TeleBehavioral Health 501 Training Series

Behavioral Health Institute (BHI)
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Northwest Regional
Telehealth Resource Center (NRTRC)
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October 18, 2024

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.

The BHI brings the expertise of Harborview Medical Center/University of Washington Medicine and other university partners together to address the challenges facing Washington's behavioral health system through:

- Clinical Innovation
- Research and Evaluation
- Workforce Development and Training
- Expanded Digital and Telehealth Services and Training

The BHI serves as a regional resource for the advancement of behavioral health outcomes and policy, and to support sustainable system change.

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

The NRTRC delivers telehealth technical assistance and shares expertise through individual consults, trainings, webinars, conference presentations and the web.

Their mission is to advance telehealth programs' development, implementation and integration in rural and medically underserved communities.

The NRTRC aims to assist healthcare providers, organizations and networks in implementing cost-effective telehealth programs to increase access and equity in rural and medically underserved areas and populations.

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Speaker Disclosures

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DISCLAIMER

Please be aware that policy changes may take place after the original date of this presentation.

Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.

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We gratefully acknowledge the support from

Washington State Health Care Authority

NRTRC NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

AHEC WW
AREA HEALTH EDUCATION CENTER
FOR WESTERN WASHINGTON AT WHATCOM COMMUNITY COLLEGE

Principles and Guidelines for Delivering Telebehavioral Health to Homebound Older Adults with Cognitive Disorders

Christine Ritchie, MD, MSPH
Massachusetts General Hospital, Harvard Medical School

Bruce Leff, MD
Johns Hopkins University School of Medicine

TeleBehavioral Health 501 Series
October 18, 2024

Goals for today

- Who needs telehealth: the invisible homebound
- Characteristics of older adults who are homebound
- Behavioral health needs of those who are homebound
- Strategies for delivering telebehavioral health to homebound older adults, with special attention to those living with dementia

Who are the Homebound?

Original Investigation

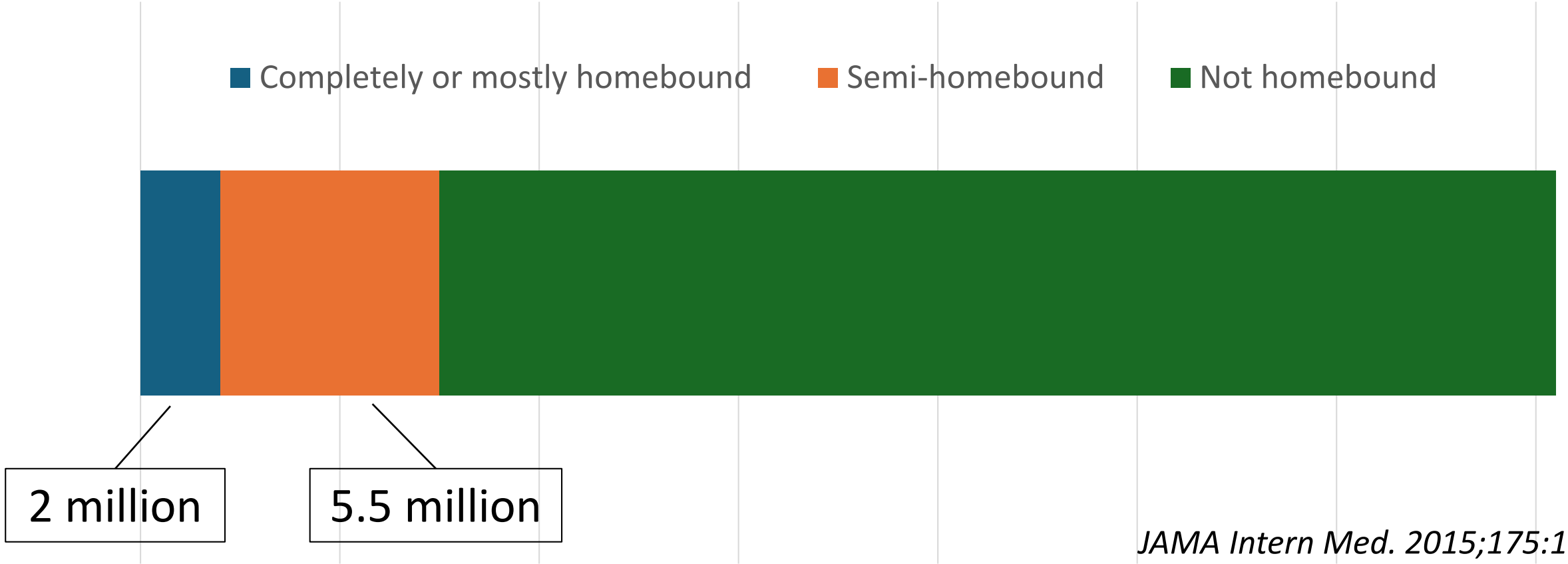
Epidemiology of the Homebound Population in the United States

Katherine A. Ornstein, PhD, MPH; Bruce Leff, MD; Kenneth E. Covinsky, MD; Christine S. Ritchie, MD, MSPH; Alex D. Federman, MD, MPH; Laken Roberts, MPH; Amy S. Kelley, MD, MSHS; Albert L. Siu, MD, MSPH; Sarah L. Szanton, PhD

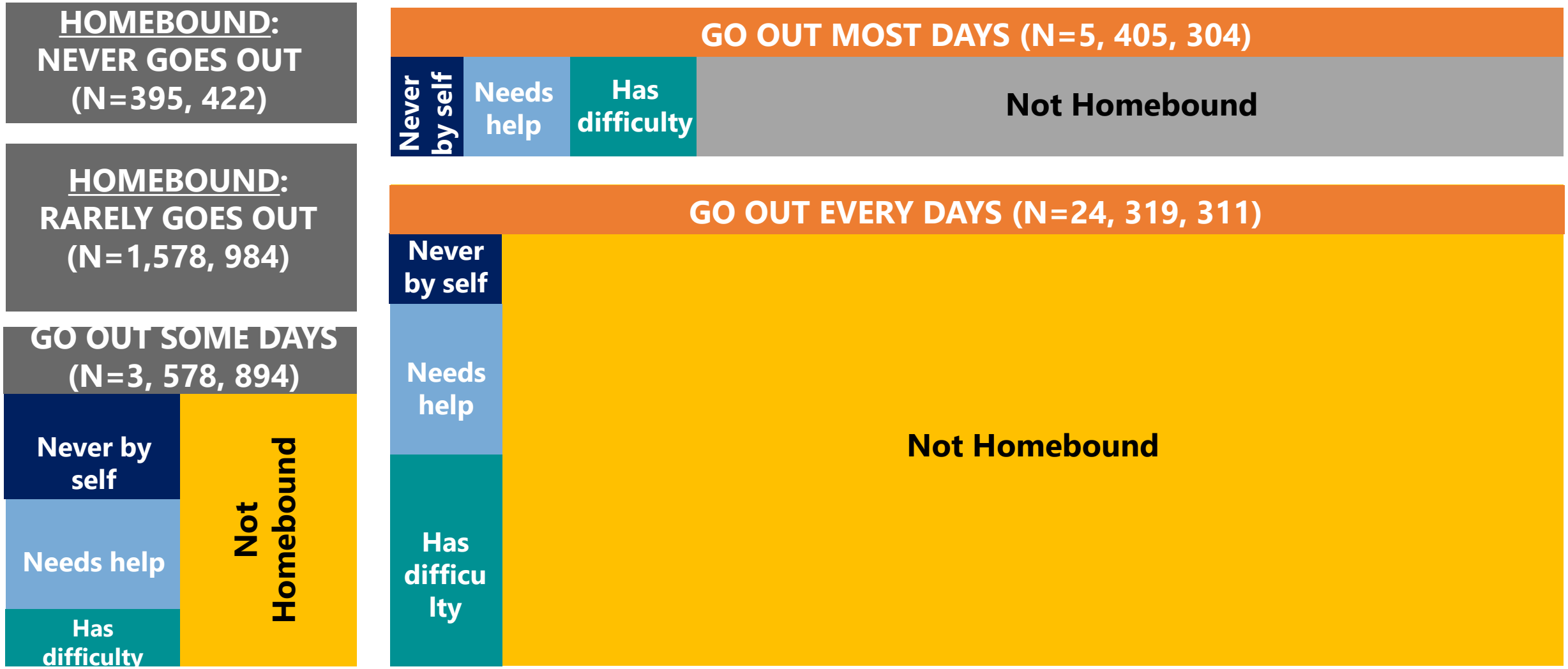
- National Health and Aging Trends Study (NHATS)
- Population-based study
- Random sample ≥ 65 Medicare enrollment rolls
- In-person interviews + physical/cognitive performance
- N = 7603 non-NH subjects
- No predefined measure of homebound
  - – capacity and ability approach

