NABH Education and Research Foundation

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TELEHEALTH IS EFFECTIVELY AUGMENTING TRADITIONAL PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT PROGRAMS

Catalyzed by the COVID-19 pandemic, many behavioral health care providers implemented telehealth services to augment existing partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs). Research shows that the use of telehealth improved access to care and optimized the reach of existing personnel.[1,2] Further, the initial findings of several National Association for Behavioral Healthcare (NABH) members indicate that relative to in-person services, telehealth delivery of care produced similar or better outcomes for PHP and IOP patients. This paper discusses the impact of regulatory flexibilities on telehealth PHP and IOP services, emerging research findings on telehealth PHPs and IOPs, and recommendations for policymakers. Key takeaways include:

- Regulatory flexibilities enabled the rapid implementation during the COVID-19 crisis of telehealth by traditional in-person PHPs and IOPs.
- Using telehealth to deliver PHP and IOP services has improved access to care for remote patients and those facing other access obstacles.
- Emerging research is showing that, relative to in-person care, the use of telehealth in PHPs and IOPs generally is improving the quality of clinical care, patient satisfaction and the overall efficiency of the health care system.
- Given these demonstrable benefits, policymakers and payers should support continued coverage of payment for telehealth in PHPs and IOPs.

PHPs and IOPs treat individuals for mental health disorders, substance use disorders and eating disorders. These programs provide intermediate-level care that often fills a step-down role following inpatient and residential services or averts hospitalization or residential placement. PHP services are usually provided four to six hours per day, five days per week for two to six weeks, and IOPs provide nine to 19 hours of programming per week. Both programs may include a combination of group therapy, individual therapy, medication management, support groups, laboratory testing, physician examinations, and other wraparound services and supports.

Pandemic regulatory flexibilities enabled PHPs and IOPs to incorporate telehealth to their services

In 2021, more than 30 million Americans received approximately 100 million telehealth visits. Notably, more than half of all telehealth services are now related to behavioral health care, with about half of all behavioral health care services being conducted via telehealth.[3] During the pandemic, providers were able to implement telehealth PHP and IOP services due to a variety of federal and state regulatory flexibilities, many of which are tied to the federal public health emergency (PHE),

[1] Hatef, E., et al. "Use of Telehealth During the COVID-19 Era." Systematic Review. (Prepared by the Johns Hopkins University Evidence-based Practice Center under Contract No.75Q80120D00003.) AHRQ Publication No. 23-EHC005. Rockville, MD: Agency for Healthcare Research and Quality; January 2023. https://doi.org/10.23970/AHRQEPCSRCOVIDTELEHEALTH.

[2] McBain, Ryan K., et al. "Mental Health Service Utilization Rates Among Commercially Insured Adults in the US During the First Year of the COVID-19 Pandemic." *JAMA Health Forum* 4, no. 1 (January 6, 2023). https://doi.org/10.1001/jamahealthforum.2022.4936.

[3] Trilliant Health National All-Payer Claims Database, Centers for Medicare & Medicaid Services. "Preliminary Medicaid and CHIP Data Snapshot – Services through August 31, 2021." CMS. Accessed December 2022. https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-08-31-2021.pdf.

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which is expected to end by mid-2023. Without the addition of telehealth to these programs, patients with or recovering from COVID-19, those beyond geographic proximity to clinics, and patients facing local service waiting lists would have faced delayed or no access. In fact, the Government Accountability Office reported that even with the addition of telehealth PHP and IOP services, behavioral health care access gaps persisted nationwide.[4]

When incorporating telehealth into existing PHP and IOP clinical protocols, physicians and other clinicians first ensured that patients received continuity of care that is safe and clinically appropriate. Specifically, clinical protocols were adapted to add patient safety checks and escalation protocols in a remote environment during both intake and program delivery. Among others, these adaptations included training clinicians to conduct visual assessments of patient safety over video and implemented secure platforms to ensure patient privacy. Providers also developed decision-support tools and protocols for clinicians to conduct patient intake and determine whether it was clinically appropriate for a particular patient to transition from in-person to virtual care.

