Telehealth Rural Remote Support Working Group Report, 2017

Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative

Increasing access to mental health care for all children and youth in British Columbia

BRITISH COLUMBIA

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Executive Summary

The provincial Telehealth Rural Remote Support Working Group was established in 2014 as part of the Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative to respond to the needs of children and youth with mental health challenges in rural and remote areas. The group was comprised of representatives from all the health authorities including the Provincial Health Services Authority (PHSA) and First Nations Health Authority (FNHA), Ministry of Children and Family Development (MCFD), and Ministry of Health (MOH), and was multi-disciplinary in nature including administrators and clinicians.

The task of the Telehealth Working Group was to identify potential solutions and make recommendations on how to utilize telehealth technology with the goal of increasing timely access to integrated mental health and substance use services in rural and remote areas of the province. Additional goals were to look at how telehealth could be used to increase community capacity to care for children and youth with mental health concerns.

This report outlines the conclusions of the working group and provides recommendations on how to use telehealth to increase access to specialized mental health services and improve the quality, efficiency, and equity of mental health and substance use services in rural and remote areas of the province.

The report is based on three main principles: 1) equitable access to telehealth services, 2) effective delivery of high quality telehealth services, and 3) sustainability of mental health services, including integration of telehealth into community systems of care and building community capacity. The main recommendations of the report are outlined below.

Summary of Recommendations:

1) **Create a comprehensive telehealth system** that creates equitable access for all children and youth in BC with mental health and substance use needs regardless of geographical location and that integrates with patient medical homes, including primary care providers (PCP's), Foundry Hubs and MCFD Child and Youth Mental Health (MCFD-CYMH) teams.
2) **Develop a standard method for sessional allocation** related to telehealth and outreach for specialist compensation across the province to eliminate the current situation of "have" and "have-not" communities.
3) **Pursue Canadian Radio-television Telecommunications Commission (CRTC) funding** to increase access to broadband internet in rural and remote areas of the province.
4) **Adopt a standard, user-friendly, secure telehealth software** that can be used without specialized equipment in a clinician's and/or physician's office, across all health authorities and MCFD.
5) **Implement mechanisms for better communication and information sharing** between telehealth specialists and community providers, including remote access to medical charts and mechanisms for transcription and distribution of specialist reports.
6) **Leverage existing provincial e-health viewers** such as CareConnect to create a repository for telehealth (and non-telehealth) specialist reports which can be accessed by community clinicians including hospital emergency departments in the case of emergent presentations.

7) **Use telehealth to build community capacity** to manage child and youth mental health concerns by supporting community providers with education and case consultation.
8) **Combine specialist telehealth services with in-person visits** to enable the development of longitudinal relationships and trust with community providers and enhance the effectiveness of capacity-building, as well as to allow providers to better understand the communities they serve.
9) **Engage individual communities in the planning of telehealth services** for their area to ensure they are culturally relevant and suit their needs.

Background:

The Child and Youth Mental Health Substance Use Collaborative was formed in 2013 with the goal of increasing the number of children, youth, and their families receiving timely access to integrated mental health and substance use services and supports in BC. Funding to support this initiative has been provided by Doctors of BC, and the Ministry of Health. More than 2,600 individuals across BC have been involved through 64 Local Action teams, eleven working groups, a Steering Committee, and Mental Health and Substance Use Faculties. These include family physicians, emergency department physicians, psychiatrists, pediatricians, social workers, school counsellors, substance use counsellors, Aboriginal services, parents, youth, RCMP and local police officers, health administrators, and others. System barriers identified by Local Action Teams are tackled by the Working Groups, each created to find solutions to specific problems. The Telehealth Rural Remote Support Working Group was formed in 2014 to improve the access to mental health and substance use services for children, youth and their families in rural and remote communities, including First Nations' Communities across BC. The group was multidisciplinary and was comprised of representatives from all the health authorities including PHSA and FNHA, MCFD, Ministry of Health, and administrators and clinicians. Work of the group included engaging with key stakeholders around telehealth, gathering information about existing services in BC, and conducting a comprehensive telehealth needs assessment survey across the province.(1) The group additionally focussed on exploring models for telehealth service delivery used in other municipalities (2-4), with the goal of understanding how telehealth technology can best be integrated into existing community services.

