# Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Webinar Series

## February 19, 2015, 1-2:30 p.m. (ET)

## "Clinical Benefits of Telehealth Technology in Behavioral Health Care"

Thank you all for standing by and welcome to today's conference call. All lines are on listen-only for today's conference. Once again, all lines are on listen-only; and our conference is being recorded. If you have any objections, you may disconnect at this time.

I will now turn your conference over to your host, Dr. Gregory Kramer. Dr. Kramer, you may proceed.

Thank you.

Good afternoon and thank you for joining us today for the DCoE T2 February webinar, Clinical Benefits of Telehealth Technology in Behavioral Health Care. I'm Dr. Greg Kramer; I'm a Clinical Psychologist at the Department of Behavioral Health at Madigan Army Medical Center on Joint Base Lewis-McChord, and I will be your moderator today.

Before we begin, let's review some webinar details. Live Closed Captioning is available through Federal Relay Conference Captioning. Please see the pod beneath the presentation slides. Defense Connect Online and Adobe Connect are the technical platforms hosting today's webinar. Should you experience technical difficulties, please visit www.dcoe.mil/webinars to access troubleshooting tips. At any time during the webinar, please submit technical or content-related questions via the Question pod. The Event Planning Team will address your technical questions as soon as possible.

While we encourage you to network and identify yourself to other attendees via the Chat Pod, please refrain from marketing your organization or products. The Chat pod will be left open for additional networking opportunities for 10 minutes after the webinar has concluded.

Today's presentation, references, and resources are available for download in the "Files" box and will be archived in the Webinar section of the DCoE website. Resources that will be available for download today are: American Psychological Association's Guidelines for the Practice of Telepsychology, American Telemedicine Association's Practice Guidelines for Video-Based Online Mental Health Services, and National Center for Telehealth and Technology's DoD Telemental Health Guidebook, Second Edition.

If you are pre-registered for this webinar and want to obtain a CE certificate or a Certificate of Attendance, you must complete the online and CE posttest and evaluation. After the webinar, please visit http://.continuingeducation.dcri.duke.edu to complete the online CE posttest and evaluation and download your CE certificate/Certificate of Attendance. The Duke Medicine website online CE posttest and evaluation will be open through 11:59 p.m. EST on Thursday, February 26, 2015.

Throughout the webinar, you are welcome to submit technical or content-related questions via the Q&A pod located on the screen. All questions will be anonymous. Please do not submit technical or content-related questions via the Chat pod.

I will now move on to today's webinar, Clinical Benefits of Telehealth Technology in Behavioral Health Care. In today's world of technology and connectivity, outpatient behavioral health care services are delivered in much the same manner as for the last 65 years: patient takes time off work or away from family, commutes to the provider's office, and meets with the provider individually or in a group in a shared, private space.

This traditional model of care may impose barriers that increase the difficulty and challenges for those seeking treatment and may lead some to avoid behavioral health care completely. Couple this with the nearly 80 million Americans living in underserved areas, and an individual's access to high-quality behavioral health services becomes a key issue facing the behavioral health field.

Telemental health care, the delivery of behavioral health care to a location where the provider is not physically present, is one way to enable access to care. Research consistently supports the use of technology, such as video teleconferencing, to deliver effective evidence-based care. This webinar focuses on the clinical benefits of remote health care, both to the patient and to the therapy process.

During this webinar, participants will learn to: define telemental health care and explain its applicability to behavioral health settings; determine clinical scenarios that may benefit from telemental health care; compare and contrast the therapeutic process between in-person and telemental health services; describe how telemental health increases patient access to behavioral health services.

Dr. Larry Pruitt is a Clinical Psychologist in the Research, Outcomes, and Investigations Division at T2. He earned his M.A. and Ph.D. in Clinical Psychology at the University of Nevada, Reno, including a clinical internship at the Sierra Nevada VA Medical Center. Prior to joining the staff at T2, he completed a two-year fellowship at the University of Washington, Department of Psychology, as a faculty Research Associate.

At T2, Dr. Pruitt serves as the Program Lead for the DoD Suicide Event Reporting system, as well as the Clinical Research Supervisor for T2's In-Home Telehealth Program. He has authored 19 peer-reviewed publications, as well as four book chapters in the areas of telemental health, PTSD treatment, suicide prevention, and the phenomenology clinical anxiety.

Dr. Kathleen Woodside is a clinical psychologist practicing at the Portland VA Medical Center and a Research Psychologist for T2. She earned her Ph.D. in counseling psychology from the University of Buffalo and completed a fellowship in polytrauma recovery at the Baltimore, Maryland VA. Dr. Woodside is recognized for her work integrating telemedicine methods and technology into clinical practice. She helped establish an innovative telemental health program at the Portland VA, and recently concluded data collection as an interventionist on a T2 research project investigating clinical outcomes of treatment provided by a webcam to patients' homes.

Dr. Woodside continues her telebehavioral health practice by offering evidence-based treatment for PTSD and complex trauma and other issues affecting U.S. military veterans through video teleconferencing, through remote community outreach clinics, and web-based applications to clientele. Beginning in 2015, Dr. Woodside will serve as the primary supervisor in one of the VA's first intraprofessional internship programs in telebehavioral health.

Thank you for joining us today, Dr. Pruitt and Dr. Woodside.

Thank you for having us. And thank you, Dr. Kramer, for those very nice introductions and to the webinar team for hosting us today.

The title of our talk is the Clinical Benefits of Telehealth Technology in Behavioral Health Care.

I want to start off with the standard disclosure that neither Dr. Woodside nor I are speaking in an official capacity for the Department of the Army or the Department of Veterans Affairs. Our opinions are really

those of our own. And neither Dr. Woodside nor myself have any relevant financial relationships to disclose.

We thought we could start off with a polling question from the audience of just how hesitant or willing you are to use telemental health to provide behavioral health services in your clinical practice.

[Pause for responses]

We're watching your responses come in.

Good, it looks like about half the folks are very willing to incorporate technology, and specifically telehealth, into their practice. And as we go through today, our hope is to really bolster and provide you some evidence and justification for why telehealth can really be a nice adjunct to clinical care.

As we were putting the presentation together, we really had this guiding question as the background that I would hope that you guys as attendees of the webinar kind of keep in the back of your mind as we go through this: What treatment, by whom, is most effective for a particular individual with a specific problem under the circumstances that are present in their lives? This is a very old question in the field, but one that still really has a lot of relevance when we think about conceptualizing a case or providing evidence-based care.

