First Episode Psychosis Programs: Responding to COVID-19

Presenters:

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Moderated by
Steven Adelsheim & Kate Hardy

Overview and Introductions

- Cathy Adams, LMSW, ACSW, CAADC, Owner and Clinical Director, ETCH
- Piper Meyer-Kalos, Ph.D., Assistant Professor, University of Minnesota, Department of Psychiatry and Behavioral Sciences, developer, trainer, and clinician for the NAVIGATE model
- Tara Niendam,Ph.D., Associate Professor, Department of Psychiatry, and Executive Director, UC Davis SacEDAPT Clinic
- Iruma Bello, Ph.D., Clinical Training Director, OnTrackNY, Center for Practice Innovations, Division of Behavioral Health Services and Policy Research

Current status of CSC program - ETCH

- Immediate switch to telehealth for all elements of CSC program (IRT, FE, SEE, Prescriber and Peer)
- Injections occurring weekly with a limited contact method
- Use doxy.me, RingCentral, phone and rarely Facetime to accommodate various needs/limitations to technology access (internet, devices, knowledge/comfort)
- Increased outreach to all participants and families—check-ins
- Added additional group interventions (or switched existing to virtual)
  - Peers- “Come As You Are” chatroom, virtual tours/outings, virtual movie night, (plus 1:1 contacts)
  - SEE- support group for work/school impacts, leisure interests group, multi-player gaming, 1:1 check-ins, focus on areas conducive to virtual meetings (resumes, job interviewing practice, mutual research on school/job curiosities)
  - Living Well group-values driven lifestyle choices, co-occurring support
  - Virtual Family Gathering-pending
- Crisis/hospital diversion—face-to-face considered
- Enrollment remains open—initial assessments via telehealth feel awkward but have been successful

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Current status of CSC program - NAVIGATE

- Programs across the country are providing a variety of telehealth options.
- Most programs have incorporated a video session option but it is not accessible to everyone.
- Programs are continuing in-person options for essential needs and offering some social distancing in-person options.
- Mixture of staff working in the office and remotely.

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Current status of CSC program - EDAPT

Leadership Team:
Khalima Bolden, Ph.D.
Dan Shapiro, Ph.D.
Laura Tully, Ph.D.
Paula Wadell, MD.
Cameron Carter, MD.

- EDAPT (commercial insurance) and SacEDAPT (Medi-caid, SAMHSA, CA Prop 63)
- Moved to telemed for core program components (intakes, meds, individual/family therapy, SEE, peer and family advocacy, case management) on March 13 - we had already developed a policy for clinic-to-home telemed.
  - All staff moved to work from home by March 23
- Adding telemed groups this week
- Using Zoom or MyChart for most of our meetings, phone if that's the only thing that works for the client/family
- Kept team meetings on Mondays – added team check-ins daily starting March 16, moved to MWF last week
- Moved team onto Microsoft TEAMS and VPN to create a 'virtual office' and to approximate some aspects of workflow from home
  - Daily announcements, sharing of files, video supervision, etc.

Current status of CSC program - OnTrackNY

- Variability across 23 teams: Most providing telehealth but in different ways
  - Teams delivering services from home
  - Teams coming into clinic to deliver telehealth
  - Teams doing face-to-face with high-risk participants and rest doing via telehealth
  - LAIs provided in person by nursing staff; 2 team providing LAIs in the community
- Staffing variability:
  - Teams fully staffed
  - Teams have staff members that have been redeployed to other areas in hospitals
  - Staff members who are out due to childcare needs or illness
- Telehealth:
  - Relaxed privacy rules- can obtain verbal consent for telehealth, using a range of platforms, some people want video and others don’t but willing to use phone

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Challenges and solutions - ETCH

- Technology—access and aptitudes, problem solve, offer coaching/practice runs
- Telehealth:
  - can't fully capture non-verbals, med side-effects assessments, etc.
  - limits scope and depth of support you can provide—can't "lean in"
  - changes in frequency/duration, though some participants and families liking the telehealth venue—perhaps more than face-to-face (convenience, lower sense of expectation, a degree of separation preferred)
  - generational dynamic with phone conversation (not interested in a lengthy call)
  - hesitancies to use tele platforms—problem solve anxieties (being recorded?), consider "playing to the" person on the TEAM with the strongest connection (Peer, SEE, FE)
  - wanting/needing multiple contacts per week—impacts workload and availability, pull in other team members
- Privacy—participants and parents may have some reservations when sharing a home together or when there are roommates.
  - check in with each individual to determine their comfort level with format
  - problem solve in advance of contact…have a "back up plan"
  - car session
  - parking lot session
- Workforce isolation/apartness—mindfulness practice/support, added a "non-agenda" meeting, check-ins with each other, increase supervision offerings
- Referral sources uncertain about how to refer—outreach, educate, reassure/support

