WEBINAR VIDEO TRANSCRIPT

Minority Fellowship Program

Utilizing Telebehavioral Health for Opioid Addiction Interventions

25 March 2020

INA RAMOS: Good afternoon, everyone. My name is Ina Ramos and I'd like to welcome you to the Utilizing Telebehavioral Health for Opioid Addiction Interventions webinar. This webinar is brought to you by the SAMHSA Minority Fellowship Program Coordinating Center. I'd like to draw your attention to the disclaimer. The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the United States Department of Health and Human Services.

I will now introduce our speaker for today. Dr. Marlene M. Maheu has been a technologist, psychologist, and pioneer since 1994. She has served various organizations to assist with the development of technology focused standards and guidelines including the American Telemedicine Association, the American Psychological Association, and the American Counseling Association. She has overseen the development and delivery of telehealth training to more than 26,000 professionals worldwide and consulted with hundreds of hospitals, clinics, agencies, groups, and independent practitioners seeking startup guidance. Dr. Maheu serves as the founder and executive director of the Telebehavioral Health Institute, which offers over 64 hours of both basic and advanced telehealth training online and offering two micro-certifications telehealth.

She is the CEO for the non-profit Coalition for Technology in Behavioral Sciences. She has authored five telehealth textbooks, including The Telebehavioral Health, Foundations in Theory and Practice for Graduate Learners In 2020, the AP published A Practitioner's Guide to Telemental Health, How to Conduct Legal Ethical and Evidence Based Telepractice in 2016, and Career Paths in Telemental Health in 2016. Her insights will help you not only get started but thrive with legal and ethical telehealth. Dr. Maheu, the floor is yours.

DR MARLENE M MAHEU: Thank you, Ina.

INA RAMOS: Thank you.

DR MARLENE M MAHEU: And I want to thank you and SAMHSA for having me come and speak today. I have to give my own disclaimer, and that is that the information I'll be offered today is organized by our Institute, the Telebehavioral Health Institute, for training purposes only. Statements are my own. They're not to be construed as coming from SAMHSA or any other

group mentioned in the presentation. I am a technologist, psychologist, and trainer, and not an attorney. I do not and cannot provide legal advice. The information that I present does not constitute and should not be relied upon as legal or ethical advice, and it should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions about your work, your billing practices, or the individuals that you serve.

Now, I'm going to give you a little about the background in telehealth and focus most of my comments on what's going on right now with COVID-19 and how many practitioners have to go to work from the home. But I'm grounded in the legal and ethical issues that do impact us, but with or without COVID. So some things have been relaxed, but many more things have not been relaxed and those fundamentals do not change.

The evidence base for telebehavioral health is very strong. It actually started in 1959 and that was in psychiatry. And that was connecting people with T1 lines, and before that just phone lines. So it's not as if all of this started in the '90s with the internet. The protocols have been there for a long time. And there's a difference between traditional telehealth and what we're seeing happen today.

But still, if you can understand the traditional telehealth you will understand the principles and then to be able to deal with any technology that comes your way. And there are many more that are close to us that will be released very soon. And I think it's very important that clinicians realize that right now we're seeing a big shift to the internet. But in another few years you'll be seeing a whole other generation of technology come in and alter how we deliver care.

If we can stick with specialized telehealth protocols that are grounded in legal and ethical principles, then we can consider how any other disorder–any order we want to treat is treatable. Now all these protocols have been developed, but if people don't follow them then they're not of any use. So I'm going to be talking to you about a lot of protocols and then some of the details about how to actually make this happen.

So a little bit of the evidence base–when people say I deliver evidence based care, a lot of times in their minds they're thinking that they looked at some studies. But the truth is, it has to start with studies and there are two other steps after that. One is, we read some things, we get exposed to material and events like this today. And then we look at the person in front of us and we say, OK, now how do I apply all this stuff I read to this person sitting right here in front of me? This person, with their unique life, and their unique needs, how do I take some of that and make this clinical?

And then I document that I did that. That documentation part is very important, particularly in telehealth. We actually have a three hour course on documentation, so there's a lot of details to it. So it's not just, you make a note.

Then you need to run that by the client and say, hey, is that OK with you? For example, right now we have a lot of people wanting to shift to telehealth because they can't go to the office

anymore. But some clients don't want to go to telehealth. It's not on us to force them to do that.

Maybe they want to talk on the phone. Maybe they have other preferences. Maybe they're OK for a while. It's their choice. So ultimately, it's their choice.

A thing I'd like to add is that it's also our choice, right? We do get to choose how we want to be available to people. And that's just how we set up our office. So you don't have to be open constantly to having people email you, and text you, and do all that. You can say, I don't do those things, if you don't want to.

