

# Initial report on best Telehealth practices for Pediatric Behavioral Health

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## Preliminary findings and recommendations

Engrossed Substitute Senate Bill 5092; Section 215(60)(b); Chapter 334; Laws of 2021

June 30, 2022

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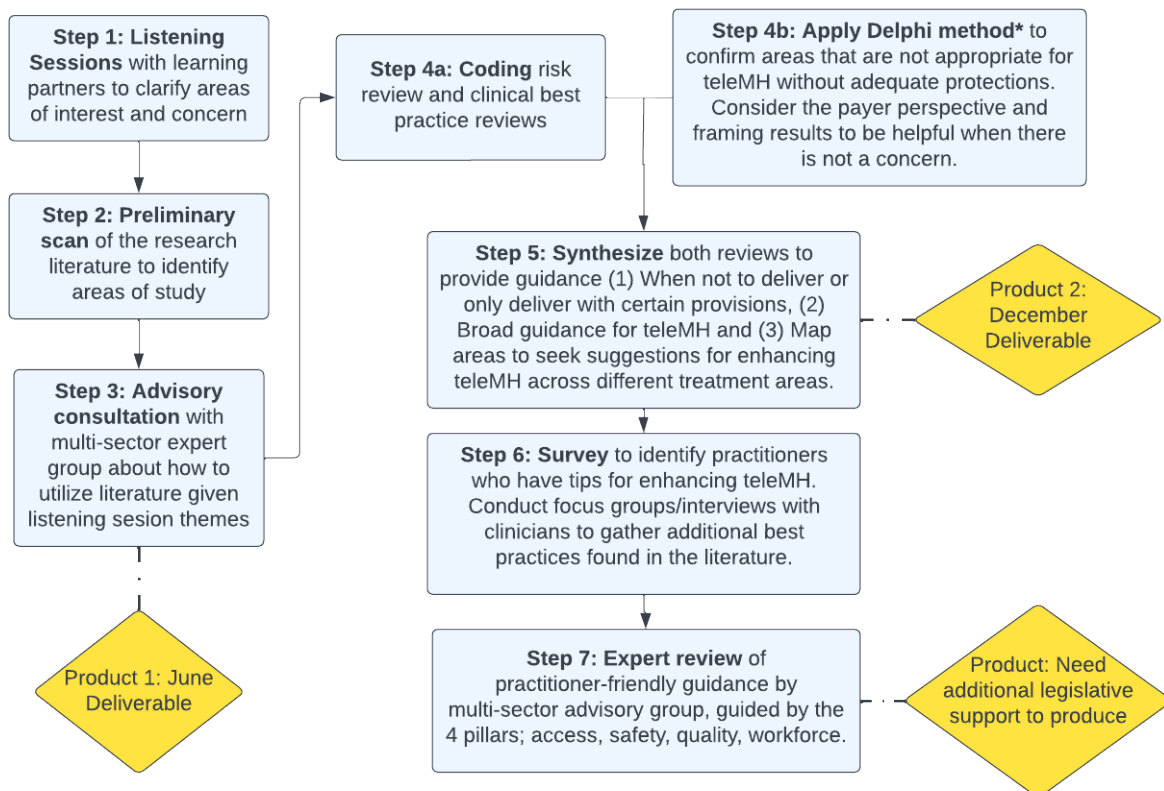
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# Report summary

This interim report summarizes processes, preliminary findings, and emerging recommendations from a seven-step framework (below) guiding our review of best practices for telehealth for clients prenatal to 25 years old. This report reflects completed work through Step 3 and partially completed work through Steps 4 and 5. Emerging clinical recommendations are presented on pages 12-13.

*Diagram below lists telemental health, but for the purposes of this chart, that is the same as telebehavioral health*

## Best Telehealth Practices for Prenatal - 25 Behavioral Health



*\*Delphi Method*

1. Identify the relevant literature: systematic reviews, then individual papers that comment on access, safety, quality, and workforce.
2. Code articles for when the conclusions/results points to an area of concern.
3. Code areas of concern for whether the literature offers solution to mitigation.
4. Clinical subject matter experts confirm synthesis.

