

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

TeleBehavioral Health 401 Training Series

Behavioral Health Telehealth Resource
Website: <https://bhinstitute.uw.edu>
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February 17, 2023

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment. BHI established initial priority programs which include:

- Improving care for youth and young adults with early psychosis
- Behavioral Health Urgent Care Walk in Clinic
- Behavioral Health Training, Workforce and Policy Innovation Center
- Expanded Digital and Telehealth Services

Speaker Disclosures

None of the series speakers have any relevant conflicts of interest to disclose.

Planner disclosures

The following series planners and team have no relevant conflicts of interest to disclose:

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BUILDING TELEHEALTH CAPACITY for BEHAVIORAL HEALTH

TeleBehavioral Health 401


Telebehavioral Health in Rural Areas: How has it changed?

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GREAT PLAINS TELEHEALTH RESOURCE & ASSISTANCE CENTER
UNIVERSITY OF MINNESOTA INSTITUTE FOR HEALTH INFORMATICS

February 17, 2023

HARBORVIEW
MEDICAL CENTER

UW Medicine  King County

Learning Objectives:

Participants will be able to:

1. Summarize changes in telehealth utilization and distribution related to the pandemic
2. Describe how telehealth changed for behavioral health providers (in contrast with other types of providers)
3. Describe the range of challenges and facilitators commonly associated with developing telebehavioral health programs

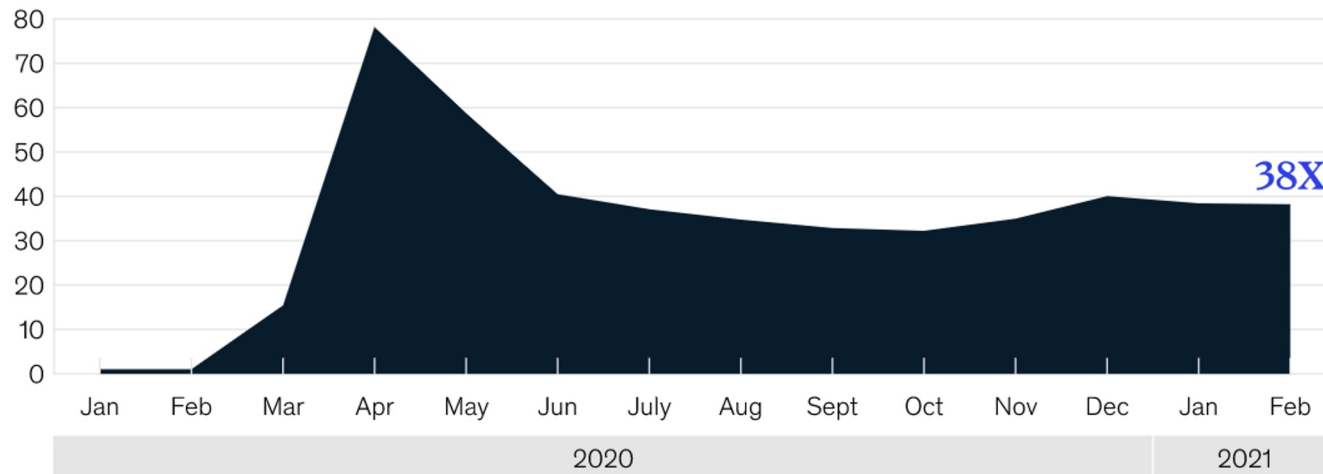
Overview

1. Changes driven by the pandemic
2. How the changes to telebehavioral health were different
3. How the changes varied by state and discipline
4. Practical experiences of rural TBH providers
5. The way(s) forward

How the Pandemic Changed Things

Growth in telehealth usage peaked during April 2020 but has since stabilized.

