PHI
Expansion of Telemental Health in the Time of
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>> MURLEAN TUCKER: Welcome to the expansion of telemental health in the time of COVID-19. This is the fifth in a multipart series on health innovation in the era of COVID-19: Lessons from the field. My name is Murlean Tucker and I'm running this D4H web forum with my colleague, Jeff Bornstein. Thank you to our partners for today's event, UC Davis Health, Transatlantic Telehealth Research Network, CITRIS and the Banatao institute, the international society for telemedicine and ehealth and the Gary and Mary west foundation.

Now, I'd like to introduce Dr. Birthe Dinesen, the moderator of this event. Dr. Dinesen is a professor and head of the laboratory of welfare technologies, health and telerehabilitation at Aalborg university. Dr. Dinesen, I'm going to hand the mic over to you.

>> DR. BIRTHE DINESEN: Thank you, for the kind introduction. It's my pleasure to introduce to you telemental health in the time of COVID-19. Social distancing during COVID-19 and the mental strain of a pandemic has affected the mental health of many and exacerbated suffering with existing mental illness, including mood and anxiety disorders and substance abuse.

Today, our panelists will address the impact of COVID-19 on adult mental health, the shift to virtual appointments for patients seeking mental health services and the lessons learned.

My name is Birthe Dinesen, and it's my pleasure to introduce to you our three speakers.

Dr. Peter Yellowlees, chief wellness officer and professor of general psychiatry at UC Davis health. Dr. Tonya wood, clinical psychologist at Pepperdine university. And Dr. Jan Mainz, executive director of psychiatry in Denmark and professor at Aalborg university and affiliated to university of southern Denmark.

Dr. Peter Yellowlees is an in psychiatry with extensive knowledge of telemedicine. He will be leading our webinar series today. Thank you for being here, Peter. And I give over the mic to you.

>> DR. PETER YELLOWLEES: Thank you very much, Birthe. And thank you everyone for organizing this presentation and conference and to the over 200 people currently listening. It's really good to have all of you here.

Now, I'm just trying to move the slide forward. I'm going to talk about telepsychiatry in the time of COVID-19. Obviously, this has been a big change. I'm going to take both the US and international perspective. Three quick disclosures, much of what I'm going to be talking about is based on the three books I've written relevant to this topic, one on telepsychiatry and two on physician well-being and suicide.

Now, if we look at the -- it's well-known that certainly in the US, telepsychiatry has been used more in the last six months because of COVID-19. But the three drivers of change in telepsychiatry over the last number of years, first is COVID-19 is relaxed regulations, the safety of patients and providers, and all of whom have been staying at home, and changed attitudes, quite honestly, among particularly people in the older generations.

But then there's a huge demographic change going on with the Gen Z and millennials coming through using phones and mobile devices is completely normal. And massive technology changes with an enormous shift with the use of mobile devices for telemental health.

There's basically three types of telepsychiatry that what we usually think of this is a synchronous approach where we have people talking and seeing each other or using a phone in real time. Asynchronous approaches or store and forward technology is increasingly being used. Remote patient monitoring, particularly using mobile devices and apps not in real time monitor symptoms and patients.

Now, going to COVID, this is an interesting quote from Dr. Fauci from 2008. If we had a massive pandemic tomorrow, all of us would be in serious trouble. And sadly, we've seen how badly the US has handled this whole situation today with over 200,000 deaths.

Now, one of the side effects of this has been a significant increase in mental health problems among patients, both patients with previous disorders as well as patients with new disorders related in particular to social isolation, lack of being able to carry out normal activities. And with kids in particular to a lack of educational opportunities.

This is an example from the CDC, the weekly statistics that focused on mental health about a month ago.

Now, I think past, there have been well-described barriers with the use of video in particular. The main area being patient satisfaction capacity, which has gone away to a great extent now. The technological barriers again have also been reduced with the increasing numbers of smart phones available. And in US, regulatory barriers have been quite honestly swept away during the COVID-19 campaign -- the COVID situation and will remain away long term. And I think provider attitudes have really changed significantly in this country. And literally, the ability to see patients on video has actually saved the practices of many physicians.

So what are the relaxed regulations that occurred in the US? There are four sets. The first is the ability for us to see patients across state lines with licensing changes. The second is reimbursement, much easier reimbursement, particularly again in different geographic areas. And also for telephones as well as for video. The third is being on prescribing and the

prescribing particular of controlled substances which in psychiatry means some things like stimulants and benzodiazepine as tranquillizers. And then finally the HIPAA in the US, once the rules haven't changed here, the federal government has made it clear that they won't be prosecuting people who inadvertently break these rules.

