

COVID-19 Pandemic-Related Practices and Policies Affecting the Continuity of Behavioral Health Care Among Children With Diabetes

Lauren Clary,^{1,2} Christine Wang,¹ Meghan E. Byrne,³ Maureen Monaghan^{1,2}

¹Division of Endocrinology & Diabetes, Children's National Hospital, Washington, DC 20010, USA

²Departments of Psychiatry and Behavioral Sciences and Pediatrics, George Washington University School of Medicine, Washington, DC 20052, USA

³Uniformed Services University of the Health Sciences, Bethesda, MD 20814, USA

Correspondence to: L. Clary, lclary@childrensnational.org

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Abstract

COVID-19 has led to substantial challenges in continuing to deliver behavioral health care to all patients, including children with chronic diseases. In the case of diabetes, maintaining strong connections among children, their families, and their care team is essential to promote and sustain daily adherence to a complex medical regimen. The purpose of this paper is to describe COVID-19 pandemic-related practices and policies affecting the continuity of behavioral health care among children with diabetes. Challenges and opportunities were encountered at the provider, patient, and family levels throughout the rapid transition period from in-person to online care to ensure continuity of services. Institutional, regional, and national policies that impacted the care team's capacity to respond swiftly to patients' changing needs were counterbalanced by those related to standards of care, education and training, and resource constraints. At the policy level, COVID-19 re-exposed a number of long-standing and complicated issues about professional licensure among behavioral health providers at the local and state levels and national long-distance practice restrictions during times of crisis. Issues of insurance reimbursement and regulations intended to protect the public may need to adapt and evolve as the practice of behavioral medicine increasingly takes place remotely, online, and over great distances. The sudden transition to telehealth instigated by COVID-19, in addition to the increasing recognition of the benefits of telehealth to favorably affect the reach and impact of traditional behavioral medicine services, offers an unprecedented opportunity to reimagine the medical home and continuity of care for children with diabetes.

Keywords

Telehealth, Type 1 diabetes, Type 2 diabetes, COVID-19, Pediatrics, Behavioral health

INTRODUCTION

The COVID-19 pandemic and associated social distancing measures have led to widespread physical, emotional, social, and economic challenges in the lives of adults and children alike. As of June 2020, the global death toll is >420,000, with about one in four deaths occurring in the USA [1]. In response to this global crisis, the U.S. health care system encountered an immediate, unplanned mandate to reorganize itself to meet the needs of the acutely ill, as well as those with underlying chronic diseases. Here, we describe a number of key patient,

Implications

Practice: Telehealth with youth and families requires unique practice guidelines and considerations, particularly for youth with high medical needs.

Policy: Institutional, local, state, and national changes and support are required to facilitate continued behavioral health care delivery via telehealth to diverse populations.

Research: Continued scientific investigations are needed to identify patient characteristics (i.e., presenting issues, biopsychosocial-cultural factors, resources, and preferences) and telehealth elements (i.e., frequency, timing, devices, location, and hybrid with in-person sessions) associated with optimal behavioral health treatment outcomes.

practitioner, and policy adaptations that were necessary to continue delivering behavioral health care to children with diabetes, including those that are particularly pertinent to youth from underserved backgrounds. As those with underlying health conditions are known to be at greater risk for COVID-19 morbidities and mortality [2], it was imperative to consider a full range of social, psychological, medical, and regulatory issues that could affect the implementation of behavioral health services for this population, and to do so in ways that took advantage of technology and remote care delivery to protect patient safety and health.

