

# **Telehealth Case Studies**

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# Case-Based Learning

## CASE STUDY

### Using Telehealth to Coordinate Care for Youth with Complex Needs Transitioning from Pediatric to Adult Care:

19-year-old young adult with autism spectrum disorder, intellectual disability, and attention-deficit/hyperactivity disorder

**Lily Payvandi, MD , Kevin Hummel, MD, Kathleen Huth, MD, MMSc-Medical Education, FRCPC, and Richard C. Antonelli, MD, MS, FAAP**

#### Needs and goals to consider

- Youth with special health care needs who transition from pediatric to adult care face challenges in care coordination.
- Providers caring for youth during these transitions face challenges in coordinating appropriate and safe hand-offs between pediatric and adult care teams.
- Access to healthcare is a critical social determinant of health and is key to such transitions. Social determinants of health affect a wide range of health outcomes. These include conditions in which people live, work, learn, and play; for example: food and housing insecurity, poverty, transportation needs, and neighborhood safety.
- Telehealth presents an opportunity to create value in the transition between pediatric and adult care by enhancing points of access and improving communication between care providers, youth and families/caregivers.
- Leveraging tools and adopted policies put forth by the AAP on the use of telehealth and care integration can drive value in the care of youth with special health care needs.

#### Suggestions for Pediatric Clinicians and Practices

To align with the American Academy of Pediatrics Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee Policy Statement on *Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems*. (PEDIATRICS Volume 133, Number 5, May 2014):

1. Use health information systems and information technology to foster collaborative communication between youth, families and the care team.
2. Leverage tools of telehealth to ensure that youth/family have access to information sharing needed across providers and health systems.
3. Ensure that co-management and communication occur among specialists and primary care providers via telehealth.

# Case-Based Learning

continued

**Note to the facilitator:** This module includes a clinical scenario that can be used to illustrate feasible ways to integrate and adopt AAP policy and recommendations related to care coordination via telehealth. The scenario can be adapted in a way that best resonates to participants. For example, instead of having participants place themselves in the shoes of a primary care provider, they can discuss the case from the perspective of another care team member such as a social worker or member of the education team. Facilitators should guide participants to consider the following questions during the case:

- How can telehealth be used to defragment care?
- How can telehealth improve youths' transition of care across health systems?
- Which team members should be included within the telehealth model for care coordination?
- What features should be included in the telehealth model to meet the needs of youth with complex or chronic care (ex: remote patient monitoring)?

Independently read and reflect on the case below and then discuss as a small group. We will then debrief as a larger group.

## David

David is a 19-year-old young adult with autism spectrum disorder, intellectual disability and attention-deficit/hyperactivity disorder (ADHD). You are David's primary care clinician and work closely with his interprofessional team, including, psychiatry, speech-language pathology, occupational therapy, education team and social work. The goal at recent visits has been to increase his functional independence and begin transition to adult care. However, David does not typically transition well to unfamiliar environments. Yesterday, his father, who is his health care power of attorney, called your office with concerns about recent aggressive outbursts at school despite behavioral and pharmacologic treatments. Staff informs you that your next available appointment is not for another two weeks. He and his siblings live in a rural area and his father drives long distances across care sites after working two jobs; the family often misses appointments. You are planning with your team to utilize telehealth to help address these acute concerns as well as his transition to adult care.

- What needs and care goals can you identify in David's case?
- Identify factors that may limit David's access to healthcare.
- How can telehealth be used to help David transition from pediatric to adult care settings?
  - ~ What team members should be involved in telehealth encounters?
- How can telehealth help address social determinants of health and connections to community organizations?
- How can telehealth provide an opportunity to focus on David's family strengths and support systems?
- What actions will you take to implement coordination of David's care via telehealth?
- What challenges might you face in coordinating care via telehealth?
- How can telehealth address his needs and care goals?

# Case-Based Learning

continued

**Note to the facilitator:** As small groups discuss their responses, consider offering the following probing questions to stimulate discussion:

- How can digital and non-digital tools be integrated to best coordinate care? Think about the interplay between in-person visits, telehealth visits, patient portals, and remote patient monitoring.
- Care integration recommendations are outlined in the AAP Policy Statement on *Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems* and consider ways that telehealth meets recommendations at a higher value than in person care delivery.

After 5-10 minutes, debrief in a larger group. Write 2 headings on the board: “Challenges” and “Actions.” Ask each small group to share their “headlines”—1 to 2 key points they discussed or key questions they had.

**Actions** may include the following practices in the delivery of care coordination through telehealth services: (3-5 promising practices)

- Inquire about the family’s access to digital technology and internet broadband coverage, as well as their digital health literacy. For example, ‘what devices do you own?’, ‘how comfortable do you feel using your device’, ‘do you have headphones for privacy?’ Please find additional tips [here](#).
  - ~ Connect them to clinic resources and/or community partners.
- Ensure that David and his family are enrolled in the patient portal.
  - ~ Establish whether the youth is independent or has a health care proxy or power of attorney. In this case, David’s father is the health care power of attorney and helps David with enrollment and utilization of the portal.
- Notify David’s family of the option of scheduling certain visits virtually.
- Inquire whether members of his care team, and future adult care team, would be willing to co-host multi-disciplinary telehealth visits to coordinate care and help with adult onboarding.
- Set expectations with David and his family of advantages and limitations of telehealth visits versus in-person care, highlighting indications for choosing each visit type.
- Refer youth and families to telehealth resources such as [Family Voices National’s Telemedicine Curriculum](#) or [Got Transition Toolkit](#).

**Challenges may include:**

- Limited youth and family access to digital health tools
- Limited youth and family access to confidential and/or private space
- Limited youth and family video conferencing skills and difficulty engaging in telehealth
- Willingness and/or availability of care team members to participate in a telehealth visit
- Creating a protocol to address youth and family chief concerns that are and are not appropriate for telehealth
- Establishing rapport and trust with youth and families virtually
- Ensuring telehealth platforms and third party applications adhere to state and federal regulations for youth privacy
- Working with insurance companies for long-term payment of telehealth visits
- Appropriately using care coordination coding
- Ensuring screening tools and assessment instruments are validated for telehealth use

# Case-Based Learning

continued

## Action Grid

Goal	Action	Who is responsible	Timeline	Contingency
<b>Ensure access to digital health tools.</b>	Inquire about family's access to digital technology and internet broadband coverage, as well as their digital health literacy. Connect them to clinic resources and/or community partners if needed.	Case Manager	Will call patient's family this week.	If unable to reach family by phone, will inquire at next in-person visit.
<b>Ensure access to digital health tools.</b>	Arrange patient portal enrollment for David and his family.	Clinical Staff	Will call patient's family this week.	If unable to reach family by phone, will walk through portal set-up at next in-person visit.  If family does not have needed digital technology and internet broadband coverage, will connect to social worker (if available) to connect family to clinic resources.
<b>Ensure access to digital health tools.</b>	Prescribe remote patient monitoring devices including a scale and home vital sign measurement kit.	PCP/Clinic nurse	Will enter order for equipment and provide information to family about its use 1 week prior to visit.	
<b>Facilitate appointment scheduling and care handoff in transition from pediatric to adult care.</b>	Transfer care to adult primary and specialist providers.	PCP/Clinic Staff	Referral sent this week; requesting an appointment within 4 weeks.	If family has not received a call from the psychiatrist office in 2 weeks, they should call the office directly at (111)-111-1111.  Our clinic administrative assistant will contact family in 2 weeks to follow up on referral.

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