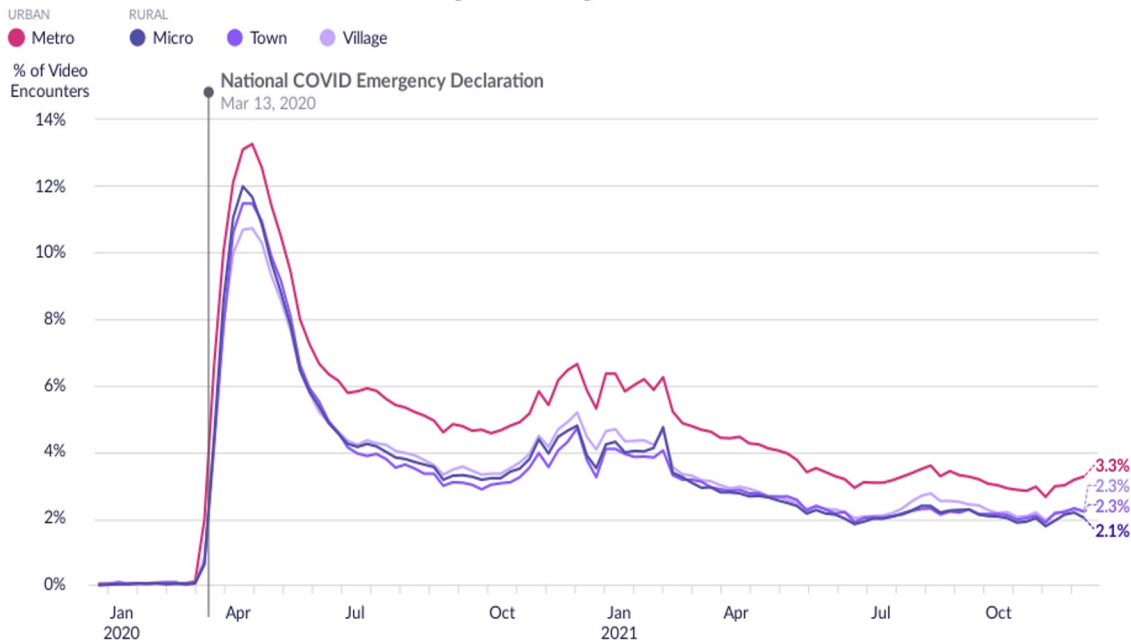
Telehealth claims volumes, compared to pre-Covid-19 levels (February 2020 = 1)¹



¹ Includes cardiology, dental/oral, dermatology, endocrinology, ENT medicine, gastroenterology, general medicine, general surgery, gynecology, hematology, infectious diseases, neonatal, nephrology, neurological medicine, neurosurgery, oncology, ophthalmology, orthopedic surgery, poisoning/drug tox./comp. of TX, psychiatry, pulmonary medicine, rheumatology, substance use disorder treatment, urology. Also includes only evaluation and management visits; excludes emergency department, hospital inpatient, and psychiatry inpatient claims; excludes certain low-volume specialties.
Source: Compile database; McKinsey analysis

Urban Telehealth Grew More Than Rural

Telehealth Video Encounters by Rurality



Telehealth Encounters by Rurality, 2022. EpicResearch.org

Figure 2. Percentage of outpatient non-procedural visits each week conducted via video. Red represents urban areas, while the shades of purple represent the areas categorized as rural.

These data come from Cosmos, a HIPAA-defined Limited Data Set of more than 138 million patients from 161 organizations using the Epic EHR, including 960 hospitals and more than 20,000 clinics, serving patients in all 50 states.

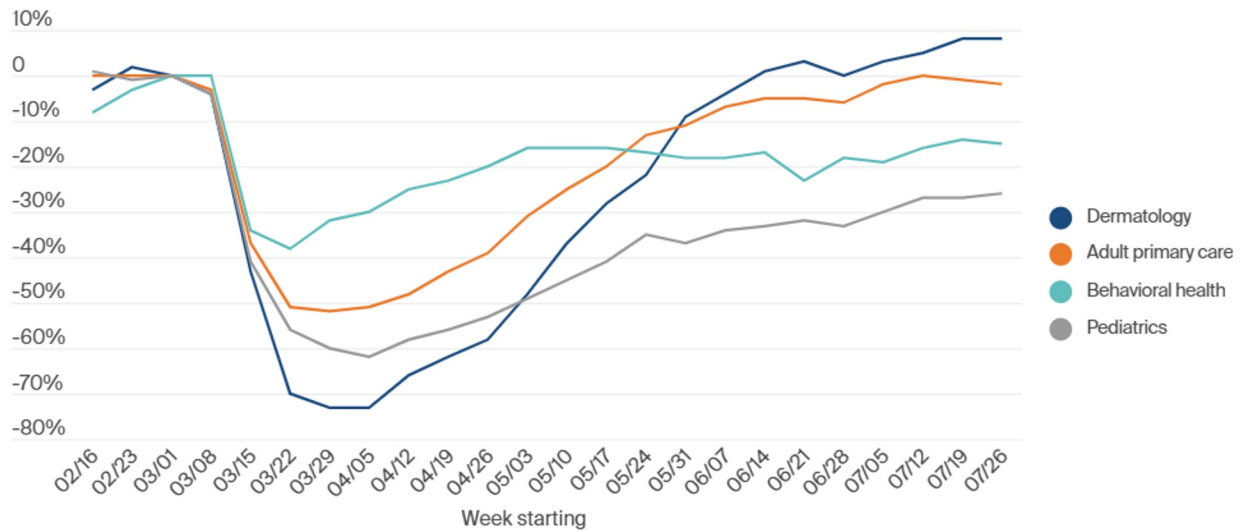
More telehealth happens where more healthcare happens;

More healthcare happens where more people are.