While the scope of this report is focused primarily on child and youth mental health, planners and leaders are encouraged to consider how telehealth services could be integrated into the continuum of services and supports for both mental health and substance use – including the enhancement of community capacity through supporting providers in areas such as education, access to specialist support, and collaboration.

Introduction

Children, youth and their families experience multiple barriers in accessing specialist mental health and substance use services and supports in BC. These barriers are most pronounced in rural and remote areas of the province, including First Nations communities, where community clinicians often feel similarly unsupported without access to specialist consultation. These barriers include a lack of service providers in these hard to reach places as well as other impediments such as; distance to services, travel costs and time missed from work and school, stigma, lack of monetary funds, and inclement weather.

With recent advances in technology, delivery of mental health services to children and adolescents via telehealth has been evolving nationally and internationally with increasing evidence that it is an effective way to deliver care.(5)

There are several reasons why it is practical to pursue a more extensive telehealth vision in the BC context. The first is to help address the current inequity of access to services. The second is cost effectiveness. Many communities in BC without access to telehealth rely on outreach psychiatrists who periodically visit the communities in person. Although in-person outreach services can be very effective, they come at substantial cost including physician travel and accommodations, fee premiums and other incentives for outreach work. The cost burden additionally falls on those children, youth and families having to travel to access care. Many First Nations communities are so remote that travel to a regional referral center or urban tertiary quaternary care centre can take days. For a family with already limited resources, it is often the case that children and youth are travelling on their own and attempting to navigate what is arguably a complex health care system or are simply not accessing services at all.

Financial savings achieved by providing outreach services via telehealth technology are significant. A review of recent PHSA statistics revealed that a traditional mental health outreach visit costs almost $6000 in physician fees, sessional payments, and travel costs. The cost to see the same number of patients using telehealth is less than $4100, a savings of $1900 even after accounting for the cost of telehealth equipment and operational costs (Appendix A).

In addition to the cost savings, telehealth services can be provided more regularly, thus decreasing time between “visits” and increasing accessibility. With this decrease in travel comes less of a time commitment for specialists, resulting in the potential for easier specialist recruitment. Telehealth addresses the issue of weather, as a barrier to services, particularly important in areas where winter makes travel dangerous. An additional advantage of telehealth is the potential to expand access to specialists beyond psychiatry to include other allied health professionals, creating virtual multidisciplinary teams.

Despite the identified advantages of telehealth, traditional outreach with its inherent face-to-face person contact has the added value of helping develop relationships between specialists and clients. Equally important, it enhances the specialist’s understanding of the community they serve, and builds stronger linkages with other community mental health and substance use service providers. The enhancement of relationships between provider and patient is especially important in First Nation’s communities. Historically, there have been issues of trust between First Nations people and health care providers (especially those working under the umbrella of MCFD), particularly where children are involved. The ability of providers to travel to First Nations communities not only strengthens relationships and builds trust, but further allows for providers to better understand many of the socioeconomic barriers that are currently challenging the First Nations communities.

While the scope of this paper is focused primarily on child and youth mental health, planners and leaders should also consider it’s applicability to substance use services and supports. A 2013 review of telehealth for mental health and substance use in BC found that relatively fewer studies have been published on the effectiveness of telehealth for substance use disorders. (7) Like other recent reviews it found that while dedicated telehealth programs for substance use disorders are being developed in many areas, there appears to be high demand for them and more research in the field is needed on its efficacy.

Successes and Barriers—the BC Context:

In the last 10 years in BC, there has been growth in the use of telecommunications technology to provide care remotely, thereby increasing access to specialist services in rural communities. Several promising programs have been developed including the Telehealth Outreach Psychiatric Services (TOPS), a collaborative initiative between BC Children's Hospital and MCFD serving sixteen communities in the North, which won a 2016 Premier's Partnership award.(8) In addition, telehealth technology is being used to provide specialist consultation and support from BC Children's Hospital to MCFD-CYMH teams across the province using a combination of educational strategies, along with indirect case consultation and direct telehealth consultation. There are several pilot programs on Vancouver Island now providing telehealth to remote communities, supporting local physicians and hospital emergency rooms. Emergency psychiatric assessments via telehealth are also being trialed from Lionsgate Hospital to Sechelt and Powell River. Additionally some communities, including Cranbrook (9) now also receive telehealth support in addition to in-person specialist visits which allows for enhanced access to specialist support, as well as community capacity building through education and case consultation to local providers. Feedback from these programs has generally been very positive.[1]

