The COVID-19 Crisis: A Mental Health Perspective and Response Using Telemedicine

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Abstract
With the outbreak of COVID-19, patients and providers were forced to isolate and become innovative in ways to continue exceptional patient care. The Cleveland Clinic went from mostly in-person medical appointments to all virtual/telemedicine care in about 2 weeks’ time. In this piece, we show specifically the thought process and our conversion of the Mellen Center for Multiple Sclerosis Behavioral Medicine to ensure that our patients still receive exceptional care and patient experience. Additionally, we discuss the importance of innovating the training and supervision of postdoctoral trainees using tele-psychology and virtual options.

Keywords
mental health, telemedicine, COVID-19, patient experience

Introduction
At the end of 2019, an outbreak of the novel coronavirus (COVID-19) occurred in Wuhan, China. COVID-19 likely originated in bats and then made its way into the seafood and poultry market. COVID-19 soon spread rapidly throughout the world. The United States saw its first COVID-19 case on January 20, 2020; the patient was a 30-year-old man who was otherwise healthy but had traveled to Wuhan. Our understanding of the virus is currently limited, but we do know that the virus typically presents as a dry cough, respiratory distress, fever, sore throat, and a patient can rapidly deteriorate to the point of intubation. Mortality rates appear to be approximately 2%, with an additional 15% to 20% requiring hospitalization. Treatment is largely supportive at this time. The virus is highly contagious and therefore can spread rapidly (1).

On January 30, 2020, the virus spread to at least 147 countries, killed more than 7800, and sickened tens of thousands of people in a few weeks (2). Therefore, by January 2020, the World Health Organization (WHO) declared COVID-19 a global health emergency and federal, state, and local governments responded in kind (1,2). Beyond the disease pandemic, there will be a resultant mental health pandemic due to the unprecedented healthcare response, closings of businesses and schools, loss of employment, and restrictions on social gatherings.

The COVID-19 crisis will be multidimensional, in so much that will have impacts across functional dimensions, including physically, emotionally, economically, socially, and psychologically. While fear and anxiety should be normalized during this time, it is also important to understand the ways fear and anxiety can be exacerbated due to uncertainty, economic downfall, and social distancing. Both the Centers for Disease Control and Prevention and WHO have widely distributed information regarding the importance of managing and coping with anxiety and stress during the pandemic (3). A major concern is that during this pandemic, the aforementioned exacerbants coupled with limited access to care can and will worsen psychiatric illness. Additionally, quarantine can mean separation from loved ones, loss of freedom, and uncertainty around health status. There is robust research that suggests when individuals are
quarantined or in social isolation for various reasons and purposes, the psychological impact can be wide ranging, substantial, and long lasting. Collectively, these concerns can have dramatic effects on mental health status (4,5) for patients and frontline health care providers (6). It is also well established that social isolation and loneliness are linked to physical comorbidities, worsening of depression and anxiety, and substantially increased risk of hospitalization (7).

Mental health practitioners are essential medical personnel in managing the psychological impact of the pandemic as well as to stay connected to patients who may be at a higher risk of mental health concerns. Therefore, mental health services have been incorporated from an enterprise-wide level to address concerns for both patients and healthcare providers impacted from COVID-19.

This article addresses the procedural changes necessary in our enterprise (The Cleveland Clinic) to address mental health needs as we transition our services to telehealth and virtual visits for our frontline providers and clinical work with patients, including group visits and provision of supervision for psychology trainees.

Telehealth History

Some background on telehealth is important to understand the drastic shift our enterprise has been able to coordinate in such a brief period of time. Telehealth and specifically telepsychology has been exponentially increasing with interest and need in the past decade. Prior to the outbreak of COVID-19, virtual care and traditional care were slowly moving toward integration (8). As most are aware, there are a number of barriers to implementing virtual care including insurance policies, state and federal regulations, and willingness to participate. Specifically, in the practice of psychology, there were few insurance companies covering psychology appointments conducted virtually. As such, it was difficult to schedule psychology visits virtually without a substantial financial burden on the patient. This limited the capability to expand our practices virtually. Additionally, it was decided that all initial evaluations would need to be conducted in person, and therefore, there were zero initial evaluations being conducted virtually. This approach to virtual visits, from a clinic and coverage standpoint, drastically shifted with the need to respond to the COVID-19 crisis. The policies rapidly changed so that psychological services could continue to be provided while also keeping people at home.