Now, let's look at the second big driver, which is the essentially the intergenerational effects and how the millennial physicians may ultimately do much better using technology than perhaps physicians from my own age group. And this is a paper that I recently had published with a colleague. And what we showed in this paper was if you look at the slide, you'll see the different drivers of attitudes and beliefs and behaviors among the millennials and the Gen Z population.

So if you look at them, they've been very focused on smart phones, on social media, on essentially a different approach to education with shorter, asynchronous processes being preferred.

And if you look at the generational parents, other generations, they've been influenced by paper records, by the TV, and similar technologies. So very different background perspectives from our different groups of people who are currently now working in the health systems as providers.

Now, what about mobile devices? Here is what I think is the biggest change. And the number of mobile devices being used around the world is simply mind boggling at the moment. There are actually 10 million smart phones and use around the world with only 7 million people in our global population.

More broad band prescriptions also than there are actual people. Many people have two subscriptions. 67 percent of all internet access through the world is via phone and China is about 99 percent. In the US, 81 percent of the population are owners of smart phones. 90 percent have access to the Internet via apps. And there are -- there's an enormous industry that's developed around this with about 40 million jobs estimated to be a part of our mobile industry where an average user is actually checking the smart phones 58 times per day.

So mobile devices have come to stay and are here and are dramatically changing the way we all live and work.

So this is a picture of my home telemedicine set up or my home desk. And if you look at it carefully, you'll see there is not a single traditional computer. I have a laptop. I have an iPad. I have my smart phone. And I have a big screen at the back that I can display anything I want to. But it's a dumb screen. And I actually no longer own what used to be a formal wired computer. Everything is mobile and I do work on mobile devices and that's increasingly the case with patients.

So what are the major clinical issues in terms of telepsychiatry that are important at the moment and that contribute to this expansion of use? First of all, convenience, safety of being at home, and the fact that people like it. Different interviewing styles are important, and I do think that it's a really good thing for providers to actually have some training in that. There are different levels of power and control within the hybrid relationship in particular, perhaps a relationship where patients are being seen both in person and online. I've written extensively about the virtual space and the advantages on both the physical and the psychological nature of that space. In the community, the car is actually the new consulting clinic, new consulting

room. And many of my patients actual going and sit in their cars to consult with me nowadays because it's the place with the greatest privacy, particularly if they're at work. And we know ultimately that an important advantage of using technology is the ability to work in teams, bringing in other family members, other members of our health care team, perhaps interpreters, people like that. Much more reasonably was possible in the physical world.

The big down side quite honestly is what is called Zoom fatigue. And I think that's a matter of us learning how best to work on computers and on mobile devices and making sure that we actually take regular breaks and go for a walk or get some fresh air partway through the day because there's a tendency once you get on the device to simply sit there and continue working on it.

Now, there are some patients who prefer telepsychiatry to personal care. I think we're going to consistently move to a hybrid approach where we see patients either online or in person depending on the patient's choice or convenience. But some of these groups of patients actually seem to do better online. So children love this. And certain disorders where perhaps there's a degree of stigma related to them like a rectal disorders male patent boldness as well as VIPs perhaps with the extra privacy like telepsychiatry. People with chronic psychosis for many years have been treated on video. Many public mental health services in America use telepsychiatry for this purpose. But also, patients who have been anxious, traumatized, paranoid, perhaps avoidant as well as those patient whose are on the autism spectrum and who actually prefer technology to human interaction as times.

And finally, there's a lot of evidence that groups can be run well on video. And CBT treatment can be treated well. So these are all areas where in fact I think we should be thinking about perhaps giving telepsychiatry the premium status rather than the second degree status.

Now, what's actually happened during COVID? My colleagues and I have published on this as well as many other people about how to rapidly convert clinics. The psychiatry outpatient clinic at UC Davis converted from about 3 percent video to 100 percent video in three days. And this is the actual graph of patients being seen. On the left, you can see the totals of patients seen per day, 80 and 81 and then going down to essentially 0 in person. And the majority of patients being seen in the lighter color were on video with a few patients who didn't want to use video or didn't have access to either a smart phone or the capacity to connect to it is still being seen on the phone.

But we converted very rapid lap. And that's pretty typical of many academic units in the use.