IMPACT ON YOUTH AND FAMILIES LIVING WITH DIABETES DURING THE COVID-19 PANDEMIC

Diabetes is one of the most common pediatric chronic diseases in the USA. Youth with Type 1 or Type 2 diabetes engage in a number of complex self-management tasks on a daily basis for optimal diabetes management, including monitoring of glucose levels, insulin or oral medication

administration, and attention to diet, physical activity, and illness symptoms [3]. Due to the COVID-19 pandemic and related stay-at-home orders, youth living with diabetes and other chronic conditions were confronted with unique challenges to their disease management routines and necessary lifestyle modifications [4]. For example, youth with diabetes may have needed to develop alternative methods for healthy eating and physical activity. Most meals were eaten at home rather than at school, and many families purchased shelf-stable foods that are often highly processed and calorie dense [5]. Additionally, sedentary behaviors may have increased, as physical activity tends to decline during school breaks and most youth activities were severely restricted [5]. Moreover, compared to their peers, youth with diabetes are already at increased risk for anxiety, depression, and sleep problems, which negatively impact diabetes self-care and glycemic control [6–8]: these and other mental health concerns increased during COVID-19 [9, 10]. Anecdotally, patients report increased worries about access to life-saving medical supplies and their medical team and multiple concerns about COVID-19 infection risks and associated outcomes. Lastly, diabetes-specific social support is associated with both improved glycemic control and behavioral functioning [11]. Yet, social distancing orders resulted in reduced social engagement that could compromise youths' sense of belonging, independence, and control over their health and well-being. Thus, continuity of behavioral health care was essential to ensure that children with diabetes and other chronic diseases are afforded the same opportunities to receive ongoing education and counseling about their condition, self-management practices, and the impact of COVID-19 on their daily lives. We detail our experiences with behavioral health care during the early months of COVID-19 as an example for other programs similarly confronted with current and future challenges to telehealth service delivery.

BEHAVIORAL HEALTH SERVICES FOR CHILDREN WITH DIABETES

The diabetes program at our large, tertiary care children's hospital serves >2,000 youths with diabetes across the Washington, DC, metropolitan region; its catchment area includes surrounding states in the mid-Atlantic region, from Delaware to West Virginia. Behavioral health care is delivered by two licensed, doctoral-level psychologists, with additional support provided by predoctoral and postdoctoral trainees. Services include outpatient individual, family, and group therapy, inpatient and outpatient behavioral health consultations, and education and support for families newly diagnosed with diabetes.

MEDICAL AND BEHAVIORAL HEALTH CARE CHANGES DUE TO COVID-19

Departmental and institutional changes

In March 2020, due to COVID-19 and related stay-at-home orders, pediatric hospitals across the USA were confronted with the urgent need to maintain the continuity of pediatric care with reduced in-person contact. To address this immediate challenge, our institution quickly broadened telehealth access via a Health Insurance Portability and Accountability Act (HIPAA)-compliant video-conferencing system for all medical and behavioral health care divisions. Within our program, the majority of diabetes medical services shifted to telehealth, including routine medical visits, diabetes technology education classes, nutrition education, and follow-up for newly diagnosed families.

For the behavioral health team, COVID-19 marked a shift to the exclusive provision of services via telehealth. Our behavioral health program had utilized telehealth for select outpatient and family therapy services since 2017, with considerations including distance from the hospital, insurance coverage and reimbursement of telehealth, local availability of diabetes-informed mental health services, and clinical appropriateness. However, starting late March 2020, given the dearth of in-person mental health options and temporary expansion of insurance coverage, telehealth services were offered to all established patients.

The expansion of telehealth services required frequent, effective team-based communication and related communication supports for our diverse patient population. Division, department, and behavioral health program leaders initiated frequent electronic communications to discuss licensure regulation changes, training program developments, and COVID-19 resources and trainings. Our behavioral health team communicated electronically to discuss clinical services, newly diagnosed patient needs, and behavioral health materials specific to managing diabetes and increased stress during COVID-19. To facilitate patient care, a variety of language-based services and technology platforms enhanced the reach and impact of telehealth among families of varying socioeconomic levels, language preferences, and digital literacy levels. For example, our institution provided email translation services, language interpreters for telehealth sessions, and recurring personal meeting IDs to minimize patient burden.