Ornstein KA, JAMA Intern Med. 2015 Jul 1;175(7):1180-6

21% of Medicare Beneficiaries (7.5 Million) are Homebound to Some Degree



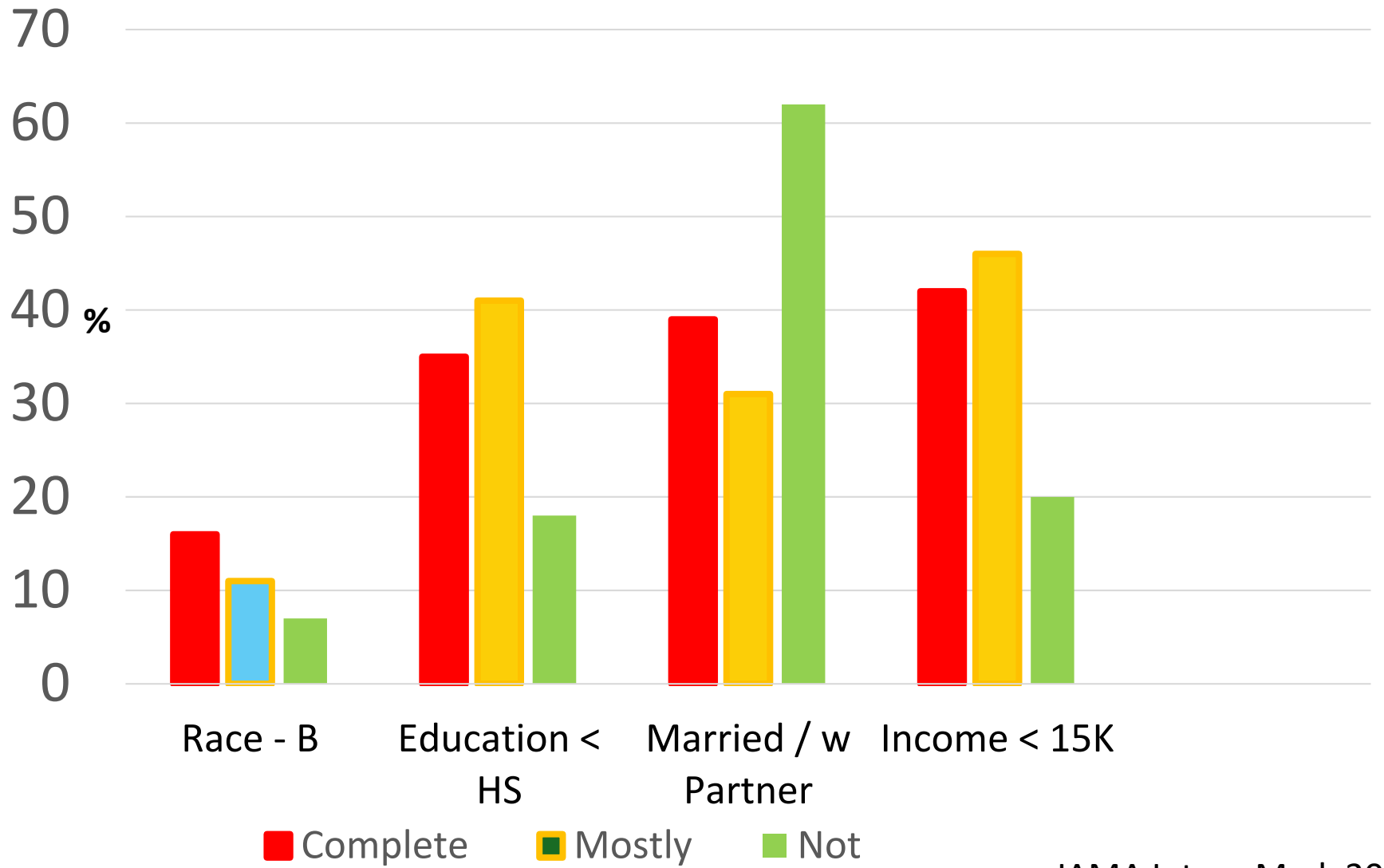
JAMA Intern Med. 2015;175:1180-6



Frequency/Ability to Leave the Home Among Community-dwelling Medicare Beneficiaries Age ≥ 65

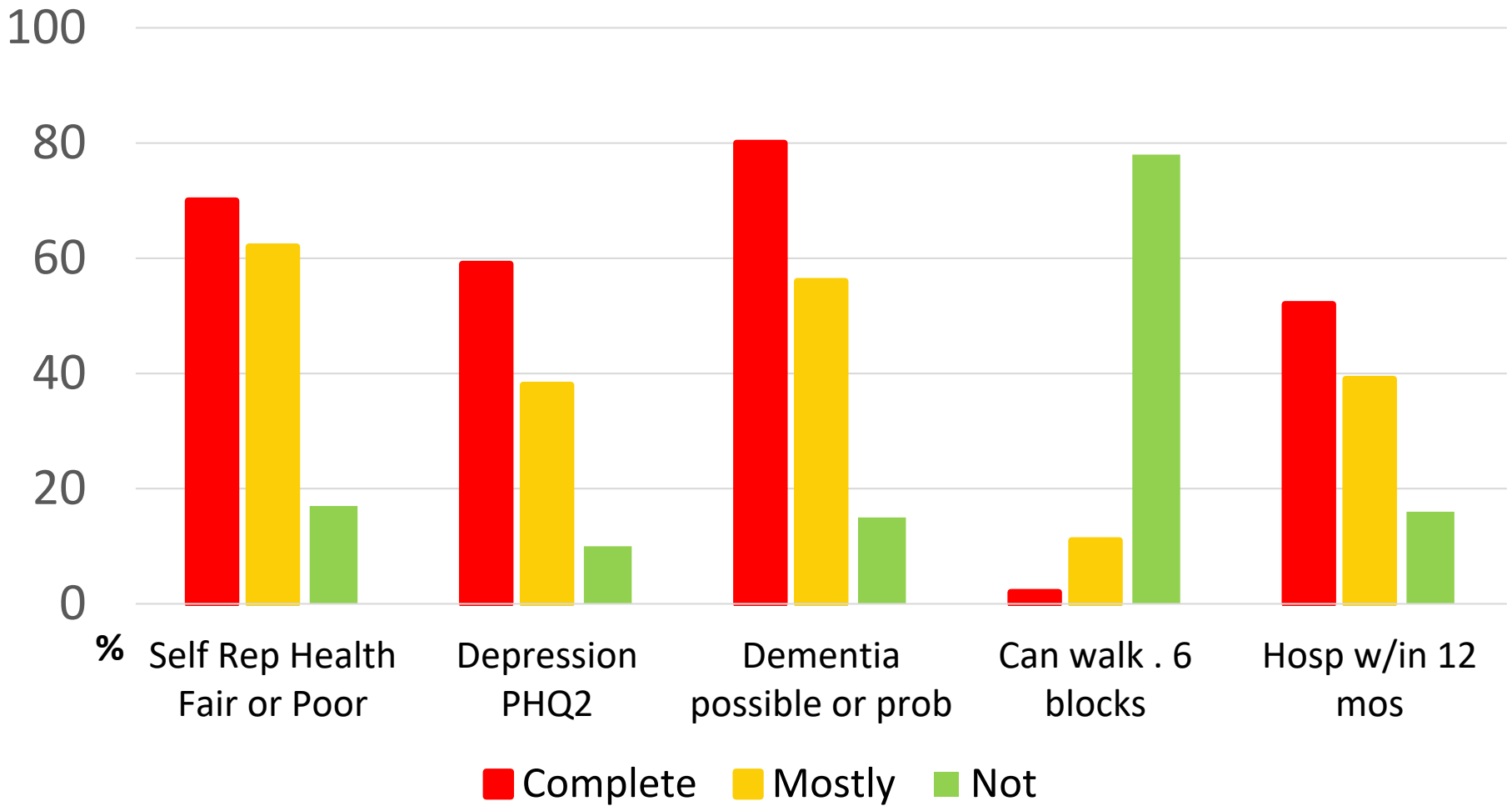
JAMA Intern Med. 2015;175(7):1180-6.