And this is an example of a Clozapine clinic from the UPMC in Pittsburgh. And Clozapine is a drug that has to be carefully monitored and they converted an in-person Clozapine clinic to a mainly virtual one. And the lines in red that you can see on this scale are the number of virtual visits that occurred in the three months post COVID, the blue being the in-person visits. Hybrid approach, but increasingly virtual.

What about across the country in the US? What we've seen is that there's been about an 8,000 percent increase in the number of consultations that private health insurance has paid for per this fair health tell health regional tracker. That went up rapidly in April, May, June. It's actually gone down a little bit since. But UC Davis health system is probably a good example of the use of telemedicine generally, particularly telemental health. We have now

reached a fairly steady state where we do about three and a how thousand consultations in our outpatient primary care and specialty clinics every day. Of those, about 6 or 700 or about 20 percent are done on video. And that's what we expect to keep long term. Now, that's across all specialties and all different types of areas of medicine.

In psychiatry, we're still doing 100 percent of consultations on video. And we won't continue that long term. But I think we'll end up in psychiatry being at least 50 percent video, 50 percent in-person, and that's primarily because a lot of the patients are actually finding this much more convenient and want to continue seeing us like this.

There are a lot of advantages for providers of doing video visits. Time and cost savings. It's often less tiring. You can work from home. I've literally been seeing our patients from home the last six months. Better relationships seeing people in person and online. You can have an increased variety of patients. It's a safer way of working but with better teamwork. And very importantly, you have both geographic and scheduling flexibility. And all of that from a provider perspective can lead to increased independence, autonomy, work-life balance, and well-being. So I think this is one of the silver linings from COVID. But many providers have found and certainly my impression is from a number of surveys now that a lot of psychiatrists in the United States are going to continue working on video, at least part of a work week once COVID has passed.

Now, there's a lot of information around about COVID. This is from -- this is from the American psychiatric association website. And the CDC. Again, the website here has a huge amount of information as well, both all very high quality.

So what's my summary? I think first of all, the big drivers are mobile devices, younger generations and COVID-19 and in the US, the emergency that has been declared are really driving long-term changes in psychiatric care delivery. I don't think that we're going to live and care in the same way post COVID that we did pre-COVID. I think this will be a form of hybrid care where the patients will have the choice of being seen in-person or online and I think it's usually going to involve the use of mobile devices rather than the traditional fixed computers.

And I think it's a very important point from a provider perspective is that telepsychiatry is really good for our own well-being and with the large amounts of burn out being shown by providers around the world, the increasing pressure on providers from financial requirements, working in particularly large health systems, this is one way of actually reducing some of that pressure and hopefully improving the effectiveness and clinical longevity of many of our mental health professionals.

So I'm going to finish with that. This is my fantasy. You'll see with absolutely no technology involved. But thank you very much indeed for listening.

>> DR. BIRTHE DINESEN: Thank you so much for the insight and presentation, Peter. And next, we have Dr. Tonya wood. Dr. Wood will be focusing on the provider side of telepsychiatry and how she has utilized virtual visits in her practice pre-and during COVID. We look forward to your presentations today, Tonya. Please go ahead.

>> DR. TONYA WOOD: Thank you very much.

I want to give now a more sort of personal account to the great overview that Peter provided for us, being a provider myself during this time of COVID and what it was like transitioning to telehealth.

And just a little bit about me. Like many of us, I wear multiple hats. So as mentioned in my introduction, I'm currently the director of clinical training at Pepperdine, in the society program. So part of my responsibility there is doing some teaching but also facilitating clinical placement and training of psychology students who also are transitioning to telehealth. I'm in private practice and I'm currently the president of the California psychological association.

So from many different sources in my life, I was at a very -- and a rapid pace -- adjusting to telehealth. You have this visual of an office. So I have my private practice and my clients. And then I have the classroom setting, working with students. So our classroom instruction was moving to telehealth as well as working with student clinicians and providers who were trying to ramp up their own level of comfort and competence with providing services. And I'm a mother of an 8 year old child whose school also went completely virtual. So the progression of the pictures here was to illustrate what I was managing as an individual and then leading to my home environment, which is not nearly this calm [chuckling] or well-decorated, but gives you a visual, a sense of the coffee cup and the laptop. So these were the things that I was managing during this time.

