Statewide Demonstration of the Effectiveness of Mental Health-care via Telehealth Required Before New Rules and Presentation of "An Algorithm of Tele-Mental Health Care"

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SUMMARY

In March 2020, health agencies coordinated with government officials throughout the U.S. to offer telehealth services during the COVID-19 pandemic. For mental health providers such as OhioGuidestone, this offers an opportunity to evaluate our services and continue to build client-centered approaches to care. While telehealth can offer greater accessibility, even after emergency lockdown orders expire, we need to demonstrate the efficacy of services delivered via telecommunication, compare modes of delivery, and ensure clients and clinicians have necessary technological tools. Behavioral health experts can help guide researchers and policymakers toward evidence, evaluation, and implementation of expanded telehealth service delivery for mental health clients. This paper offers our preliminary experiences with expanded telehealth service, driving questions for research, and paths forward for future directions.

WHO SHOULD USE THIS PAPER

- Behavioral & mental health providers
- Managed care organizations & health insurance providers
- Clinicians & mental health workers
- Researchers in health-related fields
- Policymakers & program directors
- Behavioral health clients & client advocates

TAKEAWAYS & ACTION ITEMS

- While we have utilized telehealth in the past, the unprecedented state of emergency due to the 2020 pandemic has forced health agencies to expand telehealth services dramatically, including mental health.
- The efficacy of telehealth relative to in-person, face-to-face sessions is relatively unknown, as are comparisons between various modes of service delivery (e.g., videoconferencing versus audio-only phone calls).
- Researchers and policymakers should focus their attentions on determining evidence-based strengths and limitations of telehealth, not just for the current state of emergency but for best practices moving forward.
- If clinicians, clients, and/or providers find telehealth is a valuable, useful, and efficacious mode of mental health service delivery, then it should continue to be an option for clients receiving services.

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WHERE NEW PATHS BEGIN

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Introduction

Currently, mental health services in Ohio are approved for delivery in-person and via telehealth, including psychotherapy, case management, and therapeutic behavioral services (TBS) for clients in both mental health and substance use disorder (SUD) recovery programs. In March 2020, mental health providers quickly adopted telehealth to maintain access to care for clients following national and state declarations of emergency as well as legislative and policy changes removing previous restrictions to offer telehealth to all clients across multiple telecommunication modalities. In Ohio, an emergency amendment to rule 5122-29-31 expanded videoconference modalities, clarifying that audio and video platforms (such as Zoom or Lifesize), audio only (telephone calls), and electronic messaging (email, fax, or text messaging) could be used by licensed professionals and non-licensed paraprofessionals to deliver psychotherapy, TBS, and case management services to clients. This rule is set to expire

July 19, 2020 ; however, it is expected that new proposals for telehealth rules will be considered beforehand. As the new norm of mental healthcare is being considered, OhioGuidestone calls for efforts to demonstrate effectiveness of mental health service delivery via telehealth before any additional legislative changes be proposed and adopted that will definitively allow, or revoke, extensions covered in the current emergency rule.

OhioGuidestone supports continued approval and adoption of telehealth delivery of mental health services, but recognizes the need for evidence-informed decisions to better understand the clinical effectiveness of approved videoconferencing modalities. Additionally, client satisfaction with telehealth and preference should be evaluated. We pose several research questions to drive statewide demonstration before the expiration of Gov. Mike DeWine's executive order or before the adoption of any additional rule change that would alter how mental health services are delivered.

DEMONSTRATION OF TELEHEALTH EFFECTIVENESS FOR MENTAL HEALTHCARE RESEARCH QUESTIONS

- Relative to face-to-face service delivery, how effective is telehealth in improving the symptoms and functioning of clients receiving mental health intervention?
- What is the effectiveness of telehealth mental health services delivered via various communication modes relative to each other (i.e., synchronous vs. asynchronous, audiovisual vs. text, audiovisual vs. audio alone)?
- How do clients receiving mental health intervention prefer to engage in therapy and how do they rate telehealth relative to in-person services?
- What benefits/barriers do mental health service providers (professionals and paraprofessionals) observe in telehealth service delivery?
- What are the technological barriers to and/or needs for implementing telehealth mental health intervention?

