent for the use. The hospital contacts the telepsychiartry provider and orders a consult. A private spaces provided and Jamie's mom is invited to attend. A technician is called to prepare the iPad. A Zoom meeting is launched to test the audio and video. The tech delivers the iPad to Jamie. Jamie's mom decides to wait in another room and provides her phone number for follow-up. Jamie is afforded privacy and is camera monitored by ED staff for safety. When the consult is over, the nurse marks the order as completed. The psychiatrist gives urgent recommendations over the phone to the ED care team. The full recommendations are uploaded to the electronic medical record. Jamie's nurse reviews the recommendations and shares them with the care team and Jamie's mom. In this case, Jamie received urgent mental health care without telepsychiartry Jamie could have gone days waiting for help. The workflow for telling -- telepsychiartry is much the same, adding only one step of calling a connection center. For example, Joseph, an elderly man is admitted to the ED at 4 AM. He is confused and appears to have an underlying mental health condition. The rural hospital has no psychiatrist on staff. After addressing immediate physical needs, the clinician requests a telepsychiartry consult and the hospital because the vendor connection center. They described the need for services and provide patient information. The center contacts the next available psychiatrist, who reviews the information. Hospital staff set up the technology. In this case, a telehealth card and determine if the patient has assistive needs such as an interpreter, hearing aids, screen and larger or detailed -- headphones. Audio and video is tested. The cart is moved into the room with Joseph. Connection with the psychiatrist is initiated and remains in the room throughout the consult. Afterwards, the psychiatrist calls the clinician to summarize recommendations. Documentation and recommendation is uploaded to the hospital EMR. Despite being in a rural area in the middle of the night, Joseph had access to mental health care, including recommendations for medications that the ED physician could just -- prescribed. A telepsychiartry plan is paramount for the care of mental health patients as well as for your ED overall success. Start today to get ready for telepsychiartry. REID PLIMPTON: Yes, so that is exciting. At least for all of us who have been involved in this work for two years and were involved in the video creation. In a similar vein, but sort of acknowledging that four minutes of everyone's time in the healthcare system is not always easy to get and understanding how it works in theory is not as easy as understanding what that means for you in your individual system or state or whatever. We also developed this info graphic which really tries to boil down a lot of what you heard about today into just one page, into six specific buckets but you as a health system or a state network would one to

ensure you have done your due diligence on. We include a couple of questions that would allow facilitation of conversation around that exploration of that advancement of services in each of the six buckets. This is also something that will be available in the toolkit, but will also be available for follow-up. We have a discussion question, which I will breeze past if only briefly to highlight these links, which will be available to you guys as part of follow-up and hopefully so that you can learn more about the report. And then contact information for all three of us. Thank you guys for the expertise and agreeing to join me and aria on this session today. Aria, I believe you have a few slides before Q&A. ARIA JAVIDAN: Go ahead. You can do questions first. REID PLIMPTON: Deal. With that, I am happy to open it up. Feel free to use the question and answer box and I will moderate them in real time. Or I believe you can raise your hand and Araa can allow you to unmute and speak a question aloud. Thanks to anybody who has anything they would like to ask. I will toss out a question. I know we touch briefly in this session, but one thing I thought was really interesting to be part of the conversation on but required more thought than I would have predicted as we started to embark on the two pilot projects was the scope of psychiatric support. It touches on acknowledging all mental health providers to the fullest extent of their practice and then, potentially, what you are providing for services. I personally found that to be a fascinated -- fascinating part of the project. I wonder if you had thought he wanted to share on that. ALI JOHNSON: Mark, please go ahead. DR MARK McGEE: Thanks for the question. If I understand the question or there is an observation in the question, observation is about the scope of psychiatric care as it is targeted to meet what in many respects may be a very broad and potentially diverse need. And how best to respond. I think consistent with Allie's observation that despite desired or wishes to think more broadly about how these types of supports can express a much broader need, we made an intentional effort to really limit the need, or limit the scope of the project to address needs that had been identified by emergency departments. And how best to meet those needs, obviously, are a much broader discussion. I think what we had identified in terms of a target and a scope is to really do anything that we can to support the offering of some high quality telepsychiartry services to meet these needs with the understanding that even some support in these instances may not necessarily be what the broader needs of that particular system might be. There is lots of different gaps in the system, obviously, so really, telepsychiartry is one important support in one particular range of a broad continuum of care that we think about in terms of community mental health. Obviously lots of folks come to emergency department settings when they are in crisis, and sometimes that is perfectly appropriate. There are other times when those contexts – but context might be better met with community supports but often times those