## Listening sessions

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The project approach is guided by the Interactive Systems Framework and partner-engaged evidence review methods. The Interactive Systems Framework is an implementation framework focused on aligning scholarly research evidence with practice and policy-relevant concerns. Partner-engaged evidence review methods are multi-step processes through which policy, service delivery, and community partners guide the areas of focus and priorities for information gathering and synthesis. As an initial step, our team gathered information from multiple sectors in Washington State about their chief concerns and hopes for telebehavioral health practices with pediatric (prenatal to age 25) populations. Methods of information gathering included listening sessions and surveys. All listening sessions responses and surveys were collected between September and December 2021.

## Recruitment

The Behavioral Health Institute (BHI) at Harborview Medical Center had been convening a monthly strategic oversight committee meeting as part of their telebehavioral health initiatives. Members of the project team joined the BHI September 2021 meeting to conduct a listening session with multi-sector partners. These partners included the Northwest Mental Health Technology Transfer Network, Healthier Here- Accountable Community for Health, Lakeside-Milam Recovery Centers, American Indian Health Commission of Washington State, Valley Cities Behavioral Health Care, Molina Health Care of Washington State, Community Health Plan of Washington, and Healthcare Authority.

To get feedback from users with lived experience, we partnered with the Northwest Behavioral Health Research Alliance (NWBHRA), a practice-based consumer network, to conduct a listening session with their vast network of service users and providers; they conducted both listening sessions with users with lived experience and providers.

The team also partnered with the Thurston-Mason Family Youth System Partner Round Table (FYSPRT) to conduct a listening session with this multi-sector group of providers, behavioral health administrators, and lived experience experts.

Finally, the team distributed a survey through the Washington State FYSPRT leads who sent on the survey to their multi-sector, regional partners.

## Questions

Discussions during listening sessions were captured with visual collaboration software, Miro, so that participants could respond and build off each other's responses.

During these listening sessions, we asked the following questions:

1. What are the considerations for telebehavioral health (prenatal/children/teens/young adult) for funders?
2. What are the potential benefits and drawbacks?
3. What is the key question this effort needs to answer to inform and motivate policy changes?
4. What information do we need to gather from other funder organizations and stakeholders to inform questions #1 and #2?
5. Are there additional stakeholder groups who should be included?

Questions in the survey to FYSPRT partners included open ended prompts to elicit feedback about what partners felt was positive about telebehavioral health, concerns, ideal mix of telehealth and in person care.

## Rising themes and key findings

Five major themes were identified from the listening sessions and surveys:

1. Safety
2. Effectiveness
3. Access
4. Workforce and provider experience
5. Equity

Responses revealed an interest from providers in receiving practical, actionable guidance for addressing the five themes, as well as identifying whether certain age groups, diagnostic needs, or clinical severity are not appropriate for telebehavioral health.

## Advisory group

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The purpose of the advisory group is to inform the scope, direction, and dissemination of the project deliverable. The group is comprised of diverse community stakeholders that will meet quarterly to review progress and give feedback in line with partner-engaged evidence review practices.

### Participants

Diversity of expertise and organizational domain was considered in advisory group recruitment. A list of potential advisory group members was created by members of the internal design team with advice from individuals involved in designing the proviso. Of fifteen invitees, the following agreed to participate:

- Julia O'Connor, MSW, Washington Council for Behavioral Health
- Mary Stone Smith, MA, LMHC, Catholic Community Services & Washington Council for Behavioral Health
- Kenneth Dorais, MEd, Yakima Valley Farm Workers
- Lucy Mendoza, MSW, Health Care Authority
- Marissa Ingalls, Coordinated Care
- Bridget Lecheile, PhD, Washington Association of Infant Mental Health
- Kristin Wigigns, Consultant
- Christine Cole, MSW, Health Care Authority
- Beth Tinker, PhD, MPH, MN, RN, Health Care Authority
- Kathleen Myers, MD, Professor Emerita
- Monica Oxford, MSW, PhD, Barnard Center for Infant and Early Childhood Mental Health
- Sharon Brown, Senator, Washington 8<sup>th</sup> Legislative District
- Brad Felker, MD, UW Department of Psychiatry and Behavioral Sciences, Veterans Administration

### First meeting

The advisory group first met on Wednesday, May 4, 2022, to discuss the goal of the proviso, scope of work, timeline, key collaborators and partners, project approach, and engagement expectations. There was strong participation and engagement. Highlights include:

- There is a strong community need for more specific guidance in providing telebehavioral health services to this age group.
- Many lessons learned and effective practices are held by individuals and may not be widely known in academic or grey literature.
- Psychiatry is time-limited, and a best practices document would need to include a variety of telebehavioral health disciplines (e.g., psychology, social work).
- Consider consulting with a legal expert on telebehavioral health practices and considerations, to ensure partner recommendations are in line with regulatory requirements.
- The final deliverable should have best practices with practical implementation tips.