Specialties Responded Differently

Change in Outpatient Visits by Specialty Provider Type

Percent change in visits from baseline, by provider specialty

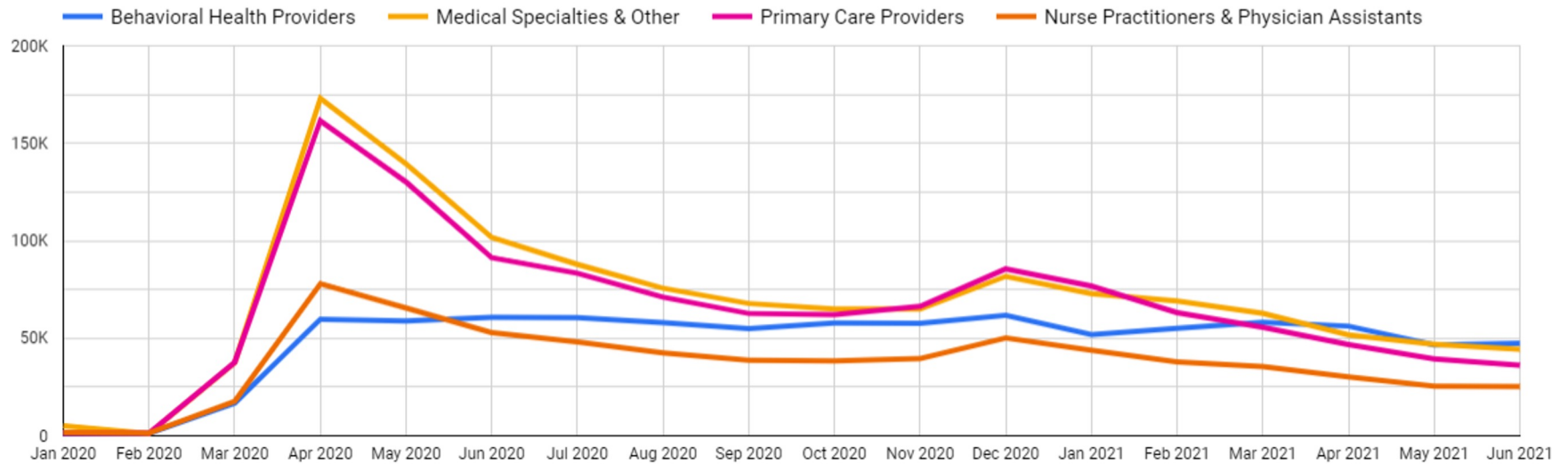


<https://www.commonwealthfund.org/publications/2020/aug/impact-covid-19-pandemic-outpatient-visits-changing-patterns-care-newest>