Practitioner changes

Similar to other behavioral health teams embedded in medical teams within our institution and around the USA, multiple changes occurred to ensure safe, secure delivery of telehealth services and continuity of care. The American Psychological Association's (APA) Guidelines for Practice of Telepsychology provide guidance related to psychological telehealth

services [12]. Our behavioral health team incorporated these safeguards as done previously for patients seen remotely. For example, practitioners obtained and documented informed consent for telehealth during all sessions. To ensure safety, patients' physical address, nearest emergency room, and primary and emergency contact information were obtained from guardians. A communication plan was developed with patients and families in cases of technological malfunction. Furthermore, practitioners emphasized the importance of privacy to patients and their families and demonstrated their own measures taken toward ensuring privacy while outside of the clinic setting (e.g., headphones and private location).

Depending on the cognitive and social development of youth, it was important that socialization to telehealth be developmentally tailored. Therefore, clinicians utilized developmentally appropriate strategies to increase engagement for youth, including the inclusion of creative and movement-based activities (e.g., drawing and playing games on telehealth whiteboard) during sessions. Furthermore, managing behavioral concerns warranted telehealth-specific techniques, such as disabling the self-reflecting video to decrease distraction, allowing only the clinician to share the screen, and clearly organizing the session content.

Outpatient individual therapy, which accounts for a large proportion of our services, continued for many existing patients; however, behavioral health services were not limited to existing patients. Prior to COVID-19, our psychology team regularly provided behavioral health consultations to patients during routine diabetes medical appointments to address concerns that arose during the medical visit, such as family conflict, adjustment, or adherence concerns. Following the onset of COVID-19, our behavioral health team conducted consultations via telehealth (phone or video), but this was no longer possible to coordinate immediately following routine diabetes telehealth appointments.

An in-person group therapy treatment program for 10–13 year olds with Type 1 diabetes was adapted for telehealth delivery. After patients were informed of the modality change, 20% of initially interested patients declined participation due to insurance coverage/economic concerns or lack of privacy and adequate technology. The original content of the group curriculum focused on communication skills, managing diabetes, and coping with diabetes distress; content was adjusted to also cover COVID-19 impact.

Patient changes

Patient-level physical and social resources, as well as psychosocial characteristics, were considered when shaping telehealth services during COVID-19. For example, patients needed electronic devices,

wireless networking technologies, and private locations with physical addresses [13]. Additionally, guardians were required to consent to and participate in at least a portion of telehealth sessions with patients [14, 15]. Though telehealth with high-risk or suicidal patients has traditionally been discouraged, telehealth was offered to patients of all risk levels during COVID-19. As a safety precaution, we required guardians to be accessible and in the same physical location as high-risk patients (including pediatric patients over the age of 18) during all sessions.

Patients and/or their guardians can obtain the maximum benefit from and satisfaction with telehealth services when they have some level of digital/technological literacy and the necessary equipment to ensure a consistent connection. Data have historically demonstrated high patient satisfaction with telehealth among youth and adults [16]; however, dissatisfaction with audio-visual quality [17] and preference for in-person meetings [18] also have been reported. Anecdotally, while the majority of our patients were able to continue with telehealth, several pre-established patients could not successfully engage with telehealth due to barriers related to physical resources (e.g., lack of private space and no access to suitable technology device) and social resources (e.g., guardians could not be present for sessions), as well as their own preferences (e.g., some patients terminated treatment due to “burden” associated with telehealth and preference for resuming in-person visits when possible).

LOCAL, REGIONAL, AND NATIONAL POLICY CONSIDERATIONS DURING COVID-19

Telehealth access and technology

Careful consideration of local, regional, and national policy changes specific to COVID-19 and states of emergencies guided all clinical decisions. Given the aforementioned patient-level barriers to accessing telehealth, local jurisdictions attempted to mitigate barriers to device and internet access for children. For example, some jurisdictions temporarily prohibited termination of housing or utility services for late or nonpayments [19–21] and some school districts distributed hot spots and laptop computers to families without these physical resources for youth to access distance learning [22] and, therefore, also telehealth services. Additionally, some internet service providers offered temporary, free internet service to families meeting qualifications [23]. While these are important steps, it was clear that some of our patients were unable to secure devices, private spaces, and adequate internet connection for full telehealth benefit.