And I probably will echo a lot of the things that were previously said, but in terms of thinking about how I individually as a provider managed and particularly some of the issues that myself and the clients that I have were managing. And I think one thing that was most notable during this transition for COVID -- and there's this pre-COVID and post COVID experience -- is the rapid pace with which we had to do it.

I was a little bit more well-prepared because I integrated some aspect already of teleconferencing or video conferencing into my practice. So it was a more seamless transition for me than some of my colleagues. But -- and being president of the California psychological association I was very well aware -- because I was hearing from my members what they needed. And I think it was the access and comfort to the technology. So having the equipment that was needed, having proper connectivity and Wi-Fi signals and access to facilitate the transition and/or using phones. I mentioned as a part of my role as director at Pepperdine, I do supervision at clinic in south Los Angeles in a low- income underresourced community. And so initially, we just went to telephone instead of videoconferencing to ensure there were no gaps in services or treatments for our clients.

And so that was one primary issue that I think everyone was thinking about. And especially, I think, providers. It wasn't just about access but the comfort and honestly knowing. I think there were dozens of emails, if not dozens, probably close to 100 that were going around about what platform to use and what -- you know, what sites were available. Which ones were HIPAA compliant, which ones provided the best quality. It wasn't just about having a computer or having a smart phone or having Wi-Fi, but it was actually knowing what are the platforms that are available for our use.

So that was something -- one of the first things and one of the more sort of pressing things that were there. But also this issue of confidentiality and boundaries and this idea of privacy at home. I mentioned in my previous slide I'm the mother of an 8 year old. So it's not that I'm now seeing my clients at home, he also is at school at home. And what was that like not just for clients who are trying to manage privacy issues and just like Dr. Yellowlees, many of my clients are also having their sessions in their cars in order to facilitate their own privacy, but for me as well, that was an issue that I have to continue to manage and ensure and protect.

And I have in here Alexa is listening just to provide an anecdote of a funny story with one of my clients. At one point, we were setting up with all of the usual check-ins, can you see here, hear me and the client was having difficulty hearing me. Okay, let me check my mute button, let me check this. And the client says, oh, wait, hold on one second. Gets up, gets back out and said he had to disconnect Alexa. So all of our conversation was being transmitted via Alexa. So all of the things, the technologies we have and the interconnection of them, you know, are also kind of -- can make us more susceptible and vulnerable for our privacy and confidentiality being at risk. So that was another thing. And then as well as updating clinic policy. For me as a provider, I had to really rethink and look closely at the informed consents and to what -- doing my due diligence to make sure my clients were agreeing to receiving services via telehealth that they're agreeing and consenting to me emailing and texting. So updating my office policies and protocols to make sure that I was not only sort of transitioning to telehealth but properly informing and protecting the privacy and confidentiality of my clients might also making sure they were aware of the risks and limitations of this were.

And then, you know, just sort of the nuts and bolts, how we're going to get paid in terms of if we had previously been working with clients who -- even if they weren't no longer paying by check but they were giving you a credit card as they left the office or sending in payments, this sort of transition to being comfortable with online payments. And that may seem not as a more -- you would think that by now with the advent of things like Venmo and PayPal and Zelle, that wouldn't be a big an issue, however, for many providers, I think it really was. At least in psychology and what I've been hearing from the members of the California psychological association, not everyone was comfortable with this idea of payment because of things like privacy and confidentiality. How can we ensure that we're protecting the privacy of our clients if they're paying us through Venmo. Is that sanctioned? Is that okay? So I think it was not just providing information about how to do it, but an increasing comfort with that process as well.

And as was mentioned earlier, these are provider issues. I think most of the kinds of questions and concerns that either I myself individually had or from the psychologists that I worked with was about effectiveness, quality, et cetera. But clients have been accepting of the use of video conferencing before this. And this is from a 2014 article that there's use and acceptance. That may vary across settings and sessions. The quality of technology that you have to use and how often they use it and the more people use it, the more they're satisfied with it. And part of the reasons that they indicate that is it does increase access to services. I think one of the challenges, though, is addressing the ability to exchange documents. So things like getting informed consents signed, exchanging any forms, et cetera, which I think have been addressed as we've been changing. But I just like to reiterate that clients have been okay with this. It really is providers who have been more hesitant and cautious and concerned. But moving forward, what is it that we're going to do? I agree with my colleague that the office without walls is the new normal. Now, I think part of it -- the transition to that is increasing client awareness of, again, what that means in terms of the logistics of it, potential risks and limitations regarding boundaries, privacy, and increasing provider readiness as a director of clinical training, that my role is in producing a field of psychologists or contributing to the field of psychology by a work force who is -- looking very different today than it did six months ago in terms of what it comp tenses are and should be in order for the clinicians entering the field to really be prepared for what awaits them. So we really need to do more integration of this and to graduate education training and jurisdictional practice and what the laws are that vary across the states.