### Next steps

The next advisory group meeting will be in July or August 2022 to review the proposed framework and approach for the December 2022 deliverable. In the interim, the advisory group will provide feedback on the development of a provider survey. The provider survey will request best practices of community telebehavioral health providers who have knowledge of effective telebehavioral health approaches but

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may not have the resource or desire to publish this in grey or academic literature.



## Goal of proviso and final deliverable

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The Washington State Health Care Authority 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 from prenatal to age 25. The following workplan details the approach to prepare an initial and final report of recommendations for best telebehavioral health practices for pediatric (prenatal to age 25) behavioral health services.

### Budget proviso

The [Budget Proviso](#) “TeleBehavioral Health Best Practices for Prenatal Through Age 25” 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 recommendations aim 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).

### Final deliverable

Based on feedback from the advisory group, the final deliverable should be a practical tool that providers can turn to when preparing for a teleBH visit with a P-25 (prenatal to age 25) patient. The deliverable will include the risk review and clinical best practices review, in addition to the findings from the community provider survey.

## Clinical subject matter expert group

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The clinical subject matter expert group will serve as advisors on the risk review and clinical best practice review. Using their clinical expertise, they will inform the search strategies, confirm the final literature lists are comprehensive, review deliverable drafts, and ensure equity has been considered across all steps.

### Participants

The design team recruited clinical experts in the fields of psychology, psychiatry, and social work over a span of three months. Of fifteen invitees, the following agreed to participate:

- Kathleen Myers, MD: Professor Emeritus, Department of Psychiatry and Behavioral Sciences; former Director, Telemental Health, Seattle Children's Hospital; Board-Certified Child and Adolescent Psychiatrist; Fellow, American Academy of Child and Adolescent Psychiatry; Fellow, American Telemedicine Association. More than 20 years of experience in using telemental health (TMH) to treat youth with early onset psychiatric disorders; completed a large community-based comparative effective trial testing two models of TMH-facilitated care to treat youth with attention deficit hyperactivity disorder; focused on using TMH to increase access to psychiatric care for youth in under-served communities and to support their providers in improving their quality of care.
- Donald Hilty MD, FAPPA, DLFAAP: nationally known for work in telepsychiatry, formerly at University of Southern California and University of California Davis, currently at Veterans Administration Medical Center, editor of Journal of Technology in Behavioral Sciences (JTBS), co-author on most of the ATA's guidelines for TMH including for child and adolescent TMH (2017).
- Bonnie Zima, MD, MPH, DFAACAP, DFAPA: Professor-in-Residence for Child and Adolescent Psychiatry at University of California at Los Angeles (UCLA); Associate Director of the UCLA Center for Health Services and Society, and Associate Chair for Academic Affairs for the UCLA Department of Psychiatry and Biobehavioral Sciences. Leading child and adolescent psychiatrist across age groups but especially school-aged children; special focus on children enrolled in Medicaid-funded programs, high risk, and underserved youth.
- Johanna Folk, PhD: Clinical Psychologist and Assistant Professor at University of California at San Francisco. She has expertise in the age range with focus on juvenile justice, substance abuse, low SES, foster, and minority youth many of whom have low level telehealth capability and often just telephony.
- Jon Comer, PhD: Professor of Psychology and Psychiatry at Florida International University (FIU) and Director of Mental Health Interventions and Technology (MINT) at FIU, an interdisciplinary clinical research program. He has particular expertise in Parent-Child Interaction Therapy (PCIT) with preschool children and in telemental health, both synchronous and asynchronous.
- Joyce Harrison, MD, DFAACAP: Psychiatrist at Kennedy Krieger Institute and Associate Professor of Psychiatry at Johns Hopkins, with expertise in infancy. Co-Chair of the Infancy Committee at AACAP and updating the Clinical Guidelines for the Assessment of Children Aged 0 to 5.
- Amritha Bhat, MBBS, MD, MPH: perinatal psychiatrist and Assistant Professor in the Department of Psychiatry and Behavioral Sciences. Brings expertise in utilizing telehealth and digital technologies to deliver perinatal mental health care to patients and to support community-based providers in providing perinatal mental health care.