Despite these advances, the majority of telehealth programs currently in place are local or regional in nature, resulting in inequity across many areas of the province that continue to have poor access to specialised mental health and substance use services and supports. In addition, existing systems issues create barriers which have hindered the spread of telehealth. Different regions and agencies use different telehealth networks which are not compatible with each other. There are no standard mechanisms in place for remote access to medical records or secure means of sharing documentation when using telehealth. In addition, not all communities have funding structures in place to support specialist telehealth services, creating inequities between communities.

Some specific barriers exist for First Nations communities who often lack basic internet services and even the infrastructure required to host internet services. Additionally, many of the services in place still fail to address the mental health needs of First Nations communities and their children and youth, particularly those seeking to access traditional indigenous cultural healing practices. Services delivery in these areas needs to be not only culturally relevant and address those issues most common to First Nations, but must be reflective of the unique nuances specific to First Nations health care delivery.

Purpose

Our goal in this document is to present a practical vision for implementing telehealth in the area of child and youth mental health in BC. Our vision is founded in **three key principles**:

A) Equitable access for children and youth across levels of care and geographical locations in the province

B) Effective delivery, both in terms of costs and timeliness

C) Sustainability, which requires the building of community capacity across the province.

[1] "CYMH In Prince Rupert has greatly benefited from tele-psychiatry and appreciate the most recent introduction of specialized consultation for low incidence diagnosis;" The Doctors we work with through telehealth are wonderful…. I appreciate that they try to understand the resources our communities have before making their recommendations for the clients. Each community in the North is unique and therefore recommendations are most beneficial when the doctor has a bit of knowledge about the community." Quotes taken from the Telehealth survey – Jan. 2016 (1)

PRINCIPAL A:

Equitable access to telehealth services:

Recommendations #: 1. Create a comprehensive tele-health system.

2. Develop standard method for sessional allocation

In an ideal system, children and youth with severe mental health concerns would have timely access to mental health specialist services, while children and youth with mild-moderate mental illness would be supported by community providers, with in-direct specialist support and backup as needed. Access to speciality mental health services would be driven by patient need, and not be dependent on the agency where the child/youth is being seen.

Currently, most outreach psychiatry services are provided through the Ministry of Child and Family Development Child and Youth Mental Health (MCFD-CYMH) teams. Prevalence data show that physicians in BC see approximately 130,000 children and youth with mental health concerns per year and MCFD-CYMH teams see 28,000. Family physicians seeking psychiatric input for their patients not involved in MCFD-CYMH teams may not have other options available to seek psychiatric evaluation.

There is an opportunity to increase access to specialist care for children and youth through the establishment of telehealth specialist teams which would comprehensively support local communities including PCP's, local MCFD-CYMH teams, and Foundry Hubs (i.e. the wider primary care home). Similar models have been developed internationally and have been successfully shown to increase access to specialist care.(5) Multidisciplinary teams could include a psychiatrist, psychologist, social worker, peer support, as well as administrative support. Services to primary medical homes could include indirect phone consultation to PCP's for medications, non-medication treatments and resources, as well as direct patient consultation when indicated. A robust triage process would be required to ensure that patients are receiving a level of intervention that is appropriate to their needs.

The telehealth specialist team would also work with the local MCFD-CYMH team in the same community (and Foundry or Youth Hubs if available), thereby increasing community cohesiveness and team approach. Assigning specific specialists to work with specific regions would allow for development of relationships with community providers, along with specialist knowledge of the community, increasing the quality of the service over time. If telehealth specialist teams were hospital based, they would be able to leverage existing robust processes for appointment scheduling, medical documentation, and dictation, transcription, and report distribution services. Extra funding to support personnel costs of this service would be required. This comprehensive team approach would avoid the many potential problems which could arise in providing telehealth specialist access directly to primary care including lack of community supports to implement treatment plans, lack of administrative support to schedule and coordinate telehealth appointments, lack of standard structures for documentation and report distribution, and lack of robust triage processes resulting in long waitlists, and increased overall costs of MSP billing.