To demonstrate this, let's consider a couple of vignettes. Vignette #1, an active duty soldier deployed to a remote forward operating base in Afghanistan who maybe is having a great deal of difficulty adjusting to life on deployment, is located pretty remotely from the nearest medical facility; and to travel back and forth really involves danger, not only to that soldier but to his comrades.

Vignette #2, let's consider an elderly veteran who comes to the VA once a week for his PTSD treatment. He has some mobility issues due to an amputated leg, and his spouse is his caregiver. The travel to the VA will put not only the veteran but the caregiver under some stress. And oh yeah, the patient lives several hours away in the dead of winter in a rural area of North Dakota.

Vignette #3 deals with a staff sergeant in the U.S. Army whose duties produce a very hectic schedule. She is a single mother, and her responsibilities don't allow her to take time off during the day. And, unfortunately, she doesn't have routine child care services in the evenings either.

Vignette #4 is a physician's assistant, who is struggling with symptoms of panic disorder. He knows from his own practice that there are treatments that can help, but doesn't like being the one in the patient's chair. And this has stopped him from seeking treatment in the past. He also has several patients who he has referred to behavioral health services and really doesn't want them seeing him sitting in the clinic waiting room.

And our last vignette, #5, is an administrative assistant for the only mental health clinic in town. She is struggling with a difficult substance abuse disorder and fears that her boss and colleagues could learn of her problem if she presents to the clinic to seek help.

So considering how technology can be used to reach out to these folks who may not have easy access to behavioral health care, ask yourself: Would you remain a customer at a bank that requires its customers to use checks rather than offering debit cards or online banking?

I'm going to just guess that most folks would say "no" to this, and certainly I would as well. So why then do we still practice behavioral health care in the same way that it was practiced 50 or 60 years ago when we have other options available?

Second polling question here: Have you ever provided treatment over the telephone?

[Pause for responses]

Most people, it looks like, have had that experience.

And how about providing treatment using video teleconference technology?

[Pause for responses]

Good, so it looks like we have a well-informed audience here – that's great.

For those who haven't had the experience, let's quickly define what telemental health is. And when we're talking about telemental health or VTC, which is video teleconference, we're really talking about the provisions of behavioral health services from one location to another where the provider and the patient are not physically in the same location. And this can be used to really deliver a range of behavioral health interventions in terms of treatment, assessment, training and supervision – you name it.

Telehealth can really be broken down into two different broad categories. There is asynchronous, which is sometimes called "store-and-forward technology," which involves a delay in the communication between the patient and the provider – so things like e-mail or text messaging. And then there is synchronous telehealth, which occurs in real-time and is actually run a lot like this teleconference, where there is the telephone or videophone; and there's a two-way interaction between the patient and the provider.

We also want to consider care settings in telehealth. The main benefit of telehealth is that it brings care to where patients are to open up access, and access is key. Telehealth settings include typically satellite clinics if you're in the VA, a community-based outpatient clinic for clinic-to-clinic specialty services to be delivered.

We're also seeing more rise in in-calling telehealth, using the patient's own equipment, where the delivery of care is via webcam. Secured facilities, like prisons, can open up opportunities for assessment and treatment where providers could be exposed to dangerous situations. So telehealth can improve access there.

And when we consider rural versus urban settings, we typically think of telehealth being (inaudible) for extending services to rural populations. But anybody with geographic barriers or busy schedules or other barriers to getting into treatment, even in urban settings, can benefit.

Question #4: Have you ever had a patient where simply attending treatment caused great stress or was hazardous to them?

[Pause for responses]

Most people have. That's actually a larger percentage than I thought, so that's great. It's not great for the patient but good for this example.

And so if you answer "yes" to that question, what kind of stress did this put on the patient?

[Pause for responses]

It looks like a pretty good division across those categories there, so we're going to speak to those a little bit.

There are some real benefits of telemental health, and we're going to start with the pragmatic and practical issues; and then we're going to move into the clinical benefits in a little bit. The most obvious ones are the cost benefits. For the patient, they may not take as much time off of work or use their leave or arrange child or elder care.

And in terms of reduced costs for the clinic, it is costly to bring specialist providers in, to hire them, train them, and pay their wages. So telehealth can really help to provide specialty services without having to make accommodations for taking on a whole new staff member.

In terms of travel, and this is especially important for patients who might be located in a very rural setting when the clinic is located in a larger city, it saves that travel time; it saves fuel costs; lodging costs, if they have to stay overnight. And for large health care systems like the VA, it saves the reimbursement for travel that is often occurred and is a large chunk of the budget for those facilities to operate. There are new recommendations as of this year that if a patient has to commute more than 30 minutes in either direction to consider opting for telehealth given that it's clinically appropriate for the case.

Just as an example, if someone says "savings," in the small rural mental telehealth team at the Portland VA, in one year, fiscal year 2013, there were a little over 6,000 patients seen. And for each of those visits, on average the patient was traveling over 150 miles per visit. That equals almost four trips around the earth, so the mileage savings can be staggering. And when we look at the cost savings – well, let's take the VA, who would be paying overnight lodging and food and travel, it could add up to almost $1.5 million just for those patients alone.

And that's at one VA medical center.

Let's talk a little bit about safety. And this is safety both for the patients and the providers. So for the patient, we have the vignette where we have the elderly veteran who had some mobility issues trying to traverse rural North Dakota in the middle of winter. That is a potential risk. There are the opportunities for falls and other accidents. There are opportunities for risky driving. And if we can avoid those, especially for our highest risk patients, it's very well worth it.

There are also safety considerations for the provider, especially if you're in a setting where you frequently provide care to individuals with a history of acting aggressively. If you are able to – even if it's one room away – provide care where you're not put in harm's way, that's a huge savings. When we look at the rates of non-fatal, job-related violence in the workplace, mental health professionals have a rate that is nearly four times greater than that of physicians and three times greater than that of nurses who are providing direct patient care. So it's not an insignificant consideration.

But for me, the biggest consideration is the issue of access to care. As you heard earlier, there are nearly 80 million Americans who live in a health professional shortage area. That's any geographic region where the psychiatrist to population ratio is worse than 1 per 30,000. And as of June of last year, there are over 4,000 identified mental health shortage areas in our country.

Just an additional benefit to telemental health in terms of access to care is the patient with no personal transportation or those who live rurally with few local options now have access to specialty care. Another way that we can think of telemental health is as opposed to being the only option for treatment is there's more of a conduit to care. There was a great team study by Gros et al a couple of years ago that showed how a patient with significant risk, who was actively suicidal, had a direct connection with his clinician and was able to do safety planning to visually clear the house. And the provider was able to stay with the patient until emergency resources were available. So it really does expand access to all kinds of care, not just direct one-on-one psychotherapy.