The Homebound Are a Seriously Ill Population with High Social Needs



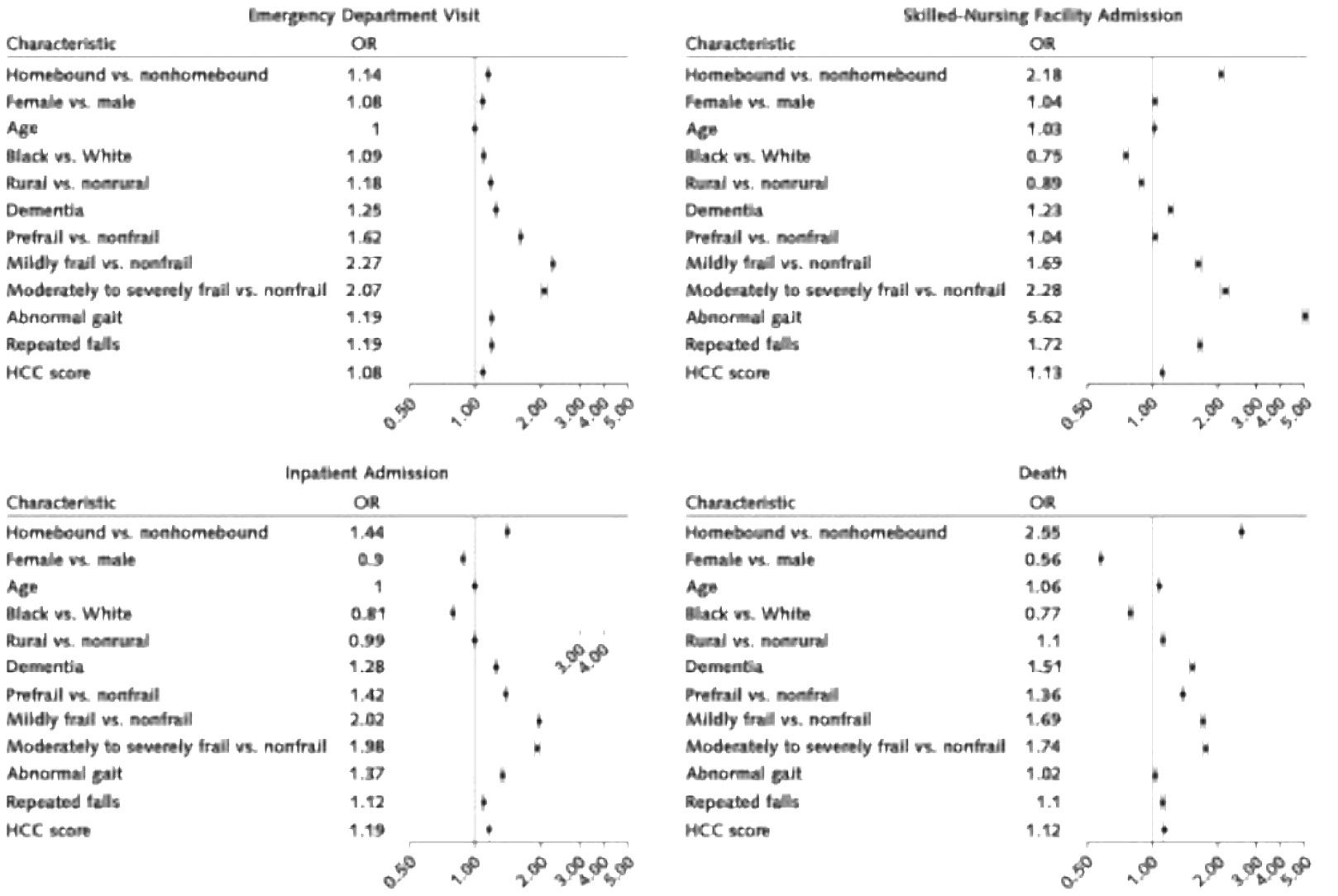
JAMA Intern Med. 2015;175:1180-6

The Homebound Are a Seriously Ill Population with High Medical Needs



JAMA Intern Med. 2015;175:1180-6

Figure 2. Adjusted odds of health service use and death.