On March 17, the Centers for Medicare and Medicaid Services (CMS) announced several waivers and changes to policies to expand telehealth services for Medicare beneficiaries during the COVID-19 crisis. This was a vital shift in policy as a means to slow the spread of the virus, keeping people at home, while also being able to provide appropriate services to patients, particularly mental health treatment (to review the full document, go to CMS.gov). Medicare paying for medical care provided via telehealth allows us to provide vital services for patients who are arguably most vulnerable, in remote locations, either home or facility bound due to the COVID-19 pandemic. Other private payers have followed CMS’s lead and are covering telehealth services during the COVID-19 crisis. Moreover, the Department of Health and Human Services has issued guidance on use of various video and audio platforms and HIPAA compliance, namely, that this unprecedented healthcare emergency warrants the use of previously non-HIPAA compliant modes of communication to deliver timely care to patients.

In the practice of psychology, guidelines have been infused throughout the rationale and application that regulate our practice including American Psychological Association (APA) standards and guidelines, including the following: Ethical Principles of Psychologists and Code of Conduct (“APA Ethics Code”) (9) and the Record Keeping Guidelines (10), APA’s “Guidelines on Multicultural Training, Research, Practice, and Organizational Change for Psychologists” (11). The above noted guidelines are informed by professional theories and evidence-based practices in an effort to offer the best guidance in the practice of telepsychology (12).

The practice of telepsychology involves a number of important considerations, which include ethical considerations, legal requirements at both the state and federal levels, technology literacy, and policy from both an organization level and professional litigating bodies. Depending on both the situation and patient being treated, clinical judgment is essential in deciding the course of action to utilize telepsychology. As such, our protocol has included a thoughtful discussion regarding inclusion/exclusive criteria, which have taken into account the above noted considerations to provide telepsychology in a time of need. The guidelines for practicing telepsychology as a psychologist are outlined by the Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (11).

Cleveland Clinic Behavioral Medicine Response

At the end of March, the Ohio Board of Psychology remained consistent with our medical colleagues and provided provisions to supervising psychologists to allow virtual supervision for our students.

On March 20, 2020, the Cleveland Clinic Psychology Team met, led by Drs Leslie Heinberg and Don Malone (Chair, Department of Psychiatry and Psychology Cleveland Clinic), to discuss guidelines for Cleveland Clinic psychologists to practice telepsychology immediately. As of today, March 23, 2020, our team has mobilized and has developed methods to treat all patients in need of mental health treatment both individually and in group setting. We would like to share our approach to this.

Behavioral Medicine, Mellen Center for Multiple Sclerosis Response

The Mellen Center for Multiple Sclerosis (MS) offers behavioral medicine services for people with MS and their
families. We offer individual, family, and group therapy. It is important to note that each of these facets of our practice are important and each patient may choose a different or combined modality. Our practice includes 2 psychologists and 2 postdoctoral psychology fellows. Our Center Director of Mellen Center, Dr Robert Bermel, has been explicit in his message that we are to do what is best for the patients and has empowered each of us to utilize our best judgment and leadership to do so. Our dedicated team has decided to take a step-by-step approach in the treatment of our patients. The first step was to manage our individual visits while also being able to properly supervise postdoctoral fellows. This was followed by innovating ways the psychotherapy groups could continue virtually and in the constantly changing landscape.

Therefore, our behavioral medicine team at the Mellen Center for MS’s protocol is as follows (Table 1). Our inclusion criterion is patients 18 years or older who have access to a virtual platform including one of the following: The Cleveland Clinic virtual platform, American Well, FaceTime, Google Duo, Skype, and Zoom. Others will likely come as we move through this process; however, it is noted that we will not allow access via Facebook or other social media platforms. This criterion was agreed upon based on direction from the Cleveland Clinic leadership and our own clinical judgment based on the population served at the Mellen Center for MS.