Mental health also has a significant propensity to impact stigma. Stigma is still a big issue in mental health care. And problems with a lack of anonymity in receiving mental health care, particularly in rural areas, really functions as a hugh barrier to care.

Translating that into internalized stigma, patients are much less likely to access services as their psychiatric symptoms worsen. I've heard from a patient directly who saw me in person once and I'd seen him for telehealth visits afterwards tapped on the screen and said, "I actually like you better this way," because he was able to feel a little more anonymous in his care.

So one of the big take-home messages we want to make sure that we leave you with today as we do this presentation is that telehealth is an additional option for behavioral health care. It has to meet the needs of the patient or case, and it has to be a means to improve the access to care. It's not a replacement though, and we're not advocating for this to substitute in-office care. It's just for those individuals who have a great deal of difficulty sessions in person, this may really be another viable option.

I know we're having some sound quality issues. We're going to do a quick shuffle of our position here, and then we'll continue on.

Okay, so our goal today is not to really run through all of the research; but I do want to impart upon you that there has been a large body of evidence supporting the use of telehealth services in a wide variety of forms for a large number of people. And so this is really just a resource slide for you all to reference back to meta-analyses and large clinical trials showing support for telehealth intervention modalities.

And just to elaborate a little bit, there has been a broad range of treatment targets. These are just a few that we've looked at here. And the interventions that have been investigated include both psychiatric services, such as medication management, and also cognitive behavioral therapy. The list here of behavioral observation and exposure therapies is not exhaustive at all.

Cognitive behavioral therapies have been investigated in a myriad of forms; but these two, specifically, I think are worth noting because they often produce feelings of anxiety in most providers who think about doing something like prolonged exposure or behavioral observation for depression remotely because there is less control you have over the clinical setting. We'll talk some more about how that's been done effectively in a few minutes.

When we look at the populations that have been examined amongst mental health, it's really the gamut. There have been studies of children and adolescents, of civilian adults, older adults, veterans, ethnically diverse populations, and active duty service members.

There is some question about, again, for whom is telehealth most appropriate. So there obviously would be some for whom it's less appropriate. The distance does present some additional challenges. Some non-verbal information is inevitably going to be lost when you're interacting over webcams. So for some patients who have visual or auditory perception problems, it may not be the modality of choice. Clients who are acutely suicidal, who are severely decompensated and an immediate need for hospitalization may not be the best suited. Again, telehealth could be used as a conduit; but ongoing, it may be more difficult to lay eyes on the patient the way you need to and to really have that foothold in the community to access other services.

Also, clients who can't tolerate occasional interruptions in service are not going to be the most appropriate. Telehealth does come with hiccups; there will be bumps in the road. And so it's important for patients and providers to understand and feel that they hang in there in the process.

So let's talk about the technical considerations. Really the biggest threat to telehealth has to do with not being able to either establish or maintain a good Internet connection, and so the transmission gets interrupted. And this can be hampered by poor Internet infrastructure, especially if you have patients who are located in very rural areas without good quality Internet services. And that can really hamper the ability. So for those who might actually need it most, that is a big issue that you have to troubleshoot and problem solve.

Also, when you're working in large facilities or health care systems, such as the DoD or the VA, there can be high-level security settings that get in the way of your ability to provide care. And because of the demands put upon our system, it may not be feasible for you to get those results easily; and you're really going to have to work hard to make sure that you can navigate that system in an approved, effective manner.

Let's transition a little bit here and talk about both the patients' and providers' experiences delivering telehealth. This is a great quote that we had from a person in one of our research studies that was engaging in telehealth with a provider. This person said that at first they didn't think that they'd be able to connect emotionally over the computer. But as they got going, they noticed the screen just kind of disappeared or melted into the background.

And you can't really summarize the telehealth process better than that because it really highlights that hesitation is common at first, whether it's a perceived lack of experience with computer equipment or unfamiliarity with the process involved on the technical side or just not having somebody sitting right in front of you, it really can become difficult.

The important thing to remember is that for your patients, you can't really have approach and avoidance at the same time. And so it really takes you, as the therapist, to listen to any sort of excuses that they might have for why this isn't going to work for them, even if you might have both determined together that this is a viable option, and work with them to kind of get their feet in the water and test it out and see how it goes. And as they do that, they'll likely have that same experience.

For the behavioral health providers, what the research really shows is that regular use of telemental health is what you have to experience to really increase the level of provider satisfaction. The more you use it, the easier it gets; the more fluid it becomes; and the more routine the process is. And we've found that satisfaction increases as that experience is gained.

For those who use telehealth in their private practice routinely – and I know we have a number of folks in the audience who do that – we find that there are more positive ratings and higher satisfaction after they've used it for a while, especially because of the increased access that they have to patient populations that can benefit from their services.

So telemental is an option. It creates an opportunity to really access a population of individuals who find it either too overwhelming or distressing to attend treatment in person. It's an opportunity to discuss services that are available, obtain informed consent from the patient, and to discuss what would be involved with treatment.

And finally, it is an opportunity to provided evidence-based care -- if the patient consents to it -- remotely in a way that suits their living situation most effectively. The great thing about having options is that it really validates that the patient's time or energy or resources are valuable to the provider. It communicates that therapy isn't just a one-way process, that there's really a give and take involved. And that embodies the collaborative spirit that really, I think, underlies psychotherapy in many, many ways.

There is still a question out there about what patient preferences really look like, and that's research that needs to be done. But what we've found from research is that for those who are non-compliant with in-person care, telehealth can actually improve that compliance rate quite a bit.

As we move into talking about the treatment process, we're going to start with treatment non-specifics and go through a few of those to elaborate how the unspoken aspect of telehealth can really benefit patients.

The first is in terms of contact. Telemental allows more frequency contact between the patient and provider, and that's especially true if your patient is limited by practical issues, such as distance or cost of presenting to treatment face-to-face. But it's also useful in treatments where you may have extensive between-session homework you're asking the patient to complete -- things like activity monitoring or exposure exercises -- and you want a way to check in with them between sessions to ensure that they're practicing and engaging with those homework exercises.

It's also use for patients in crisis when you need to reach out, and just talking on the phone may not cut it. If have access to teleconference services, you may be able to connect with them that way. And also among those at risk for treatment drop-out, this is a little bit of old research but still, I think, important to

discuss that individuals who received a telephone calls between sessions were more likely to attend their next session than those who did not.