- Alissa Hemke, MD: Acting Assistant Professor, focus on early childhood, psychotherapy, and medical education.
- David Brieger, PhD: Clinical Associate Professor, focus on Neurocognitive outcome in children with brain tumors, and neurodevelopmental disorders; Neurocognitive functioning in children with heart failure, urea cycle disorders, sports concussions and the role of expectancy in patient's responses to illness.
- Bradford Felker, MD: nationally recognized as a leader in veterans' telemental health services, he brings expertise in leveraging emerging telehealth technologies to improve mental health care; developed, implemented, and led the first telemental health service at VA Puget Sound, and his research has focused on evaluation and implementation of telemental health programs. He also serves as a Professor in the University of Washington Department of Psychiatry and Behavioral Sciences.
- Monica Oxford, MSW, PhD: research professor, Family and Child Nursing; Executive Director, Barnard Center for Infant Mental Health; Director, Parent-Child Relationship Programs. Dr. Oxford's research focuses on birth to five Parent-Child relationship quality and how that dyadic relationship impacts child developmental outcomes for vulnerable families living in challenging environments. As the director of Barnard Center, she is also involved in training providers (home visitors, nurses, social workers, childcare professionals) about infant mental health and how parenting behaviors and context operate to support or detract from healthy outcomes. Dr. Oxford is principal investigator of three NIH grants aimed at examining the impact of a relationship-based intervention program in different populations: parents involved with child protective services, American Indian families in a rural setting, and parents recently reunified with their child after foster care placement. She is PI on a fourth NIH grant is aimed at addressing the interaction between family, school, child, and contextual risk such as poverty and early child developmental outcomes; and is co-PI on four NIH funded grants testing the effectiveness of intervention programs for vulnerable populations.

## Firstmeeting

On June 16, 2022, the clinical subject matter experts convened to review the goal of the proviso, approach to the reviews, and share input on the progress to-date. The meeting had good engagement and recommendations for how to improve the search and review strategy. In addition to specific coding and literature search strategy recommendations, highlights from the meeting include:

- Pre-COVID and current recommendations and guidelines should be noted to account for the rapid changes and learning that occurred at the start of the pandemic.
- Include special equity considerations in using teleBH for children with communication disorders.
- The search should consider going beyond strict meta-analyses, as the final product should be a practical tool for clinicians.

## Next steps

The group will meet for an additional two meetings, one in August and another in October, to review the risk review and clinical best practice review progress, and initial findings. We may request their feedback in the interim on documents and article lists to ensure the conducted searches were comprehensive and are not missing major articles or guidelines.

## Literature review approach

The literature review is a core component of the final deliverable and is expected to comprise the majority of identified best practices. The internal design team anticipates that new literature will be added to the collection as we learn of new resources and publications, and as our clinical subject matter experts group and advisory group share additional documents with us. We expect to do a final surface-level literature review before the final deliverable is completed to ensure we have not missed essential recently published scholarly or grey literature. We are conducting two approaches to literature review. The first is to identify areas in which teleBH presents a risk to pediatric care: "Risk Review." The second is focused on identifying specific clinical guidance for the delivery of prenatal and pediatric BH that provides practical strategies for special considerations in age, diagnostic presentation, clinical severity, and extenuating needs.

It is important to note that systematic review and meta-analysis articles were prioritized in this search. Rather than approaching the literature review from the perspective of piecing together small outcomes from individual articles, our team approached it from the belief that teleBH care is effective and we are seeking to identify literature identifying where teleBH for pediatric populations is counter-indicated or needs substantial enhancement to resolve the five core concerns of multi-sector partners (Safety, Effectiveness, Access, Workplace culture, Equity). This approach allowed us to work more efficiently and cover a broader scope in a limited amount of time.