Creating an equitable telehealth system requires that communities have equitable access to funding for telehealth, including specialist and administrative support. Specialist payment for telehealth mental health

services in BC is most commonly via a mixed billing model with a combination of MSP (fee for service) for direct face-to-face patient contact, and sessional support for other activities (e.g. team meetings, consultation to MCFD-CYMH clinicians and PCP's, documentation, phone calls, etc.). Sessional requirements for specialists are up to one session (3.5 hours) per full day of work. In other words, if a community needs access to specialist services two days/month, it would require 24 sessions for the year. Currently there is no standard process to allocate specialist sessions to communities. This results in an inconsistent allocation with some communities in the province having access a greater number of sessions to support telehealth specialists than others.

Development of a standard method for sessional allocation related to telehealth and outreach for specialist compensation across the province to eliminate the current situation of "have" and "have-not" communities is recommended.

Telehealth service delivery is increasing among First Nations communities in combination with provider-based 'outreach in-community care'. This hybrid model of care delivery, albeit best practice, has implications on many providers eligibility for certain funding initiatives. For example, the Medical On-Call Availability Program (MOCAP) was created to address gaps in continuous, sustainable on-call provider coverage in rural and remote areas. Within this initiative, providers are only compensated for those days they are directly in community delivering care and not for those where coverage is provided via telehealth. These disincentives need to be addressed collaboratively with FNHA, MCFD, and the relevant Health Authority.

PRINCIPAL B:

Effective delivery of high quality telehealth

Recommendations #: *3. Pursue Canadian Radio-television Telecommunications Commission funding.*
4. Adopt a standard, user friendly secure tele-health software
5. Implement mechanisms for better communication and information sharing
6. Leverage existing provincial e-health viewers

The effective delivery of high quality telehealth services requires secure, reliable technology, as well as established work flows and systems to support its implementation. These requirements are outlined below, as well as suggestions for practical implementation.

1. High speed internet connection and a computer (or other hardware device) with web cam and speakers

   While many communities have reliable access to high speed broadband internet, gaps continue to exist, particularly in the most remote and often vulnerable communities. Remote communities often lack basic internet services and even the infrastructure required to host internet services. These gaps have been the focus of a recent Canadian Radio-television and Telecommunications Commission (CRTC) report (10), which established a universal service objective that all Canadians, regardless of where they live, should have access to broadband Internet services. Importantly, the CRTC is setting up a fund to build/upgrade infrastructure to address these gaps, particularly targeting rural and remote areas.

It is strongly recommended that these funds be accessed to create comprehensive access to telehealth for all British Columbians, regardless of where they live.

Furthermore, fiscal considerations must be made for isolated, remote, often First Nation's communities, where the costs and sustainability of the connectivity services are prohibitive. The costs cannot be borne exclusively by the community, as they have limited resources and competing demands. Many communities will require partnerships to ensure all elements of a telehealth service are available.

2. User-friendly software program that allows for a secure, high quality telehealth connection that is readily accessed from community providers' and specialists' offices.

Efficient use of telehealth requires that it be available in practitioners' offices. Uptake will be substantially lower (and human resource costs much higher) if specialists or community providers are required to travel outside of their place of work to access telehealth facilities. In addition, telehealth software that is inexpensive and does not require specialized equipment to use, is essential to decrease set-up costs.

If applications do not include adequate technical security safeguards, the exchange of information becomes vulnerable for a security breach. Any proposed technology must be pre-approved for use before any site can engage in telehealth with a specialist.

Currently, different health authorities have diverse specifications on which software can be used. In addition, MCFD-CYMH offices use Microsoft Lync for teleconferencing, but this software has not been accepted by the health authorities outside of provisional acceptance by PHSA. These institutional barriers are a significant impediment to the development of easily accessible telehealth throughout BC.

Adoption of a standard, user-friendly, secure telehealth software that can be used without specialized equipment in a clinician's office, across all health authorities, MCFD-CYMH, and communities is strongly recommended.