We define client functioning as an externalized measure of the ability to navigate through daily life without being adversely impacted or displaced by symptomology (internal change). If telehealth is as effective in improving client functioning and symptoms, then it should remain and be adopted into new rules for mental health service delivery and fully covered by insurance companies, including Medicaid.

Furthermore, client preference should be the deciding factor for service delivery. If telehealth is demonstrated as effective in improving client functioning and symptoms but without greater or equal effectiveness as face-to-face delivery, then a stratification of effectiveness among the various modalities should be demonstrated. Thereafter, modality for delivery of care should be aligned with more clinical effective modalities when possible.

This paper presents OhioGuidestone's position on telehealth for mental health services, expanding the rationale of the identified research questions, and proposes an evidence-informed stratified approach to choosing telehealth modalities.

Relationship, Therapy, and Technological Limitations

Relationship is a common factor in psychotherapy that produces change. Our clinical model focuses on client-therapist relationship, attunement, nonverbal communication, implicit awareness, and intuitive awareness. During a session, a client may switch posture and put both feet on ground, and the therapist may observe the client's leg shaking and intuit that the client is becoming more aggravated. This awareness is intuited—the therapist didn't ask or inquire—and now is explicit because it has been verbalized in their own head. And this awareness presents without it having to be discussed or verbalized.

When services are delivered via telehealth, our implicit and intuitive awareness capacities are significantly limited. They aren't translated, either as well or at all, through technological processes because the provider can't observe the client's full body, complete gestures, and other important nonverbal communication cues. By the time the therapist sees activation in a client's upper body, it may too late. By the time that information gets that high in their body, the client may already be in a dysregulated state. Technology, therefore, limits our capacity to intuit and experience empathy and be mindful of the body. If relationships are so important, then we can assume that depending on technological options—such as used in telehealth—reduce the level of interpersonal relational cues. When using videoconferencing, people may engage in more socially inappropriate behaviors than in person. In a room together, people are overwhelmed with social connection cues that limit socially inappropriate behaviors. On a computer or other device, your focus narrows and impulsive behaviors may burst out, which can feel much more private when looking at a camera.

Audio-only services, such as delivered via telephone, will have even more limitations since the only nonverbal cues that providers can observe are auditory (e.g., breathing, emotionality, volume). And with text communication, nonverbal cues are absent entirely. If these tools are used clinically, they should be used in proportion to their relational value and balanced primarily with emergencies and urgencies. If, for example, a client texts "help me," "call me," "get me through this minute," or "I'm so mad," a text response can be beneficial. But then that moment should lead to a phone call, a video conference, and eventually face-to-face interaction, if possible.

Even when the new normal of telehealth is implemented, the predominate mode should be face-to-face whenever possible, then videoconferencing when in-person sessions aren't possible, then audio-only phone calls when needed for crisis management, and finally text messaging, respective to urgency. This hierarchical structure likely will prove to be the best method for determining service delivery. Even if clients find texting to be their preferred mode of communication, we expect this to be the least therapeutic intervention, on the whole.

Still, it is important to note that even with

texting, providers can engage a client, link them to services or offer crisis responses, and utilize case management. But if telehealth continues as it currently stands after the emergency rule expires, these interactions should be very short.

What We've Learned and What We Still Need to Know

Even now, most of our services are delivered with phone calls during the COVID-19 pandemic. Either clients, clinicians, or both clearly have an overwhelming preference to deliver services this way, with about 50-70% of services delivered via phone versus videoconferencing.

