

Preliminary report on best Telehealth practices for Pediatric Behavioral Health

Workplan

Engrossed Substitute Senate Bill 5092, Section 215(60)(a), Chapter 334, Laws of 2021

December 31, 2021

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Acknowledgements

This request is supported by the Children & Youth Behavioral Health Work Group and Representatives Lisa Callan, Frank Chopp, Lauren Davis, Debra Entenman, Roger Goodman, Kirsten Harris-Talley, Mari Leavitt, Marcus Riccelli, Alicia Rule, Lillian Ortiz-Self, My-Linh Thai, and Emily Wicks.

With special thanks to Dr. Kathleen Myers, Northwest Mental Health Technology Transfer Center Network, AAP, Molina, Valley Cities, HCA, Community Health Plan, Tribal State Court Consortium, Healthier Here, Family and Youth Voices for Empowerment, King County Community Collaborative, Salish FYSPRT, Thurston Mason Family Alliance for Mental Health, Beacon Health Options, North Sound Youth and Family Coalition, Greater Columbia FYSPRT, and the Northwest Behavioral Health Research Alliance.



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Background

The **Washington State Health Care Authority** has contracted with the Behavioral Health Institute at Harborview Medical Center to engage consumers, the UW CoLab/Evidence-Based Practice Institute, and other stakeholders to review current and emerging data and research and make recommendations regarding best practices for virtual behavioral health services to youth and young adults ages prenatal to age 25. The following workplan details the approach to prepare the initial and final reports of recommendations for best telehealth practices for pediatric behavioral health services.

Budget proviso

The TeleBehavioral Health [Budget Proviso](#) originated from work completed by the [Children and Youth Behavioral Health Work Group](#).

Rationale and needs

The intent of the proviso is to recommend best practices for remote behavioral health (TeleBH) services for prenatal through age 25. The aims of the recommendations are to:

1. Ensure ongoing TeleBH.
2. Examine clinically-effective ways to deliver TeleBH for various consumers, diagnoses, and treatments.
3. Identify safeguards for delivery of care across modalities (e.g., audio-visual, audio only).

Stakeholders

There are several provider stakeholder groups important to optimizing the access of children and young adults to TeleBH services including mental health service providers, clinical directors, and managers. The key stakeholder groups to be consulted in this work are policy experts, funder organizations, providers and provider organizations, consumer experts, and clinical synthesis experts (see figure below).

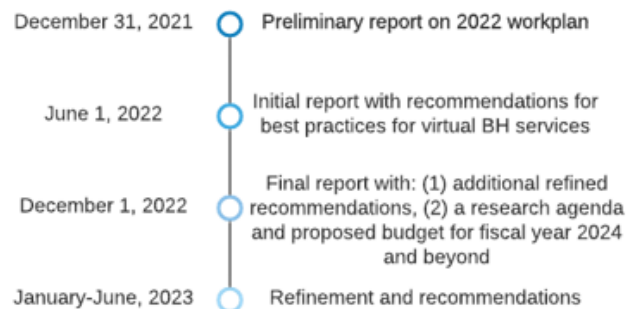
Key Stakeholder Groups



Timeline overview

Overall, work on this project will be broken down into four phases:

1. Development and submission of the workplan.
2. Data collection.
3. Evidence synthesis and draft of the initial report.
4. Modified Delphi process to build consensus around priorities and revision to the final report.



Scope of work

In this project, the Behavioral Health Institute, UW CoLab and Evidence-Based Practice Institute (EBPI) are charged with engaging key stakeholders to:

- **Review current and emerging data and research**, including:
 - The collection and analysis of data about clinical efficacy of behavioral health services and supports through virtual modes.
 - Methods for determining and maximizing the health benefits of the different virtual modalities.
- **Make recommendations regarding best practices for virtual behavioral health services to youth and young adults from infancy through age 25.** Focusing on:
 - The development of services and supports that deliver clinically effective outcomes for youth, young adults, and families.
 - Identifying safeguards for "in-person," "audio-video," and "audio only" modes.

While the initial scope of work specified an age range of prenatal through age 25, here we would like to suggest revising the scope of work to infancy through age 25. Prenatal behavioral telehealth involves such distinct stakeholders, provider types, and healthcare systems than infancy through young adulthood behavioral telehealth that it may not be feasible to include within this project given budget and timeline constraints. We ask that this recommendation be considered and further discussed.

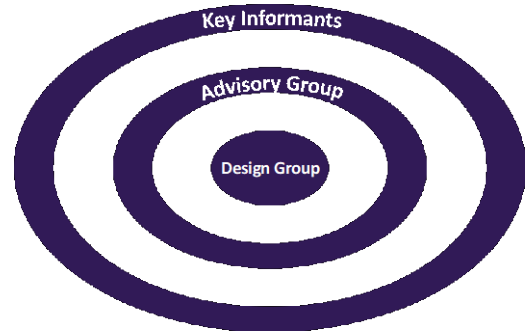
Based on initial stakeholder conversations with funder organizations, provider organizations, and consumer experts, we have chosen to prioritize three domains of best practices within this scope – 1) safety, 2) equitable access, and 3) broadly generalizable practices for maximizing clinical efficacy and health benefits.