3. Secure, reliable mechanisms for communication and sharing of medical information

Currently, many barriers exist which impede information flows between telehealth specialists and community providers. There is lack of standardization of work flows between communities, different electronic medical record systems, and barriers to timely access to specialist reports, particularly when patients present in emergent situations.

Telehealth providers typically make medication recommendations but do not prescribe directly. Thus, delays in transmission of information directly impact clinical care, causing delays in needed treatments and potential safety issues particularly if needed information cannot be accessed in emergency situations. These information sharing issues are detailed below, with suggested solutions.

a. Specialist access to relevant patient/client information

To provide effective care, specialists require access to relevant patient/client information including previous assessments. Patient information is currently housed in multiple venues including PCP charts, MCFD-CYMH team electronic client records (PARIS and CARIS), and hospital charts. This contributes to potential fragmentation and may decrease quality of care. Strategies to mitigate these challenges include:

i Provide psychiatrists contracted by MCFD-CYMH teams access to the existing electronic record (CARIS or PARIS). Currently, there are protocols in place for remote access, allowing for review of the client chart. **This recommendation could be added to the MCFD-CYMH telehealth policies and implementation toolkit to create a standard across the province.**

ii A mitigating strategy until a fully effective information sharing mechanism is in place would be, when possible, giving youth and families access to their medical records, so they are able to share reports between care providers.

b. Reliable mechanism for transcription and distribution of telehealth specialist dictations to community providers

Depending on where the specialist provider resides, workflows for allowing secure transcription and distribution of medical documents may not be in place, particularly for specialists working remotely with MCFD-CYMH teams who are not connected by hospital based transcription and report distribution systems.

Currently there is no standard mechanism for report transcription and distribution, with health authorities and MCFD-CYMH having differing practices. There are a variety of different electronic medical record systems in use across the province that cannot interact. In addition, MCFD-CYMH clinician reports are not routinely distributed due to legislative constraints.

Telehealth specialist recommendations need to be shared appropriately and in a timely manner with community providers including MCFD-CYMH team and the primary care home physician in a timely manner. ***In addition, should a client in crisis arrive at a local emergency room, having specialist reports readily accessible provides better continuity of care.***

These information flow challenges result in unnecessary delays and potential care interruptions, as well as decreased quality of care. Potential strategies to improve flow of information include:

i. When available, **leveraging existing dictation and report distribution services in the health authorities many of which are efficient and well-established.**

ii. **Creation of a standardized system for report transcription and distribution for MCFD-CYMH teams across the province.** This would allow for efficiencies of scale and routine quality monitoring for timeliness, and take burden off individual communities to each create their own system.

iii. **Other options for MCFD-CYMH contracted specialists would include the provision of a government email (@gov.bc.ca) to allow secure transfer of files.** If the specialist is using a digital recorder for dictation, they would first send audio files to the MCFD-CYMH team for transcription and then get transcribed files returned for review and approval. If voice recognition software such as *Dragon Medical Dictation* is being used, the Word file would be sent directly. Use of dictation software would require start-up purchase costs but save on ongoing costs of report transcription. Use of a digital recorder would incur lower start-up costs, but entail ongoing transcription costs.

iv. **Distribution of MCFD-CYMH assessments to PCP's, with appropriate consents in place, to enhance continuity of care.**

c. Availability of information in emergency situations

In emergency situations, access to medical information is needed to be able to provide high quality assessments and determine patient disposition. Currently, if a client/patient with mental health concerns arrives in crisis to their local emergency department, hospital staff typically do not have access to needed information. This negatively affects the quality of the assessments the emergency department is able to provide and can result in duplicate work and investigations, incurring additional costs to the system

One solution is to **leverage existing provincial ehealth viewers such as CareConnect to create a repository for telehealth (and non-telehealth) specialist reports which can be accessed by community clinicians including hospital emergency departments in the case of emergent presentations.**

PRINCIPAL C:

Sustainable telehealth that builds community capacity and integrates with community care systems:

Recommendations #: 7. Use Tele-health to build community capacity.
8. Combine Specialist tele-health services with in person visits
9. Engage individual communities in the planning of tele-health services.