Telebehavioral Health Was Different

TBHH utilization jumped up and stayed up through the PHE

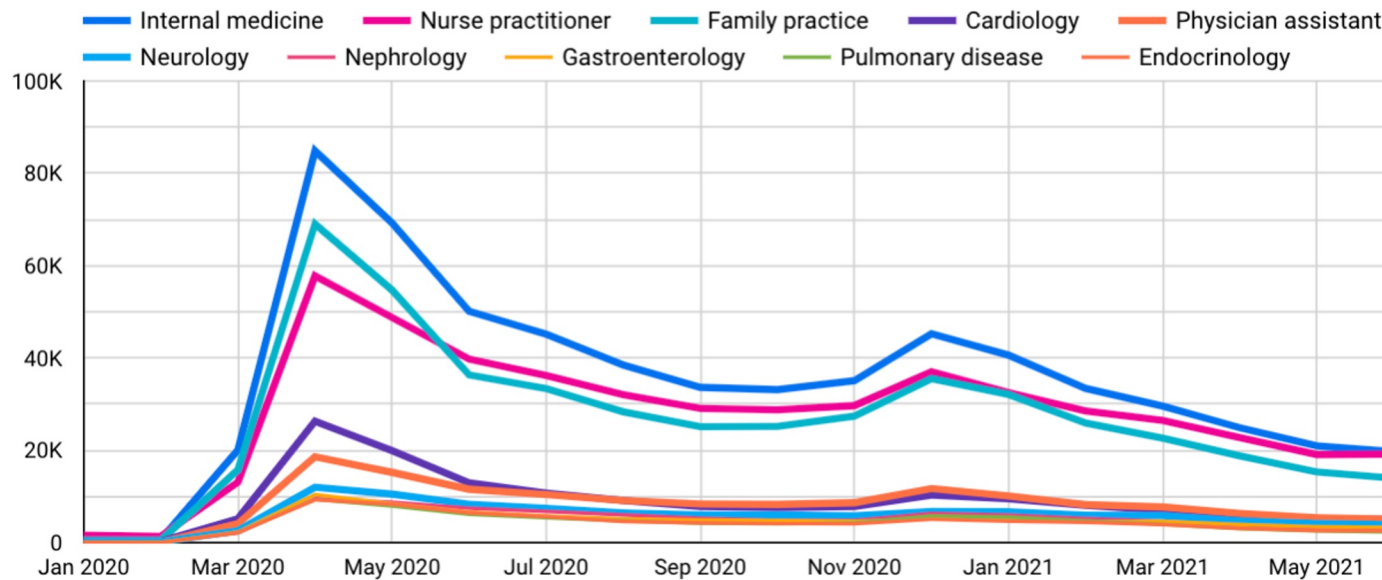
Medicare Visits *



Telebehavioral Health Was Different

Multiple types of medical providers

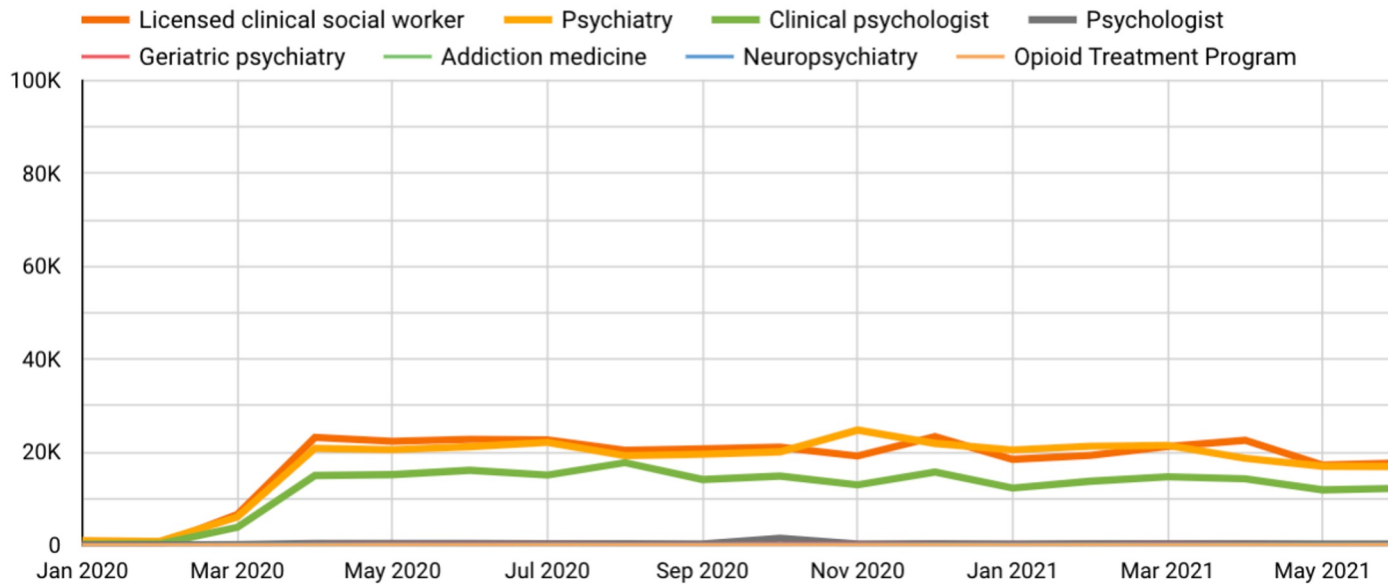
All Medical Providers Allowed Service Count *