Licensure

Each jurisdiction in the USA has the duty to protect its citizens and, as such, has an independent

board of psychology that oversees state-specific licensure and professional practice requirements. Prior to COVID-19, a clinician was required to be licensed in the location where they physically provided in-person services. If providing services by telehealth, a clinician was required to be licensed in the jurisdiction of the patient's physical location. The immediate halt of in-person services exposed numerous, long-standing licensure challenges to service provision across state lines due to changes to the primary service location (now the patient's home) and temporary geographic mobility due to work, childcare, or other reasons.

As an example, the unique location of our institution requires understanding the professional licensure and practice requirements of the District of Columbia, Maryland, and Virginia (DMV) area. Each DMV jurisdiction created separate guidelines for telehealth. For example, MD passed interstate reciprocity, such that any person with a valid psychology license from another state could engage in provision of services to patients in MD if they applied for a temporary license (for a fee) and provided a list of current patients. VA allowed continued care across state lines with established patients, but required temporary licensure (free) or full licensure to see new patients. DC waived licensure requirements for clinicians licensed in other jurisdictions (in good standing) to allow for continuity of care for established patients. These changes evolved rapidly throughout March 2020 and continue to change as emergency orders are lifted, adding to confusion as some families travel across state lines and still wish to pursue telehealth services [24].

Importantly, during this confusing time, the psychology and legal departments worked together to clarify evolving licensure regulations and advocate for continued, expanded patient care, particularly for existing patients who lived across state lines. Our psychology faculty communicated with psychology licensure boards of the surrounding jurisdictions for clarification on COVID-19 provisions for care. We obtained assurance from current patients that they were located in DC, MD, or VA at the time of services based on the licenses held by their provider or supervisor for patients working with psychology trainees. Patients were asked to alert the clinician if they relocated to another jurisdiction, given our inability to provide services outside of the DMV region, a barrier that had not been in place for new patients previously willing to travel to the hospital for specialized behavioral care services for children with diabetes.

Insurance coverage and reimbursement

COVID-19 instigated rapid, temporary changes for telehealth reimbursement, allowing many of our patients previously unable to access telehealth to do so during this crisis. By the end of March 2020,

Medicare and Medicaid allowed patients' homes to serve as originating sites for telehealth [25] and commercial and public insurance programs expanded reimbursement for many telehealth services. Prior regulations related to parity ensured that telehealth services were reimbursed at the same amount as in-person services [26, 27]. Increasing access to care was also addressed at a national level. In March 2020, the U.S. Department of Health and Human Services temporarily suspended potential penalties for HIPAA violations to encourage providers to deliver necessary care, even if they did not have access to HIPAA-compliant telehealth platforms [28]. Anecdotally, barriers to coverage still occurred under the temporary expansions of coverage, primarily at the onset of the crisis for patients generally seen in person. For example, one insurance provider representative indicated that a family would only be able to receive covered services if a specific telehealth platform was used during behavioral health care sessions. However, when informed that our telehealth platform was HIPAA secure and used throughout the hospital, insurance coverage was authorized.

PREDOCTORAL PSYCHOLOGY TRAINING CONSIDERATIONS DUE TO COVID-19

There were multiple challenges for psychology trainees to participate in telehealth services, including conflicting information about providing services to established versus new patients, uncertainty about accumulating enough supervised practice hours for internship or licensure, and interacting with patients, supervisors, and medical team members solely through virtual methods. There are, however, benefits to gaining telehealth competencies early in their careers, especially as models of care shift during this time and likely following as well [29].

While licensed psychologists were able to provide telehealth immediately after remote work was encouraged in mid-March 2020, supervised, unlicensed trainees waited 2 weeks until trainee delivery of telehealth was clearly approved based on decisions made by local jurisdictions and our institutional legal team. As needed, patients seen by trainees met with the supervising, licensed psychologist to prevent a gap in care. Initially, the supervising, licensed psychologist was present for the entirety of each trainee's telehealth sessions; however, eventually, trainees were able to independently conduct telehealth (with a licensed supervisor available to join sessions as needed).