As the pandemic evolved, continuous health system leadership support was critical to the success of telehealth PHPs and IOPs. These leaders removed operational obstacles for their teams by making the necessary investments in technology and training, implementing more flexible work policies, and helping staff navigate the changing regulatory landscape by acquiring the needed expertise. In addition, to continue refining telehealth delivery of services, several organizations implemented rapid-learning cycles to continually assess and improve clinical delivery of the telehealth modification.

Emerging research supports telehealth PHP and IOP services

The NABH members interviewed for this policy brief report the following lessons on the telehealth option for PHPs and IOPs:

- **Telehealth facilitates access to PHPs and IOPs**.
  - Facilitates treatment for patients who otherwise would face access barriers due to a lack of transportation,[5] health issues, childcare needs, work, school or family commitments. These access challenges are exacerbated for patients requiring multiple weeks of services.
  - Enhances access to specialist consultations that otherwise would be hard to secure, which can materially improve quality of care for more complex patients requiring less-available clinical expertise, such as for rural patients who primarily have access to generalists.
  - Enables participation in group care for patients who require this treatment approach.
- **Telehealth improves patient adherence and continuity of care.**
  - Reduces patient "no show" rates, thereby improving successful patient outcomes and program efficacy.
  - Increases participation of family members in treatment sessions.
  - **Helps patients and health plans avoid more expensive residential and inpatient stays, which can** disrupt work, school and family norms—especially for parents who end up having to choose between receiving treatment and caring for their children.
  - **Would boost treatment continuity during and following the phaseout of the COVID-19 pandemic.**
- **Telehealth offers behavioral health care workforce flexibility.**
  - **Optimizes the utilization of key clinical and other personnel who are in short supply**, which is especially critical for those shortages that are expected to persist after the official conclusion of the pandemic period.
  - Improves **recruitment and retention of clinical and other staff** who must or, as a condition of employment, prefer to work remotely.

[4] U.S. Government Accountability Office. "Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts." U.S. GAO, March 29, 2022. https://www.gao.gov/products/gao-22-104597.

[5] Vinella-Brusher, Emma, et al. "Potential of Telehealth to Mitigate Transport Barriers: Evidence from the COVID-19 Pandemic." Findings. Findings Press, July 22, 2022. https://findingspress.org/article/37060-potential-of-telehealth-to-mitigate-transport-barriers-evidence-from-the-covid-19-pandemic.

Member Spotlight: Universal Health Services (UHS) provided data on ~84,500 PHP and ~50,500 IOP visits from July 2021 through July 2022, with 15% of these visits provided via telehealth. For approximately 30% of these telehealth patients, self-reported symptom-rating scales were available. For both PHP and IOP patients, the proportion of patients whose assessment scores improved between admission and discharge was either comparable or higher for services delivered via telehealth compared with in-person treatment.[6]

Summary of NABH Member Research Findings

Several NABH members have published their evaluations of the efficacy of telehealth in PHPs and IOPs.

Key Findings	Supportive Evidence
Patient attendance and participation in telehealth PHP and IOP care are higher than for in-person delivery.	• Northwell's Zucker Hillside Hospital cited a 5% increase in the attendance of its enrolled patients in its 2020–21 telehealth PHP, with an attendance rate of 89.5% compared with 84.5% for its 2019–20 in-person program.[7] Anecdotally, patients cited not having to travel and ease of scheduling PHP around their existing commitments as facilitating factors for attendance. • This is consistent with data found in other studies.[8]
Patient-reported clinical outcome scores show similar symptom reduction and functional improvements between in-person and telehealth PHP and IOP patients.	• From August 2020 to February 2021, Rogers Behavioral Health compared clinical outcomes across its adult PHPs and IOPs (1,192 in-person and 1,192 telehealth). There were no significant differences in patient assessment results across different clinical groups. Similarly, the preadmission and post-discharge assessment improvement scores were similar across in-person and telehealth groups.[9] • Research studies from Zucker Hillside Hospital[10] and McLean Hospital[11] generated similar results in patient-reported rates of symptom reduction and improved function.
Patient satisfaction measures are very similar between in-person and telehealth PHPs and IOPs.	• McLean Hospital identified no statistical differences between in-person and telehealth patient satisfaction scores in their PHPs. The majority of patients reported feeling informed about and included in their care (8.7/10 for the overall rating of the program for telehealth and 8.6/10 for in-person PHP). • On average, patients reported feeling "much improved" and "quite a bit helped," and "would recommend the program to a loved one." Further, 95% would recommend the program for both telehealth and in-person PHP.[12] • UHS found similar or higher patient satisfaction scores for patients who received care via telehealth compared with in-person. Among patients who used telehealth services, 70% would recommend it to others.[13]

[6] Universal Health Services, Inc. "UHS PHP and IOP Patient Utilization Data (July 2021–July 2022)." UHS. Accessed November 2022.

