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ADVANCING EQUITY IN BEHAVIORAL HEALTH THROUGH TELEMEDICINE

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About CHDI

The Child Health and Development Institute (CHDI) is a not-for-profit organization established to improve the health and well-being of children so they can grow up healthy and thrive. CHDI advances effective, integrated health and behavioral health systems, practices, and policies that result in equitable and optimal health and well-being for children, youth, and families.

OVERVIEW

On March 13, 2020, the State of Connecticut issued guidance regarding public and private payment for telemedicine services, and the Governor subsequently issued Executive Order 10C extending reimbursement for telemedicine services through April 20, 2021.[1, 2] Prior to this, policies supporting telemedicine had been limited in Connecticut. The COVID-19 pandemic demonstrated the value of telemedicine beyond engagement of rural populations or critical specialists outside a patient's geography, and into fundamental delivery of health care. Furthermore, early indicators from the expansion of telemedicine during the pandemic point to the value of telemedicine as a tool to promote access for all, and particularly for improving equity among socioeconomically, racially, and ethnically diverse families.

Access to and engagement in services has been a long-standing goal of health care policy making, as well as a long-standing challenge in the behavioral health service delivery system. Telemedicine has reduced or eliminated common barriers to care such as non-emergency medical transportation, two-parent work schedules, lack of child care options, and the stigma that can be associated with visiting a behavioral health clinic. Support of telemedicine is grounded in its powerful potential to promote better and more equitable access, engagement, and outcomes, particularly among traditionally underserved populations. Research supporting the use of telemedicine pre-dates the pandemic, and has shown telemedicine to generally be as effective as in-person psychotherapy for a range of diagnoses, modalities, and for children, adolescents, and adults.[3, 4]

This brief seeks to educate and advise advocates, providers, and public and private payers about policies that will support long-term effective telemedicine services for children and their families. This brief focuses primarily on the role of telemedicine as applied to delivery of behavioral health services for children and families, while acknowledging the broader implications of policy that supports the use of telemedicine for a range of conditions, and across the lifespan. The brief is framed around four recommendations, each of which is described in detail below.

RECCOMENDATION 1

Extend Medicaid and commercial reimbursement for telemedicine services beyond the expiration of current federal and state emergency declarations.

The state should permanently extend the modification in Provider Bulletin 2020–09 that places no limitation on originating site for accessing telemedicine.

Connecticut's health care organizations and providers quickly responded to policy adjustments that allowed for telemedicine in replacement of an in-person visit, changes that offered a level of flexibility, convenience, and safety that were welcomed and enthusiastically embraced by youth, families, and providers. State plan amendments in development prior to the onset of the pandemic intended to implement a "hub-and-spoke model" that would restrict telemedicine service delivery to designated originating sites (i.e., the location of the member at the time of the telemedicine service). The modifications outlined in Provider Bulletin 2020–09 authorized telemedicine and eliminated originating site requirements. This allowed youth and families, and providers, to participate in behavioral health services from their homes. Long-term youth and family engagement in behavioral health services will be significantly enhanced if originating site requirements are permanently removed from all future telemedicine proposals developed by the state.

In addition, **it is important that telemedicine rates match those of in-person visits.** In the longer term, telehealth has the potential to reduce the costs of care delivery. However, behavioral health providers across the state incurred enormous unplanned expenses in order to make a rapid transition to telemedicine services, while simultaneously maintaining existing physical space in anticipation of the future re-opening of face-to-face service delivery. Equivalent rates for in-person and telemedicine visits advances the goal of improved access, engagement, and outcomes of behavioral health services. It recognizes the cost of implementing telemedicine, the significant contribution of telemedicine as a tool for promoting access and engagement, and the value of the service that is being provided rather than the location in which it is being provided.

RECCOMENDATION 2

Affirm through policies and regulations that a patient-provider relationship may be established via telemedicine.

It is essential to affirm through policy, regulatory, and practice changes, that appropriate patient-provider relationships may be established via real time audio-video telemedicine technology and should remain an acceptable and reimbursable form of healthcare for children and families. The patient-provider relationship is one of the most important aspects of quality medical care.[5] The rapport developed between a client and their provider is based on trust, respect, and effective communication. Telemedicine has been used for decades as a means for families to access quality care, including initial diagnostic evaluations, by their established clinicians at a distance.[6] This frequently occurs in rural settings where time, convenience, and transportation issues are significant barriers to face-to-face visits.[7] Prior to and during the public health emergency, in Connecticut and nationally, children and families have been effectively seen, evaluated, admitted, and discharged using audio-video technology from an emergency room during a behavioral health crisis.[8] For other children and families, a 2-1-1 call during a behavioral health crisis resulted in an urgent new patient outpatient assessment using telemedicine, thereby avoiding emergency department visits and potential inpatient admission. In the months since the onset of the pandemic, people have witnessed the effectiveness of telemedicine visits for creating and maintaining a patient-provider relationship. National reports as well as local patient satisfactions scores have verified this view; for example, among patients surveyed following telemedicine visits at Yale New Haven Health System and Yale Medicine between March and July 2020, most patients were satisfied with care via video and felt that video visits lessened disruption in care, 94% of families felt the technology was easy to use, and all families felt that time was saved by using this tool.[9, 10]