IMPLICATIONS AND FUTURE DIRECTIONS

Practice

The benefits of telehealth with youth have been documented [14–16], including reduced costs, time, and stigma, as well as increased coordination of care,

access to specialty care, and flexibility and convenience. Certainly, connection to a care team during and outside of times of crises is crucial for children and families with chronic illness, and telehealth was the only means of doing so for many. However, delivery of telehealth with youth also poses a number of challenges, with specific practice considerations and implications (Table 1) [30]. We share our behavioral health program's experience during COVID-19 as an example, highlighting key practice and policy considerations that guided rapid program adaptation. This experience can inform current and future care for youth with chronic conditions and raises issues related to continuity of care, licensure, and insurance coverage and reimbursement that must be addressed beyond the temporary protections under the COVID-19 states of emergency.

Practitioners had to quickly learn and utilize new strategies to engage with youth and parents via telehealth and incorporate challenges due to COVID-19 into sessions. Furthermore, providing telehealth to youth and young adults with safety concerns presents ethical, clinical, and legal dilemmas. It is vital that clinicians discuss safety, privacy, and confidentiality initially and throughout treatment, particularly when working with adolescents. Ensuring that roles and responsibilities are clarified upfront with the patient and supervising adults (e.g., parent and teacher), who is present and available at the time of the telehealth session is paramount.

While telehealth can expand behavioral health reach and impact, the "digital divide" persists, and children from lower socioeconomic status (SES), rural, ethnic minority, and non-English speaking backgrounds are less likely to have internet access and other technologies [31]. Telehealth is not a panacea if disadvantaged populations cannot access the technology required of telehealth and it is important to directly address these disparities [13]. For example, the Society of Behavioral Medicine has advocated for expansion of high-speed internet access to rural communities and underserved areas across the USA to ensure access to the technology needed for telehealth [32].

Several strategies can enhance benefits and reduce the drawbacks of telehealth moving forward. One, access to care will be enhanced if hospitals, agencies, and/or governmental bodies provided families with the physical resources needed to engage with telehealth [13]. Two, modifying the location, timing, and frequency of telehealth sessions can further reduce barriers [13]. For example, telehealth has been successfully delivered to patients located at community clinics or schools and, for some families, a hybrid of in-person and telehealth sessions may be optimal [15]. Three, it would further decrease barriers if institutional bodies offered tailored support and resources to enhance digital literacy skills among families, as has been implemented by

medical trainees during the COVID-19 pandemic [33] and by on-site staff members prior to COVID-19 [15]. Four, delivery of telehealth via telephone may increase access for families without videoconferencing/internet capabilities or comfort with videoconferencing technology [13]. Telephone has been shown to be an efficacious modality with youth comparable to in-person and videoconference modalities [14, 15]. Of note, Medicaid approved reimbursement for provision of telehealth services by telephone during the COVID-19 pandemic [34].

Overall, telehealth will likely be used more frequently than prior to the onset of COVID-19 and clinicians may be providing more cross-state care to patients, especially those seen in specialized medical and behavioral health care clinics. Updated practice guidelines are needed to clarify the clinical, ethical, and legal obligations relevant to identifying which patients are appropriate and eligible for such cross-state telehealth services and how to address emergent issues that may make telehealth clinically inappropriate (e.g., changes in patient presentations).

Policy

APA telehealth guidelines inform psychologists of their obligation to be familiar with and comply with all regulations and laws when providing telehealth across state (or national) lines [12]. The rapid uptake of telehealth services due to COVID-19 has drawn attention to the complicated nature of the current system. Unfortunately, due to interjurisdictional licensure challenges and confusion, many pediatric patients at our institution went weeks without access to established mental health care. Our experiences support the need for a national licensure credential or portability of licensure status across state lines. Other professions, such as nursing, allow nurses to practice in other states under a Nursing Licensure Compact without obtaining additional state licenses [35]. The Association of State and Provincial Psychology Boards Psychology Interjurisdictional Compact Taskforce was introduced in early 2015 with the goal of protecting the public in each participating state in the Compact and allowing for interjurisdictional practice across participating states (telehealth and in-person services). However, few states have enacted legislation to make multijurisdictional credentialing a viable option for most providers [36]. In light of the current lifting of emergency orders in some states, licensure policies again need to be addressed. It is important for jurisdictions to provide clear guidelines on allowable services beyond the temporary license period, particularly for telehealth, and to consider the provider burden and associated costs with maintaining multiple state licenses. Many patients and families, particularly those with complex medical presentations, will likely desire continued telehealth services due to safety concerns and convenience.