In terms of rapport, oftentimes when we talk about this, people are a little bit skeptical. But I really wanted to make this point that cooperative problem-solving of technical issues is actually really beneficial for treatment. You've heard Kate say earlier that there are going to be hiccups. There are going to be times when the patient can't connect or you can't connect or the internet slows down for whatever reason and there's a glitch.

A lot of times if you can enlist the participant's support in helping problem solve that issue, especially at the beginning of a session, it can really do a lot of good things in terms of developing rapport. And what we've found is that a lot of our patients actually have a good deal of technical expertise and in some ways expedite the problems of getting those issues solved.

It also gives you the capability to view the patient's home environment if you're doing home-based care and the personal effects in their home. And this gives you an opportunity to connect with them in a more basic way, to share an interest or get to know them and how they set up their environment. Maybe they have a favorite sports team or a specific photo that you see on the wall. And with their permission, you can use those to really discuss what that means to them and how important those things are in their life as a way to ease into treatment.

I was just thinking about a couple of patients who really surprised me that I did not think that would be interested in telehealth – an older gentleman had not had much computer use and not very computer savvy. And it seemed that by the time we got through the installation process and they were able to show me around the home, treatment was ending. It was kind of what was called for, just having that invitation for cooperation.

To speak to that point just a little bit more – and again, right now I'm really talking about in-home telehealth. It gives you an ability to observe the content -- with the consent of patients – the content of their home in a real-time manner. So if we look at a couple of clinical presentations, assume you're seeing a patient with insomnia. Well, now you can go through the sleeping environment and look for things that may be distracting when they're trying to get to bed at night – bright alarm clocks or windows that aren't covered, things of that nature.

For a patient who is seeking treatment for substance abuse, you can work collaboratively with them to go through and dispose of paraphernalia or relapse triggers in their home environment, whereas in face-to-face treatment only you're relying on them to do all of that very difficult work on their own between your sessions.

And for patients who are reporting hoarding behavior, this can really allow you to get a secondary, very objective assessment of their living environment, as well as the changes they may have made over the course of the treatment and see if it matches with their report.

We're going to turn to talking about more specific clinical presentations and really just the big ones that we see very often, which are anxiety and depression. In terms of anxiety, we're talking about things like social anxiety, panic disorder, and so on.

The one key point I really want to make here is that telemental health should not be used to facilitate avoidance. This is isn't an option for a patient who just finds it a little bit overwhelming to present in your office. Really this is about reaching out to individuals who are not going to present in the first place, that the anxiety they feel may be so overwhelming that they're going to avoid seeking treatment. And so it's a foot in the door. It gives you an opportunity to expose those individuals who normally wouldn't present to services that they may not know exist out there. And over the course of treatment, actually working towards face-to-face sessions can become an important exposure hierarchy.

I wanted to also talk about PTSD specifically here. One of the facts that I always just am dumbfounded by is that the median length of time for individuals to treatment following a trauma can be right around 12 years following the traumatic event. So we think about, well, how can we reduce that? How can we reduce the time that somebody is suffering with the aftermath of a trauma so that they can get into treatment?

Telemental health may offer some inroads there as well: increasing the access patients have to care, reducing the stigma that they may feel regarding seeking treatment that they have to go to, physically go to a provider's office. We may be able to expose them to fewer trauma triggers before you have a chance to build a rationale for why exposure is important and how to do it effectively. And again, there is a question here about differential willingness, as a function of patient preference, that needs to be addressed by the research community.

Right, you can't do treatment if you can't get the patient into your office. And telehealth really reduces that barrier. When we're thinking about people with depression, the hallmark symptom is withdrawal, lack of motivation, difficulty initiating. And so telemental can help really reach patients with a first possible foot in the door to establish a foundation to begin to get them activated so that they can participate more fully.

Another question for the audience: How many of you feel that telehealth would have a negative impact on the treatment relationship between a patient and provider?

[Pause for responses]

It looks like a good chunk of people are saying that, no, it would not. And that is consistent with what the research is saying. If we look over the last decade or so, there are very comparable rates of treatment satisfaction between in-person and telemental health services, and that includes satisfaction with the treatment, with the outcomes of the treatment, as well as ratings of therapeutic or working alliance.

The exception to this, and we've made this point previously, is low-quality connections over the Internet. And so if the fluidness of the telemental health gets interrupted or the sound quality is low or the images are frozen, that produces frustration that can get in the way of you really engaging with the patient.

The other caveat here is that group therapy via telemental health is still, I think, working out how best to deliver that. There are really three main ways to provide group therapy over telemental health. One is with a provider located remotely and all group members remotely as well. But you only see the provider, and you get the audio of the other attendees in the group.

The second option is sort of the Brady Bunch manner in which every part of the event is showing up on the screen, and you're getting sort of small boxes for each person. And you're getting both the video and audio.

And then the third option is to have a group that's all housed in one location – maybe they're all members of the same small community – and a provider who is located locally. And what the research is really suggesting is that the less amount of disruption you have is probably the most effective. So either having just the provider's image up on the screen or having all the group members located physically together but with one provider up on the screen are going to be your best options.

In terms of social support, telemental health has been used to build relationships with socially isolated caregivers. And this actually facilitates those caregivers being more effective in their duties caring for others because they now have a social outlook that was absent and not accessible before. And also for those at risk for treatment drop-out, as we've talked about before, receiving a call between sessions can really boost attendance at future sessions.

And also in terms of safety planning, right now there are no published studies suggesting that, in this case telemental health, but telemental health in general, is any less safe or effective than in-office care. Patient safety during telemental health, including home-based care, really can be managed effectively. And there

are some great case studies out there which are cited here that can walk you through exactly how that's managed and what steps were taken.

The important part of any safety plan when you're providing remote care is thinking through ahead of time what crisis might result and then what plans you need to lay in order to handle that effectively -- so locating the emergency contact number for services in that patient's area because they may be completely different in terms of the city or county resources than the area that you are in. And we do have a guide available for how to manage suicidal crisis in home-based telepractice that is available.

In terms of privacy and stigma, patients who forgo seeking treatment due to concerns may actually find that receiving care remotely allows them to not have to face those risks that may prevent them from seeking care in the first place because now they can either stay within their community or even the possibility of staying in their own home and receiving care. And there are steps that can be taken to really enhance privacy.