And that's perfectly legitimate. So you just take what you're comfortable with, and right now that's video for a lot of people because you get to see a whole lot more and get the real experience of people as opposed to on the phone, you're missing a lot of information. And a lot of that information is what we were trained to use to diagnose and treat. The visuals are what we consider with a lot of our mental status exam. There are a lot of things that we take into account when we're working with people that if you lock that out and just have someone on the phone, it's not quite the same. You're missing a lot.

So one of the big resources that I wanted to let you know about is the Center for Connected Health Policy. This group is funded by Health and Human Services in the United States. And their only job is to look at policy and make it available to people online. And when you call them, they will answer your questions.

Now they are not behavioral in focus. They are generally telehealth, telemedicine for the most part. But they have been getting into behavioral more and more. And so I really want to push you to go take a look.

It's federally funded. These people are there 40 hours a week to help you out. And they have a lot of information that is available. I believe one of the handouts that I gave for this talk was from them. But I'm just going to tell you a little bit more about their website.

They have resources that you can sort by, let's say, state. And you can see where the current laws are for telehealth in general. You can also sort it for pending laws so you can see what's coming down the pike. Is this state better than that state for me to develop my service in, my practice in, or not? And so you just look at the laws and compare.

Right now they have a wonderful resource tool that will compare what's happening with the COVID changes in the law because different states require different things. For example, in California telephone calls are approved for general health care–not Medicare, but for general health care for COVID, as a replacement for in-person contact. Other states don't have that. Maybe some states that's happening, it's in the works, but it's not there yet. You see?

So what you can do is just go and you can look at your own state and then see what's going on. Or if you have a client or a patient that has traveled to another state before the current condition, then you can see, well, we need to look up that state. Gee, you're in Iowa? Well, what does Iowa have to say about my ability to go practice in Iowa because that is my person when they're home with me in their home state? You see?

So this kind of thing is very important for you just stay on it. And this is the group that does it for telehealth. So their only focus is telehealth. And you see, it says it on their own home page that it tracks US telehealth policy changes, and things like reimbursement and licensure have to do with policy, OK? So that's your main source for that.

Now what we do is look at the evidence base. So we have documented 4,500 references. Because I'm an author, so I've written five books. We've looked at a lot of evidence base. And then we have references on our website, and you can get that for free. And I gave you the URL here, telehealth.org/bibliography. And so it's that we have 1,200 of those that are searchable on that page, but 4,500 people that actually come take courses from us from the Institute.

So we're going to talk mostly about video conferencing today because that's what's required for Medicare to date. I haven't heard that they've released it for the telephone yet. It may have been released but I haven't seen it yet.

One of the main things I want to let you know about is also published by the Center for Connected Health Policy. I actually got this off their website. It was a law that was passed a couple of years ago. It was called HR 6, and it was for opioid treatment. So it's called the SUPPORT for Patients and Communities Act. And I put the URL here for you for the Center for Connected Health Policy. And I encourage you to go there.

I'll show you a little bit about it today but I don't have the time to give you a whole lot about it. I'll just give you a little something with some of these states, OK? They made several changes to state Medicaid programs to address opioid and substance use disorder, as well as this law alters Medicare requirements to address opioid use.

Among the changes, it authorizes Medicare, beginning this year, to waive through rulemaking of any of the geographic and originating site reimbursement restrictions for the treatment of opioid use disorder, or a mental health disorder that's co-occurring with opioid use under certain circumstances. So Medicare has lots of caveats and things that you have to keep track of.

But basically what they're saying is that in the original set of rules for Medicare telehealth you had to be in a certain area. You had to be in a rural area, or what they called a metropolitan shortage area, or HPSA area. And you can type that in by zip code and find out. It's not really yours, it's where your patient is or your client is. And only if they were there could you bill for them getting treatment, and if you were designated provider.

So in the behavioral world, most of the medical world is recognized as a designated provider. So that's physicians, nurses, nurse practitioners. I believe it's physicians' assistants. They include psychologists, they include social workers. Counselors and marriage and family therapists were not included, because they're not Medicare providers. They're not recognized by Medicare, which especially right now, I hope they change that soon.

In that case, what they're saying is you don't have to bother with that. And you also have to be focused on the particulars of how this is delivered. I'm not going to interpret the whole thing for you, but I'm just letting you know that there are eligible services that are identified. You can go read this on the Center for Connected Health Policy website.

And also there's eligibility for a facility to have a facility fee. Now a facility fee is a unique thing to telehealth, because it is an extra charge that you can submit for–you can't do it as a clinician. The facility submits it, and it is state based. For example, in New Mexico you can make, last I checked, over $200 per session for the facility fee for telehealth. Why? They don't have enough practitioners there.

And so the government is saying please, please, please, please come and serve our people in this state. Because we really need you. And to make that happen we're going to give you a facility fee, which in the olden days, when it was expensive to set up telehealth, it would encourage the facility to get a telehealth installation. And it is for every contact, so you get this bonus for every contact.