RECCOMENDATION 3

Make Medicaid and commercial reimbursement available for audio-only telemedicine services for children and families, as a critical strategy for addressing disparities in access and outcomes.

Although audio-plus-video telemedicine has improved access for all populations, the availability of audio-only modalities for most types of clinical visits has promoted access even further. A critical supporting factor for ongoing reimbursement of audio-only telemedicine is the heightened need to promote equitable health care access regardless of household income or racial/ethnic background. The ability to access care with video capabilities requires an internet enabled smartphone or computer, as well as available, affordable, and reliable broadband internet access. These relatively expensive technologies will clearly limit access to telemedicine among lower-income families. A survey conducted in early 2019 by Pew Research found that 82% of white respondents owned a desktop or laptop computer, whereas only 58% and 57% of Black and Hispanic respondents, respectively, owned such devices.[11] Similarly, the availability of home broadband internet was 79% among white respondents, but only 66% and 61% among Black and Hispanic respondents, respectively. Based on 2020 Medicaid claims data from the Connecticut Department of Social Services, audio-only telemedicine services were used at higher rates by Hispanic and Black families, indicating that continuation of audio-only services will improve equity in access to behavioral health services.[12] The economic conditions that make technology less accessible to lower-income populations are unlikely to change quickly, even when the pandemic is controlled. Consequently, ongoing access to audio-only services helps to promote improved access and engagement among some of our most disadvantaged populations.

Ensuring the availability of audio-only telemedicine will require the state to work with partners to consider privacy and HIPAA compliance, promote the ability to triage risk and safety needs, ensure access to crisis management services, and promote parent engagement and participation in services. In Connecticut, DSS authorization of reimbursement for audio-only telemedicine was driven by the federal emergency declaration at CMS. If the federal emergency is lifted and CMS no longer allows states to seek reimbursement for audio-only telemedicine, then Connecticut will need to submit a state plan amendment to continue reimbursing for this practice.

RECCOMENDATION 4

Embrace internet connectivity for all as a core strategy for achieving equitable health and developmental outcomes.

Embracing connectivity for all is fundamental to achieving equitable health and developmental outcomes. The pandemic has accelerated the extent to which the internet has become a primary conduit of health care, education, financial management, and social connection. Despite this, 21 million Americans still lack broadband connectivity and many other low- and moderate-income families are "under-connected" in some way.[13, 14] This initial barrier can set in motion a downward trajectory for families who would most benefit from telemedicine services. As one study put it, "the more connectivity challenges families face, the less they use the internet to help them access opportunities that support family stability and well-being."[15] Internet connectivity, on the other hand, provides crucial support for vulnerable children and families. Healthy use of the internet, when guided by the development of a family media use plan in collaboration with a trusted healthcare provider, can increase the utilization of necessary health care, enhance academic performance, and enable socialization.[16, 17]

The results of a national telephone survey of parents suggests that the direct benefit from increased connectivity is most evident for at-risk families; those with the lowest household incomes, lowest levels of education, and whose dominant language is not English; and that greater connectivity increases the frequency with which children and parents use the internet.[18]

Following the governor's "Stay Safe, Stay Home" executive order, behavioral health organizations across the state had to overcome myriad connectivity challenges to convert to remote telemedicine services. At The Village for Families & Children, for example, families' access was limited by whether they owned an internet-capable device, had available internet service, and possessed the technical skills and experience to navigate the available technology. Many families had no reliable computer or only one device to share among all members of the household. In addition, numerous families did not have Wi-Fi and relied on a landline connection. Most often, families were reliant on mobile-only internet access, which poses a unique set of barriers. These families report frequent service interruptions and many did not have a plan that provided enough minutes or data for sessions with providers. Competing priorities and skills gaps have made it difficult for parents and caregivers to overcome these barriers on their own.

Given the potential of telemedicine for delivering high-quality and cost-effective behavioral health prevention and treatment services, digital equity should be the next major access initiative for children's behavioral health.

