To: committee members

I am speaking today from more than 30 years' experience working in the behavioral healthcare industry serving in both public and private agencies. I have worked as a provider and as an insurer, providing oversite for Medicare and Medicaid mental health care in MA. I currently serve on the board of VT Mental Health Counselors Association and on the board for a peer-driven social support organization Another Way. I have also recently earned a Distance Counseling Certification that is sponsored by the NBCC, the same national organization that certifies Licensed Mental Health Counselors.

I am testifying on H.50, because of 2 issues –

1) There is a long history of clinicians providing telephonic support to their patients during times of high stress – not necessarily crisis at the level of potential injury to self or others, but during times of immediate distress. The 'check in' telephonic session that fills a gap until a next scheduled appointment fills a niche for acute care. From a parity perspective, these calls are similar in nature as those of the medical community, including follow up calls post-surgery, update on lab or other test result, on-call support, and prescribing. Unlike our medical colleagues, mental health providers have not been paid for this valuable, clinically/medically necessary service. Similar to telemedicine, video conferencing with its added visual connection presents one more invaluable enhancement to the patient/clinician dialogue.

2) Ease of access to experienced specialists is essential. For those patients who struggle with complex concerns requiring a specialist, are challenged to find time for counseling and commuting to counseling, live and work at a distance from their best fitting provider or feel embarrassed and stigmatized by receiving mental health care, this avenue of connection is very useful in expanding access to specialized mental healthcare.