And I think increased resource and attention to telehealth outcomes. Again, just to inform providers and the public about the effectiveness of telehealth and that we can be more assured and confident in the application of it.

So I think -- I appreciate the opportunity to speak with everyone. I apologize for my technical glitches in the beginning. But look forward to answer any of your questions at the end. And I think I will now turn it over.

>> DR. BIRTHE DINESEN: Wonderful perspectives and insight. Thank you so much, Tonya, for the interesting presentation. Finally, we have Dr. Jan Mainz from Denmark. He will be presenting the perspectives of telemental health during COVID-19. Thank you for being here. Please, the floor is yours.

[No audio].

>> MURLEAN TUCKER: Dr. Mainz, you might be muted locally. This is Murlean. Please check your local mute button.

>> DR. JAN MAINZ: Can you hear me?

>> MURLEAN TUCKER: Yes.

>> DR. JAN MAINZ: Thank you for this opportunity to share a small case from the Danish health care system.

I will give you a brief introduction to the Danish health care system, share with you some of the strategies for utilization for Denmark and present -- tell you a little bit about the organization that we have in our psychiatric service and then what we experienced during COVID-19 with regard to telepsychiatry in Denmark and some of the lessons learned from telepsychiatry during the COVID-19.

Denmark is a small country. It's a small kingdom. And on the very top of Europe, actually. And as I said, a small country with 5.7 million inhabitants. And the Danish health care is, I would say we have four corner stones. We have universal coverage. We have free and equal access both to psychiatric care but also to [indiscernible] care and also free choice for choosing TP's. We have a high degree of decentralization. And almost entire health care system is financed by general taxes.

We have three administrative layers, the Ministry of Health that prepare legislation and regulation in our health care system. Five regions. I belong to the very top of Denmark, region north of Denmark, and the regions are responsible for hospital care, in and outpatient care, and the 98 municipalities are responsible for basically prevention and also for home care.

We have strategies for digitalization in the Danish health care system. Nice strategies and actually describe since 2012, the first national action plan for telemedicine was implemented. But it was a strategy. We initiated digitalization of the public sector in the period for 2016 and 2020 for the citizens. And it should aim at being easy to use, high quality, and also provide high security and user confidence.

Here, you see the strategy for digital health for 2018 and 2022. That should improve coherence, quality, and also geographical equality in health care, use of digital solution is in

focus. For example, in terms of one app to get digital access to the general practitioner, use of PRO data, the voice of the patient, and digital rehabilitation.

So we are, I think, as a country, as a whole, the health care system, we are among the top three most digitalized countries among 28 EU member states in 2020.

Public services are going digital, and Danish citizens are some of the most frequent users of the internet in the EU.

So Denmark is gradually implementing a digital by default strategy for the most frequently-used citizen public services, taking advantage of the high percentages of the e Government users, which is the second highest among the EU countries.

This is my part of the Denmark, very top of Denmark, region north of Denmark.

And this slide actually shows the distribution of psychiatric services in region north Denmark. The red bullets shows where we have inpatient facilities. The orange dots shows where we have outpatient care. And the green one is emergency psychiatric emergency care. It's a small health care system in the part of the region north of Denmark. You can see we have around 1200 full-time employees. And we have 130 doctors, 112 psychologists, and approximately 400 nurses and 200 other health workers. So it's a small facility. We have 270 number of beds. And you see some of the other administrative figures that we have -- that says a little bit about the capacity that we have in our part of the health care system.

We're starting up telepsychiatry in 2016 in terms of the implementation of videoconferences for health care professionals for communications within the hospital and with external partners and from 2017 until 2020 projects with focus on full implementation on video communication between patients and health care professionals were initiated.

So even though we -- and this is more or less the infrastructure of the video consultations between the hospital and patients in their own home. So you see, it's app based video solution built on video software between the hospital and between the patient home. So even though you can see we have a nice strategy and we have also some infrastructure, then there was a lot of barriers. It was actually -- there were some areas very much related to the health professionals because they were really doubting whether they would obtain the same quality when -- if they should meet the patient using app-based solutions. And also, some of the patients were very reluctant to take up this opportunity.