[7] Vlavianos, Theodore, and Marguerite McCarthy. "Positive Outcomes in a Virtual Partial Hospitalization Program." Joint Commission Journal on Quality and Patient Safety vol. 48,9 (2022): 450–457. https://doi.org/10.1016/j.jcjq.2022.04.007.

[8] Childs, Amber W., et al. "Showing Up Is Half the Battle: The Impact of Telehealth on Psychiatric Appointment Attendance for Hospital-Based Intensive Outpatient Services During COVID-19." *Telemedicine Journal and e-Health: The Official Journal of the American Telemedicine Association* vol. 27,8 (2021): 835–842. https://doi.org/10.1089/tmj.2021.0028.

[9] Bulkes, Nyssa Z., et al. "Comparing Efficacy of Telehealth to In-Person Mental Health Care in Intensive-Treatment-Seeking Adults." *Journal of Psychiatric Research* vol. 145 (2022). 347–352. https://doi.org/10.1016/j.jpsychires.2021.11.003.

[10] Hatef, E., et al. "Use of Telehealth During the COVID-19 Era." Systematic Review. (Prepared by the Johns Hopkins University Evidence-based Practice Center under Contract No.75Q80120D0003.) AHRQ Publication No. 23-EHC005. Rockville, MD: Agency for Healthcare Research and Quality; January 2023. https://doi.org/10.23970/AHRQEPCSRCOVIDTELEHEALTH.

[11] Hudson, Chloe C., et al. "Treatment Outcomes and Patient Satisfaction of a Virtual Partial Hospital Program: A Mixed-Method Study." *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, 1–16. (June 24, 2022). https://doi.org/10.1080/10503307.2022.2088314.

[12] Ibid.

[13] Ibid.

NABH members' preliminary findings indicate that telehealth PHP and IOP services are resulting in **clinical outcomes that are the same as or better than** those of traditional in-person services. While further research is warranted, collectively, these initial results point to the value that telehealth PHPs and IOPs provide for patients and providers, which warrants continued coverage of PHP and IOP care via telehealth beyond the pandemic.

Policymakers and payers should continue covering telehealth in PHPs and IOPs

Given the perennial gaps between behavioral health care service needs and provider shortages, telehealth will continue to be essential in care delivery and improving access to both low-acuity behavioral health counseling and higher-acuity services, such as those provided by PHPs and IOPs. NABH is concerned that without continued coverage and reimbursement for telehealth PHP and IOP services, access gains that were achieved through COVID-19 flexibilities will be lost and, to prevent this reversal, proposes the following guiding principles for policymakers and payers:

Parity

- Following the official PHE, maintain parity in coverage for tele-behavioral PHP and IOP services.
- To achieve parity in payment, reimburse telehealth PHP and IOP services at the same rate as comparable in-person services.

Coverage

- Ensure that Medicare Advantage and other payers are covering and reimbursing providers for individualized patient care, including determinations of whether telehealth options are clinically viable. Such individualized treatment plans must be set by the treating physician and other clinicians evaluating the patient, without unilateral health plan restrictions.
- Expand the list of Medicare and Medicaid telehealth covered services to include all clinically appropriate tele-behavioral PHP and IOP services.
- Permanently expand the type of covered practitioners eligible to furnish telehealth services.
- Remove the Medicare coverage requirement for in-person treatment prior to telehealth services.
- Make permanent the pandemic flexibilities on cross-state licensure for behavioral health and other clinicians.
- Cover audio-only tele-behavioral PHP and IOP and other remote services to enable the treatment of patients lacking video capability.

Policy Development

- Support additional research on telehealth PHP and IOP services to identify best clinical and operational practices, including recommendations on patient screening, safety and crisis response, medication management, technology/connectivity, and staff training.
- Develop quality measures for IOP, PHP and other behavioral health care services delivered via telehealth.

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