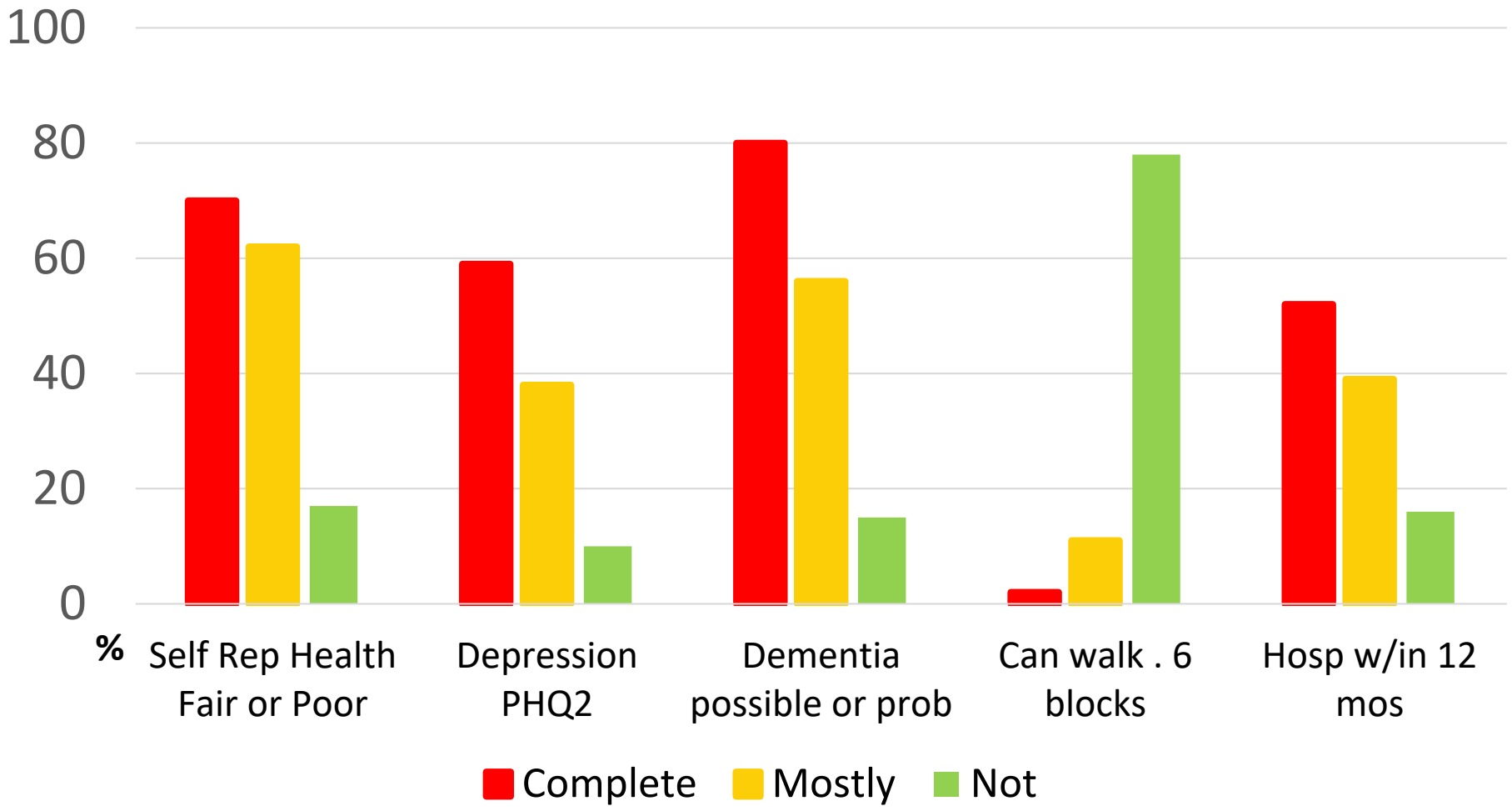


Adjusted for homebound status, sex, age, race, rural status, region, plan type, low-income status/dual eligibility, frailty group, repeated falls, abnormal gait, and weighted HCC score. HCC = Hierarchical Condition Category; OR = odds ratio.

Homebound status independently associated with Adverse Outcomes in Large National Medicare Advantage Plan

Leff B, Epidemiology of Homebound Population Among Beneficiaries of a Large National Medicare Advantage Plan. Ann Intern Med. doi: 10.7326/M24-0011. PMID: 39133927.

The Homebound Are a Seriously Ill Population with High Medical Needs



JAMA Intern Med. 2015;175:1180-6

Many who are homebound have significant behavioral health needs

- Depression: ~40%
- Anxiety: 20-40%
- Dementia: ~ 50%
- Caregiver stress: 40-70%

National Home-Based Primary Care Learning Network

Data on use of telehealth / telemedicine in HBPC

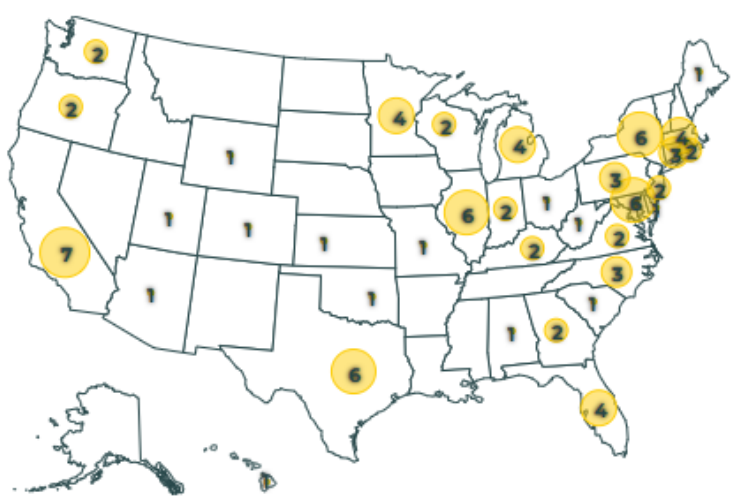
National Home-Based Primary Care Learning Network

Goal

To create an expanded Learning Network focused on fostering a culture of continuous learning and quality improvement among home-based primary care practices

Practices

87 practices have joined the Learning Network and represent quite a diverse range of practices – large and small, academic and non-academic and commercial, MD and NP practices; they are from 36 states



~97K patients and growing!

Wave 8 Kick Off Meeting

June 26, 2024

Quality Improvement Tool

Practices are using simpleqi to test change and engaging in PDSA cycles. Completed 635 PDSA's

Naomi Gallopyn
ngallopyn@mgh.harvard.edu

https://improvehousecalls.org/

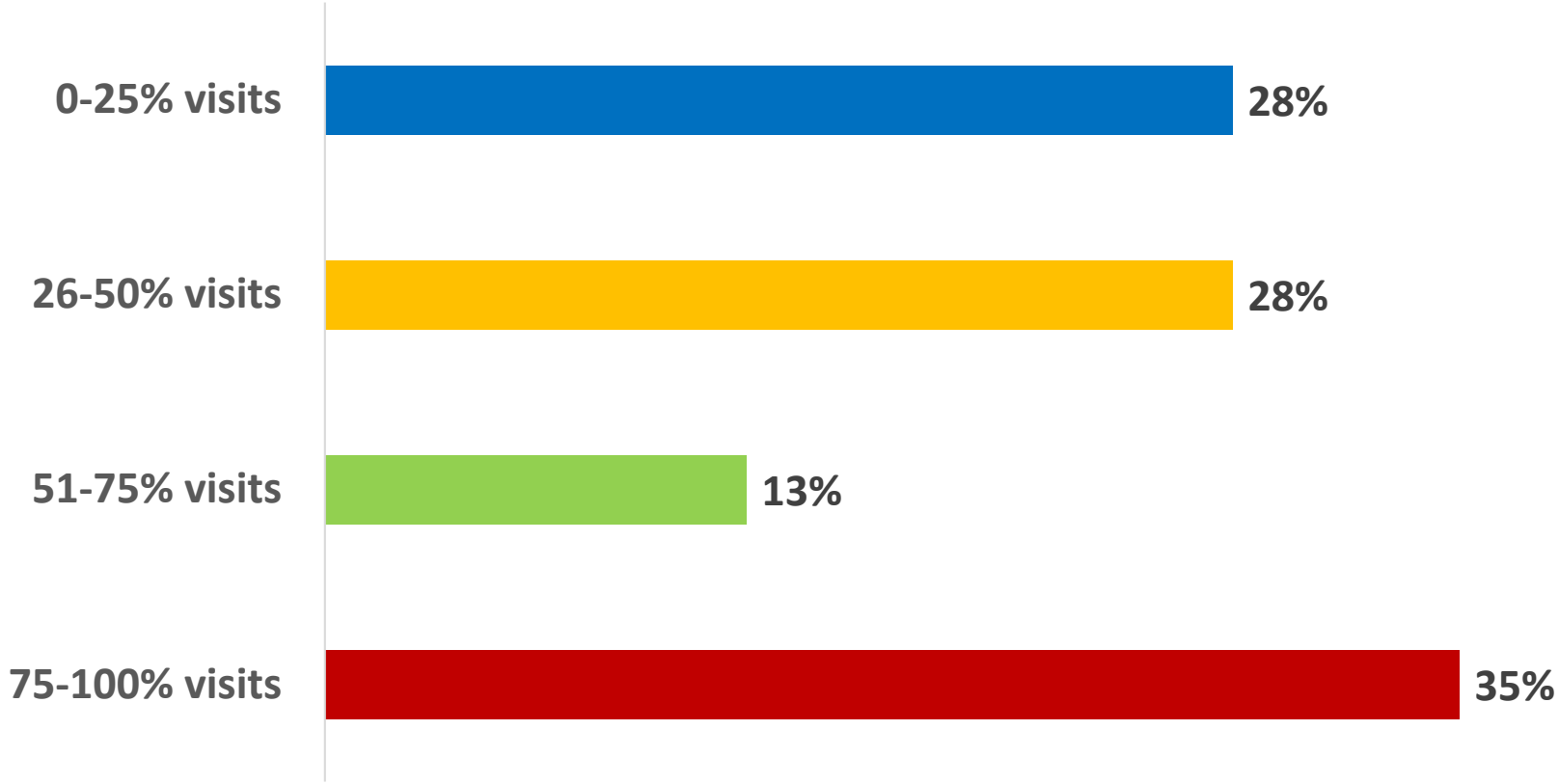
Did your practice perform telemedicine visits by physicians, nurse practitioners, or physician assistants during the COVID pandemic?