Table 1 | Key practice and policy challenges and responses resulting from the transition to virtual delivery of services within a pediatric diabetes behavioral health program

Challenges	Response
Practitioner level	
<ul style="list-style-type: none"> Ethical, clinical, and legal dilemmas in providing telehealth to patients with safety concerns 	<ul style="list-style-type: none"> Discussed privacy measures and confidentiality up front and throughout treatment Obtained and documented consent for each telehealth visit Obtained patients' physical address at the time of the session, nearest emergency room, and primary and emergency contact information Created communication plan for technological difficulties
<ul style="list-style-type: none"> Barriers to providing behavioral health consultations to patients during routine diabetes medical appointments Inclusion of challenges and impact of COVID-19 in individual and group treatment 	<ul style="list-style-type: none"> Conducted consultations via telehealth following medical visits (with some delay for coordination of session) Adjusted session content to include COVID-19 topics related to stress, communication, coping strategies, and diabetes management
Patient level	
<ul style="list-style-type: none"> Managing behavior and maintaining engagement virtually 	<ul style="list-style-type: none"> Provide developmentally tailored socialization to telehealth Incorporate visual aids, as well as creative and movement-based activities
<ul style="list-style-type: none"> "Digital divide": youth from disadvantaged backgrounds have less access to technologies 	<ul style="list-style-type: none"> Advocacy for expansion of high-speed internet access to rural and underserved communities Provide families with physical resources and digital literacy skills needed to engage with telehealth Ensure accessibility to interpretation services for telehealth with families from non-English speaking backgrounds
Policy	
<ul style="list-style-type: none"> Providing services in multiple jurisdictions, with little or no prior notice 	<ul style="list-style-type: none"> Advocacy for a national licensure credential or portability of licensure status across state lines to allow clinicians to broaden access to care
<ul style="list-style-type: none"> High financial burden of maintaining multiple state licenses 	<ul style="list-style-type: none"> Institutional provision of necessary technological and financial supports to encourage continuation of telehealth
<ul style="list-style-type: none"> Insurance carriers may end telehealth reimbursement coverage for mental health visits during or following COVID-19 	<ul style="list-style-type: none"> Incorporate reimbursement of telehealth into standard benefits for policy holders

The COVID-19 pandemic has forced commercial and public insurance companies to approve and reimburse telehealth visits, and it is not clear if these changes will be permanent. Patients would benefit from continued or enhanced access to telehealth, and it is recommended that these reimbursement practices are offered as standard benefits for policy holders. Patients rely on insurance coverage for mental health visits, and it is concerning that some insurance carriers may end reimbursement of telehealth coverage, leading to increased barriers to mental health services as high levels of stress and uncertainty will likely persist.

CONCLUSION

The sudden transition to telehealth instigated by COVID-19 has presented multiple opportunities and challenges to clinical practice and behavioral health care. We have had a unique opportunity to recognize the feasibility and acceptability of providing telehealth to many patients and families in our practice, but barriers to care still exist. Mental health professionals require clear guidance from institutions, licensure boards, lawmakers, and insurance providers as we proceed with next steps as this crisis continues.