Initially, we had extensive exclusionary criteria which included suicidal ideation, recent hospitalization, or psychosis in order to ease the adaptation to seeing patients virtually while also supervising postdoctoral fellows. After much discussion, our team agreed the uncertainty and anxiety associated with our immunocompromised population is likely to cause significant mental health concerns in our patients. Therefore, we lessened our exclusion criteria to extend our reach and ensure we are putting patients first. It is likely this pandemic will impact this population in a unique way and our team is passionate about caring for our patients’ mental health concerns at this time. As such, in the below protocol, you will note our suicide screen and instructions as to what to do if a patient is at risk for harm or suicide. Currently, our exclusionary criteria include those who require an interpreter and those who live outside of the state of Ohio. However, as of this morning, this author (A.B.S.) requested privileges or the ability to provide telemedicine in 2 states and was granted access almost immediately, with a letter of approval in my e-mail box.

As such, prior to contacting or seeing a patient, we determine the patient’s appropriateness using the inclusion/exclusion criteria. If the patient is appropriate for virtual visits, our team contacts the patients to explain the rationale for converting in-person visits to virtual visits. You can see a copy of our MyChart message (“MyChart” is the Cleveland Clinic EPIC medical record secure communication portal) in Table 2. The patient chooses their virtual platform and provides a phone number in case we are disconnected.

When the patient agrees to the telemedicine or virtual platform that they prefer, we work with our schedulers to

| Table 1. Mellen Center Behavioral Medicine Virtual Visit Protocol During COVID Crisis. |
|---------------------------------|-------------------------------------------------------------|
| Inclusion criteria for virtual visits | • Access to Cleveland Clinic Express Care, Google Duo Skype, FaceTime, or telephone |
|                                  | • 18+ (for new patients)                                      |
| Exclusionary criteria for virtual visits | • Interpreter needed, English as second language |
|                                  | • Does not reside in Ohio (or not in Ohio at the time of visit) |
| Psychology fellows protocol for telehealth visits | • Confirm with patient (via phone or MyChart) switch to virtual visit |
|                                  | • Denote “virtual visit” in “notes” section of EPIC schedule |
|                                  | • Confirm they have FaceTime, Skype, or Google Duo (if they don’t, the fellow cannot see them for an initial evaluation) |
|                                  | • Send patient questionnaires and informed consent in MyChart |
|                                  | • If they do not have MyChart, verbally go over informed consent at the start of the session, document. |
|                                  | • Connect to patient via FaceTime, Skype, Google Duo, telephone |
|                                  | • Confirm their location (MUST BE IN OH) and if there’s anyone else in the room. Caregivers may be present, but we want to know who is in the room. |
|                                  | • Conduct session as usual                                     |
|                                  | • Staff with licensed psychologist for initial evaluation (either in room or invite them to the call) |
|                                  | • Can send handouts or other forms to patients via e-mail      |
|                                  | • Confirm e-mail address in EPIC, update if needed             |
|                                  | • Ask PSR staff to “arrive” patient in EPIC                    |
|                                  | • Write documentation as usual (with virtual visit language)   |
|                                  | • Schedule follow-up by messaging scheduling pool              |
| Supervision for psychology fellows | • Licensed supervising psychologist MUST STILL STAFF NEW PATIENTS |
|                                  | • Supervisor can be in same room, or you can add using FaceTime/Google Duo call |
|                                  | • Follow-up visits do not require in-person staffing          |
|                                  | • Weekly supervision meetings must still take place but do not need to be in person |
| Billing                         | • Billing will occur under virtual psychology visits. You will still note how many minutes you were with the patient, and for fellows, please note either supervised OR supervised and staffed by supervisor |
Prior to visit

Dear (patient), for your health and safety, we are converting our in-person visits to virtual visits. We would like to see you virtually for your visit (date). You will not be charged a co-pay for this visit.

There are several options to meet with me virtually:
- Face Time (only on Apple devices)
- Google Duo (on Android and Apple)
- Skype
- Telephone (for follow-up visits ONLY)

HIPAA rules governing patient privacy have been changed with COVID-19 response, and these services have been approved for us to use to deliver your care.

Let us know what works for you and at what # to reach you.

