

Using telemedicine and mobile crisis teams to improve mental health care access: Exploring U.S. policies and their relevance to Norway

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Improving access to mental health care is a shared policy priority in both Norway and the United States, particularly addressing access barriers in rural areas. Telemedicine and crisis response systems have gained importance in these efforts, having the potential to expand timely access to care.

The adoption of telemedicine has increased significantly in recent years. However, the impact of telemedicine on clinicians' geographic reach remains unclear, especially in rural areas. One of my Harkness Fellowship projects addressed this gap by analyzing Medicare data to assess the geographic reach of mental health specialists adopting telemedicine.

Mobile Crisis Teams (MCTs) have become crucial in U.S. mental health crisis response systems, supported by recent federal policies increasing their Medicaid funding. However, there is limited knowledge about how this funding has affected access to care. My second Harkness project explored the implementation of Medicaid-funded MCTs in selected U.S. states.

Findings from both projects aim to inform researchers and policymakers internationally. The Harkness Fellowship has provided valuable interdisciplinary perspectives on health policy and leadership, shaping my future research and policy efforts aimed at strengthening public health care systems.

Timely access to mental health care remains an international challenge. Both Norway and the United States display geographic variations in the availability of mental health care providers, particularly in rural areas. Patients may need to travel long distances for care and often encounter

lengthy wait times. While primary care physicians can address some mental health needs, access to community-based specialists is limited in many areas. This service gap increases reliance on law enforcement, emergency departments, and hospitalizations, highlighting the urgent need for more accessible mental health care (1, 2).

Unlike Norway's publicly funded universal health care system, access to care in the U.S. typically depends on employer-sponsored insurance or public programs such as Medicare and Medicaid. Medicare, a federally funded program, covered approximately 67 million Americans in 2024, including those aged 65 and older, as well as younger individuals with disabilities and certain medical conditions. Medicaid, a joint federal-state program, provided health care for about 72 million low-income Americans in 2024, many of whom experienced mental health issues or substance use disorders. The federal structure allows states the flexibility to tailor services to local needs, but it also contributes to variations in mental health care provision across U.S. states (3). Medicaid beneficiaries often face barriers in accessing timely mental health care, including variations in state-covered services, provider reluctance to accept Medicaid patients, and disparities in access between urban and rural areas. While the Affordable Care Act of 2010 expanded mental health coverage by mandating essential health benefits, many Americans remain uninsured or underinsured – particularly in the ten states that have not expanded Medicaid since 2010.

As a Harkness Fellow, my projects explored health policies aimed at improving mental health access through U.S. public insurance programs. Telemedicine and crisis response services have become increasingly important in addressing access barriers in recent years. Telemedicine offers a remote alternative to in-person care that can potentially improve access, especially in rural and underserved communities. Similarly, Mobile Crisis Teams (MCTs) are crucial for providing community-based interventions for individuals in mental health crises (4). Both Medicare and Medicaid serve as primary funding sources for these services. Despite their different health care systems, understanding policies to improve access within U.S. public insurance programs can provide valuable policy insights for Norway's health care system.

This article provides an overview of my two main Harkness projects: the geographic reach of mental health specialists adopting telemedicine and the implementation of Medicaid-funded MCTs across selected U.S. states. I will then discuss key lessons from my Harkness fellowship and conclude with reflections on future research and policy work.

The Geographic Reach of Mental Health Specialists via Telemedicine in Rural and Underserved Communities

Telemedicine has become increasingly important for mental health care provision and can potentially overcome geographic access barriers. The Covid-19 pandemic accelerated the adoption of telemedicine among mental health care providers (5), and research suggests that it is as effective as in-person care (6). However, studies indicate that disparities persist, with rural residents and older individuals using telemedicine less frequently (7). Given the high demand for specialist care amid limited provider availability, clinicians may prioritize established or local patients over new or rural ones, regardless of whether care is delivered in-person or via telemedicine. No studies have assessed how telemedicine adoption influences the geographic reach of mental health specialists.

To address this gap, I led a project analyzing Medicare fee-for-service claims data from 2018 to 2023 to assess the association between telemedicine use and the geographic reach of mental health specialists, including psychiatrists, psychologists, social workers, and psychiatric nurse practitioners. Specialists were categorized into four equal groups based on their telemedicine use. Using a difference-in-differences analysis, we measured differential changes between the highest and lowest telemedicine users in the study period across four primary outcomes: the percentage of visits provided to patients living in underserved areas, rural areas, out-of-state, and more than 20 miles from the provider. A secondary outcome examined the percentage of visits with new patients. Specialists' geographic reach can increase either by seeing new patients from farther away or by existing patients moving. To explore this, we fixed patient locations to their initial zip codes in part of the analysis, ensuring that any increase in geographic reach reflected only new patients coming into practice.

The findings will be disseminated through high-impact journal publications and presented to researchers and policymakers in Norway and the United States.

Implementing Medicaid-Funded Mobile Crisis Teams Across U.S. States

MCTs are essential to crisis response systems by providing community-based interventions for individuals in mental health crises (4). These multidisciplinary teams aim to de-escalate crises in familiar environments, connect individuals to appropriate care, and reduce reliance on law enforcement, emergency departments, and hospitalizations (8). However, it remains chal-

lenging to integrate MCTs into the mental health continuum, as access to and funding for MCTs vary significantly within and between U.S. states.

The American Rescue Plan Act (ARPA) of 2021 introduced financial incentives for states to strengthen crisis services through Medicaid to address these challenges (4). ARPA provided an 85% federal match for Medicaid-reimbursed MCTs for the first three years if states met specific eligibility criteria, including staff training, 24/7 services availability, and community linkages (9). As of September 2024, 21 states – including New York, Massachusetts, and North Carolina – had opted into increased Medicaid funding under ARPA. However, little is known about how the implementation of this increased Medicaid funding for MCT has impacted the access to mental health care.