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Compliance with Ethical Standards

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References

- Johns Hopkins University and Medicine (Producer). COVID-19 dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU). 2020. Available at <https://coronavirus.jhu.edu/map.html>. Accessibility verified June 13, 2020.
- CDC COVID-19 Response Team. Preliminary estimates of the prevalence of selected underlying health conditions among patients with coronavirus disease 2019—United States, February 12–March 28, 2020. *Morb Mortal Wkly Rep.* 2020;69(13):382–386.
- American Diabetes Association. 13. Children and adolescents: Standards of medical care in diabetes—2020. *Diabetes Care.* 2020;43(suppl 1):S163–S182.
- Gostin LO, Wiley LF. Governmental public health powers during the COVID-19 pandemic: Stay-at-home orders, business closures, and travel restrictions. *JAMA.* 2020;323(21):2137–2138.
- Rundle AG, Park Y, Herbstman JB, Kinsey EW, Wang YC. COVID-19–related school closings and risk of weight gain among children. *Obesity.* 2020;28(6):1008–1009.
- Buchberger B, Huppertz H, Krabbe L, Lux B, Mattivi JT, Siafarikas A. Symptoms of depression and anxiety in youth with type 1 diabetes: A systematic review and meta-analysis. *Psychoneuroendocrinology.* 2016;70:70–84.
- Reutrakul S, Thakkinstian A, Anothaisintawee T, et al. Sleep characteristics in type 1 diabetes and associations with glycemic control: Systematic review and meta-analysis. *Sleep Med.* 2016;23:26–45.
- Silverstein J, Cheng P, Ruedy KJ, et al.; Pediatric Diabetes Consortium. Depressive symptoms in youth with type 1 or type 2 diabetes: Results of the pediatric diabetes consortium screening assessment of depression in diabetes study. *Diabetes Care.* 2015;38(12):2341–2343.
- Holmes EA, O'Connor RC, Perry VH, et al. Multidisciplinary research priorities for the COVID-19 pandemic: A call for action for mental health science. *Lancet Psychiatry.* 2020;7(6):547–560.
- Altena E, Baglioni C, Espie CA, et al. Dealing with sleep problems during home confinement due to the COVID-19 outbreak: Practical recommendations from a task force of the European CBT-I Academy. *J Sleep Res.* 2020;e13052:1–7.
- Wang YC, Stewart S, Tuli E, White P. Improved glycemic control in adolescents with type 1 diabetes mellitus who attend diabetes camp. *Pediatr Diabetes.* 2008;9(1):29–34.
- Joint Task Force for the Development of Telepsychology Guidelines for Psychologists. Guidelines for the practice of telepsychology. *Am Psychol.* 2013;68(9):791–800.
- Nouri S, Khoong EC, Lyles CR, Karliner L. Addressing equity in telemedicine for chronic disease management during the Covid-19 pandemic. *NEJM Catal Innov Care Deliv.* 2020;1(3):1–13.
- Slone NC, Reese RJ, McClellan MJ. Telepsychology outcome research with children and adolescents: A review of the literature. *Psychol Serv.* 2012;9(3):272–292.
- Nelson EL, Patton S. Using videoconferencing to deliver individual therapy and pediatric psychology interventions with children and adolescents. *J Child Adolesc Psychopharmacol.* 2016;26(3):212–220.
- Ignatowicz A, Atherton H, Bernstein CJ, et al. Internet videoconferencing for patient-clinician consultations in long-term conditions: A review of reviews and applications in line with guidelines and recommendations. *Digit Health.* 2019;5:2055207619845831.
- Taylor A, Morris G, Pech J, Rechter S, Carati C, Kidd MR. Home telehealth video conferencing: Perceptions and performance. *JMIR Mhealth Uhealth.* 2015;3(3):e90.
- Almathami HKY, Win KT, Vlahu-Gjorgievska E. Barriers and facilitators that influence telemedicine-based, real-time, online consultation at patients' homes: Systematic literature review. *J Med Internet Res.* 2020;22(2):e16407.
- State Corporation Commission. SCC directs electric, natural gas and water companies to suspend service disconnections during COVID-19 state emergency. 2020. Available at <https://www.scc.virginia.gov/newsreleases/release/2020-00048>. Accessibility verified June 12, 2020.
- The Office of Governor Larry Hogan. Governor Hogan orders closure of bars and restaurants, announces unprecedented public health surge to combat COVID-19 crisis. 2020. Available at <https://governor.maryland.gov/2020/03/16/governor-hogan-orders-closure-of-bars-and-restaurants-announces-unprecedented-public-health-surge-to-combat-covid-19-crisis/>. Accessibility verified June 12, 2020.
- Fenit Nirappil ML. D.C. Council freezes rent hikes but omits undocumented immigrants from covid-19 relief bill. 2020. Available at https://www.washingtonpost.com/local/dc-politics/dc-council-freezes-rent-hikes-but-omits-undocumented-immigrants-from-covid-19-relief-bill/2020/04/07/407d506a-78f5-11ea-a130-df573469f094_story.html. Accessibility verified April 7, 2020.
- WTOP News. Maryland's largest county loans laptops to students for remote learning. 2020. Available at <https://wtop.com/montgomery-county/2020/03/marylands-largest-county-loans-laptops-to-students-for-remote-learning/>. Accessibility verified June 12, 2020.
- Fortek J. Utilities suspend service disruptions; cable providers expand access during coronavirus outbreak. 2020. Available at https://www.insidenova.com/news/utilities-suspend-service-disruptions-cable-providers-expand-access-during-coronavirus-outbreak/article_e0a17a58-6851-11ea-b4df-8bc17d4e3d2b.html. Accessibility verified June 12, 2020.
- Association of State and Provincial Psychology Boards. Temporary/telepsychological practice and COVID-19. 2020. Available at https://cdn.ymaws.com/www.asppb.net/resource/resmgr/covid19/6.3.2020_temporary_&_telepsy.pdf. Accessibility verified June 10, 2020.