Below is the Informed Consent you would have been asked to review and sign tomorrow prior to the start of your visit. Please review before your visit (but you don’t have to sign)

Lastly, please complete the questionnaires sent to your MyChart prior to your visit.

Thank you for your flexibility during this time!

New informed consent language

Telepsychology: Your provider offers the option of virtual visits for follow-up. While specific encryption measures have been taken by the Cleveland Clinic to protect the information that will be communicated between you and your psychologist, the privacy and confidentiality of computer-mediated communication cannot be 100% guaranteed. Your psychologist will take every measure to safeguard your information, but you should be aware that there is a very small chance the information may be stolen from transmission between yourself and the psychologist. Also, if you decide to save the information discussed in your online counseling session to your computer as a transcript, you are encouraged to take steps to ensure this information remains confidential. Possible breaches to your privacy could occur if another individual(s) has access to your computer.

Additionally, because psychologists have a duty to warn and to protect if there is an indication that the patient is a danger to themselves or others, the program requires that the patient provide information on where the patient will be receiving the virtual visit. Virtual visits provide many conveniences and advantages for the patient. However, not all personal problems are clinically appropriate for online services. Your psychologist may recommend the provision of face-to-face services for specific issues. The clinical appropriateness of virtual visits is at the discretion of the Mellen Center Behavioral Medicine staff.

convert the appointment. An informed consent and mood questionnaires are sent via EPIC, the Cleveland Clinic’s electronic medical record. It is still important for us to track mood and progress, and decreases in mood or stability, as this impacts our treatment decisions.

At the Mellen Center for MS, we run 6 unique support groups: Young Professionals Group, Men’s MS Support Group, Caregiver Support Group, MS Support Group, Progressive Neurological Disorders Group, and a Sleep and Fatigue in MS Educational Session. When we initially were asked to see our patients virtually, we could not figure out a way to see the groups and they were canceled for the short term. The group members shared the importance of the groups in their mental health journeys and so we had several conversations with leadership to determine the best way for us to have the groups. As in individual sessions, we also take confidentiality of our group members seriously and have discussions about confidentiality and consent. We have as of today, March 23, scheduled each of these groups via Zoom. Zoom has the capability of a virtual platform and seeing a person’s face while also hearing their voice. This is incredibly important to our group members, as during this time of isolation, we need to connect to help manage depression and loneliness.

Our patients are virtually checked in, which occurs by way of us sending an e-mail to our schedulers. When we start a visit with our patients, we confirm the following: address, location, phone number, and if anyone else is in the room. If another person is in the room, we want to get verbal consent from our patient to allow us to continue this session.

The session occurs as usual; however, in our typical in-person practice, we use biofeedback tools and we are not able to utilize those tools to see changes in physiological responses to stress and stress management. As mentioned above, we are still giving our patients questionnaires and we are also asking about suicidality. If a person is experiencing suicidal ideation, intent, or plan, we have a plan in place to address this (see Table 3).

The Mellen Center Behavioral Medicine Team also values training the next generation of psychologists and we provide a year-long postdoctoral psychology fellowship in chronic disease and MS. We have done our best to continue our vital role as supervisors and train and so our postdoctoral fellows are also still seeing patients virtually. This means that as supervisors we have a responsibility to supervise and ensure our patient’s and fellow’s safety. We are checking in with our fellows on a very regular basis to ensure that they feel comfortable and also to supervise their cases. All supervision of cases will be done virtually. We will FaceTime into our fellow’s sessions to supervise the cases. We will also Zoom connect for our supervision times so that we can see and hear how each other are doing and supervise cases.

