COVID-19 PANDEMIC CPQCC GUIDANCE FOR HRIF TELEHEALTH VISITS

I. BACKGROUND AND PURPOSE

The COVID-19 pandemic has substantively impacted how many High Risk Infant Follow up (HRIF) clinics approach follow up care for children and families. Results from the recent California Perinatal Quality Care Collaborative (CPQCC) HRIF Clinic Virtual Visits survey demonstrated great variation among HRIF clinics in terms of

- Use of "telepractice" or "telehealth" (which include both audio and video capabilities together in a virtual visit) vs. only telephone.
- Types of standardized assessments and questionnaires utilized for telehealth, if any.
- Whether those assessments are appropriate for non in-person visits.

It is clear that most HRIF clinics and other outpatient specialty groups expect to continue to utilize telehealth visits for at least the moderate-term future, and that HRIF teams desire guidance on developmental assessment options and prioritization for telehealth visits. Therefore, stakeholders from across the state were assembled to form the **CPQCC HRIF Telehealth Guidance Work Group.** The goals of the Work Group were to share insights and expertise, provide input on considerations for in-person and telehealth visit benefits and challenges as well as prioritization, and develop high level guidance to inform changes/ additions to the Standard Visit options. This document is guidance from a CPQCC work group, and does not constitute a California Children's Services (CCS) or Department of Health Care Services (DHCS) document.

II. GENERAL CONCEPTS AND CONSIDERATIONS: TELEHEALTH VISITS

A. Telephone "visits" alone allows for continued family contact, as well as follow up on referred patient services, and touchpoints on family needs. However, there is *limited value* of telephone only for developmental or motor assessment.

B. Telehealth (audio + visual) "virtual visits" utilizing appropriate assessments, and with patient/ parent as well as clinic/ provider preparation, can allow for evaluation and observation in the familiar setting of the family home.

- However, it is recognized that not all HRIF clinics have access to telehealth options.
- Importantly, not all families can participate in telehealth, in some cases due to resource, access, and economic disparities.
- Therefore, it is not yet clear whether telehealth may level or widen disparities associated with successful HRIF engagement.

C. In-person visits are ideal for comprehensive patient assessments and evaluation. But consistent in-person visits may be considered challenging at present due to the COVID pandemic. The current public health crisis coupled with linked difficulties for parents and primary care providers have made it more difficult for patients and families to travel to clinic locations.

- In-person access and allowable patient volume have been limited for many HRIF clinics during this period, thus telehealth may be considered the best or only option for some visits and assessments.
- It is also recognized that some parents and families are appropriately concerned about exposures and contacts, particularly in high or increasing COVID risk areas.

D. For sites offering both telehealth and in-person options, and during periods when in-person visits are possible, issues to consider that may prioritize in-person visits include but are not limited to:

- Families with resource challenges including computer or digital access limitations that may preclude telehealth or make it more difficult.
- Families who express preference for in-person visits.
- Patients considered at especially high risk due to previous evaluations or risk factors.
- During periods with expected escalating motor and developmental trajectory (e.g., Standard Visit 2 and 3), particularly if family/ team concerns or risk factors.
- Patients scheduled for research evaluations.

E. Telehealth visits may be optimized by parent discussions and preparations in advance, integrating concepts including but not limited to:

- Assuring that parents/ families have appropriate technology to allow for telehealth visit and providing "trial runs" in advance as desired.
- Explaining to families in advance what should be available (i.e., toys, play mat/ blanket, etc.) and how the home area should be set up to allow for optimal observation in relation to the computer/ tablet/ phone camera.
- Making sure to have a phone contact for the parent/ family prior to the telehealth visit in case connection is lost, and reassuring parent/ family that HRIF team will call parent/family if that occurs.
- Attempting to develop a telehealth approach that supports **"Team Visits"**, allowing for integration of all members of the HRIF team (i.e., provider, coordinator, social worker, OT/PT, nutrition, etc.) as required for the needs of the patient and family.
- ***"Telehealth Ideas for Families"*** *developed by Centre of Research Excellence in Newborn Medicine, Murdoch Children's Research Institute & The University of Melbourne*

