

COVID: A Burning Platform for Telehealth Delivery of Behavioral Health

Lori J. Stark, Ph.D., ABPP

Director, Division of Behavioral Medicine & Clinical Psychology

Co-Director, Mind Brain Behavior Collaborative

Cincinnati Children's Hospital Medical Center



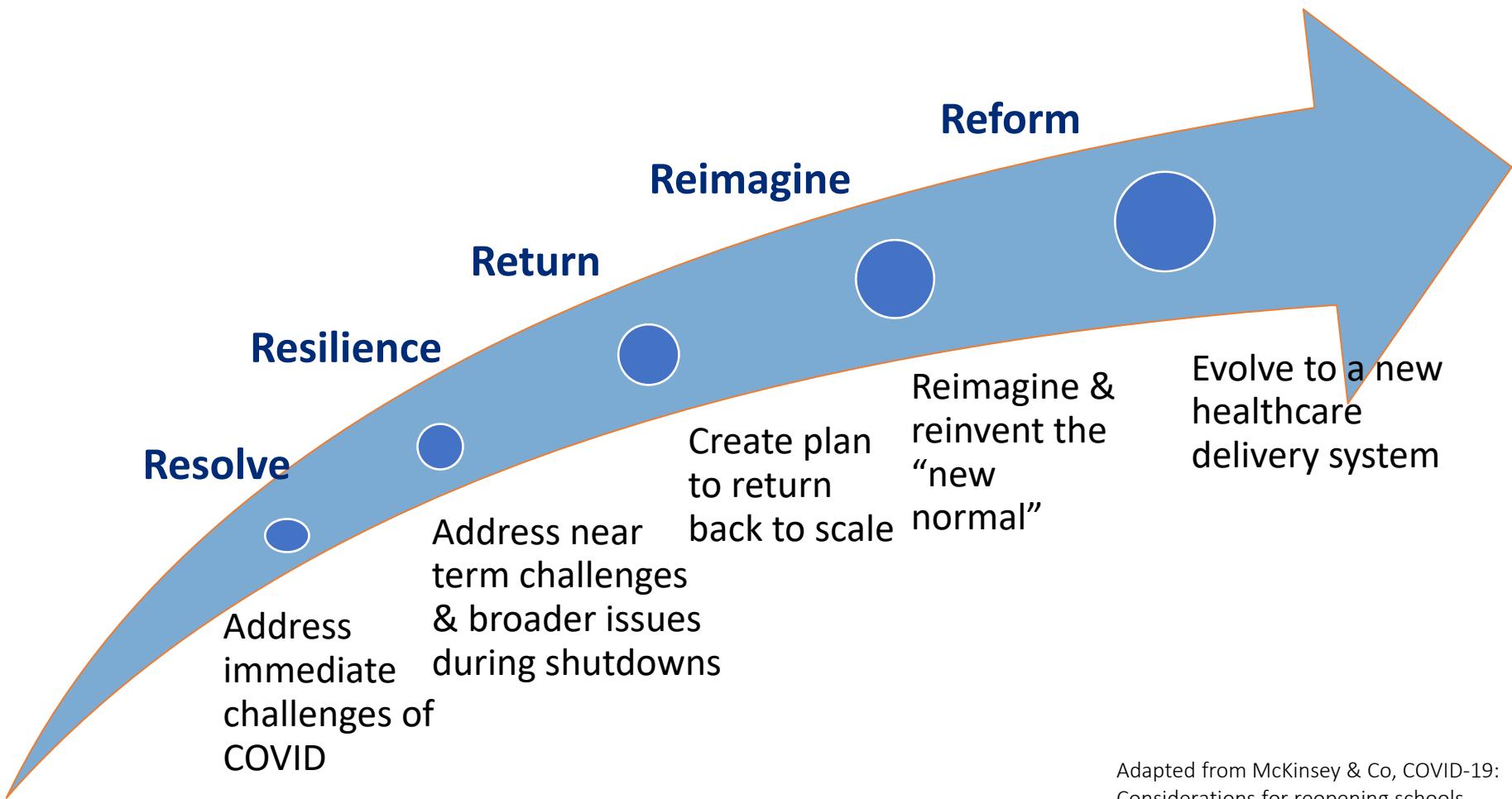
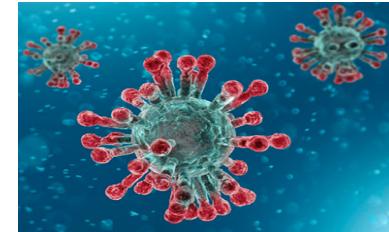
CCHMC Framework of BH Care