Proposed methods

Overall, work on this project will include four phases: 1) development and submission of the workplan, 2) data collection, 3) evidence synthesis and draft of the initial report, 4) modified Delphi process to build consensus around priorities and revision to the final report.

Stakeholder roles and recruitment

Stakeholders are a key part of each of these phases. The following framework will guide our stakeholder engagement across all steps of planning, conducting, and disseminating this work. Each of our stakeholder groups (policy, provider organizations, funder organizations, consumer experts, and clinical synthesis experts) is represented as follows:



- At least 1-2 members from each stakeholder group are included in our Design Group, with whom we will meet monthly to seek feedback and suggestions on our synthesis methods, data sources and collection, contextual interpretation and analysis, and dissemination use cases. To date, we have recruited initial members of our Design Group and their input has helped inform the strategies and methods of this workplan, and we will continue to recruit additional Design Group members to meet the final target. This will include at least 3 consumer expert members to help ensure that every Design Group meeting has at least two attending consumer expert members, as prior work has shown that having such a peer can mitigate some of the challenges caused by the power dynamics in mixed groups.
- 2-5 members from each stakeholder group are included in our Advisory Group, who we will communicate with quarterly to seek feedback and suggestions on scope, priority questions, identification of additional stakeholders, and dissemination strategies. Depending on the preference of Advisory Group members, we may conduct meetings spanning multiple domains of Advisory Group stakeholders (funding organizations + provider organizations, for example), or we may meet with groups by domain if Advisory Group members have concerns that competing business needs or confidentiality concerns leave them unable to engage as fully in a mixed group setting.
- The number of key informants per stakeholder group will vary depending on the data collection strategy employed – for example, surveys afford larger numbers of participants than do focus groups or individual interviews. Likewise, the total pool of stakeholders is larger in some groups (such as consumer experts) than in other groups (such as funder organizations). Our proposed methods aim to include enough key informants from each stakeholder group to approach saturation (e.g., so that most topics or themes that would have arisen in even a larger group will have been addressed). As we identify additional gaps in the existing evidence base regarding best practices, we will likely target additional key informants for recruitment who can help us best elucidate best practices in those specific areas, settings, and/or populations.

Those stakeholders in the Design Group will also be eligible and encouraged to participate Advisory and Key Informant activities, and likewise those in the Advisory Group will also be eligible and encouraged to participate in Key Informant activities. Stakeholders will be recruited via the snowball method, with existing stakeholders asked to help identify additional stakeholders – both within their stakeholder group

and from other groups – who might bring substantially different experiences and perspectives. Targeted outreach will then be used to identify and recruit additional stakeholders from groups, settings, and backgrounds underrepresented in our initially recruited group, with an additional wave of snowball sampling perpetuating out from this group. In prior projects, this has proven an effective way of developing a stakeholder panel representing a broad range of experiences and perspectives and will allow data collection to efficiently reach saturation.

Some of our stakeholder groups have additional factors we will need to take into account in stakeholder recruitment and engagement. Given the age range of infancy to age 25, we will consider how to best engage consumers – children, adolescents, young adults, and parents/caregivers - to provide valuable input to the design process. In engaging with provider stakeholders, it will be important that we connect with private practice behavioral health providers (including psychiatrists, psychologists, social workers, counselors, and masters' level and pastoral therapists) as well as those who are agency or clinic affiliated. Although most providers in private practice initiated TeleBH service only when the pandemic necessitated an alternative to in-person care,³ they comprise a significant proportion of the total behavioral health workforce. Likewise, given that adolescents and young adults are commonly seen by adult behavioral health providers – and even younger children are currently treated by adult behavioral health in rural settings without access to pediatric behavioral health – it will be important to engage with adult providers as well as pediatric specific providers. Lastly, we will also want to include representation from referring providers, including primary care providers (PCPs) (pediatricians, family physicians, nurse practitioners, and physician assistants)¹ and school-based health providers.²

Review of existing evidence

Our review and synthesis of the existing published evidence will focus primarily on sources of data:

1. Clinical guidelines and best practices documents from relevant professional societies, including but not limited to the American Psychological Association (APA), the American Academy of Child and Adolescent Psychiatry (AACAP 2017), the American Academy of Pediatrics (AAP, 2016), and the American Telemedicine Association (ATA, 2009; 2010, 2017). Additionally, we will seek consultation regarding practical implementation issues from the National Consortium of Telehealth Resources Centers (www.telehealthresourcecenter.org), specifically the Northwest Regional Telehealth Resource Center (www.nrtrc.org), established by the Health Resources and Services Administration (HRSA).
2. Journal articles as found via PubMed and PsycInfo.
3. Reports published by governmental agencies (federal, state, and local) and related non-profit organizations, both within the United States and in countries with roughly similar behavioral healthcare delivery models.