But it changes during COVID-19 in the week 8 this year, the first version of an app-based video solution for patient consultations in own home is implemented and ready for use. In Denmark, we then experienced a national lockdown, a lockdown that both countries had experienced. This year, we had that in week 20.

And some of the lessons that we then learned during the COVID-19 was that during the national lockdown, we saw a decrease in terms of outpatient referrals in our use -- both in our youths and adults in psychiatry.

We saw that the outpatient enrollment also was affected. And you see the differences. During the national lockdown and in the period after the lockdown. So during the lockdown, we saw a clear decrease, a significant decrease. And then we had -- we had a slight increase in the weeks after.

Outpatient visits also decreased significantly during the national lockdown and then afterwards, again, we saw increases.

Then the virtual visits during the national lockdown, we actually experienced that our health professionals and also our patients really tried to use telepsychiatry. And you can see there was an increase during the national lockdown.

And in terms of the proportion of virtual consultations in terms of phone versus video use, you see the change here. You also can -- from this picture, you can see that we have -- that most of the transition that we experienced in this time period was actually the highest increase was related to phone consultations. And we did not manage, actually, to really implement video conferences.

And this is the total capacity related to the national lockdown.

We have also in our health care system tried to analyze some of the COVID instance in psychiatry, some of the adverse, actually. Some of the transitions we have experienced during the national lockdown and during the COVID-19 period, you can see we have experienced serious adverse events, also some mild, but also some lethal. And we have to dig into them and we need to describe them in further details also in order to learn some of the side effects of this.

Some of the COVID-19 adverse events in psychiatry relating -- were related to confusion with new procedures and workflows. Also, some related to physical meetings versus conference calls and also to -- also for visits.

As I said, we really need to dig down in these adverse events and also get experience from these adverse events.

Some of the lessons that we have learned from our patients is that they do not want to come physical to the hospital to meet with the health care professionals, and they are very motivated for using video consultations and also phones in addition to physical visits due to important to keep contact with the hospital due to feeling of continuity.

The log-in procedures are too complicated to use for some patients. They get frustrated as they cannot log in. And the technical video app solution can only be used on iPhones and some other -- for example Samsung and Motorola, but they cannot be used on all devices.

Some of the lessons that we have learned related to health care professionals is that a minority was reluctant on their technical skills on using the video solution. Most were motivated to shift from physical visits to video visits or phone calls when they had the lockdown. And health care professionals found the implementation process too fast. Log files show that the health care professionals have gone back to plan and perform physical visits with the patient. You could also see that from some of the figures I've shown. And we have to get down on the adverse events.

We are planning now to dig down in the patient satisfaction. So we prepare questionnaires, asking the patients for how they had experienced this transition from physical visits to video or phone consultations, and we're doing exactly the same in order to provide provider satisfaction. In Denmark, we actually need to dig into do patients who -- which patient groups do actually prefer telepsychiatry and adverse events and what are the real outcomes using telepsychiatry. Thank you very much for your attention.

>> DR. BIRTHE DINESEN: Thank you so much, Jan, for sharing your experience with telepsychiatry in Denmark. I would like to ask some questions for the panel. My first question will be for you, Peter. Are there some patients that cannot receive telemental health due to not having mobile technologies? And what are your experiences when you reach out to them?

>> DR. PETER YELLOWLEES: Thank you very much. There are some people who are unfortunately unable to access the digital world, essentially. And certainly in our experience, the group that we had -- working from a semi private outpatient perspective, the group we have worked with are the very elderly. Now, the majority of those people can find sort of a 16 year old grandson or granddaughter to help them, and we've certainly had them happen on a number of occasions. But, you know, we're very comfortable seeing patients, particularly patients we have already seen for previous assessments. So we're comfortable seeing them on the phone if they can't manage video.

I think there are also groups of disenfranchised people. The homeless, the very poor, people from some of the black and brown communities where poverty is more wide spread and who are adversely affected by what is still a digital divide, who clearly find it more difficult to access care this way.

But in many places in the States, even people who are homeless can be given phones as a part of a package of support if they can register for that.

But the reality is there are still a group of people who we should be able to access, but we can't because they simply don't have, you know, easy access to devices.

>> DR. BIRTHE DINESEN: Thank you so much, Peter. And I have a question for you, Tonya. What factors had biggest transformations in telemental health for you in your case?