Telebehavioral Health Was Different

Multiple types of behavioral health providers

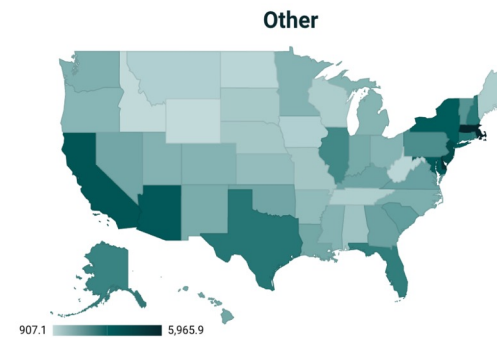
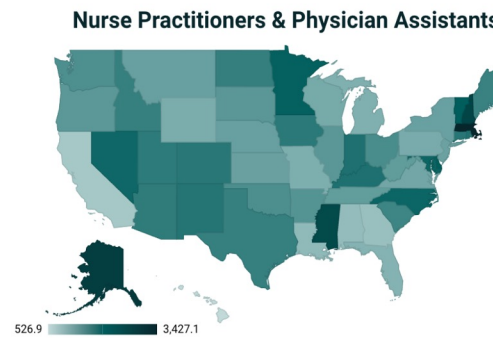
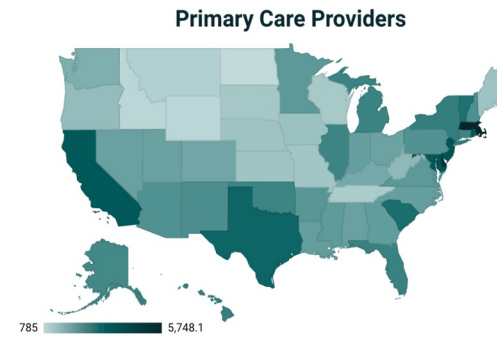
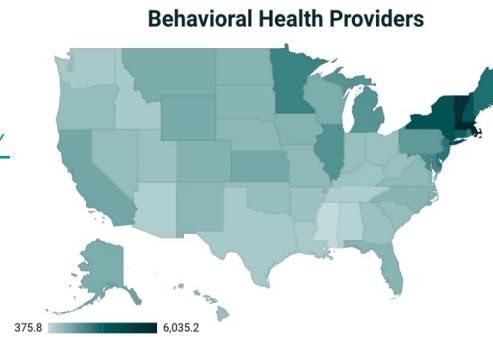
Behavioral Health Providers Allowed Service Count *



States Responded Differently

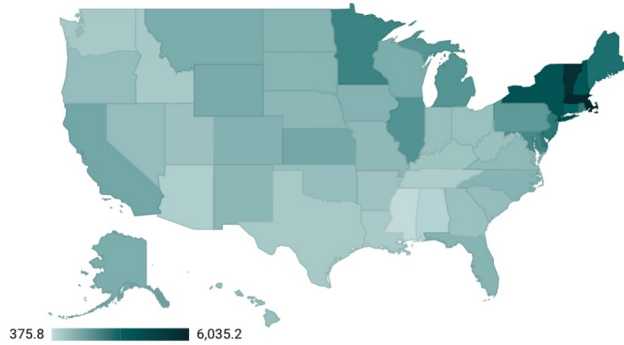
Changes in Medicare Telehealth Billing by State and Provider Type