As those privacy considerations decrease though, the risks of confidentiality increase; and so the provider has less control over their environment. And you have to work really hard to make sure that the patient is taking charge of ensuring their confidentiality at either the clinic or home location where they're at – whether that's closing doors or making sure they have time to get away from family members during your session or making sure that the nurse has left the room before you start care – those sorts of things. And there is a guide available for setting up a private therapy environment as well.

Privacy and safety in telehealth really need to have some extra attention. When your patient comes to see you in your private practice office face-to-face, the patient can take in what's on your bookshelves. They can see the exits. They know that there is good soundproofing. In telehealth, they don't have those same assurances. So we need to take extra time to really consider what the patients' experience is.

We want our lighting to be well done so that the patient sees you in your best light. And consider the frame because your patient will get only a small snapshot of who their provider is, and so it's important to really make that count.

There also are some implications in telehealth about the relaxed environment. And I think we'll get into that a little bit more in future slides. But when you're sitting behind your computer, this is a place where you're maybe used to being on social networking sites or chatting with your friends; and suddenly your patient is there. But you may be accustomed to some similar behaviors – kicking off your shoes under the desk and kind of settling in. And so that sort of relaxed environment can have implications, one way or another, for how you're going to practice with your patients.

So these two photos you see here are examples or either overexposure or under exposure to light and for the level of conscientiousness we have to have to make sure that you're getting the settings set up just so.

Let's turn our attention to some ethical considerations. We have an audience here today who already is fairly well experienced with telehealth, which is great. But a lot of questions come up for folks who are just beginning telehealth or considering telehealth because telehealth does present some interesting question.

So our first vignette – a 30-something-year-old mother with three children whose husband has been physically abusive with her. She has disclosed this to you in your last session; and in the next session, which is happening to occur in her home, he presents with her. And so what do you do? As her provider, you want to ensure her safety and ensure the safety of the children. You may want to be talking with her about her options for staying or leaving if the abuse is ongoing.

But now with the introduction of the partner, it makes it more challenging. So we want to protect her privacy and be certain that we know who our client is. And it really means that up front, in the beginning of treatment with telehealth, we have to be absolutely certain in our informed consent that we know what the

emergency procedures will be; we know what all of the lines of communication are; and we've clearly defined our expectations with our patients.

For another vignette, we talked about social media. We are never more than an arm's length from any of our devices, and there is an expectation of instant gratification of communication. And so if you are at your desk one day checking your personal social media and you see a message -- a patient has found you on Facebook or some other site -- how will you handle that when you get a distress signal sent up on those sites?

It's really important, again, to establish very clearly up front in telehealth what the limits to communication are – how you will or will not respond over electronic communication -- to protect the patient's confidentiality and also to protect the confidentially of patients and providers. So it's very important to define roles and responsibilities of the therapy relationship up front.

Telehealth is becoming so popular that the American Psychological Association is now writing guidelines for the practices of psychology by telehealth. It says: "The use of telecommunication technologies in the provision of psychological services presents unique potential threats to the security and transmission of client and patient data and information."

And this is sort of the big question that everybody talks about – that everybody thinks about. Information security is very important, and it's key; and so we have to be very careful, again, to provide good informed consent up front to our patients and ensure that we have secure forms of transmission.

But some of the other ethical challenges that may be less obvious are the potential boundary issues involved in what we can consider "micro" changes to our practices as a result of this two-dimensional world that we're working in or the small changes to our practice that can happen. There are some things that most of us would never do in a traditional face-to-face psychotherapy setting. We turn our phones off; we turn our alerts off; we adopt our most dignified therapist posture; and we're ready to work.

In telehealth, we're right there at our computer. Again, our e-mail may be up next to the patient's head; and it could be very tempting to take a glance or to answer the phone if you know that you've got an important call coming in or maybe even text out a very quiet response to an important e-mail message that comes in. So we have to really consider our personal behaviors of the teletherapist to make sure that we're maintaining a professional practice.

On a positive note, self-monitoring in telehealth can increase clinicians' awareness of their impact on the patient. We ask trainees all the time – every time they start practicing by telehealth – do you leave your self-view up so that you can see how you're looking, or do you prefer to shut that down because it's too much? So it really can increase our awareness of how we're coming across to our patients.

Telehealth also, as we've discussed, can prevent some multiple relationships in small communities. But then on a macro level, the broader issue is, "If you build it, they will come." If we are offering brand new mental health services to a community that has been sort of untapped in that way, who have had very limited access to mental health care before that, we may be uncovering some significant mental health problems, some significant pathology. And are we going to be prepared to deliver the treatment that's needed for the patients who are coming forward? The question becomes, is it better to offer some treatment than none? And it's really an ethical decision.

And there are limitations to what telehealth can provide or what can be provided via telehealth. The biggest threats are really lack of training and insufficient experience. And the great news about that is those are completely modifiable. Providers can seek out training opportunities; they can engage in information sessions; they can do the work needed to really make sure that they become competent and comfortable delivering telehealth. Whether it's practicing with a colleague over Skype during your lunch break or engaging in consultation that way before you actually take on your first patient, those sorts of practice exercises can really minimize this as a barrier to preventing care.

The second one that we have to sort of expect is that there is some loss of clinical data when providing care over telehealth. There's some gain, like we talked about – being able to see the patient's environment. So you listen to olfactory data that tells you maybe that patient was up all night drinking or the view of the patient's entire body if you're looking for things like psychomotor agitation or if you're assessing gait disturbance or another physical process that you want to. The thing is, you're going to have to either make a change to the environment or have them make an accommodation so that you can visualize that using the technology and equipment that you have at your disposal.

It's also just kind of a fact that teleclinicians have less control over the patient's treatment environment. We can encourage and support and coach patients to really pay attention to crafting a really well-protected therapeutic space if we're seeing them in their home. But if we're seeing them in a clinic, we really don't get to choose where the patient is sitting and how they're entering and exiting the treatment room. We don't know what the receptionist's familiarity with mental health patients might be.

And so sometimes we're kind of taking a leap of faith and needing to work together with our clients and with our partners in the distal sites to make sure that we're building an environment that's going to be mental-health friendly. If we're going into a primary care clinic, the staff in the clinic may be in need of some extra coaching and some extra training.

Privacy also may be much more difficult in-home. One of the great benefits of telehealth is that people who are jugging multiple roles can now access mental health care more effectively, overcoming some logistical barriers. So if a busy, stay-at-home mother can't find child care, telehealth may seem like a really great option. And it may be, but interruptions from the kids still may be present. So we have to really pay attention to structuring the environment so that it supports a really good, solid therapeutic space.