But is this a clinician or client preference? We need to find out, and we need to ascertain the effectiveness of clinical change, client improvement, and service delivery before making any lasting changes to the rules surrounding telehealth-delivered mental health services. Is it a matter of convenience, e.g., it's easier to hold a phone for a call rather than videoconferencing? If so, is that at least partly due to technological limitations, due to platform software, broadband access, and device capabilities? Are there preferred functions of phone calls that allow clinicians to move towards using that mode versus moving to videoconferencing? Is videoconferencing more aggravating and frustrating than a phone call?

As of publication, our staff's videoconference sessions with clients last longer on average than phone calls (about 40-50 minutes compared to 30-40 minutes, respectively). Whichever telecommunication mode is used—audiovisual or audio-only—we find that clients truly do engage in telehealth-delivered psychotherapy. This has demonstrated that our clients are not resistant or even seemingly reluctant to use this service. We need to determine further whether this is a phenomenon due to the pandemic or whether we have discovered, in general, a preferential way for our clients to engage in therapy. In a post-COVID-19 world, will clients still desire this menu of service delivery options?

It is highly likely that many clients and clinicians will want to return to face-to-face sessions as soon as possible, while others will want to continue telehealth. We also could discover that face-to-face services are useful or preferred for clients with greater intensity of symptoms or who prefer or respond to high levels of relational services.

So our questions include:

- How do our clients prefer to engage in the therapeutic process? If their preference is phone calls, then we should honor their preference.
- Are these modalities of equal effectiveness? Because if face-to-face is much more effective, then this should be recognized as well.

To answer these, we need to measure the effectiveness of these modalities to improve symptoms and functioning.

Measuring and Monitoring Client Outcomes

In our paper *Push for PROMs: Patient-Reported Outcomes Are Necessary for Evidence-Based and Client-Centered Community Mental Health Treatment*, we discuss the importance of measuring client outcomes with clear, straightforward questions that target specific critical domains of client functioning—primarily externalized, such as family functioning, crisis management, and substance use—and symptomology—primarily internalized, such as anger, depression, and anxiety (Pope et al., 2020).

Patient-reported outcome measures (PROMs) allow for client and, for child and youth clients, caregiver engagement and empowerment in clients' own treatment, assessment, and service delivery. While we utilize the National Institute of Health's PROMIS (Patient-Reported Outcomes Measurement Information System) questionnaire to measure client symptom levels, we had to develop our own tool to measure life functioning for clients that matched our theory of change and clinical model. These tools, implemented throughout client treatment at regular intervals by clinicians, give us data that help demonstrate the effectiveness of a variety of interventions, settings, and modalities. Therefore, PROMs can be used to ascertain the effectiveness of telehealth services as compared to in-person delivery.

Inherent in the therapeutic process is a constant assessment of functioning—asking "How are you doing?" versus "How are you feeling?" Organizations like ours must measure and monitor functional change for our clients, over time and long-term. A client's self-report of functioning is valuable for short-term recollection, but it's less valuable for long-term recollection (e.g., 6 months to a year later). This limits our capacity to compare change, both over time and long-term. A clinician might ask a client what they are doing now versus 6 months ago, but this will be more strongly influenced by a client's motivation for how they want to be functioning and what they want the clinician to hear. But, systematically and longitudinally, by collecting functioning data, we can validly monitor functioning change.

It's important to our entire structure that our clients experience functioning change. Supervisors equip staff with the skills and capacities to regularly facilitate longitudinal functional changes. Organizations, like us, want to know with confidence that we are effecting change in the lives of our clients and that we are doing something that works. And it matters to funders, who want demonstrable results that their funds are impacting real-world, valuable change. So systematically capturing client experiences around "How are you doing?" is actually very valuable for clients, clinicians, organizations, and funders.

Determining the Path Forward for Telehealth

Clients receiving mental health services may want to change their emotional/affective experiences, but they also want to change their functioning. They want symptoms reduced to a level where they do not adversely affect behavior or are displaced . That's the goal, and, if we can arrive there through several avenues, we should explore those pathways. If all service delivery modalities—telehealth or in-person, videoconferencing or phone call—are equally effective, then client preference should be the deciding factor for service delivery. If they are not equally effective, then we should direct clients to the more clinically efficient modalities when possible. This is true across all services, because all services that focus on behavioral health are focused on change and symptom reduction. Therefore, all are focused on functional change and the same theory of change we laid out earlier for attunement, relational processes, and co-regulation.