As we anticipated, relatively little is available that is specific to pediatric behavioral telehealth, our review of the existing evidence across each of the above sources will also include best practices identified for adult behavioral telehealth, general pediatric telehealth, and early intervention and related developmental services as delivered via telehealth when those resources are appropriate and relevant.

We will perform a qualitative synthesis of this published evidence, seeking both to identify best practices and to identify the gaps in information (both overall and how it applies locally here in Washington State), so that our primary data collection can focus principally on those gaps.

Stakeholder convenings in the data collection phase

After our review of the published evidence regarding best practices in pediatric behavioral telehealth, we will seek to fill the gaps in this knowledge via surveys, focus groups, and individual interviews with key informants from our stakeholder groups. Stakeholder panel members from the consumer expert group will be paid for their time in participating across all stages of the project. All focus groups and interviews will be recorded and then transcribed with anonymous IDs replacing all participant names, workplaces, or other identifiers, after which the recordings will be destroyed to protect confidentiality of responses. Surveys will be completed anonymously, with the respondent entering a code that demonstrates they were indeed a recruited participant but with no link retained between the study code and any participant identifiers.

Focus group questions, interview guides, and surveys will be developed to target the gaps identified by the literature review and with input from our Advisory Group (about general topics) and Design Group (about specific questions and wording). Preliminary topics that have been identified so far for consideration in this phase based on initial stakeholder convenings include:

- Privacy and security concerns
- Patient safety
- Consent process
- Adaptations (e.g. televisit structure, frequency, and time)
- Patient-selected modality
- Provider capacity-building
- Equity and access
- Planning for TeleBH in Value Based Payment
- Building provider-patient rapport
- Technology limitations of families
- Treatment, therapy, and service compatibility with TeleBH
- TeleBH modality, e.g., real-time audio-visual, and audio only TeleBH
- Structural considerations, e.g., TeleBH to patient at home, TeleBH to patient at distant clinical site, TeleBH to school-based setting, etc.

Synthesis of the evidence

In addition to the initial qualitative synthesis of the literature review, we will also perform a thematic analysis of the data gathered from the focus groups, interviews, and surveys to identify and categorize additional best practices for pediatric behavioral telehealth.

We will then use a modified Delphi Panel approach with three rounds^{4,5}. The Delphi panel would include Advisory Group stakeholder members plus select key informants chosen to balance representation (including geographically across the state) where needed and to bring key expertise and lived experience around the gap areas (identified during the literature review) and priority areas (identified by the Advisory Group). In the first round, Delphi Panel members receive a report of preliminary findings regarding best practices, and are asked to respond to a survey regarding to what degree they agree with each item and whether they have concerns that any item has been misinterpreted or communicated unclearly, as well as whether they feel any critical elements have been left out. The report is then revised based on this feedback and sent out again for the second round, and Delphi Panel members are sent a survey asking

them to priority rank the identified best practices for which would have the greatest potential impact on patient safety, equitable access, and health benefits of care. The report is then revised based on this feedback and with the highest priority best practices identified, and sent out to the panel for the third round. For this round, interested Delphi Panel members participate in a meeting to collaborate on how best to communicate the identified high priority best practices, with a focus on enhancing clarity and facilitating action.

Dissemination products and strategies

The primary dissemination product will be the legislative report required by the budget proviso, including a two-page executive summary and a 20-40 page technical report. The report will be aimed at policy stakeholders and funder organizations, and will aim to include actionable recommendations where possible. We also intend to develop a 2-4 page summary aimed at provider organizations, a 1-2 page summary for consumer stakeholders, and a research journal article discussing the process and findings to increase the generalizability for behavioral health policy experts in other locations.

Detailed timeline

December 31, 2021

- A preliminary report on the 2022 workplan will be sent to the Health Care Authority and will include the report background, proposed methods, and project timeline.

June 1, 2022

- The initial report with best practice recommendations for virtual behavioral health services will be sent to the Health Care Authority. The report will be approximately 15-30 pages and will include sections such as synthesized literature, stakeholder recommendations, and a preliminary thematic analysis.

December 1, 2022

- The final 20-40 page technical report will be sent to the Health Care Authority and will include additional refined recommendations, a research agenda, and a proposed budget for fiscal year 2024 and beyond. We will also produce an accompanying executive brief summarizing the technical report and aimed at legislative, policy, and payer stakeholders; and a summary report for clinical providers and healthcare organizations focusing on key recommendations for implementation.

January through June 2023

- Six months will be spent refining and expanding on recommendations as needed. We will also produce one research manuscript for publication as a journal article, discussing the methods and outcomes of our work in producing these reports and how they could be utilized in other settings.

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