III. CONSIDERATIONS AND ADDITIONS: DEVELOPMENTAL ASSESSMENT TOOLS

A. Telepractice and the Bayley-4

- Per Pearson Assessments guidance, The Cognitive, Language and Motor subtests **cannot be administered in a standardized format via telepractice**. The Social-Emotional & Adaptive-Behavior Questionnaires can be administered in telepractice using Q-global for Remote On-Screen Administration (ROSA) which does not require video contact, using Q-global for On-Screen Administration (OSA) via video-conferencing.
- *"Telepractice and the Bayley 4", also found at https://www.pearsonassessments.com/professional-assessments/digital-solutions/telepractice/telepractice-and-the-bayley-4.html*

B. Additional assessment options included in the Standard Visit (SV) form:

"Developmental Assessment Test" section of the SV form:

1. **Developmental Assessment of Young Children 2nd Edition (DAYC-2)**
   - Birth to 5 years 11 months
   - Domains available: Cognition, Communication, Physical Development, Social-Emotional, and Adaptive Behavior.
     - Reflects areas mandated for assessment and intervention for young children in IDEA.
   - ~ 10-20 minutes per domain; Spanish available; "Level B" required qualifications

- Data to be collected in the SV form:

DAYC-2		
Domain/Subdomain	Standard Score	Age equivalent
Cognitive		
Communication		
Physical Development		
Social-Emotional		
Adaptive Behavior		

2. **Developmental Profile -3 and -4 (DP-3 and DP-4)**
   - Birth to (12 yrs 11 mo: DP3, 21 yrs 11 mo: DP4)
   - Physical, Adaptive Behavior, Social-Emotional, Cognitive, Communication.
     - Reflects areas mandated for assessment and intervention for young children in IDEA.
   - ~ 20-40 minutes, Spanish available, "Level B" required qualifications
   - Of note: One potential drawback with this instrument is that the range of items in the infant- toddler range is limited.
   - Data to be collected for SV form:

DP-3 or DP-4		
Scale	Raw Score	Standard Score
Physical		
Adaptive Behavior		
Social-Emotional		
Cognitive		
Communication		

"Developmental Assessment Screener" section of the SV form:

3. **Warner Initial Developmental Evaluation of Adaptive and Functional Skills** (**WIDEA-FS**)
   - Birth to 36 months
   - Multidisciplinary observation criterion scale designed to examine emerging functional skills in the following domains: 1) self-care in feeding, dressing, and diaper awareness, 2) mobility, 3) communication, and 4) social cognition
   - 50-item checklist, 1-4 point scale for each query, ~ 10 -15 minutes, Spanish available
   - Data to be collected for SV form:

WIDEA-FS	
Domain	Score
Self-Care	
Mobility	
Communication	
Social Cognition	
TOTAL	

IV. CONCLUSION

In-person HRIF visits are ideal, but the COVID-19 pandemic has created barriers to consistently meeting that goal for some HRIF clinics and families. Despite potential hurdles and provisos, telehealth visits may be an opportunity for quality improvement in HRIF, allowing for some evaluation for high-risk children who may not be able to attend in-person visits, particularly during the period of the COVID-19 pandemic. With additional assessment options for telehealth visits, the goal is that HRIF clinic teams will be better able to appropriately evaluate children even in the current challenging circumstances.

CPQCC HRIF Telehealth Guidance Work Group

Susan Hintz, MD, MS – Medical Director, CPQCC HRIF
Erika Gray – Program Manager, CPQCC HRIF
Teresa Androvich, RN, PNP – Anderson Lucchetti, Sutter Sacramento
Raquel Brekken, MD – Kaiser Roseville
Jazmin Burns, Psy.D. – UC Davis MIND Institute
Brandi Chew, PhD - UC Davis MIND Institute
Nicole Diab, RN – UC Davis Children's Hospital
Mary Fortin, PT – Kaiser Santa Clara
Jessica Gates, RN – Valley Children's Hospital
Lynne Huffman, RN - Lucile Packard Children's Hospital
Bridget Johnson – UCSF Benioff Children's Hospital San Francisco
Lydia Lee, RN, BSN – UCSF Benioff Children's Hospital San Francisco
Sandra Lombardi-Lytle, RN, CCM, PHN, IBCLC – Lucile Packard Children's Hospital
Gayatri Mahajan, MD – Anderson Lucchetti, Sutter Sacramento
Elizabeth Rogers, MD – UCSF Benioff Children's Hospital San Francisco
Rosa Stewart – UC Davis MIND Institute