Telehealth should never be about avoiding client contact. But we should honor our clients' varying preferences, contexts, and needs. We must recognize that technology will always change, and we will need to adapt our services accordingly. New generations of clients may find that expressing themselves through texts and other telecommunications are familiar and comfortable or appropriate for specific situations. Still, we need our practices to be research-based and evidence-informed, so collecting evidence and conducting research around these service delivery modalities is paramount to responding to our current world, both culturally and contextually.

Given what do know and understand about therapeutic relationships, the importance of nonverbal communication, and change, we still prefer in-person services first, then videoconferencing, followed by audio-only phone calls, and finally text-based communications. However, any of these methods of service delivery can be valuable, integrated into treatment, and adaptable to differing contexts. It also may depend on the type of service provided. While psychotherapy is almost certainly most effectively delivered either in-person or through videoconferencing, support services such as TBS, case management, or certain SUD services not only can utilize telehealth services, they may be more efficiently delivered with these options in place.

It also is vital to note that some of the limitations to telehealth service delivery—especially videoconferencing—are determined by technological limitations. Clients, particularly those who utilize Medicaid, may not have access to adequate hardware and/or broadband connection. Clinicians may be limited by platform software depending on its performance and encryption capabilities. If telehealth is found to be effective and continues to be offered into the future—which appears to be a strong possibility—then clients and providers will need increased access to high-quality technological equipment and services.

We expect Ohio's emergency rule for telehealth to be extended beyond its July 19, 2020 expiration. The federal state of emergency may change, too, which could impact and potentially limit texting and phone calls

for service delivery. In this scenario, the Ohio Department of Medicaid would have to put in a federal request to the Centers for Medicare & Medicaid Services for a waiver to be able to provide these services. Whether or not the state of Ohio administration does extend and continue telehealth rules beyond their current emergency scope, then we recommend the following:

- Research to determine the effectiveness of telehealth-delivered mental health services.
- Research to determine the relative effectiveness of varying telehealth service delivery modalities, relative to the service provided (e.g., psychotherapy, TBS, etc.).
- Research to determine client and clinician preferences for service delivery.
- Research to determine client access to adequate technology, especially for those living in economically depressed neighborhoods and regions.
- Aware of the time and resource restraints needed to conduct this research and determine efficacy, we also call for the following:
- Indefinite continuation of telehealth options (or at least videoconferencing) for psychotherapy. This will allow us to determine over time the effectiveness of psychotherapy in various delivery modes.
- Indefinite continuation of all current telehealth options (videoconferencing, audio calls, and text communication) for behavioral health case management and support services, such as TBS, psychosocial rehabilitation, community psychiatric support treatment, SUD case management, and behavioral health nursing. This will allow us to determine over time the effectiveness of each service and offer greater efficiency of service delivery.

REFERENCES

Interactive videoconferencing, Register of Ohio (emergency filing March 20, 2020) (amended Ohio Admin. Code § 5122.29.31). http://www.registerofohio.state.oh.us/pdfs/5122/0/29/5122-29-31_PH_EM_AE_RU_20200320_1032.pdf

Ohio Gov. Executive Order 2020-05D (2020). https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/executive-order-2020-05d

Pope, B. R., Hu, I., D'Agostino, M., Yoder, W., & Fagan, E. (2020). Push for PROMs: Patient-reported outcomes are necessary for evidence-based & client-centered community mental health treatment. The Institute of Family & Community Impact.

Telehealth during a state of emergency, Register of Ohio (emergency filing March 20, 2020) (Ohio Admin. Code § 5160.1.21). http://www.registerofohio.state.oh.us/pdfs/5160/0/1/5160-1-21_PH_EM_NE_RU_20200320_1032.pdf

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