Levels 0 -5

Level	Categories of Programs	Specific Programs
0	Home	A. Partnership with Community Health <ul style="list-style-type: none"> ▪ Parents on Point, Moving Beyond Depression
1	Community and School Based Management	A. Integrated Behavioral Health - Psychologist in pediatrician offices B. ECHO - Pediatrician medication management of basic mental health issues C. School based management of mental health problems (mental health therapists in school)
2	Specialist Outpatient Mental Health Management	A. Classic outpatient care B. Community Agencies C. School based management of mental health problems (mental health therapists in school)
3	Intensive outpatient services	A. Patients who need care coordination B. Intensive Outpatient Programming (IOP, 2-3 times/week) C. Urgent care/crisis management/stabilization
4	Intensive Integrated Services (without 24-hour Psychiatry management)	A. Partial Hospitalization programs
5	24-hour Psychiatry management	A. Inpatient services B. Residential programs



Healthcare System Response: 5 Steps



Adapted from McKinsey & Co, COVID-19:
Considerations for reopening schools,
4/23/20

Level 2: Outpatient Therapy Services

Challenges

- Had to rapidly adopt a telehealth delivery platform
 - This required several evolutions and iterations to get a platform that met the needs of clinicians and patients
- Where could telehealth be delivered? (had to set some limits—family could not be driving)
- How to ensure child is safe during therapy? (required an adult in the home)