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Challenges and solutions - NAVIGATE

- Connecting people to technology
- Transitioning to telehealth sessions
  - Managing sessions with decreased nonverbal information
  - Using manualized intervention with handouts remotely
  - Assessing risk, stress, and symptoms
- Supporting and empowering individuals
  - Revisiting and updating goals
  - Activities to fill unstructured time
  - Coping skills for stress and negative feelings
  - Practicing skills in session

Challenges and solutions - EDAPT

- Technology needs for the team
  - Phones (only 4 staff had work phones), computers, workstations/chairs, Wifi, privacy, access to shared drives on network → Let staff take "check out" items from clinic, install "phone" program on computer (voice over internet protocol)
  - Switched from paper to electronic, overnight → created fillable PDFs, Qualtrics surveys for self-reports
  - Posted how-to videos and check-lists for getting telehealth and telecommuting running
- Administrative difficulty in oversight, tracking, QM
  - Developed new flow-sheets and checklists for clinicians regarding documentation changes (and constantly changing guidance from payers)
  - Checklists for telehealth reimbursement requirements
  - Workflow checklists and coordination documents to maintain and coordinate intakes/referrals when admin staff are in different places
  - Clinicians submit daily accounting of billable activity, billing codes, etc. for verification by admin staff and supervisor review
- Technology needs/concerns for the clients
  - Access to zoom on phones has worked for current clients/families
  - Newer clients are hesitant to use zoom or even phone… Let's do the best we can!
- Consent
  - Verbal vs written consent → documentation standards and templates
- Keeping clients out of the hospital
  - Focus on ongoing risk assessment and safety planning, regular brief check ins, team work to keep folks stable
  - Shorter but more frequent sessions
- Keeping clients 'connected' and helping them build daily structure
  - Family advocate using family listserv to increase sense of connection with families. Share updates and information, as well as brief articles by her normalizing the difficult experience and sharing appropriate lived experience
  - SES having weekly meetings to do schoolwork, build work skills, resumes

Challenges and solutions - OnTrackNY

- Staffing: different configurations and rules which impact team functioning and team morale
  - Sought Office of Mental Health guidance for minimal recommended staffing to prevent total team re-deployment
  - Have sent out two state-wide surveys to stay informed of team functioning since it changes so quickly
  - Adapted fidelity document to help trainers consider aspects of the model requiring adaptation & strategies to do so
- Team functioning:
  - Intakes: most teams doing remote assessment- some hospitals allow video and/or phone, some don't. Teams getting creative, e.g. developing new materials/ videos for participants. Navigating work with homeless participants.
  - Engagement: 1 team developed video to send to all participants; shorter sessions, joint sessions across roles (e.g. Clinicians and SEES), sending participants information via email/text.
  - LAIs/meds: teams considering other meds that last longer (Invega Trinza); moving some people to orals if reasonable; nurses/MDs seeing people outside the home; using PPE; spreading out appointments.
  - Managing Crises when ED and Inpatient units closing: Staying informed re: changes & new ED procedures (e.g., evaluating people outside), enlisting family support in transporting people and developing a plan, using mobile crisis
  - Supported Employment/Education: Becoming familiar with systems for unemployment, exploring companies hiring online, supporting students transitioning to online learning- helping them navigate platforms, connecting with the schools for info
  - Peer Specialist: Developing packages with support strategies, many have started blogs/ FB groups, facilitating groups- gaming, developing list of activities people can do from home (online concerts, visiting parks virtually, etc.)
  - Working with families: Giving families more support since they are likely more stressed, offering virtual sessions and multi-family groups, helping families navigate resources available to help with finances and employment.