supports may be laughing -- lacking as well. Across the system of care, primary care sites in rural communities often have significant lack of access to psychiatric care, psychiatric support period many designated agencies that have been referenced as important components of our system of care may also have significant capacity challenges in terms of meeting the broader community demand for psychiatric care. We know that across the full continuum of care, there are lots of areas where additional psychiatric support would be welcomed and necessary. So we made a very deliberate and intentional system -- choice to be limited about the need and to limit the scope according to the need to supply -- provide support according to the setting knowing full well that the need more generally was considerably broader and deeper than we anticipated being able to address. The thing about telepsychiartry, both in emergency departments and other settings, is it is a scalable, clinical support that can be readily adapted to many different settings, whether that is in a primary care setting or an emergency setting, whether that is in a crisis stabilization setting. Telepsychiartry can be utilized in inpatient settings as demonstrated by other projects undertaken in Vermont. So I think the take-home is it is a further support that telepsychiartry is adaptable to multiple settings and meets significant unmet needs, is readily scalable to a broader continuum and really is a vital and necessary tool to ensure that timely access to psychiatric care is available in the right amount, of the right kind in the right place. So I think this product -- project has validated support of other groups that suggest it is a viable unnecessary support and whatever efforts are necessary to further expand this type of effort are good with this type of excellent return on investments as well. REID PLIMPTON: Ali, did you have anything to add on that? We did get a question in the chat which I will read aloud, but I will just say I think there is a two-part question and one part is probably the better way to ask what I was getting at. As Mark alluded to, what I was trying to allude to is that, to me, one of the values of this is how specific the clinical encounters were in the sense that it highlights that this is not your only ball of wax when we are talking about mental health encounters and ED. There are other scenarios due to this gap in American healthcare currently that having a psychiatrist available at certain times for certain things is not going to empty every unanticipated bed fill in your ED. It's going to help. That is one of the great things about this effort here. We highlight that it will help and then you, as a system, figure out how it can help in the best way for you and for your community. It is kind of an eye-opener for me. I think when we embarked on this, I had rose-colored glasses and thought we were about to cut bed stays 20. It wasn't. That is fine because we learned a lot from it and we still made an improvement. Anyway, I know aria has a few slides to round up. He Prograf the two-part question here, in the clinical workflow, where did you find the biggest fallouts? And

then the second question, who were your trainers for the implementation. I will take the second one and then I will stop rambling. The second one, for training, it differed in the pilot sites. So the site that use the in-state support, it has already had a big tele-site presence and support so their staff had some training and that is one of the areas also where (indiscernible) hopped in. We worked with them and the hospital to ensure that everybody was feeling comfortable in terms of roles and tele-presenting and all the equipment. After that, it was helping hands. They took it away. We didn't have to help them build a workflow or anything else. They understand well and good. With the other group, they chose the national vendor. The national vendor has a training series that is for the end-user site and they also have a repertoire of training that their staff has created. They are ready and willing to take additional trainings of the additional sites that may provide, may need, make required. They have their stuff -- staff trained. And they have (indiscernible) Back to the first one around clinical workflow, some potential fallouts, I guess I will say that I don't think I called whether they are asking from the health system and but if either of you too can speak to either? DR MARK McGEE: I can address that a little bit. Whenever I think about telepsychiartry programming implementation, for me it's a really important aspect of it. As was referenced, one of the real challenges to timely implementation of the project and the contracting was really around provider credentials. That is a process that can be time-consuming, requiring a great deal of administrative support that can be cumbersome, frankly. As I recall, for this project, which was relatively low volume for the clinical access hospital, I believe they required credential 17 of the outside providers. So that is 17 times a cumbersome process. I think, in my experience, working with telepsychiartry projects of this nature, any significant barriers to implementation has a direct impact on care because the delays in setting up programming are delays in individuals accessing this type of care. For me, that is a significant clinical workflow issue because it is on the backend. In terms of the actual day-to-day operations of the projects, I think they function and run quite smoothly. I think if staff on site are familiar with how to set up the familiar. This highlights the need for high quality but easy to use equipment and sufficient training on utilizing the equipment. As many of us have experience in using telehealth supports, particular since the pandemic, I think many of us have discovered that the technology needed, as long as it is thought out and set up and of decent quality, I think many of the technical aspects that people fear as barriers to effective implementation simply are not the case, and we often, I think, many people are surprised at how streamlined the processes are. One interesting data point I run into that I think is worth mentioning, with any implementation process, the most frequent skeptical stakeholders in any element -- implementation process is often clinicians themselves, whether it is clinical

leadership, emergency department, medical directors, even providers themselves who use telemedicine, they are just not sure it will be as good. And then consistently, all the research suggests that the skill level, comfort level, satisfaction with providing treatment in these ways is really equivalent to other forms of care delivery. Those are some relevant issues that come up again. I think implementation and perhaps looking at opportunities to streamline that process can really decrease the administrative and time burdens with getting this up and running. ARIA JAVIDAN: Thank you, oh. We are running out of time so I will close up the passion. Heads up for our next webinar on April 18 on AIM health care. Registration -- AI and healthcare. Registration is on our website. Lastly, please take a few short minutes to complete the survey that will pop up at the end of the webinar. Thank you again to our guests today for their presentation. Have a great day, everyone. Live captioning by Ai-Media.