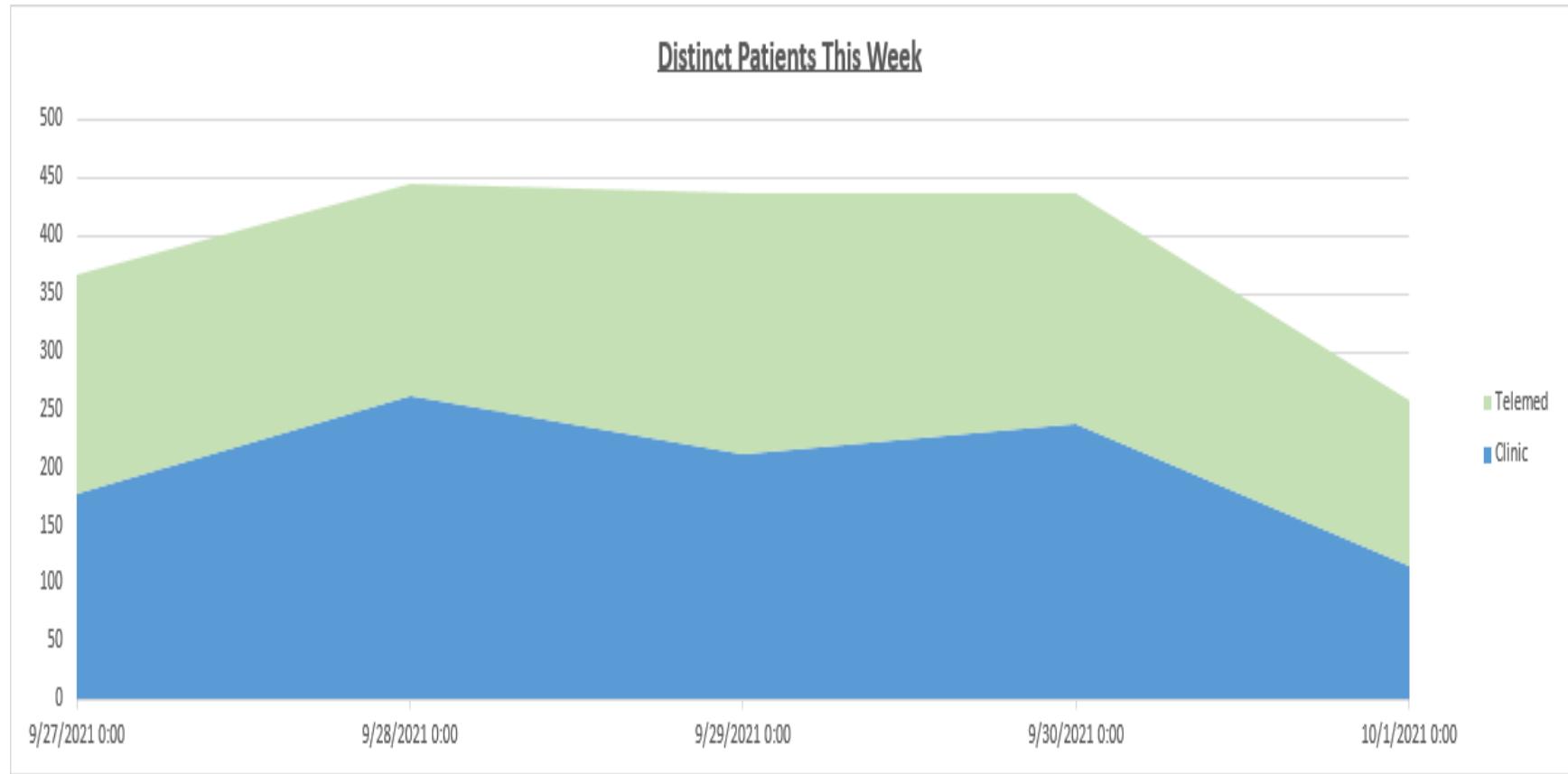


Level 2: Outpatient Therapy Services

Overall Telehealth Worked well for Outpatient Services

- Benefits
 - For many patients, clinicians having the opportunity to observe in-home practices of interventions during the sessions was beneficial for treatment (e.g., exposures with response prevention and behavior modification)
 - Treatment could continue even if patient/family or clinician was in quarantine provided they were feeling well enough to log on to telehealth visit
 - Reduced burden on families thus reduced no shows and missed sessions

Currently 50% of Patients Receiving Telehealth for Level 2 Outpatient Therapy



Level 3: Crisis Care

We have developed two levels of service to prevent unnecessary ED visits

- Bridge. Immediate availability to assess a child/teen in crisis and provide stabilization and “bridge” to outpatient care
- Intensive Outpatient Care. For children/teens with a higher acuity of BH symptoms, provide 2-3 therapy visits per week until child/teen stable enough to return to weekly outpatient treatment (Level 2)

Level 3: Telehealth for Crisis Care

- Both Bridge and IOP services pivoted to telehealth.
 - Generally, first visit/encounter occurred in person, and then follow up visits could be a combination of telehealth and/or in person based on treatment plan.
 - Given the frequency of the sessions (multiple times per week) this helped reduce barriers to care for many families.
- Currently Telehealth delivery of these service range from 25-50%

Level 1: Integrated Behavioral Health

- Within CCHMC we have psychologists integrated into
 - Medical Clinics
 - Intervention
 - Pediatric Primary care
 - Prevention
 - Intervention
- Within Community Primary Care practices, we have master's level therapist integrated to provide:
 - Early Intervention
 - Co-located Intervention

Level 1: Telehealth for Primary Care Worked

- Co-Location
 - As these are stand alone appointments with the psychologist at greater frequency than primary care visits these worked similar to Level 2 and were initially telehealth and then a combination of telehealth and/or in person based on family preference and clinical appropriateness
- Integrated Behavioral Health (IBH) in community primary care
 - Offered combination of telehealth and in person based on family preference and clinical appropriateness

Level 1 Telehealth Did not Work

Integrated Medical Clinics either when

- Both physician and psychologist both delivered care via telehealth
 - This was challenging to coordinate hand offs from one provider to the next
 - Needed to change platforms
 - Platforms evolved
- Or physician in person and psychologist via telehealth
 - Nurse or other clinic personnel needed to guide the family to use telehealth equipment

Level 1: Integrated Medical Clinics

- While telehealth was not a fit with multidisciplinary clinics
- It was very useful for chronic illness patients who were referred for more frequent BH follow-up between clinic visits—especially those who lived a distance from the hospital

Level 1: Integrated Behavioral Health: Prevention

- Our prevention model is designed so that the psychologist sees every child 0-5 years at every well child visit using prevention CPT codes
- Because primary care was not allowed to provide care via telehealth it was difficult to provide the behavioral health prevention visits
 - Could not do in clinic because of high volume and lack of personnel to set up, as well as focus on minimizing face to face time in the clinic
 - Typically unable to reach families via phone after the well child visit

Reimagining Care

- Currently collecting data on family preference to “right size” telehealth service
- Where our workforce can “sit” (remote workforce as well as patient/families)
- Challenges
 - Commercial Insurance Coverage of telehealth beyond pandemic
 - Access to broadband internet by families
 - Licensure across state lines allowing continuity of services
 - Scheduling follow-up appointments
 - Collecting patient outcomes