<https://www.gptrac.org/resources/data-tools/medicare-data-tool>

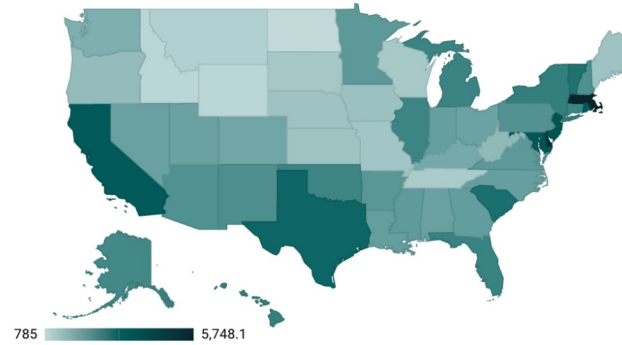


Growth in Medicare TH Billing 2019-2020

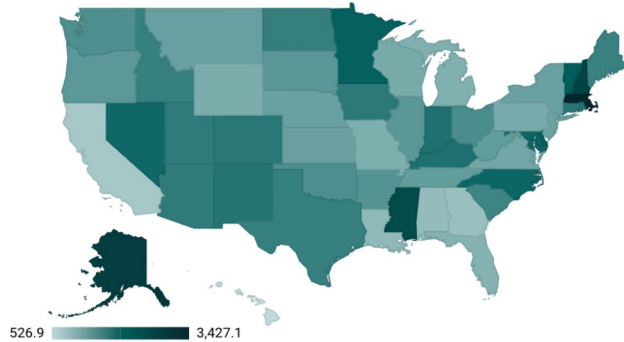
Behavioral Health Providers



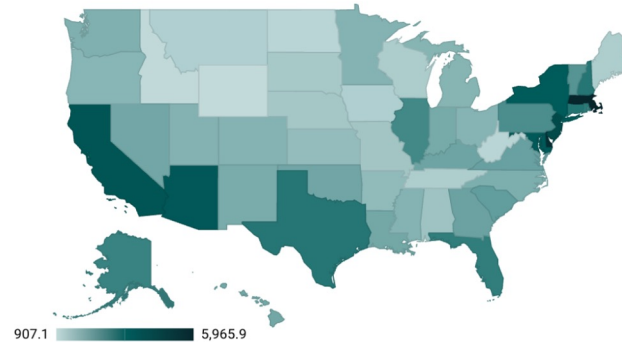
Primary Care Providers



Nurse Practitioners & Physician Assistants



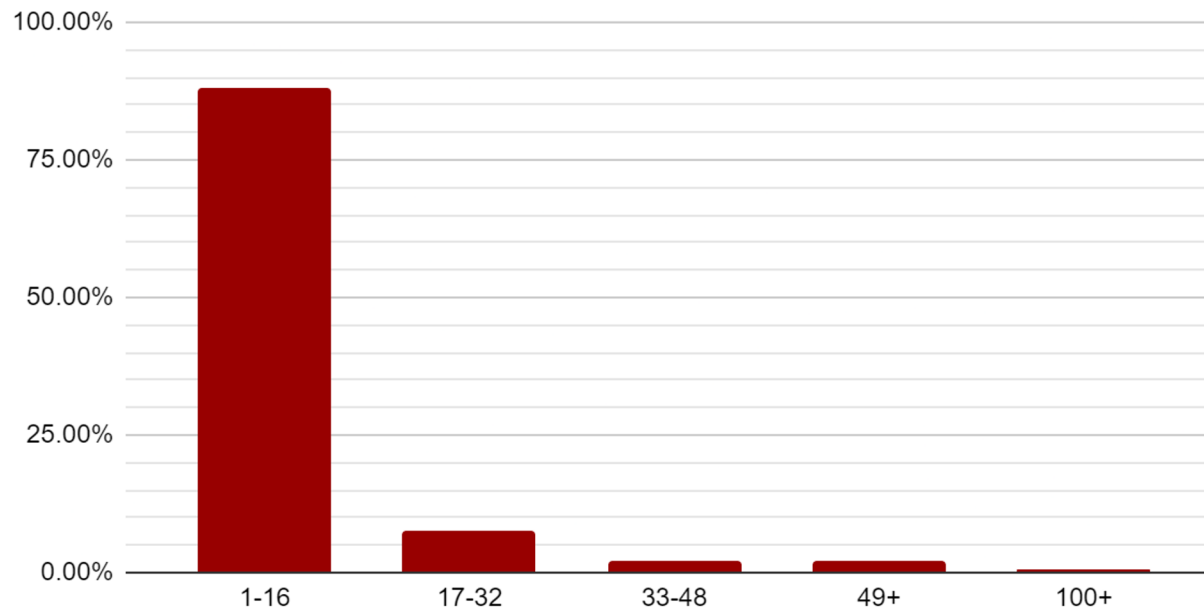
Other



The Revolution is Smaller Outside TBH

Total Visits Provided by NPs Across the Pandemic

March 2020 - June 2021



Includes all Medicare outpatient telehealth claims for March 2020 - June 2021

- 16 months of data DURING the PHE
- 16 or fewer encounters is less than 1 encounter per month

Challenges in Rural Areas

- The 2019 EB-THNG program
- Major findings
- Data collection & other challenges
- Response to the pandemic
- The nature of “evidence” of equivalence

RESEARCH

Open Access



Comparison of in-person vs. telebehavioral health outcomes from rural populations across America

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Abstract

Background: This study investigates outcomes from two federal grant programs: the Evidence-Based Tele-Behavioral Health Network Program (EB THNP) funded from September 2018 to August 2021 and the Substance Abuse Treatment Telehealth Network Grant Program (SAT TNGP) funded from September 2017 to August 2020. As part of the health services implementation program, the aims of this study were to evaluate outcomes in patient symptoms of depression and anxiety across the programs' 17 grantees and 95 associated sites, with each grantee having data from telehealth patients and from an in-person comparison group.