Creating a sustainable telehealth system includes focus on building community capacity to care for child and youth with mental health needs and integrating with existing community care systems, including primary care homes.

Effective mental health care requires team work with PCP's, MCFD-CYMH clinicians, youth and families, and specialists working together. This is particularly relevant for telehealth specialists who typically would make recommendations for PCP's regarding medications, rather than prescribing directly.

A sustainable telehealth system must also be sensitive responsive to the needs of the individual communities it serves. This is particularly relevant for First Nations communities and their youth who often seek access to

indigenous healing practices. Service delivery must be culturally relevant and be reflective of the unique nuances specific to First Nations Health care delivery.

Recommendations for building community capacity and increasing effective integration of telehealth with existing community services team include:

1. **Collaborate with individual communities in the planning of tele-health services for their area to ensure they are culturally relevant and suit their needs.** Consultation with PCP's, Pediatricians, MCFD-CYMH teams, First Nation's services, and youth and families will assist in greater engagement and participation in the telehealth services by all parties as well as provide opportunities for strengthening community capacity. Consultation will also provide an opportunity for understanding of culturally relevant issues and supports needed for all members of the community needing services. Engagement work can be supported through avenues such as Local Action Teams; community tables; Divisions of Family Practice and regional management tables.

2. **Use telehealth to build community capacity to manage child and youth mental health concerns by supporting community providers with education and case consultation**.
    a. Create the expectation that part of telehealth specialist role is to teach/build capacity in local community including:
        i. Discussion of patient-specific recommendations with PCP's, pediatricians, MCFD-CYMH clinicians, and youth/families.
        ii. Indirect consultation to PCP's and MCFD-CYMH clinicians about clinical cases.
        iii. Educational presentations on areas of interest to local clinicians and PCP's, as well as youth and families.
        iv. Engaging in networking opportunities and case discussions with specialists, local clinicians and PCP's, e.g. holding a virtual luncheon.
    b. Capacity building needs to be supported by sessional contracts for specialists to fund team meetings, indirect care time, and case-based teaching

3. **Assign individual specialists to work with specific communities to enable development of longitudinal relationships with community providers and enhance effectiveness of capacity-building.** This model also allows the specialists to develop knowledge and understanding of the local community, particularly important in vulnerable, culturally sensitive areas.

4. **Whenever possible, include periodic in-person specialist visits to the community to help develop relationships between care providers and patients and increase team effectiveness.** In-person visits to help build and strengthen relationships are particularly important in First Nations communities where historically there have been issues of trust between providers and patients.

Conclusions

In conclusion, telehealth technology has great potential to increase access to mental health services for children and youth in BC, while remaining cost-effective and timely compared to traditional service delivery models in rural and remote areas. While some telehealth programs are in place in BC, they are currently developed in an ad hoc manner, with each community developing its own combination of software, communication protocols, triage systems, etc. and serving only certain communities and agencies.

Cost implications for developing a comprehensive program would require further analysis and are beyond the scope of this paper. Nevertheless, as noted above, some costs such as sessional support for specialists would likely be achievable through redistribution of existing resources, whereas others would likely require new funding.

We strongly advocate for a comprehensive, effective telehealth system that creates equitable access for all children and youth in BC with mental health and substance use needs, that includes a focus on long term sustainability through engagement, community capacity and integration with existing community care systems including primary care homes.

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Appendix A

BC Children's Hospital Cost Comparison of traditional outreach versus telehealth (2015).

	Traditional Outreach Visit	**Telehealth Equivalent**
Number of Patients Seen	8 Total, 4- New 4 – Follow up	8 Total, 4- New 4 – Follow up
Physician MSP Fees	$2416.00 (includes rural retention premium)	$2080.00 (no rural retention premium)
Physician Sessional Fees	$1272.00	$1104.00
Other Costs	$1308.04 (airfare, hotel and meals)	$885.65 (Equipment and Operational costs)
Travel Time Honorarium:	$1000.00	$ 0.00
Total:	*$5996.04*	*$4069.65*
Cost Saving= $1926.39 per average visit, or $240.81 per patient		

Appendix B

Working Group Membership:

Dr. Susan Baer, Co-chair	C&A Psychiatrist BCCH co-chair
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