Let's talk a little bit about practice recommendations. The important thing here is to really know and do the research ahead of time to know the telemental health laws and regulations at your site and at the remote site. I know on the screen here there have been some questions about licensing and licensure. That's an important issue to deal with ahead of time. Determine if your license, if you're in an area where you would be crossing the state line, has the ability to expand to another site. Sometimes states will grant reciprocity between states; other times they won't -- so it's knowing what the laws and regulations are in your state.

If you're working in the Federal system, your license extends nationally and so knowing what goes on there. If your patients are paying with private insurance, know what your state allows those insurance companies to bill for and if your services fit within those principles and regulations. So it's a lot of footwork up front, but it's worth it in terms of being able to provide care in a very effective manner.

The second practice recommendation here is to think critically about the patient's treatment-seeking barriers and how those barriers affect compliance. Telehealth isn't appropriate for everybody, and it really is a case-by-case decision about what are the barriers that are facing the patient? Are those barriers worth having them sort of leap over them to attend in person, or can we gently avoid them by providing care remotely. And again, it's up to you as the provider to weigh the pros and cons of that and come to a decision that's going to be effective for that situation. It goes back to that guidance question that we had put on the screen at the very beginning.

And finally, and perhaps the most important recommendation here is to get training and achieve competence. Practice, practice, practice -- it's the only way to do this in a way that's comfortable for both you and the patient and that instills confidence in the patient that you're able to deliver care in this manner.

The great thing is that there are, at this point, a lot of different guides available to individuals. As mentioned earlier, the American Psychological Association has developed a telemental health guide that's available for download for free. I think it's also included in the resources along with this presentation.

The American Telemedicine Association has a number of different guidebooks, but there is one specifically on delivery of behavioral health services. And here at T2, we have developed our own telehealth and technology guidebook that goes through some of the very practical issues, some of the legal issues, and some of the how-to group of issues that individuals will have to face as they're developing their own telemental health practice.

Okay, so final question here: How hesitant or willing are you to use telemental health to provide behavioral health services? We asked you this question at the beginning, and we want to get a posttest on it as well.

[Pause for responses]

I think we were going to try and get our pre and post comparison here.

I'm don't see any "very's" yet.

Well regardless, it looks like folks are willing; and at least (inaudible).

It looks like we've bumped the "hesitant" and "neutral" folks up a category.

That's great, and we still have answered the willingness question.

Great, okay, so in summary, we hope that over the course of the webinar we've been able to really define for you what telemental health is and explain how it can apply to various behavioral health care settings. We hope to have determined some of the clinical scenarios that may benefit from telehealth care and to draw some conclusions about how to effect the therapeutic process and how that differs from in-person care to remote care.

At this point, there are references available to you all. We've tried to provide an extensive reference list, so feel free to peruse that. These are all resources that should be available through your local library system at either your installation or medical center. And I think with that, we'll turn to questions.

Thank you both for a great presentation.

If you have any questions for Dr. Pruitt or Dr. Woodside, please submit them now via the Q&A pod located on the screen. I see that many are already coming in. So let's take some of the questions from the audience. There are a lot coming in I see already, so we will respond to as many questions as time permits.

The first question is: What are the barriers to more military providers providing telehealth services?

From the DoD side of things, the barriers at this point are easing. There are telehealth clinics that are being set up; services are being provided remotely. Here at Joint Base Lewis-McChord, we have a clinic that serves our patients in Alaska and Kansas, I believe.

Also, telehealth is being used in theater to prevent the movement of troops across dangerous areas in order to still have those front line soldiers receive the access to care that they may need.

How do we overcome the barriers that still exist? Well, there are a lot of practical things that need to be solved, one of which is the licensure issue that you guys have talked about; although since we're a Federal system, that's a little bit easier to do. But along with your licensure, there is the hospital credentialing that goes on at each medical center. And so to provide care in another state, you have to actually receive credentialing at that remote site as well.

So a provider who is seeing patients at Madigan Army Medical Center here in Washington and at the hospital up in Alaska and Kansas have to go through the credentialing process three times. And that can

be quite a burden on both the provider and the system. So looking at administrative solutions to reducing that process, I think, is an important one.

On the VA side, it's very similar -- similar barriers, but also similar energy around adopting telehealth. And a lot of programs and new funding has been bringing specialty telemental health focus groups and programs teams to deliver specialty care, so there are telehealth-only teams. So the energy is there and the momentum is there.

I would say another barrier, in addition to those same administrative barriers that Dr. Pruitt mentioned, is getting staff educated and trained. It tends to be that people are either excited and interested in telehealth because they like technology and they think it's neat and the wave of the future, or they feel that it's going to really compromise their practice or that it's going to feel strange or that their patients won't like it. So it really is a matter of more exposure and getting people training in practice.

The next question is: How does the provision of telehealth differ in civilian and military environments?

Well, I think it's actually a little more difficult in the civilian world because you're having to now deal with a lot of regulatory issues that you don't have to deal with in a DoD setting or a VA setting. I spoke to this a little bit earlier in terms of you're going to have to get insurance accounting going on and making sure that the services you're providing are covered by the insurances that you're credited to bill to and that they're reimbursing properly. You're going to have to make sure that your license and malpractice insurance is sufficient to cover those sorts of practices, and that's going to vary by state. And so it takes a lot of know-how on the provider side to really understand those limitations.

The other thing is you're going to have to foot the upfront costs of the equipment, whether it's cameras or computers or whatnot, to provide care. The great thing about that is that as time goes on and technology continues to improve, those devices are getting smaller and cheaper and easier to find. So that's a barrier that will be reducing.

Next question: What changes to the informed consent do you recommend for providers that want to begin providing telehealth services?

Well, I think we've been sort of speaking to that all along. We want to use the same informed consent. The therapy process is still the same; it's just got some additional layers. And so we want to make sure that we're addressing how information will be transferred and used and that it won't be stored, that this camera is not taking video events. We want to make sure that we cover all of those concerns about privacy and confidentiality up front and informed consent.

We also want to pay more attention to some of the clinical environmental issues. So taking our patients kind of on a virtual tour of our office so that they know exactly where they are getting their treatment and exactly what's happening in the environment.

Next question: How has the quality and cost of the technology influenced the adoption of telehealth in clinical care?

I think that we'd have a very different answer if we were giving this 10-15 years ago than we do today. So over time, as infrastructure of the Internet (inaudible) and the development of high-speed Internet versus dial-up – those sorts of things – has really influenced technology along with it. And so we've seen that cameras have gone from hand-held phones with video screens on them that were really tiny and hard to use and difficult to get good audio and were kind of really sketchy in terms of the fluidity of communications to now cameras you can buy off the shelf at your local tech store and just plug into your USB drive and essentially be ready to go.