Methods: The research design is a prospective multi-site observational study. Each grantee provided data on a non-randomized convenience sample of telehealth patients and an in-person comparison group from sites with similar rural characteristics and during the same time period. Patient characteristics were collected at treatment initiation, and clinical outcome measures were collected at baseline and monthly. The validated clinical outcome measure instruments included the Patient Health Questionnaire-9 (PHQ-9) for depression symptoms and the Generalized Anxiety Disorder-7 (GAD-7) scale for anxiety-related symptoms. Linear mixed models, with grantee as the random effect, were used to determine the association of behavioral health delivery (telehealth versus in-person) on the one-month change in PHQ-9 and GAD-7 while adjusting for covariates.

Results: Across a total of 1,514 patients, one-month change scores were improved indicating that PHQ-9 and GAD-7 scores decreased from baseline to the one-month follow-up at similar rates in both the in-person and telehealth groups. Reduction in scores averaged 2.8 for the telehealth treatment group and 2.9 for the in-person treatment group in the PHQ-9 subsample and 2.0 for the telehealth treatment group and 2.4 for the in-person treatment group in the GAD-7 subsample. There was no statistically significant association between the modality of care (telehealth treatment group versus in-person comparison group) and the one-month change scores for either PHQ-9 or GAD-7. Individuals with higher baseline scores demonstrated the greatest decrease in scores for both measures. Upon adjusting for baseline scores and grantee program, patient demographics were not found to be significantly associated with change in anxiety or depression symptoms.

Conclusion: In our very large pragmatic study comparing behavioral health treatment delivered to a population of patients in rural, underserved communities, we found no clinical or statistical differences in improvements in

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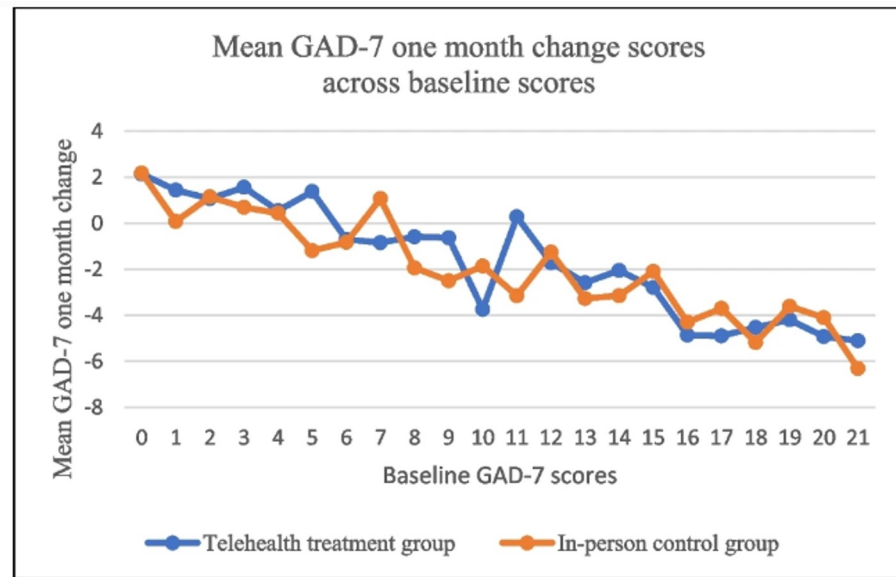
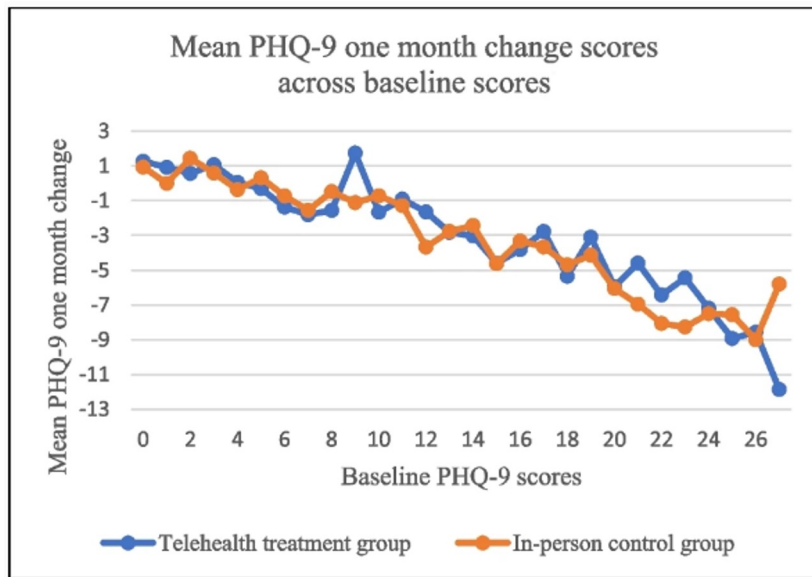
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TBH Outcomes Equivalent to In-person