At the practice level:

- 27 did perform telehealth visits.
- 3 practices did not perform telehealth visits.

Total individual: 46
Practices responded: 30

During peak(s) of COVID what proportion of visits were telemedicine visits?

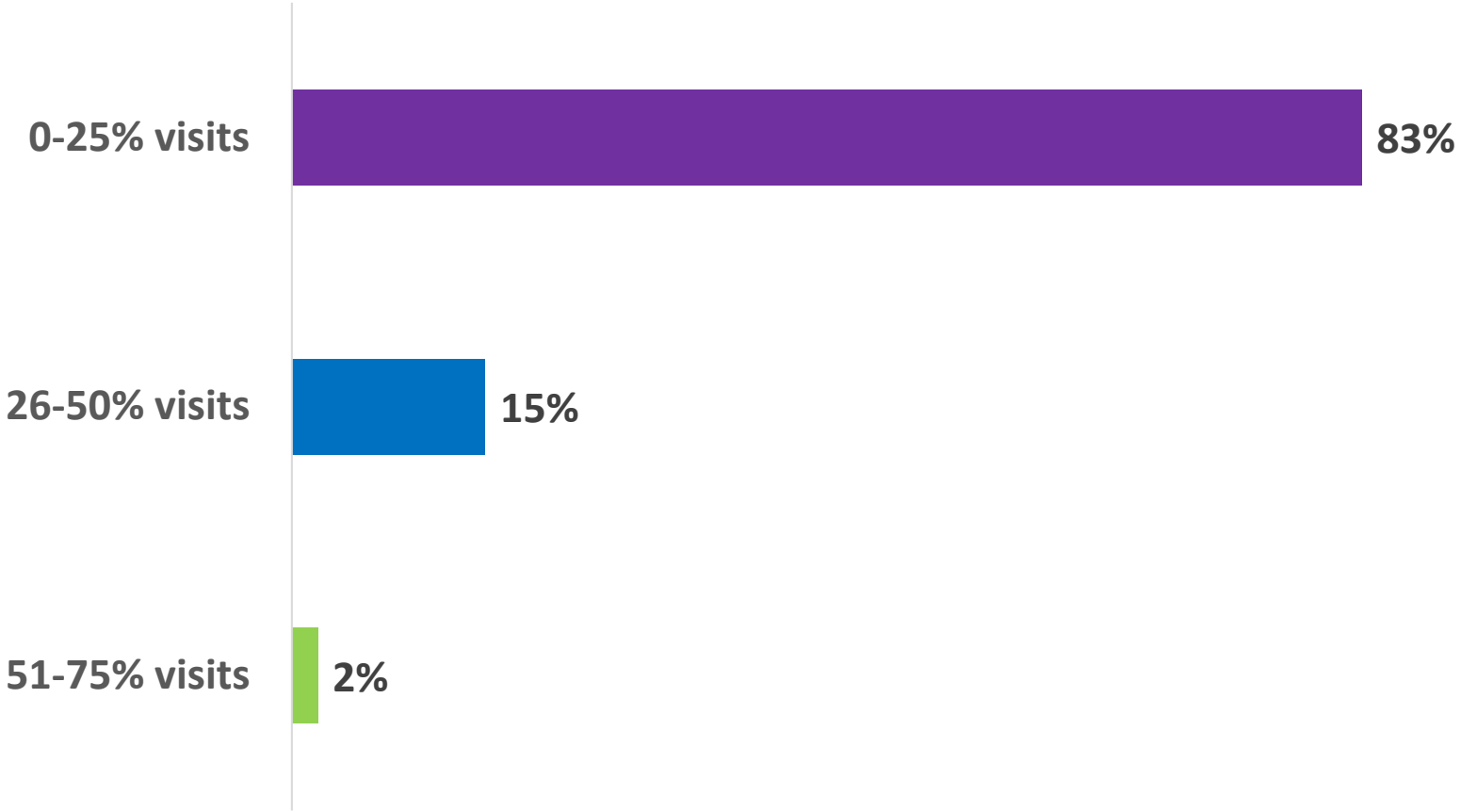


Does your practice currently perform telemedicine visits by physicians, nurse practitioners, or physician assistants?

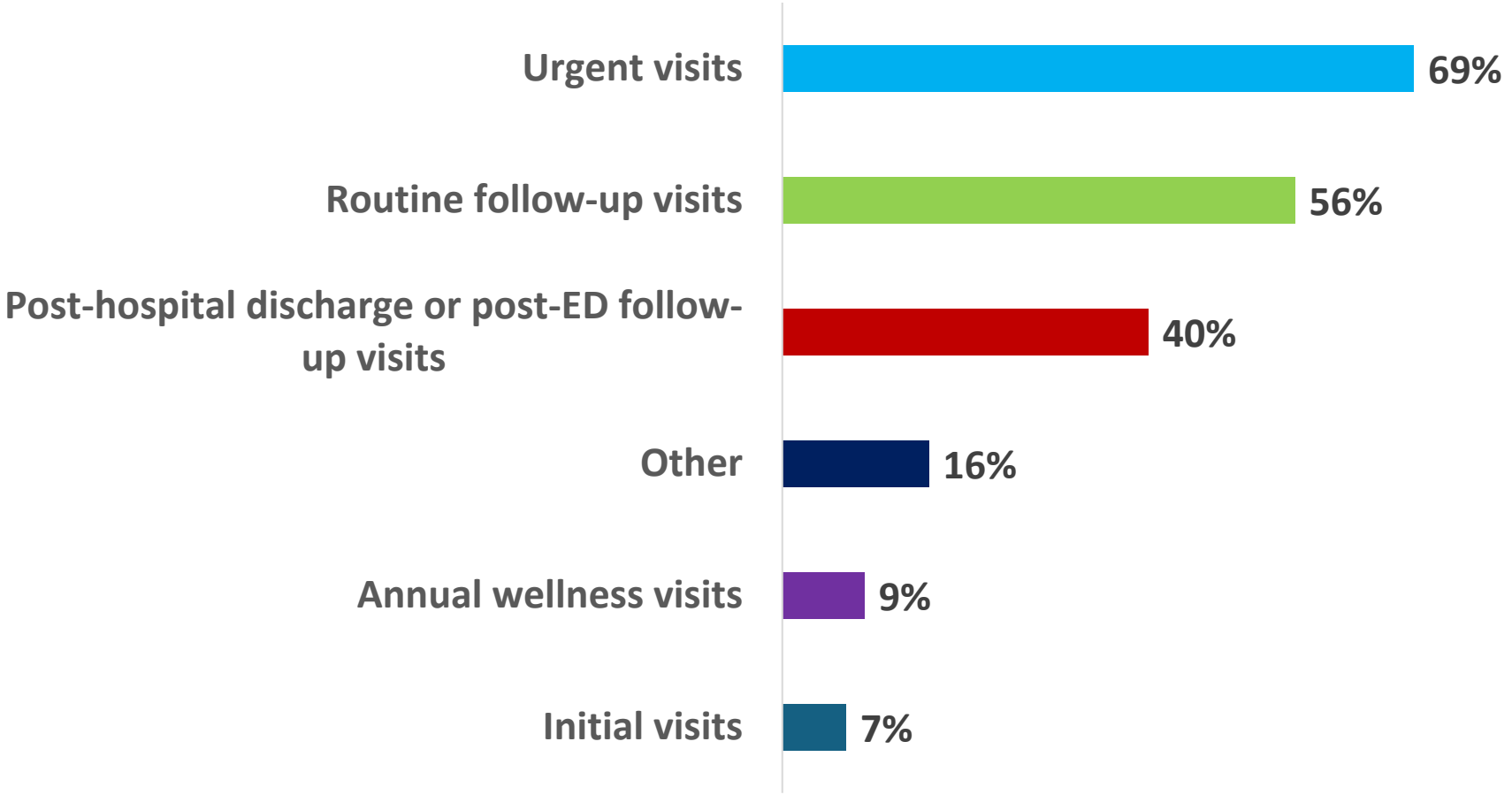
At the practice level:

- 27 do perform telehealth visits.
- 3 practices don’t perform telehealth visits.

Approximately what proportion of visits are telemedicine visits?



For which of these visit types do you currently perform telemedicine visits?



Other:

- Telewound
- Acute problems
- Weather issues
- Providers that are ill
- Sick patients/caregivers

Signals from the Literature

DOI: 10.1111/jgs.17365

Journal of the
American Geriatrics Society

Home-based primary care: A systematic review of the literature, 2010–2020

Robert M. Zimbroff MD[1] | Katherine A. Ornstein PhD, MPH[2] |
Orla C. Sheehan MD, PhD[3]

Identified the role of telehealth as one of 5 overarching themes

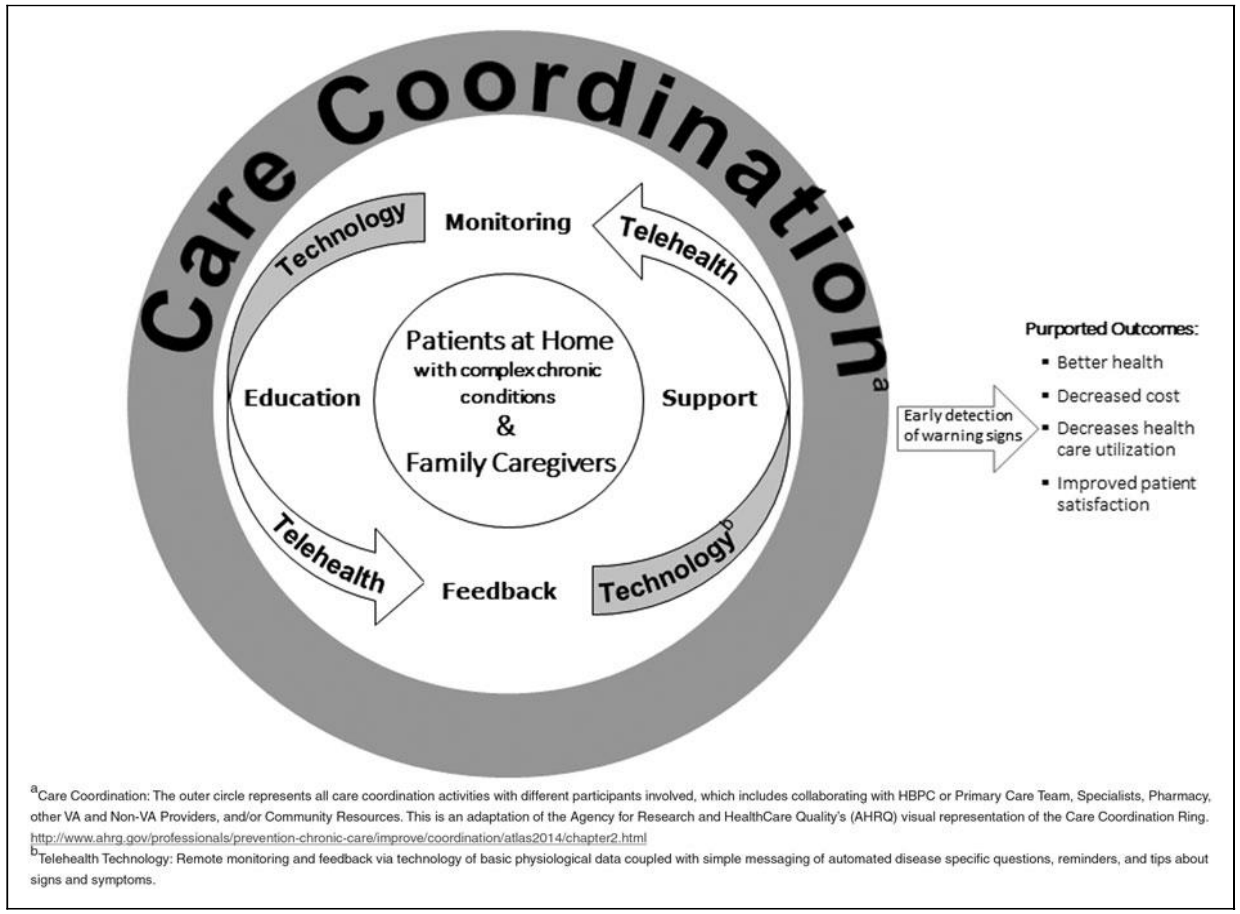
Key idea was the use of *telehealth to extend the reach of HBPC*

J Am Geriatr Soc. 2021;69:2963-2972. PMID: 34247383.

Telehealth in Home-Based Primary Care: Factors and Challenges Associated With Integration Into Veteran Care

Stuti Dang, MD, MPH,*†‡ Tobie Olsan, PhD, RN,§¶ Jurgis Karuza, PhD,§‖** Xueya Cai, PhD,§†† Shan Gao, PhD,§†† Orna Intrator, PhD,§‡‡ Jiejin Li, PhD,§‡‡ and Suzanne M. Gillespie, MD, RD§‖

- National VA survey
- 232/394 HBPC sites (59%) response
- 76% of sites used home telehealth
- More likely to use when:
  - HBPC sites were aligned with VA Geriatric and Extended Care Services
  - There were more disciplines on the team
  - When PCPs made home visits
- 81% Program directors viewed home telehealth as a positive for managing complex chronic illnesses
- Home telehealth not well-integrated into care planning process



Schematic of VA Home Telehealth Chronic Disease Model.

Telemed J E Health. 2019;25:309-318. PMID: 29969381. J Am Geriatr Soc. 2019;67:1928-1933. PMID: 31343732.

Research: Not Yet Ready for Primetime—Video Visits in a Home-Based Primary Care Program

- Mount Sinai Visiting Doctors Program – NYC –Pre-COVID
- Testing telehealth among stable patients (cog intact and tech capable or with CG to operate the tech) assigned to 5 medical SW case managers
- **The Question: did telehealth have potential to replace some in-person visits?**
- N=56, 70% with ≥ 1 successful tele-visit
- Overall video success rate 49% (56 of 119 attempted)
- **Connectivity and lack of familiarity with technology were major barriers**
- Patients and caregivers preferred video visits to longer wait-times for in-person assessments

J Am Geriatr Soc. 2019;67:2202-2204. PMID: 31348530.

