Rapid Service Transition of Traditional Operations to Telepsychiatry in Response to Covid-19 in a Southeastern Academic Health System

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By mid-March, almost all of our clinics, except for those with unstable or emergency cases, urgent Electroconvulsive therapy (ECT) and Long Acting Injectable (LAI) clinics, moved completely to telehealth.   Once the Dean and the hospital system closed normal campus operations, the Department rapidly converted nearly all outpatient clinics (with over 150 providers) to telehealth and began to develop mobile televideo stations for the Institute of Psychiatry Inpatient units and for Emergency Room consultations across our three main hospitals. Although initially our visits were occurring via multiple legacy platforms, over a week services were diverted to two major products across the department. By the end of March, most of the clinical enterprise across all specialties had followed.   Departmental leadership initiated daily 8 AM meetings with clinic directors, compliance and HR staff, educational leaders, and research staff to update, discuss, and task critical issues in a fan-out approach to the entire department. The evolving "best practices" were shared across the department, the hospital, and the various divisions. Information was flowing rapidly regarding reimbursement, rules, and hospital policy requiring consistent communication and revision.

Prior to COVID-19, CMS reimbursement regulations, and often minimal guidance around resident supervision, limited wide adoption of telehealth in residency programs. With COVID-19, supervision of residents/fellows shifted to virtual with trainee and supervisor in different locations, and the patient in a third. To engage adequate supervision, we required a program that allows multiple providers (attending, resident) and or family members simultaneous access to the virtual encounter. This was initially to ensure adequate supervision and patient safety, but of course later facilitated the ability to begin billing for professional services and recoup at least some revenue lost to disaster preparation. The rapidly evolved CMS guidance for supervision that negated the co-location requirement for attending and resident was a "game changer." In addition, the ability to bill insurers regardless of setting - whether provider initiated the visit from home, in hospital, at a patient home, etc. - allowed much broader and earlier access to needed services and allowed us to develop modifications to our visit capture in order to process insurance claims as a needed component of system continuity and disaster recovery.

Our non-Medicare South Carolina-managed programs and a number of the private insurers lagged behind in their acceptance of telepsychiatry. Still, over a two-week period in late March and early April, most adopted relaxed reimbursement and coverage processes, facilitating even greater flexibility in line with the national changes from CMS and other regulatory groups. The approval of group therapy coverage, though later in the process, was a major win for our substance use disorder programs and intensive outpatient services, many of which continued regardless, to ensure no lapse in patient care. The regional nuances in regulatory change

appears to be state-dependent and quite variable, based on list-serve questions and comments (ACLP, AADPRT, APA Disaster Committee) reported by colleagues around the country. Medicaid held out initially in South Carolina, but by mid-April allowed telehealth much more broadly for mental health services and rehabilitation.

The EPIC MyChart and other in-house video visits were the initial focus on our telehealth expansion efforts as these visits integrated into our EMR. However, many challenges including inclusion of the need to support multiple individuals from more than 2 locations in the patient led many service areas and clinics to more flexible platforms. We are now using primarily standalone VidyoConnect for hospital consults and psychiatry rounding when appropriate and Doxy.me for outpatient visits, as both have proven consistent and reliable with the added ability to include other learners, interdisciplinary team members, and family or significant others. This was particularly important for children and elderly patients. Doxy.me has become the most flexible and user-friendly platform for all our stakeholders - patients, providers and credible trainee supervision.   Though initially reluctant, our Probate Courts became "televideo flexible" and civil commitment proceedings, which had occurred in the hospital, have become virtual as well.

As the regulations adjusted, we were able to move the rest of outpatient clinics to home-based telehealth. For our inpatient general hospital consults, we have predominantly used in-house legacy Cisco systems, which are closed networks and require access by providers from specific devices within the hospital. These systems are in place for patients under respiratory isolation, allowing providers to directly care for the patient while conserving PPE and minimizing potential exposures. For our inpatient services, we use VidyoConnect, which is set up on a computer on wheels (COW). This system allows users to participate in patient care remotely by connecting directly to a specific COW, the caveat being that a limited number of authorized-user accounts exist, and that there is a provider present with the COW physically on the unit with the patients. We otherwise default to our institutional secure Webex platform when there is a failure of other platforms. In worst case scenarios, including the time before the integration of supervision, we had visits where the patient and one provider were connected via Epic-embedded video visits, and the other providers including the attending were brought in via concurrent FaceTime. Luckily, this has been only an infrequent occurrence.

Overall the move to telehealth went much smoother and occurred faster than anyone expected. Much of the progress in the area of telehealth could have quite possibly taken years under normal circumstances. Team work, flexibility, and compromise were many of the key ingredients that made this rapid transition successful.   As the health system began to report departmental and service area transitions to telehealth, psychiatry was consistently ahead of other clinical areas. In fact, health system data suggested outpatient visits climbed to between 80-110% pre-COVID visits and the patient "no-show" rate declined.   The vast majority of patients had 'smart phones' or home Wi-Fi, even though a large portion of our case load is served by Medicare, Medicaid or one of the Affordable Care Act exchange insurance plans. We believe anecdotally that more elderly patients and chronically mentally ill patients in group

housing were less able to adapt to telepsychiatry, due to poor phone or Wi-Fi access, though most were not averse to the concept. Telephone visits were offered as alternatives.

In the years leading up to COVID-19, change related to telehealth has been relatively slow to penetrate usual care and often faced resistance for one systemic reason or another. Typically, each component of the system waited for another to provide clarity, innovation, or change. Our VA affiliate had been conducting extensive telepsychiatry, though even in that setting, the co-location rules for trainee and supervisor impeded the addition of residents in many cases, as their faculty were often home-based providers or caring for out of state patients.   Without this crisis situation, the progress would not have happened as efficiently or as collaboratively, if at all. It was particularly helpful having a Center for Telehealth on campus with a psychiatry-specific medical director, who was able to liaise in support of departmental needs and work with our numerous clinic directors and education leadership to problem solve all of the components where services had to adjust away from usual practice. A few times in the process, psychiatry's need for variant algorithms and processes were interpreted as "being difficult" by other specialties and administrators, whereas in most cases, we had inherent differences in our practice settings and our patient population.   In the end most worked well across specialties and components of the health system.

The daily update leadership calls led by the Chair, which included representatives from all our departmental and hospital functions, helped to get everyone on the same page, prioritize critical issues for the group as a whole, and allow the diverse clinical areas to learn from each other in real time.   The interdisciplinary nature of the group added incredible value for real-time brain storming and developing new processes that could be implemented almost instantly and then adapted even more rapidly, as the critical variables are changing so frequently.