Acknowledgement of the right to connect to the internet is the first step in a series of actions. State-level action is needed to ensure a holistic, cross-sector approach to providing device and broadband access through cost-sharing arrangements across funding silos as well as through public-private partnerships. Many cities across the U.S. have taken similar approaches in an effort to make broadband wireless internet available for free to its residents, which could also be piloted in Connecticut cities. In addition, the scope of child and family services must be expanded to ensure that families have digital literacy skills and the ability to access and navigate technical support.

SUMMARY AND CONCLUSIONS

The pandemic exacerbated long-standing health disparities affecting Connecticut and the nation. Normalizing and embracing telemedicine is an important strategy to help improve equity by reducing barriers to care and increasing the flexibility of service access and delivery. A full range of HIPAA-compliant technologies, internet capable devices, and broadband internet access can be made available to support telemedicine, promoting access for a wider population of children and families that may otherwise experience significant barriers to accessing and engaging in behavioral health services. Access to audio-only services should also be maintained through ongoing reimbursement for services, which may hold particular value for low-income families and communities of color, those living in remote areas of the state, and anyone with limited access to healthcare. As data become available from the rapid scaling up of telemedicine during the pandemic, providers and state policy makers should invest in analyzing that data to demonstrate the ways in which telemedicine has impacted access, engagement, satisfaction, outcomes, and cost/cost savings.

REFERENCES

1. Department of Social Services, CT Medical Assistance Program. Provider Bulletin 2020-09 (March 13, 2020). https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=pb20_09.pdf&URI=Bulletins/pb20_09.pdf
2. https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-10C.pdf
3. Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: a 2013 review. *Telemedicine and e-Health*, 19(6), 444-454.
4. Schaffer, C. T., Nakrani, P., & Pirraglia, P. A. (2020). Telemental Health Care: A Review of Efficacy and Interventions. *Telehealth and Medicine Today*.
5. Meredith, L. S., Orlando, M., Humphrey, N., Camp, P., & Sherbourne, C. D. (2001). Are better ratings of the patient-provider relationship associated with higher quality care for depression? *Medical Care*, 349-360.
6. Yellowlees, P., Richard Chan, S., & Burke Parish, M. (2015). The hybrid doctor–patient relationship in the age of technology–Telepsychiatry consultations and the use of virtual space. *International Review of Psychiatry*, 27(6), 476-489.
7. Shore, J. H., & Manson, S. M. (2005). A developmental model for rural telepsychiatry. *Psychiatric Services*, 56(8), 976-980.
8. Yellowlees, P., Burke, M. M., Marks, S. L., Hilty, D. M., & Shore, J. H. (2008). Emergency telepsychiatry. *Journal of Telemedicine and Telecare*, 14(6), 277-281.
9. Myers, K. M., Valentine, J. M., & Melzer, S. M. (2007). Feasibility, acceptability, and sustainability of telepsychiatry for children and adolescents. *Psychiatric Services*, 58(11), 1493-1496.
10. Childs, A. W., Klingensmith, K., Bacon, S. M., & Li, L. (2020). Emergency conversion to telehealth in hospital-based psychiatric outpatient services: Strategy and early observations. *Psychiatry Research*, 293, 113425.
11. https://www.pewresearch.org/fact-tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gaps-with-whites/
12. Connecticut Department of Social Services (April 9, 2021). Update on Husky Health Strategies during the Public Health Emergency. Presentation to the Medical Assistance Program Oversight Council. https://www.cga.ct.gov/ph/med/
13. Federal Communications Commission (2019). 2019 Broadband Deployment Report, https://www.fcc.gov/document/broadband-deployment-report-digital-divide-narrowing-substantially-0.
14. Rideout, V. J. & Katz, V.S. (2016). Opportunity for all? Technology and learning in lower-income families. A report of the Families and Media Project. New York: The Joan Ganz Cooney Center at Sesame Workshop. http://www.joanganzcooneycenter.org/wp content/uploads/2016/01/jgcc_opportunityforall.pdf
15. Katz VS, Gonzalez C, Clark K. Digital Inequality and Developmental Trajectories of Low-income, Immigrant, and Minority Children. *Pediatrics*. 2017; 140(Suppl 2):S132-S136. doi:10.1542/peds.2016-1758R
16. https://www.brookings.edu/wp-content/uploads/2020/02/20200227_BrookingsMetro_Digital-Prosperity-Report-final.pdf
17. https://www.healthychildren.org/English/family-life/Media/Pages/How-to-Make-a-Family-Media-Use-Plan.aspx
18. Vikki S. Katz, Meghan B. Moran & Katherine Ognyanova (2019) Contextualizing connectivity: how internet connection type and parental factors influence technology use among lower-income children, *Information, Communication & Society*, 22:3, 313-335, DOI: 10.1080/1369118X.2017.1379551