### Risk review

To identify literature suggesting areas where pediatric teleBH is counter-indicated or needs enhancement, we followed best practices for conducting narrative systematic review, following Joana Briggs Guidelines. An initial search was completed in PubMed, Web of Science, and PsychInfo. The results were presented to the advisory group and refined for a second search. Applying the updated key terms in the three search engines produced 6 PubMed results, 57 Web of Science results, and 8 PsychInfo results. After removing duplicates, outdated (>10 years old), and excluded articles (e.g. virtual reality), the final literature list included 45 articles.

### Risk review search terms

The search terms were applied with the "AND" terms *across* the categories and "OR" terms *within* the categories. With this approach, both an article on perinatal telepsychiatry for suicide and an article on parent management of externalizing child behaviors in telebehavioral health would be pulled.

Category 1	Category 2	Category 3	Category 4	Category 5	Category 5 cont.
<b>Pediatric</b>	Telehealth	Psychology	Review	Parent management	<b>ADHD</b>
<b>Child</b>	Telehealth	Psychiatry	Meta analysis	Cognitive behavioral	<b>Evaluation</b>
<b>Adolescent</b>	<b>Telebehavioral health</b>	<b>Psychotherapy</b>		<b>Parent child interation</b>	<b>Psychometric</b>

<b>Young adult</b>	<b>Telemental health</b>	<b>Mental health</b>	<b>Infant mental health</b>	<b>Telemedicine</b>
<b>Prenatal</b>	Telepsychiatry	Behavioral health	Suicide	<b>Parent behavior management</b>
<b>Youth</b>	Telemental health		Co-occurring	<b>Dyad</b>
<b>Youngsters</b>	Telemedicine		Serious emotional disturbance	<b>Dyad</b>
<b>Perinatal</b>	e-health		Ecological assessment	<b>Co-morbid</b>
<b>Infant</b>	Remote		Psychological assessment	<b>Emerging adult</b>
<b>Pregnancy</b>	Audio		Neuropsychological assessment	<b>College</b>
	Video		Autism	<b>Transition age youth</b>
	Phone		Depression	<b>Bipolar</b>
	Synchronous		Anxiety	<b>Psychosis</b>
	Asynchronous		Substance use disorder	<b>Post-traumatic stress disorder</b>
	<b>mHealth</b>		<b>Eating disorders</b>	

## Clinical best practices review

Recognizing the clinical guidelines are available through the peer reviewed published literature as well as through professional associations, the clinical best practice search was conducted through the search described above as well as Google searches, professional association and organization website searches, and through direct outreach to experts in the teleBH field. We list five clinical guidelines, here, as illustrative of key emerging resources:

1. APA & ATA (2018) Best Practices in Videoconferencing-Based Telemental Health.
2. APA Committee on Telepsychiatry; APA College Mental Health Caucus (2020) Best Practices, Policy Considerations, & Covid-19.
3. AACAP (n.d.) Tips for Clinicians Treating Patients Diagnosed with Neurodevelopmental Disorders via Telepsychiatry.
4. AACAP Committee on Telepsychiatry and AACAP Committee on Quality Issues (2017) Clinical Update: Telepsychiatry with Children and Adolescents.
5. ATA (2017) Practice Guidelines for Telemental Health with Children and Adolescents.

## Clinical best practices initial summary

The following table summarizes the initial clinical best practices results by population and theme (see “Rising Themes and Key Findings”). A similar table will be completed after the final search is conducted to indicate where there is clinical best practice guidance and where there are persistent knowledge gaps.