25. Centers for Medicare & Medicaid Services. Medicare telemedicine health care provider fact sheet. 2020. Available at <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicinehealth-care-provider-fact-sheet>. Accessibility verified June 10, 2020.
26. Barnett ML, Ray KN, Souza J, Mehrotra A. Trends in telemedicine use in a large commercially insured population, 2005-2017. *JAMA*. 2018;320(20):2147–2149.
27. Yang T. Health policy brief: telehealth parity laws. *Health Affairs*. 2016;1–5. Available at: https://www.healthaffairs.org/doi/10.1377/hpb20160815.244795/full/healthpolicybrief_162.pdf. Accessibility verified June 10, 2020.
28. US Department of Health & Human Services. Notification of enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency. 2020. Available at <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>. Accessibility verified June 10, 2020.
29. Saenz JJ, Sahu A, Tarlow K, Chang J. Telepsychology: training perspectives. *J Clin Psychol*. 2020;76(6):1101–1107.
30. Seager van Dyk I, Kroll J, Martinez R, Emerson N, Bursch B. COVID-19 tips: Building rapport with youth via telehealth. 2020:1–2.
31. Dolan JE. Splicing the divide: a review of research on the evolving digital divide among K–12 students. *J Res Technol Educ*. 2016;48(1):16–37.
32. Ford S, Buscemi J, Hirko K, et al. Society of Behavioral Medicine (SBM) urges congress to ensure efforts to increase and enhance broadband internet access in rural areas. *Transl Behav Med*. 2020;10(2):489–491.
33. Triana AJ, Gusdorf RE, Shah KP, Horst SN. Technology literacy as a barrier to telehealth during COVID-19. *Telemedicine and e-Health*. 2020:1–2. doi:10.1089/tmj.2020.0155
34. American Psychological Association. Temporary changes to federal Medicare telehealth policies. 2020. Available at <https://www.apaservices.org/practice/reimbursement/government/medicare-telehealth-temporary-changes>. Accessibility verified June 10, 2020.
35. National Council of State Boards of Nursing. Nurse Licensure Compact (NLC). 2020. Available at <https://www.ncsbn.org/nurse-licensure-compact.htm>. Accessibility verified June 10, 2020.
36. PsyPact. PsyPact Map. 2020. Available at <https://psypact.org/page/psypactmap>. Accessibility verified June 10, 2020.