>> DR. TONYA WOOD: Thank you. There were several. I think, like I mentioned before, I was somewhat well-positioned because I already -- I already had the infrastructure, in some sense, with an electronic record system that embedded a video conference that I was already using. But some of those factors, though, were then things like some of the regulations that were mentioned before. So would insurance companies reimburse? To what extent were the use of telehealth compliant with HIPAA regulations as well as just, again, sort of the client access and level of comfort. So I think the greatest challenge that I faced was sort of ramping up quickly in light of possible, laws and regulations related to the provision of care as well as informing and ensuring clients had access to the services and technologies that they needed as well as just, I think, their preference. And many of them already were -- in light of COVID, many of them were preferring sort of safer ways of communicating. But I think they were concerned about missing that, you know, person to person contact or in-person session, which I haven't necessarily seen born out, quite frankly, in my private practice. But do think that that shift required a rethinking of how we conducted our sessions and the way that sort of -- as mentioned before, the interview process itself went and how to be of service to clients so that they didn't feel sort of a lack of person to person presence through the video screen.

>> DR. BIRTHE DINESEN: Thank you very much, Tonya. And then I have a question for you, Jan. You can see from your statistics that the health care professionals at the hospital and the use of video consultation. Now we have an increase of COVID-19 affected persons in Denmark. What do you predict in the future with the use of video with your health care professionals?

>> DR. JAN MAINZ: I think actually basically, I think, that our clinicians went back to old habits shortly after the national lockdown. And now it seems that the number of infected persons and patients in the health care system are increasing. So I expect an increase in video consultations and in phone consultations for sure. I think we will -- basically, now we know that it can be done. And we also want to use the experiences from the first phase of the COVID-19 to -- as I already in my presentation indicated, we want to dig down to see what is the provider satisfaction, what is the patient satisfaction, and which adverse events should we try to avoid. We have a task force now that should try really to stimulate and develop telepsychiatry in our region in further detail. So I'm quite optimistic.

>> DR. BIRTHE DINESEN: That sounds good, Jan. There are some questions here from the audience that registered, and one of them, I would like to ask Peter. Many Americans have gone into hiding because of the risk during the pandemic and this has resulted in under testing of the COVID-19 case review. They're asking what's being done for -- in this case. Would you like to answer this question, please?

>> DR. PETER YELLOWLEES: Yes, I think that's obviously tragic and the indication of the racial messages that's been put out about the virus, which is a virus, can which is not necessarily related to one connected to one geographic population. You know, I think there are a number of programs that specifically target Asian Americans in the mental health field, and there's one in Berkeley in California. But I think this is an example where we need to get some more consistent messaging to groups like this, you know, both from a federal and state point of view to try to reassure them that in fact they're not going to be targeted. And quite honestly in this country, we don't have that message at the moment. There's a divisive approach being taken rather than an inclusive approach. So I'm not sure what the answer is, trying to message these people, encouraging them to come forward for assistance.

>> DR. BIRTHE DINESEN: Thank you, Peter. Jan, do we see something similar like this in Denmark to help somebody who is in hiding and we have an increase in the --

>> DR. JAN MAINZ: Yes. I think so. We don't have a clear picture at this point. But we are actually trying to make some analysis and trying to dig into this. But yes, I'm sure that some of our patients have been hiding. And I'm sure also that some of our patients have tried to avoid getting -- be getting admitted to some of our hospitals. As I said, we don't at this point have a very clear picture. But we need to make -- to dig into this and get more insight in order to plan the next phases of COVID-19, which seems that we are entering right now.

>> DR. BIRTHE DINESEN: Thank you, Jan. I think time is flying. There's so many questions. We could have used another hour for questions here. So we -- it's two minutes before we're closing up. So I would like to thank our speakers for sharing the experience and expertise on this webinar. And thank you to our sponsors, the Gary and Mary west foundation and the TTRN and the international society of telemedicine and health, CITRIS and UC Davis health university. It wouldn't have been possible without your gracious contribution. Our next webinar will be taking place on Tuesday, October 20th. Families during COVID-19 will be the theme. There will be questions to evaluate this webinar. We ask you, if you have ideas for future ideas, we have one in November and December, please send us an email, and we would like to look at it. So finally, thank you to all of you, the audience, for joining us today. It's been a pleasure for moderating this webinar. And I wish you all a good day, good evening, and good night. Thank you so much.

[End of webinar].