	Perinatal	Infancy and Postpartum	Early Childhood	School Aged Children	Adolescence	Young Adults
<b>Safety</b>	Red	Red	Red	Green	Green	Green
<b>Effectiveness</b>	Yellow	Red	Red	Green	Green	Blue
<b>Access</b>	Yellow	Red	Red	Yellow	Green	Green
<b>Equity</b>	Yellow	Red	Red	Yellow	Yellow	Yellow
<b>Workforce and Provider Experience</b>	Red	Red	Red	Red	Red	Green
<b>Identifying subgroups clinically inappropriate for telehealth</b>	Red	Red	Red	Red	Red	Red

Color Key	Adequacy of Evidence for Actionable Recommendations	Current Work	Needed Next Steps
Red	No expert consensus and negligible existing synthesized evidence	Identifying current gaps in the <u>evidence</u> or <u>evidence synthesis</u>	Expand literature search to individual studies in key target gap areas
Yellow	Moderate existing evidence, not yet translated into actionable recommendations	Identifying current gaps in <u>actionable recommendations</u>	Using Delphi process to develop actionable recommendations and consensus in key target gap areas
Green	Moderate existing evidence and developing expert consensus on recommendations	Identifying current gaps in <u>expert consensus</u>	
Blue	Strong existing evidence and/or expert consensus on recommendations	<u>Summarizing</u> actionable recommendations	Update recommendations as field progresses

The following table offers emerging recommendations based on a preliminary analysis of clinical best practice documents. The final recommendations will be categorized into guidance that has broad consensus and guidance that might be developing or in the earliest stages without comprehensive evidence.

	Consensus Recommendations	Developing Recommendations
Safety	<ul style="list-style-type: none"> <li>• All participants should share name before session begins. Patient/family should share location and contact information in case of emergency or patient support needs (APA-ATA 2018, AACAP 2017, ATA 2017, AACAP ND)</li> <li>• Prior to teleMH visits, providers should be familiar with local community partners to assist during times of emergencies. Knowing patient location in advance is essential in identifying local services that can support patients in crisis (APA-ATA 2018, AACAP 2017, ATA 2017)</li> <li>• For teleMH in non-clinically supervised settings (such as the home), providers should consider the use of a "Patient Support Person" (family, friend, or community member selected by the patient and who can be called by the provider for support in an emergency (APA-ATA 2018, ATA 2017) or working with the patient's primary care provider for monitoring and emergency support (AACAP 2017)</li> <li>• Providers should ensure all technology and systems are compliant with local laws and policies, are HIPAA-compliant, and bandwidth adequate for uninterrupted patient interaction and assessment (APA-ATA 2018, AACAP 2017, ATA 2017)</li> <li>• For teleMH with children in non-clinically supervised settings (such as the home), providers should be aware of and consider the mental health status and violence history of the</li> </ul>	

	adult(s) participating in the session and their ability to safely supervise care (APA-ATA 2018, AACAP 2017, ATA 2017)	
Effectiveness	<ul style="list-style-type: none"> <li>To build rapport with patients and ensure assessments and treatments are not interrupted, providers should have properly lit settings, align cameras and screens appropriately, avoid distracting backgrounds, and confirm bandwidth is adequate. Distraction-free teleMH will promote eye contact and conversation (APA-ATA 2018, AACAP 2017, ATA 2017)</li> <li>In teleMH visits with younger children, providers should consider whether the space where the patient will be during the session has adequate space, play items, and camera angle to show parent-child interactions. The camera should be positioned to allow the child to play and participate in activities (APA-ATA 2018, AACAP 2017, ATA 2017)</li> <li>During assessments, providers should consider whether the instruments have been previously validated or used in teleMH settings. Some constructs, such as eye contact, would be expected to differ in teleMH vs in person care. Other symptoms, such as tremors, may be difficult to adequately assess via tele-mental health. (AACAP 2017, ATA 2017)</li> </ul>	<ul style="list-style-type: none"> <li>The use of provider cameras with tilt/pan functions or which are movable can allow providers to better demonstrate activities to patients (AACAP 2017), or to reassure parents and youth that there are no hidden observers in the room (ATA 2017)</li> </ul>
Access	<ul style="list-style-type: none"> <li>In case of network disruptions or technological challenges, providers should establish a back-up plan and communicate the alternative plan to the patient in advance (APA-ATA 2018, AACAP ND, AACAP 2017, ATA 2017)</li> </ul>	<ul style="list-style-type: none"> <li>TeleMH can be utilized as a continuity of treatment bridge while local resources are established for long-term mental health care (APA 2020)</li> <li>When treating highly mobile populations (such as young adults or college students), providers should proactively explain how geographic boundaries and associated laws/regulations impact treatment and care options (APA 2020)</li> </ul>