Workforce support - ETCH

- Miss the “tickings” of the daily workspace—the lack of daily connection and working in various degrees of isolation has been challenging—limits opportunities for case support, debriefing, affirmation, innovating, humor, hugs/support.
- Weekly team meetings continue with a mindfulness, grounding, affirming, connecting exercise at the start. Some sites have increased meetings per week
- Supervision with individual team members continues or has increased
- Resumed sessions with mindfulness coach
- Virtual coffee hours on Fridays—no set agenda, a place to connect, chat, share vulnerabilities/solutions/triumphs
- Group text chain—keep in touch, send meaningful messages, humor, etc

Workforce support - NAVIGATE

- Suggestions for helpful handouts to address emerging issues of negative feelings, stress, and boredom
  - Files of digital handouts
  - Options to share handouts with individuals (email, text, snail mail, internet)
- Flexibility in manualized approaches to respond to individual need
  - Targeting specialized needs in manuals
  - Suggesting more frequent and shorter contacts as needed
  - Offering opportunities to develop support communities (zoom drop-in groups)

Workforce support - EDAPT

- Personal needs for team
  - Childcare, difficulty problem solving/maintaining focus → allowed shifts in schedule to accommodate, extra supervision when needed, prioritization of tasks.
  - Feeling lonely, disconnected → shared games on Teams, people connected outside of work hours
- 'Resources wiki' with both material supports (e.g., school meals, food banks, SSI, census, etc.) and clinical ideas and handouts for clinicians
- Information sharing for sense of movement and direction
  - Created and sent FAQs on virus and local status. Daily emails from hospital leadership
- Daily Check ins
  - SUDS ratings, reinforce PROACTIVE coping, active problem solving to promote self care, prevent burnout and compassion fatigue. Normalize and validate that things take longer, reduced productivity, decreased cognitive capacity
- Supervisor of the day
  - One go-to person, one daily email for updates (or post to Microsoft Teams)
- Regular supervisor/leadership discussions to review staff concerns and make changes quickly
  - Remember supervisors need support too!
- Supervisor "drop ins" to zoom meetings for risk assessment
- Know your sick/family care/bereavement leave policy and be ready to provide coverage (across the team)

Workforce support - OnTrackNY

- State-wide role-based calls
  - Teams asked for more connection with each other so we started role-based statewide calls monthly; collecting innovative practices that trainers can share across calls
  - Training team sharing resources from the state and other avenues
  - Training team offering office hours where people can call in and connect with us
- Advocating for staff impacted by different agency rules
  - State level, local level and agency level rules vary and some staff are nervous
- Sharing information about strategies:
  - How to apply for unemployment
  - How to navigate school and employment supports
  - How to navigate new employment opportunities and using SDM to consider balancing risks
  - How to deliver telehealth/ get consent, creative ways to connect with participants/families remotely, run groups, do CBTp
- Participants needing concrete needs to stay in touch with team or to pursue work/school goals.
  - Guiding teams on using money in their budget to buy phones for participants
- Teams meeting more frequently:
  - Using Microsoft teams to chat, doing grounding exercises, supporting staff members who need to take time off due to childcare, illness, etc.
  - SEES particularly report finding it challenging to stay home or in the clinic all day- missing being out in community
  - Staff member uncertainty related to having to commute in public transportation and being exposed

Sustaining for the future? - ETCH

- Pre-COVID, had some telehealth for Prescribers. Will consider flexibilities to continue with other interventions, though worry that many aspects of support, assessment and care can not fully happen without face-to-face. (This would also depend on whether insurers “roll back” reimbursements for telehealth).
- Is an expectation being formed that appointments can be “briefer”—what will be lost if that continues?
- Likely to continue an array of Peer supports/access provided through virtual means—created an opportunity for a larger Michigan-wide community, ease of access, anonymity
- Though MHBG seems stable, other streams of income may be reduced. Concerns about overhead expenses not payable through grant funds.

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Sustaining for the future? -NAVIGATE

- Continuing to provide telehealth options for individuals to engage in services
- Creating ongoing opportunities to engage people in online learning and socialization

Sustaining for the future? - EDAPT

- Ongoing use of clinic-to-home telemedicine – and financial support for it
  - Has enabled more regular participation for clients who live far away
  - Clients have enjoyed it – showed their rooms, dogs, art… but this is a very tech-savvy generation. Has been harder for their families.
- Providing staff with sufficient supervision and support to prevent burnout

Sustaining for the future? - OnTrackNY

- Telehealth
  - Working well with some participants/families so determining how to keep some of these phone and video-based practices as regulations allow
  - Important for engaging families and running multi-family groups
  - Could inform how to do model in rural communities- seems more probable if we can keep the current more relaxed rules
  - Doing CBT and other supportive psychotherapy online
- SEES role
  - Becoming more familiar with online world since things are moving more and more in this direction for work and school opportunities
- Peer Specialist role
  - Creativity in connecting with people- blogs, videos, online groups, etc.
- Fidelity
  - More work in distilling potential key elements of the model to pay attention to moving forward

Q & A time!

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Thank you!

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