Also, one great thing is the development of dedicated telehealth software that includes HIPAA-compliant encryption and various other safety precautions that allow you do this in a very quick, easy set up sort of manner.

Next question: What would be required for there to be wider adoption of interim telehealth services by military providers?

Really, there is a lot of interest in doing that; and what we're waiting on are the results from some projects that will inform the DoD and the policymakers about how feasible in-home care is amongst the military population and the active duty population, as well as whether it can be delivered and managed in a way that's safe and compliant with the DoD standards. So we're really just waiting on policy changes, and it's actually not standard of care.

I see a later question and so I'm skipping: Is the DoD restriction on providing telehealth behavioral going to be revised? And I think that what you said –

That being the open question that we're trying to get information on.

You know, just a few years ago in the VA we had many more restrictions than we do now on telehealth. And with a few research studies that are demonstrating the feasibility of this modality and some of the safety of this modality, those restrictions have been lifting. And in the VA, barriers are already being overcome. There are dedicated servers for in-home telemental health, and dedicated geek squads basically, nationally and locally, who can support providers and patients directly. So I think we really are moving in that direction, and I'm glad that the DoD is too.

Next question: Have you heard of Medicare or Medicaid paying for telemental health?

I don't know if it does.

I don't either. Both of us are working in direct-pay environments, and so we don't encounter those issues very often. I don't have an answer for that one, I'm sorry.

It's a great question. I wish we did have a good answer.

Next question is: How do telemental health guidelines apply to personal hand-held devices, such as an iPhone or a tablet?

Well, in the VA, one of the studies that's going on right now is looking at the safety and feasibility of several different software platforms on several different types of devices; and so encryption settings need to be built into the software. And while on current VA computers we can't use application-based software, on some devices we're moving in that direction.

I think that's something that the (inaudible) in general is looking forward to, is moving us into a mobile format that's, again, all about making this easier for patients to engage in services. And if they can do that on their lunch break from a private office or something like that, that would be wonderful. It's making sure that we're taking steps to ensure that maintains the privacy and confidentiality of the individual patients and doing the work ahead of time to make sure that's been tested adequately.

And I see two questions around this same thing, so you probably can describe in more detail: What kind of practical platforms do you use at the DoD and VA to provide telemental health?

In the DoD, we use a software program called Jabber, which offers a very high level of encryption and very easy access in terms of plug-and-play cameras and microphones and those sorts of things. And that's what the Army has approved for telehealth.

The same in the VA, although we're investigating a couple of other platforms and hopefully are going to have some results of that soon.

And so a related question is: What technology do you recommend using for increased patient security? I know in the Federal systems there are restrictions on that, but anything you want to add to that?

It's really about ensuring the encryption level of the transmission and the communication services. The other piece though is making sure that you're working with the patient on your end and their end to set the environment that way. Even if you have the greatest encryption on your computer and camera to transmit information securely, if somebody is walking by and you have the window open, you're going to have a breach of privacy. If somebody's wife comes home from work and they're talking to their therapist in the living room, all of a sudden you have a situation where they have been compromised in the privacy of their care.

So it's a matchable to technology as well as the environmental aspect.

I think to add something that's kind of just a side note to that, privacy for the patient and the provider – you can only know things as they develop. Sometimes you can only think so much ahead. And something that's been occurring more and more for us is patients taking screenshots of their providers to hang onto those and do with them what they will. And that's a privacy issue that we haven't really thought through, so something to add to informed consent.

All right, the next question: Are you familiar with the Ryan Haight Act? So I'm curious how your employees have interpreted this in regard to medication management.

I've only recently become familiar with this. And I think there is legislation managing telehealth services, especially in terms of medication management, that requires providers to do a certain amount of work in person before medications can be managed remotely. And so it's making sure that you're in compliance with those regulations that can really protect both the patient and most importantly the providers to make sure that they aren't providing care out of left field.

And I believe it depends on the class of medication too. Narcotics need an in-person evaluation, and some other classes of medications can have telehealth coming in earlier.

Next question: Are telemental health services preferable over providing vouchers to clients for private care when they are unable to travel?

I think it depends on the client and the circumstance. If somebody needs substance abuse treatment programming and there is a really wonderful intensive program that is two towns over and the patient really needs comprehensive programming, it might be preferable to provide vouchers for that if we don't have a telemental health comprehensive substance abuse treatment service.

But for other services, providing in-home care if it's a sort of standard care and you've got a provider who is competent to provide it, as long as the patient is comfortable with telehealth, you can save travel; you can save funding. Telehealth is a great option.

And that's something I want to add to that, is this is a really great opportunity in that situation to have a conversation with the patient about what their preference would be and why. If there's a valid reason for wanting to receive care in one way or the other, or if boils down to the practicalities – and if you can save them some costs or a hassle, that can be a determining factor as well.

Next question: Are there care case management support for providers who may be providing such services? If so, are they a member of the telehealth team, member of the primary medical home team, or both?

The question is, are there care management services for the provider?

I think to accompany the remote services. So that's going to depend on the health care system in which you're working. If you're completely in private practice, it's going to be dependent on your practice

organization or what you're willing to pay for in terms of staff. But in large settings, like the VA or the DoD, there are recommendations we have if you're seeing a patient at, let's say, as a community-based outpatient client – to have staff available to greet the patient; get them into the room, all checked in; to prepare the equipment; make sure the connection is established; and then you kind of turn it over to the provider to conduct treatment. So there are those staff services available depending on the setting in which you're providing your services.

I'm understanding the question. Thank you. I'd add to that, again, it depends on the clinic; and it depends on the team that's serving the clinic. Telehealth is as varied as the practitioners and teams who are willing to delve into it. And so like on our team, we have nursing care managers who are providing support for patients and really serving as liaisons with our remote clinics so that the greet-and-seat people and some of the support stuff on the other side feel closer to us and more integrated teams across the distance.

For home-based care, one of the recommendations is to have the patient actually identify the very trusted family member or friend – somebody they're close to and can trust their confidentially with – to be available in case of an emergency. So if the patient does present in practice during the session or to have some (inaudible) develop between sessions, the provider has the contact information – and this is something the patient has agreed to – to reach out to that support person, who can then physically go and check in and make sure that person is safe and not sort of escalating into crisis or to facilitate that patient connecting back with the provider if you're unable to reach them directly over the phone or through your VTC.