Mean one month change scores across baseline scores for telehealth treatment and in-person comparison groups.

Note. PHQ-9 has a maximum score of 27 and is shown in the left panel. GAD-7 has a maximum score of 21 and is shown in the right panel

Variable	PHQ-9 Score Change ^a			GAD-7 Score Change ^a		
	Coefficient	P -value	95% CI	Coefficient	P -value	95% CI
Telehealth group ^b	0.05		-0.53, 0.62	0.19		-0.35, 0.74
Baseline score	-0.38	0.001	-0.42, -0.34	-0.35	0.001	-0.40, -0.31
<i>Age group (0–18 as reference)</i>						
Age group 19–34	-0.58		-1.54, 0.38	-0.23		-1.08, 0.62
Age group 35–64	-0.77		-1.70, 0.16	-0.31		-1.13, 0.50
Age group 65+	-1.48	0.05	-2.70, -0.27	-0.95		-2.03, 0.13
<i>Sex (Male as reference)</i>						
Female	0.42		-0.15, 0.99	0.80	0.01	0.23, 1.36
<i>Race (White as reference)</i>						
Non-Whites	0.30		-0.74, 1.35	0.35		-0.65, 1.35
Unknown race	-0.55		-1.59, 0.49	-0.34		-1.31, 0.63
<i>Ethnicity (Hispanic as reference)</i>						
Non-Hispanic	-0.18		-1.46, 1.10	-0.02		-1.23, 1.18
Unknown ethnicity	-0.39		-1.93, 1.15	-0.24		-1.65, 1.17
<i>Insurance status (Private ins. as reference)</i>						
Public insurance	0.29		-0.36, 0.95	0.37		-0.22, 0.96
Self-pay/unknown /other insurance	0.19		-0.76, 1.15	0.01		-0.82, 0.80
N	1,514			1,284		

^aBoth models adjust for age, gender, race, ethnicity, insurance type, and baseline score. Additionally, random effects are specified at the grantee level. None of the covariates are significantly related to the outcome variable (last follow-up change scores) other than baseline scores in both models and self-pay/unknown/other insurance in the subsample model

^bTelehealth treatment group is a binary variable coded as 1 for patients in the telehealth treatment group and as 0 for patients in the in-person control group

Challenges Remain in Rural Areas

Major local findings - anecdotal

- Execution is hard in small, rural clinics
- Workforce is going to be a MAJOR ISSUE for the foreseeable future
- Even when the services are GIVEN AWAY, some clinics can't use them effectively
- Differentiation by CAPACITY is real and likely to grow

What's Next?

- TBH “services” will proliferate and consolidate
- Providers who are “all in” on telehealth will differentiate from those that avoid it or use it sparingly
- Fee-for-service payers will struggle to define and reimburse increasingly fractionated and refactored services; value-based and capitated services will grow
- Rural providers will have less access to and uptake of more progressive systems and services (by capacity? by choice?)

- QUESTIONS & DISCUSSION



TELEHEALTH EVERYWHERE

Region's *Premier* Telehealth Conference

Radisson Blu - Mall of America | **May 23-24**

2023



Jonathan Neufeld, PhD

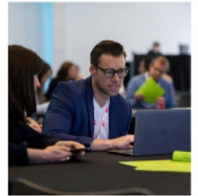
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<http://gptrac.org/conference>

<http://telehealthresourcecenters.org>

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TELEHEALTH
EVERYWHERE!



May 23-24, 2023



Additional Free Resources for Washington State Behavioral Health Providers

EDUCATIONAL SERIES:

- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO
- UW TelePain series

PROVIDER CONSULTATION LINES

- UW Pain & Opioid Provider Consultation Hotline
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line

