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Editorial: Transition to Telehealth for Mental Health Clinics: Future Considerations

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The acute mental health demands during the COVID-19 pandemic galvanized early adoption of telehealth for care delivery in all medical settings. This is even more so for the field of psychiatry.¹ Whether an established telehealth program existed or not, the abrupt lifting of regulations and urgent need for access to care opened the telehealth flood gates. While video visits and telephone visits improved immediate access to care, they simultaneously challenged our ability to structure, organize, educate, operationalize, and track such visits.¹ This swift shift in health care delivery forced providers, health care systems, and patients into a nationwide experiment to learn what works well via telehealth and what does not. The ground-breaking article by Folk *et al.*² focuses on challenges and successes for a new shared phenomenon: the sudden pivot from in-person to video/telephone care. We examine the data collected by this consortium and compare it with our own experience at UPMC Western Psychiatric behavioral health outpatient settings, both academic and rural.

In this nonrandomized retrospective study, 8 academic child and adolescent psychiatry programs (7 in the United States and 1 in Canada) evaluated their transition to telehealth during the height of the COVID-19 pandemic compared with a parallel time frame in 2019.² Telehealth was defined as real-time telephone or videoconferencing. Sites noted that during the pandemic the originating site (ie, location of the patient) for most services was at home or another nonclinic location. The consortium sites completed surveys characterizing their clinical services, telehealth services, and use of services and identified barriers to implementing telehealth visits. There was attention to bias mitigation, with strategies such as weighting of survey responses based on program size and exclusion of preexisting telepsychiatry services. Results showed that within 2 weeks all sites shifted abruptly from in-person care to some form of telephone or video visits. While access to video and telephone follow-up visits

resumed quickly, some locations experienced delays in new intake access, and many sites struggled with implementing group therapy via video visits. Videoconferencing platforms varied across sites, with Zoom being used by 56%. Before COVID-19, 78% of sites provided some videoconferencing services, but with restrictions for originating site (location of the patient) and distant site (location of the provider): 71% required the provider to be in the clinic, and 57% required the patient to come to a designated clinical location. Direct-to-consumer telehealth (ie, patient in their home or preferred location) was not common before COVID-19. Regulatory variability was noted across sites, states, and the country. Most common identified barriers to telehealth delivery before COVID-19 included regulatory limitations and insurance billing challenges. After COVID-19 onset, the most common barriers to telehealth centered around patients lacking access to devices needed for telehealth or reliable internet. Other notable barriers after COVID included concern for liability, patient's technology comfort level, patient training for technical assistance, diagnosis, age, and inability to write electronic prescriptions for controlled medications.

Folk *et al.* identified limitations in the study, including the nonrandomized sampling of programs, minimal focus on rural settings, data gathering challenges during the crisis, retrospective data collection, and the potential for error when data concerning visit types and billing codes are extracted from electronic medical records.² The authors also acknowledged that not all sites differentiate between telephone and video visits. The pandemic provided an unprecedented opportunity for the technological transformation of health care delivery, and these types of studies can help us adapt care in data-driven ways.

As noted by the authors, the transition from in-person to video group therapy was challenging in many sites. An additional consideration for the next iteration of this study is to examine strategies for group therapy via video—

specifically how this service implementation differs from individual video visits. We evaluated this domain within our psychiatric department and hope that our observations help inform a better way forward in this hybrid space.

The UPMC Western Psychiatric Behavioral Health Service Line, part of the University of Pittsburgh Department of Psychiatry, averages more than 30,000 outpatient visits per month, including psychiatric care, individual therapy, group therapy, case management, and so on. The extensive group therapy footprint across this academic and rural network consists of 45 intensive outpatient program tracks (3 days per week, 3 hours per day, average of 10 patients per group), 10 partial programs (5 days per week, 5 hours per day, average of 10 patients per group), and more than 80 weekly groups. At the start of the COVID-19 pandemic, we too experienced unique challenges for video group therapy specifically. Given that this level of care is a core component of our behavioral health services, there was shared motivation among providers, clinicians, and patients to make this work. Our telepsychiatry and behavioral health leadership solved several impediments that surfaced. Four main problems and solutions are highlighted below:

- **Problem:** Video platforms set up before COVID-19 did not account for sessions lasting 5 hours, greater than 10 participants, and the need to display all faces at once. **Solution:** Through provider and patient feedback, the behavioral leadership team as well as the broader UPMC telemedicine team found that Vidyo, Microsoft Teams, and Zoom all fulfilled these requirements,¹ though some of the platforms required modifications or upgrades to allow for extended length of sessions. One of the main limitations identified is the need for a reliable internet connection and appropriate patient devices.
- **Problem:** Workflows for setup and connection differed from individual video visits. **Solution:** The leadership team incorporated patient and provider feedback to create specific instructions for scheduling group sessions and connecting.¹ We held office hours weekly during the first 9 months of the pandemic to troubleshoot problems and disseminate workflows. Care was taken to avoid group e-mail invites to keep participant e-mail addresses private. A limitation remains that after COVID we will need to adapt to a new workflow, likely hybrid video and in-person visits.
- **Problem:** Privacy considerations for group visits differed from individual video visits. **Solution:** Group leaders reviewed the chat function with participants, specifically

when to use it, when it is not private, and how it will be monitored. Group leaders also encouraged patients to limit identifiers when entering their screen name, and guidelines were set to ensure that each participant was in a private location.

- **Problem:** Engagement during groups can be difficult. **Solution:** Group therapy leaders transitioned all education materials to screen share options, e-mailing information ahead of time and being mindful to maximize time for patients to see each other for optional engagement.¹ Several clinical leaders shared their lessons learned and “websites” manner tips through our weekly office hours, allowing for fastest adoption of group therapy across the system.¹ A limiting factor is that as a field we need to continue to investigate when an in-person connection is still optimal (eg, play therapy for younger children or for parent–child sessions).

We successfully shifted greater than 90% of our groups to video visits during the initial months of the COVID-19 pandemic.

As we move forward with telehealth for psychiatry, the solution is “one size does not fit all.” Providers, not regulators, should guide what type of visit modality facilitates best medical care. Providers practice under the minimum standards set forth by their licensing bodies and best practices in the field. Video visits are a vehicle for delivering care, not a new type of treatment.³ Going forward there will continue to be scenarios when video visits, telephone visits, or in-person visits make more sense for an individual. Choosing one of those vehicles does not change the provider’s responsibility of care to the patient. Moving to a hybrid of video visits and in-person visits is the most likely outcome after COVID. The ratio should be left in the hands of the provider, who is responsible for the quality of care and who understands the nuances that may impact whether a patient should attend a video or in-person visit.

Our collective experience during the pandemic is unprecedented. It is hard to find a similar health care scenario with this sudden halt to the way care is delivered without allowance for planning, piloting, or evaluating. An analogy might be if the country suddenly mandated electric cars starting tomorrow. We still know how to drive safely and the rules of the road, but do we have the right equipment, charging stations, operational understanding, and awareness of strengths and limitations? As such, we all sit at the starting line for a new era of health care. What lessons should we apply to care delivery going forward? Who will take the lead in this race, and how do we make sure that patients and providers alike benefit from a more flexible and individualized approach to care delivery?

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