Equity	<ul style="list-style-type: none"> <li>• Prior to visits, providers should determine patient/family prior exposure, experience, and comfort with technology (APA-ATA 2018, ATA 2017)</li> </ul>	
Workforce and Provider Experience	<ul style="list-style-type: none"> <li>• Providers must practice within their scope of competence just as they would for in person care, and refer to specialty care as indicated (APA 2020, APA-ATA 2018, AACAP 2017, ATA 2017)</li> </ul>	<ul style="list-style-type: none"> <li>• Providers should have explicit boundaries with patients regarding which technologies are appropriate for patient-provider communications, what content is appropriate to share via technology, and anticipated response times for asynchronous communications. (APA-ATA 2018)</li> </ul>
Identifying subgroups clinically inappropriate for telehealth	<ul style="list-style-type: none"> <li>• There are no absolute contraindications to treatment or assessment via teleMH services, but providers should consider a variety of factors, including (but not limited to) access to support staff, local patient support system, history of cooperation with treatment, family violence or maltreatment history, physical hazards/weapons present in the home environment, and distance to nearest emergency facility (APA-ATA 2018, AACAP 2017, ATA 2017)</li> </ul>	<ul style="list-style-type: none"> <li>• Which patients are appropriate for teleMH differs depending on whether it is in a clinically supervised setting with support staff immediately available, a non-supervised setting with a patient-selected support person present or available, or a non-supervised setting with no immediate support available (APA-ATA 2018)</li> <li>• In some cases where direct patient care via teleMH is deemed clinically inappropriate or raises safety concerns, tele-consultation by the mental health provider with primary care, other medical providers, or school officials may be indicated instead (ATA 2017)</li> </ul>

## Coding strategy

Initial codes were proposed by the design team and reviewed and refined over the course of one month. Codes were tested with a second team member to identify discrepancies of code definitions and applications of codes.

The **risk review** will be reviewed and coded with the following codes:

- Authors
- Title
- Year
- Type of article
- Age range
- Level of practicality
- Diagnosis or behavior covered

- Level of severity addressed
- Was access discussed?
- How was access evaluated?
- Was equity + access discussed?
- Was safety discussed?
- How was safety evaluated?
- Was safety + equity discussed?
- If safety was compared between groups, what was the result?
- Was quality discussed?
- How was quality evaluated?
- If quality was compared between groups, what was the result?
- Was quality + equity discussed?

The **clinical best practice review** will be reviewed and coded with the following codes:

- Authors
- Year
- Publisher or sponsoring organization/journal
- Title
- Age range
- Diagnostic area of focus
- Prevention/treatment category
- Was operational guidance discussed?
- Operational guidance level of practicality
- Describe operational guidance
- Was access discussed?
- Was access + equity discussed?
- Access level of practicality
- Describe conclusions about access
- Was safety discussed?
- Was safety + equity discussed?
- Safety level of practicality
- Describe conclusions about safety
- Was quality discussed?
- Was quality + equity discussed?
- Quality level of practicality
- Describe conclusions about quality
- Was workforce experience discussed?
- Was workforce experience + equity discussed?
- Workforce experience level of practicality
- Describe conclusions about workforce experience
- Other notes and relevant referenced sources

A revised codebook was reviewed and discussed by the clinical subject matter experts and will be refined one last time before finalization.

## Next steps

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This report summarizes activities through Step 3 and partial completion of Steps 4 and 5 of the partner-engaged review framework. For the remaining deliverable, the project team will:

- Complete synthesis of the identified literature,
- Survey clinical providers to identify innovative enhancements to teleBH where no enhancements can be identified in the literature,
- Apply the Delphi Method to confirm areas of clinical risk, and
- Complete a technical report of findings.

Meetings with the Advisory Group and the Subject Matter Experts will be scheduled to seek input and share progress updates. Next steps include:

1. Incorporate Subject Matter Expert feedback for the final risk review search.
2. Confirm coding strategy with Subject Matter Experts and complete coding of risk review and clinical best practice.
3. Survey teleBH clinicians to understand community best practices.
4. Partner with Subject Matter Experts to ensure comprehensive synthesis based on risk review, clinical best practice review, and ensure survey results are meaningful and accurate.
5. Complete the December deliverable with teleBH guidance and recommendations.