Documentation of sessions occurs as per normal standard, but an additional smart phrase is added regarding the COVID-19 crisis and telemedicine. This states:
Table 3. Telehealth Suicide Screening Protocol During COVID Crisis.

| If patient is suicidal during a session | 1. Essential that we are confirming the address of the patient during the start of every visit. I would urge us to do this even if we do not think they are at risk of harm. These are challenging times for our patients whom are already at a higher risk for suicide.  
2. If patient endorses PHQ-9 #9 prior to session or suicidal ideation during session, conduct usual suicide risk assessment (below) |
| The patient reported the following | Are you feeling hopeless about the present/future?  
Have you had recent thoughts about taking your life?  
When did you have these thoughts?  
Do you have a current plan?  
Do you have any weapons?  
What and where are they? |
| Chronic risk factors |  
- Depression  
- Alcohol and drug abuse  
- Psychosis  
- Instability  
- Corrosive self-image  
- Isolation  
- Financial problems  
- Insufficient coping skills  
- Chronic medical problems  
- Previous history of attempts |
| Acute risk factors |  
- Interpersonal loss  
- Critical life events  
- Hostile interpersonal environment  
- Increased agitation and tension  
- Pervasive feelings of hopelessness/helplessness  
- Apathy |
| Suicidal ideation (select one) | Thinks about suicide but has no intentions of doing it  
Has an intent and plan |
| Protective factors |  
- Social support system  
- Economic security  
- Spiritual resources  
- Obligation to others  
- Psychological maturity  
- Willingness to seek help  
- Future oriented |
| Professional risk assessment | Risk assessment  
- Discussed following safety plan with the patient. Patient verbalized understanding: (Detail plan here) |
| Protocol for fellows | 1. Contact supervising licensed psychologist via text during the session with no identifying information  
   - Example of text: I am currently seeing my 11 AM via (module, telephone, etc) and patient is endorsing suicidal ideation  
2. Supervisor will come in to session (via virtually/telephone, etc)  
3. Supervisor proceed with suicide assessment  
4. If positive, urge the patient to go to the emergency department  
5. Ask permission to call the patient’s emergency contact in the chart  
6. Fellow or supervisor remain on the phone with the patient while the other clinician contacts  
   a. the police where the patient resides  
   b. emergency contact in the chart  
7. Explain situation and provide police with the address of the patient  
8. Remain on the phone until help arrives |

Due to the federal, Ohio state of emergency and the need for ongoing mental health services, the following visit was completed *** (virtually or via telephone) to reduce the risk of COVID-19 exposure. Consent related to virtual visits was provided verbally after information was sent via MyChart or read to patient if MyChart not available.
Finally, we discuss when the patient would like to come back and we send a note to our scheduling team to help us schedule. We determine if the patient had a good experience with the virtual or telephone platform and ask if they would like to continue this in our next session. Billing occurs as usual, specific to the time and platform used for the service.

**Department of Psychiatry and Psychology**

Specific to the Department of Psychiatry and Psychology, 200+ mental health providers are being mobilized and deployed out of their section-specific specialty to staff a crisis hotline for members of the Cleveland Clinic caregiving teams. Led by Dr Leo Pozuelo, we are recognizing the important need of mental health providers to take care of our own caregivers who are on the frontline of the COVID-19 as nurses, doctors, administration, leadership, food service, environmental services, and so on. There are a range of emotions from our frontline colleagues from fear, ambiguity, intensity, anger, to pride and all emotions in between. Our colleagues have expressed a willingness to help, and as mental health practitioners, we have a unique skill to offer our own. Given the decrease in patient volumes in some clinical practices, this is an excellent example of how to redeploy behavioral health caregivers to where they are most needed. This unique opportunity allows us to take care of our own Cleveland Clinic caregivers by way of a 30-minute supportive phone call to caregivers who are impacted by COVID-19. Each mental health provider is asked to sign up for as many 24/7, 4-hour shifts to staff the hotline, and we anticipate that this will occur for several months.

**Conclusions**

A mental health crisis is occurring along with and in response to COVID-19. Uncertainty about health, wellness, and the economy leads to fear and anxiety. Social distancing and isolation can lead to and exacerbate existing symptoms of depression. Suicidal ideation, intent, plan, and completion may increase. Mental health practitioners are in an excellent position to be “frontline” yet virtual crisis caregivers to both our patients and fellow caregivers. We have presented our transition from in-person specialized behavioral medicine to virtual, and in some ways general mental health practitioners. We are a group of resilient individuals who want what is best for our patients and our caregivers. We realize that this information is changing rapidly and that by print some of this will be outdated. We will change with the evolving situation and we will always do what is best for our patients.

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