Next question: Are either of you aware of whether anyone in the VA or DoD is doing biofeedback via telehealth?

I have not heard of this. I think that pre-discussion would be very dependent on having staff available to help set up the equipment and monitor what was happening. So there are probably some logistical issues that have to be dealt with. But primarily what I'm familiar with is the application of (inaudible) treatment and various modalities. Biofeedback is one that I haven't seen included in that.

Well, you know, we have the capability to use all kinds of peripheral devices in delivering any kind of telehealth. So there is teledermatology, teleretinal – all sorts of teleservices are delivered. So I would guess that if somebody could do it, they're doing it – although I'm not aware.

Next question: Are you aware of military chaplains using telehealth tools/methods in their provision of counseling?

I'm not aware of them making that an official option for them, but it certainly wouldn't be something that's a barrier for having care that way. I think it's up to the provider and what they're comfortable with and whether they've received training on how to do that, and if they feel that it's effective to do the work that they're sort of entrusted to do.

Is talking with the patient over the phone considered to be telehealth? If not, why not?

It is. For the earlier forms of telehealth, it was kind of precursor to where we've come now.

And we can kind of get bogged down in definitions of what constitutes health care. If you're just doing a five-minute check-in – have you completed your homework assignments – does that constitutes health versus I'm going to do a full 50-minute or 90-minute treatment session over the phone. But regardless, if this is a provision of services that you would normally do in person and you're doing that over the phone, then, yes, it is telehealth.

If a clinician is interested in providing telemental health in the DoD or VA, and the clinic currently does not provider care in this manner, how might the clinician go about setting up a telemental health option in their clinic?

Well, I first would refer you to the guidelines that we've included in the handouts. I think you have available to you for download. There are really great guidelines to understand what's involved in setting up telehealth clinics. And there is an extensive network of providers in VA and DoD who have all these experiences, very willing to help out and support and share their expertise.

I would just add to reach out to the communities that are already providing that care and see if there are listservs or other information sources where you can get on about the feasibility of providing care and what would be needed. And again, consult those guides for various technical requirements and (inaudible).

In the VA, it seems that it's becoming easier. We're not using the same huge technologies that we were – giant video screens and big cameras that require a lot of upstart. We've got a pretty easy-to-download software package and a plug-and-play camera and some SOPs in place already to support getting involved.

Next question: How was the safety of the abused mother handled with her husband wanting to sit in?

That's a great question. That was just supposed to be a vignette for your consideration. We have to really pay attention to all of the factors involved. We can expect similar things to happen when patients come in, in person. They're disclosing what's happening at home. You don't know what the risk level is. You don't know what the actual threat is. With in-home telehealth, we actually get an interesting extra glimpse into what's actually occurring in the home.

I think in those situations, one place to start thinking is what would I do if this happened in person? What if I had this patient coming to my office in the community and for Session 3, she showed up with her husband trailing behind her and said, "We're going to do couple therapy from now on." How would you handle that situation? What sort of steps would you take, and how would you discuss that with her in a private manner?

And the same thing applies to telehealth. You just have to be cognizant of how am I going to adjust this given the modality change -- not necessarily what you would discuss.

Another question: Can you both describe your experiences in learning to become telemental health providers and how it might have changed the way you've provided care?

I'd love to. I actually was not a telehealth supporter in the beginning. I was asked to come to Portland and be involved in starting up this telehealth team. And I thought that there was no way that I would like doing telehealth and seeing a flat screen in front of me all day. But I've since obviously become a huge adopter, a huger supporter, of telehealth because it really opens up services. It expands access, and it's bringing really needed health care to people who don't have access to it.

And I've really enjoyed sort of the collaborative process. I'm new to technology. I still fumble with trying to get my TV recorder to work. But learning the telehealth process as I go with my patients and helping them learn it with me has really been a stimulating clinical endeavor. It really has changed some of the process elements in session, and I think I have become more flexible and even further appreciative of collaboration in therapy than I was before telehealth.

And for me, it was really through researching, looking at sort of the priorities and doing the legwork of testing those out. And I would agree that I was actually skeptical at first too. I had come from a clinical background where that wasn't a standard practice, and I didn't know how it was going to play out. And I had some doubts. Even though you review the research and it looks very promising, you're actually like, well, when you actually get in there with a patient, is it going to work this way? And providing care and supervising others providing care, I really got a quick and great appreciation for the fact that the screen does disappear with patients. As we said, it's one of those things where you have to really be willing to try and take that step and see what happens.

Next question: Can you both describe how you envision telemental health 10 years from now? What do you see as its future?

Oh boy, I see every provider and every patient with their hand-held device and being involved in invivo activities together – kind of virtually sitting next to your patient at the Blazer's game that he's trying to go to for the first time in 12 years. I see just a really fluid back and forth, and telehealth being sort of an integrated piece of everybody's practice.

And I think one thing I'm really looking forward to is the continual increase with the Internet infrastructure so that there are faster speeds and more seamless care so that you don't have the lags and the problems that pop up. Maybe if we can really advance both the software and the hardware available, this can really be something that I think people enjoy delivering and people benefit from receiving.

Great, that's an excellent bunch of questions. We're going to wrap it up about now. Thank you all for your questions. After the webinar, please visit the website listed and complete your online CE posttest and evaluation and download your CE certificate or Certificate of Attendance. And that's: www.continuingeducation.dcri.duke.edu. The Duke Medicine website online CE evaluation and posttest will be open through Thursday, February 26, 2015, until 11:59 p.m. EST.

And to help us improve future webinars, we encourage you to complete the feedback tool that will open in a separate browser on your computer. To access the presentation and resource list for this webinar, you may download them from the "Files" box on the screen or at the DCoE website; that's www.dcoe.mil/webinars. An audio recording and edited transcript of the closed captioning will be posted to that link in approximately one week.

The Chat function will remain open for an additional 10 minutes after the conclusion of the webinar to permit attendees to continue to network each other.

The next DCoE Psychological Health webinar topic, Physical Symptoms and Mental Health, is scheduled for Thursday, February 26, 2015, from 1:00 p.m. to 2:30 p.m. EST.

The next DCoE TBI webinar topic, Change your Mind about Brain Injury: Prevent, Recognize and Support, will be on Monday, March 2, 2015.

And the next DCoE T2 webinar topic, The Well-Being of Military Children: Augmenting Clinical Care with Web and Mobile-Based Tools, is scheduled for Thursday, March 19, 2015.

Thank you again for attending. Have a great day.