Care Team Perspectives and Acceptance of Telehealth in Scaling a Home-Based Primary Care Program: Qualitative Study

Andrzej Kozikowski[1], PhD; Jillian Shotwell[2], MPH; Eve Wool[2], MPH; Jill C Slaboda[3], PhD; Karen A Abrashkin[2], MD; Karin Rhodes[2], MD; Kristofer L Smith[2], MD; Renee Pekmezaris[1], PhD; Gregory J Norman[3], PhD

- Qualitative, 16 semi-structured interviews & 3 focus groups, NY-based HBPC program
- MD, RN, NP, care managers & coordinators, SW
- 4 Broad Themes:
  - Pros and cons of scaling
  - Technology impact on: staff autonomy, competence in providing care; patient-caregiver-provider relationship
- **Providers felt tech could broaden the reach, enable caregivers to engage more fully in care, and increase the amount of patient contact in HBPC**
- **Good use for mental health issues**

JMIR Aging. 2019 Jun 2;2(1):e12415.. PMID: 31518266

"There Is Something Very Personal About Seeing Someone's Face": Provider Perceptions of Video Visits in Home-Based Primary Care During COVID-19

Emily Franzosa[1,2], Ksenia Gorbenko[1], Abraham A. Brody[3], Bruce Leff[4], Christine S. Ritchie[5], Bruce Kinosian[6], Orla C. Sheehan[4], Alex D. Federman[1], and Katherine A. Ornstein[1]

- Qualitative, N=13 interviews: MD, NP, RN, Managers/clinical directors, SW at 6 NYC practices
- Provider perceptions of video visits – first wave of COVID
- Benefits – triaging patient needs, collecting patient information, increasing scheduling capacity
- **Barriers – cognitive and sensory abilities, technology access, reliance on caregivers and aides, addressing sensitive topics, incomplete exams**
- Need to consider how to integrate tech into practice
- Platform flexibility was essential

J Appl Gerontol. 2021;40:1417-1424. PMID: 34210200

Principles & Guidelines for Telehealth & Aging

Received: 11 August 2022 | Revised: 11 October 2022 | Accepted: 14 October 2022
DOI: 10.1111/jgs.18123

SPECIAL ARTICLES

Journal of the American Geriatrics Society

Development of telehealth principles and guidelines for older adults: A modified Delphi approach

Liane Wardlow PhD[1] | Bruce Leff MD[2] | Kevin Biese MD[3] | Carly Roberts MPH[1] | Laurie Archbald-Pannone MD[4] | Christine Ritchie MD[5] | Linda V. DeCherrie MD[6] | Neal Sikka MD[7] | Suzanne M. Gillespie MD RD[8] | The Collaborative for Telehealth and Aging

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[2]The Center for Transformative Geriatric Research, Johns Hopkins University School of Medicine, Baltimore, MD, USA
[3]Emergency and Geriatric Medicine, University of North Carolina Health, Chapel Hill, NC, USA
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[5]Palliative Care and Geriatric Medicine, Massachusetts General Hospital and Harvard University, Boston, MA, USA
[6]Clinical Strategy and Implementation, Medically Home, New York, New York, USA
[7]Emergency Medicine, The George Washington University, Washington, DC, USA
[8]AMDA The Society for Post Acute and Long Term Care, Columbia, MD, USA

Correspondence
Liane Wardlow, Clinical Research, West Health Institute, Rd La Jolla, CA 92037, USA.
Email: lwardlow@westhealth.org

Funding information
West Health Institute

Abstract

The COVID-19 pandemic elevated telehealth as a prevalent care delivery modality for older adults. However, guidelines and best practices for the provision of healthcare via telehealth are lacking. Principles and guidelines are needed to ensure that telehealth is safe, effective, and equitable for older adults. The Collaborative for Telehealth and Aging (C4TA) composed of providers, experts in geriatrics, telehealth, and advocacy, developed principles and guidelines for delivering telehealth to older adults. Using a modified Delphi process, C4TA members identified three principles and 18 guidelines. First, care should be person-centered; telehealth programs should be designed to meet the needs and preferences of older adults by considering their goals, family and caregivers, linguistic characteristics, and readiness and ability to use technology. Second, care should be equitable and accessible; telehealth programs should address individual and systemic barriers to care for older adults by considering issues of equity and access. Third, care should be integrated and coordinated across systems and people; telehealth should limit fragmentation, improve data sharing, increase communication across stakeholders, and address both workforce and financial sustainability. C4TA members have diverse perspectives and expertise but a shared commitment to improving older adults' lives. C4TA's recommendations highlight older adults' needs and create a roadmap for providers and health systems to take actionable steps to reach them. The next steps include developing implementation strategies, documenting current telehealth practices with older adults, and creating a community to support the dissemination, implementation, and evaluation of the recommendations.

KEYWORDS
equity, inclusion, health care delivery, technology, telehealth

Members of the Collaborative for Telehealth and Aging and their Affiliations are provided in Table S1.

The principles and guidelines reported here were previously presented at the Mid-Atlantic Telehealth Resource Center's Annual Meeting (May, 2022).

Principles for Telehealth & Aging

01 

Person-Centered

The older adult being served should be at the center of all decision-making. The older adults' care preferences, goals, wishes, abilities, support system, and conditions should be accounted for.

02 

Equitable & Accessible

Regardless of age, ability, socio-economic status, health literacy, technology literacy, and access, everyone should have equal access to the same level of high-quality care.

03 

Integrated & Coordinated

Systems should be set up to facilitate access to the info & support necessary to provide quality care to older adults. This includes cooperation and communication between and within systems and stakeholders.

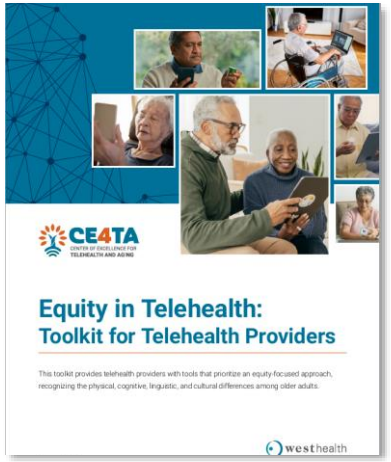
The Center of Excellence for Telehealth & Aging

CE4TA
CENTER OF EXCELLENCE FOR
TELEHEALTH AND AGING

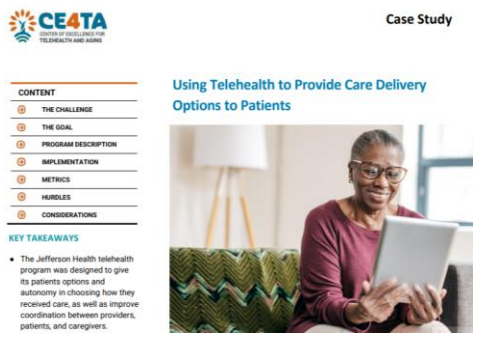
An open learning community that supports providers and organizations in delivering high-quality and effective care to older adults that accounts for their unique needs and supports their ability to age in place and live with dignity.

https://ce4ta.org/

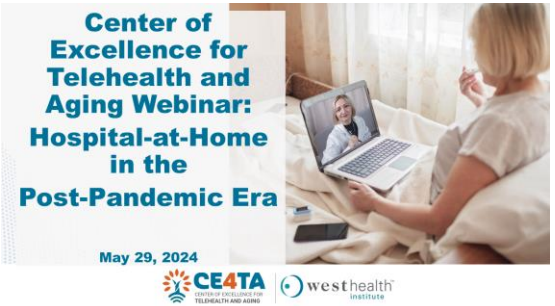
Toolkits & Guides

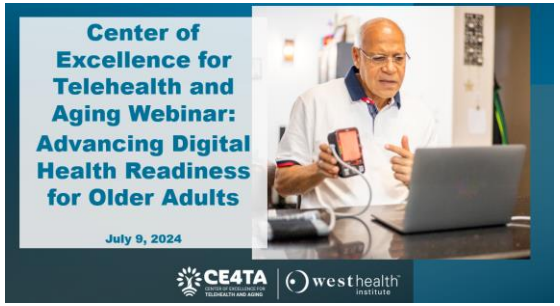


Case Studies



Webinars





Real World Application of Telehealth for People Living with Dementia and their Caregivers