To fill this knowledge gap, I was the principal investigator in another project to explore the perceived impact of implementing these MCTs in New York, Massachusetts, and North Carolina, as well as identifying perceptions of key facilitators and barriers to their implementation. This qualitative research used semi-structured interviews with purposefully sampled stakeholders, including state Medicaid officials and MCT providers. We developed an interview guide informed by the Consolidated Framework for Implementation Research (CFIR), a comprehensive theoretical framework that identifies key domains influencing implementation processes. Participants were recruited from each state and selected for their diverse geographic, sociodemographic, and political contexts. The transcribed interviews were thematically analyzed, guided by CFIR as the theoretical framework.

More broadly, this project addressed a core policy challenge: balancing local autonomy with the need to ensure access to quality services funded at the national level. Policymakers face the ongoing task of finding an adequate level of regulation to reduce unwarranted variations while allowing flexibility for local implementation. The federal structure grants U.S. states considerable autonomy in shaping health policies, resulting in varying crisis response models. While the requirements for increased Medicaid funding may contribute to reduced variations and improved quality in MCTs, achieving 24/7 availability can prove challenging in states with large rural populations. Moreover, reliance on fee-for-service reimbursement through Medicaid may threaten financial sustainability, particularly in areas with lower call volumes and less predictable funding (10). Striking the right balance between local autonomy and national regulation is challenging in both the U.S. and Norway, and this project provides valuable insights for addressing it.

The findings will be disseminated through high-impact journal publications, including an opinion piece in *Milbank Quarterly Opinion* (10), and presentations at universities, conferences, and policy forums in the U.S. and Norway. Additionally, future research will build on these findings through a comprehensive mixed-methods implementation science project.

Lessons from the Harkness Fellowship

The Harkness Fellowship has truly broadened my perspectives. By engaging with other Fellows and participating in Harkness seminars, I have gained new insights into various issues, including health disparities and effective leadership. Through my mentors and colleagues, I have had the opportunity to collaborate with different research groups on several projects. Their ability to navigate diverse fields, continuously explore new research avenues guided by data, and apply cutting-edge methods has been truly inspiring. I have also learned valuable leadership lessons from their ability to create well-functioning teams by building strong relationships, delegating responsibilities strategically, and playing to the strengths of individual team members. I have applied these lessons in practice when mentoring three Master of Public Health students in the MCT project. I have also been struck by the more informal and less hierarchical mentorship culture in the U.S., which I aim to foster in future leadership roles.

One of my goals as a Fellow was to expand my research expertise. Being immersed in rich academic ecosystems has allowed me to connect and collaborate with leading health policy experts, equipping me with new research methods and strengthening my interdisciplinary approach. For example, I led another project analyzing care patterns for Medicare enrollees with bipolar disorder, focusing on how telemedicine is integrated into outpatient therapy, evaluations, and management. Using Medicare claims data from 2022 to 2024, we categorized patients based on their mental health specialists' use of in-person care and telemedicine. Quality outcome measures included emergency department visits, hospitalizations, outpatient follow-up, and medication adherence. This project aimed to provide key insights for policymakers into the relationship between telemedicine use and quality of care, and findings will be disseminated via high-impact journal publications and presentations.

Living and working in the United States has prompted reflections on Norway's society and health care system. The diversity in demographics and viewpoints I encountered daily reflected the complexity of U.S. history and culture. A nation's health care system often mirrors its broader societal structures: the fragmented U.S. system reflects deep political and economic

divisions, whereas Norway's universal coverage model is shaped by a more homogeneous and consensus-driven society. However, fragmentation in the U.S. varies by state. Massachusetts, for example, has coverage rates comparable to those of countries with universal health care. Understanding the vast scale of the U.S. has helped me grasp its health policy landscape. Just as Brussels can feel distant to many Europeans, federal policies from Washington may seem remote to many Americans. In the uncertainty of the current political climate, the foundations of U.S. federalism are being tested.

On a personal level, experiencing the disparities in health care access and outcomes in the United States has been another important lesson. A limited public safety net leaves many vulnerable populations without adequate care. For example, it is heartbreaking to witness individuals with severe mental illness struggling in inner cities while world-class health care exists blocks away. Although the U.S. has a well-developed discourse on disparities, translating awareness into systemic change and improved outcomes remains a fundamental challenge. The true measure of a nation is how it treats its most vulnerable. Experiencing these disparities firsthand has strengthened my conviction that robust safety nets and a publicly funded health care system are essential to ensuring access for all.

Reflections on Future Research and Policy Work

In my future career, I want to continue working at the intersection of research and health leadership. As Head of the Secretariat in the government Committee on Decision-Making Capacity, I drew on my clinical, legal, and academic expertise to navigate complex legal frameworks and translate research findings into actionable policy recommendations for the Norwegian Ministry of Health and Care Services. This work resulted in a comprehensive report that balanced different perspectives with up-to-date research (2). This hands-on experience deepened my understanding of the complexities of health policy implementation and the importance of close collaboration among stakeholders. I plan to apply these lessons in Norway and internationally, contributing to health policy as a researcher and policymaker. I am particularly passionate about integrating research into policymaking to drive innovation and bridge the fields of medicine, law, and ethics to create lasting, impactful changes in health policy and practice. My previous roles as Senior Advisor at the Norwegian Directorate of Health, litigating lawyer representing the Norwegian state, and Chief Physician in adult psychiatric divisions have given me valuable experience in translating complex legal frameworks into practice and addressing systemic challenges in health care.

delivery. These experiences and the insights gained through the Harkness Fellowship will continue to shape my future research and policy work.

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