For Persons Living with Dementia

Early Stages

- may be able to navigate technological hurdles (would assess and not assume)

Middle to Later Stages-

- will need assistance from a care partner or navigator
- accomodate verbal comprehension issues using simple sentences and questions
- provide visual cues

Real World Application of Telehealth for People Living with Dementia and their Caregivers

For Persons Living with Dementia

Diagnostic Assessment

- Use “blind” MOCA or TICS

Early Stages

- may be able to navigate technological hurdles (would assess and not assume)

Middle to Later Stages-

- will need assistance from a care partner or navigator
- accommodate verbal comprehension issues using simple sentences and questions
- provide visual cues

Real World Application of Telehealth for People Living with Dementia and their Caregivers

For Care Partners/Caregivers

Virtual may be much less taxing than in in-office visit

Management of behavioral symptoms

- may be able to observe symptoms in natural environment
- sensitivity requires to navigate dyadic dynamic/relationship

Management of caregiver stress

- 1 in 3 caregivers report depressive symptoms
- 20% have suicidal ideations
- Access to behavioral health providers key and often not feasible if in-person visit required

PMID: 35111579; 26593303

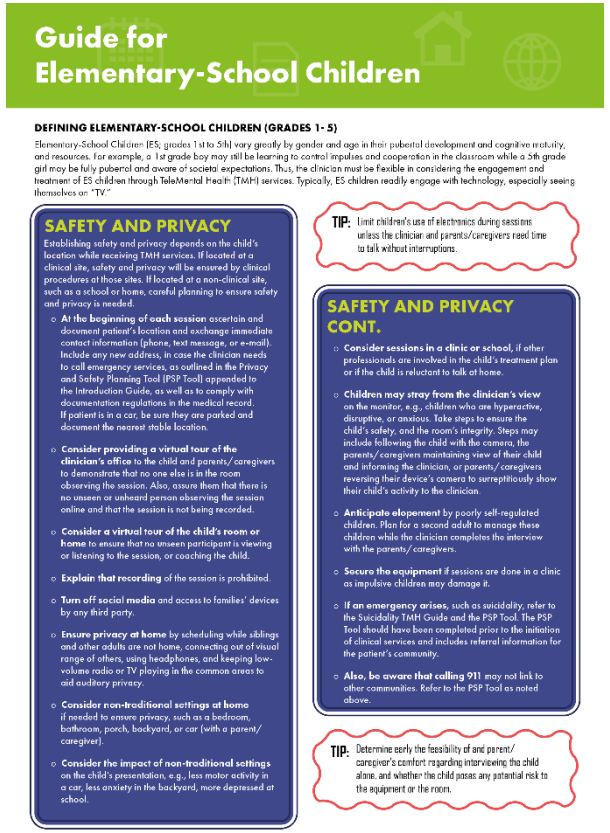
Summary

- The homebound is a large but unappreciated population
- Many would benefit from behavioral health support through telehealth
- Adaptations will be necessary to optimize quality of services and uptake

TeleMental Health Guides for Infancy to Young Adults

Guides (8)

- Infancy and Toddlers
- Pre-schoolers
- Elementary School Children
- Middle School Youth
- High School Teens
- Young Adults
- Neuropsychological Testing
- Suicidality



Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1- 5)

Elementary-School Children (ES; grades 1st to 5th) vary greatly by gender and age in their pubertal development and cognitive maturity, and resources. For example, a 1st grade boy may still be learning to control impulses and cooperation in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Thus, the clinician must be flexible in considering the engagement and treatment of ES children through TeleMental Health (TMH) services. Typically, ES children readily engage with technology, especially seeing themselves on "TV."

SAFETY AND PRIVACY

Establishing safety and privacy depends on the child's location while receiving TMH services. If located at a clinical site, safety and privacy will be ensured by clinical procedures at those sites. If located at a non-clinical site, such as a school or home, careful planning to ensure safety and privacy is needed.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patient is in a car, be sure they are parked and document the nearest stable location.
- **Consider providing a virtual tour of the clinician's office** to the child and parents/caregivers to demonstrate that no one else is in the room observing the session. Also, ensure them that there is no unseen or unheard person observing the session online and that the session is not being recorded.
- **Consider a virtual tour of the child's room or home** to ensure that no unseen participant is viewing or listening to the session, or coaching the child.
- **Explain that recording** of the session is prohibited.
- **Turn off social media** and access to families' devices by any third party.
- **Ensure privacy at home** by scheduling while siblings and other adults are not home, connecting out of visual range of others, using headphones, and keeping low-volume radio or TV playing in the common areas to aid auditory privacy.
- **Consider non-traditional settings at home** if needed to ensure privacy, such as a bedroom, bathroom, porch, backyard, or car (with a parent/caregiver).
- **Consider the impact of non-traditional settings** on the child's presentation, e.g., less motor activity in a car, less anxiety in the backyard, more depressed at school.

TIP: Limit children's use of electronics during sessions unless the clinician and parents/caregivers need time to talk without interruptions.

SAFETY AND PRIVACY CONT.

- **Consider sessions in a clinic or school,** if other professionals are involved in the child's treatment plan or if the child is reluctant to talk at home.
- **Children may stray from the clinician's view** on the monitor, e.g., children who are hyperactive, disruptive, or anxious. Take steps to ensure the child's safety, and the room's integrity. Steps may include following the child with the camera, the parents/caregivers maintaining view of their child and informing the clinician, or parents/caregivers reversing their device's camera to surreptitiously show their child's activity to the clinician.
- **Anticipate elopement** by poorly self-regulated children. Plan for a second adult to manage these children while the clinician completes the interview with the parents/caregivers.
- **Secure the equipment** if sessions are done in a clinic as impulsive children may damage it.
- **If an emergency arises,** such as suicidality, refer to the Suicidality TMH Guide and the PSP Tool. The PSP Tool should have been completed prior to the initiation of clinical services and includes referral information for the patient's community.
- **Also, be aware that calling 911** may not link to other communities. Refer to the PSP Tool as noted above.

TIP: Determine early the feasibility of and parent/caregiver's comfort regarding interviewing the child alone, and whether the child poses any potential risk to the equipment or the room.

TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

Abdul is a 10 y/o Afghani refugee boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and falling behind academically. The Mother noted similar difficulties in the home, especially regarding homework. Both parents worked and lived in an urban neighborhood with poor transportation options, so they agreed to home-based TMH. The family used their smartphone for the sessions, with adequate, but not optimal, cell reception. Sessions were held in the parent's bedroom, for privacy. An older sister watched the siblings in another room or took them for a walk.

Abdul was readily engaged over the smartphone and told of his favorite videogame, his love of Legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Even with the spotty connectivity, the clinician appreciated Abdul's good verbal skills, intellect, charming personality, as well his impulsive intrusiveness and mild mid-facial and guttural tic. To assess his gross motor skills, the clinician asked Abdul to do some movements, including some dance movements. He was awkward and had difficulty cooling down once wound up. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, Abdul was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly returned to the smartphone to show his artwork: not an animal, but he enthusiastically told of its meaning, demonstrating his creativity and knowledge.

The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services, and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

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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

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