Now in most states that fee is not 200-some, it's $25 and some cents. But still, whatever you're getting, if you got an extra $25–not you, but if the facility got $25, then it could make it reasonable for them to pay for a room with a video camera in it, you see, and all the wiring, and the connectivity to make that happen. And there are other grants with government, too, for patient connectivity. But basically the government wants to enable facilities to be able to make this happen.

So another thing I want to let you know about is there have been some publications by SAMHSA that have direct relationship to opioid treatment, and here's one. You're not going to be able to read all of this. But I'm just trying to give you some screenshots of what to look for if you want to search online.

Rural behavioral health, telehealth challenges, and opportunities, they go into some detail about what you can–this comes from that prior article. But see, it talks about online substance use questionnaire, you see? So that's part of what can get paid if you use that. And then cognitive behavior therapy through videoconferencing for substance use. So these kinds of things can really be helpful for you if you want to get reimbursed for some of the work.

Group chats for relapse prevention, webinars for clients, and for providers. So if they have a speaker come in, like me, you can get reimbursed. So there are lots of things like that that are available to you.

This says it's put out by the Agency for Healthcare Research and Quality. And this publication is called Increasing Access to Medication-Assisted Treatment of Opioid Abuse in Rural Primary Care Practices. Lots of primary care physicians don't know what to do. The president has declared opioid a national emergency, so this is the government's response is to fund groups that will actually get materials out for you.

I'll just give you a little outline of why they're doing this. Many of you probably know this, but I'm going to zip through this real quickly just in case somebody wants some of this information. So patients with OUDs face a substantially high risk of early death. And the medication-assisted treatment, MAT, has been shown to reduce the risk of death by nearly 50%.

It's not for everybody, but it does have a proven track record. And so these treatments involve a number of different medications. And some of these are trickier than others. There are strict prescription rules that you have to attend to, and they're different for the different medications, OK?

While the requirement for clinicians to obtain federal waivers has relaxed in some years, rural areas lack the number of prescribers. And that's why they're making this available through telehealth. They're saying, OK, we'll pay you if you want to start serving people in that area over there.

Now a lot of these rules, because of COVID, have been relaxed right now. But once this current situation passes, the old rules are going to come back. It's a temporary relaxation, so this may be of use to you not only for the short term but also for longer term, OK? So we're seeing differences across prescribers, and they're trying to get everybody on board with using these federal waivers and following the rules, OK?

The Ryan Haight Act is something you want to pay attention to, because this restricts the ability of prescribers to prescribe over state lines. So somebody could be very well qualified but that state line prohibits them from being able to do it legally. Now this has been getting worked on for at least seven years that I know of. Because I'm a member of the American Telemedicine Association, and they've been very active in this. And we've done a lot of work over there.

But they were supposed to submit a new plan for changing this rule in late 2019. And as far as I know, it's not yet been submitted. So they were late in submitting that. So what the hope is by the telehealth community is that a special registration process would allow providers to prescribe controlled substances via telemedicine over state lines. So we'll see. And I've given you the original Act that says that you've got to get this report in to Congress by 2019, and they missed it. So just a little brief on that.

Now with COVID we have a Preparedness and Response Supplemental Appropriations Act, which was issued. It was signed into law by the president declaring the COVID situation as a national emergency. And it grant certain powers to the Secretary of Health and Human Services to waive some of the health limitations on Medicare.

So Medicare is now different, and this new law addresses the barriers in Medicare to telehealth in particular. And we have a handout on that that is from CMS, Center for Medicare and Medicaid service so that you can read what the current changes are. So I don't have time to talk about today, but do look at the handout.

And I just printed out when I could get this week. That source that you see on the handout, go back to that website because it may change again today. These things are changing regularly. And particularly if it's related to telehealth, go to the Center for Connected Health Policy, because they have updates in their blog that, frankly, for those of us working in telehealth, I've been here for 26 years now, it's mind-blowing to see how these rules are getting waived because they really need to get care out to people. And they want us to be able to do that.

I'm going to shift now to just giving you an overview of the basic technologies that are involved in telehealth. First is video, of course, because we can see people. We can hear people. We can't touch people. We can't smell people, which is a disadvantage if you're trying to deal with some of the more fundamental screening issues that are involved with people that you treat.

But in any case, video truly is the next best thing to being there, not the telephone anymore, OK? So if you could focus on video only–if you're trying to get into this–I encourage you to do that. And just study some of that literature so that you're more versed in that, rather than starting to dabble in all these things at the same time. Because you could very well overwhelm yourself. Or one of your patients or your clients catch you off guard, and all of a sudden you compromised.

You see, you've compromised the treatment because you were too gung-ho. And you're just going to jump on board and do anything without understanding the risks and benefits of each and every one of these. Because every channel you open up now creates other opportunities for people to participate with you in a different world. Right now people are working from their homes and they haven't stopped to think about what's going on in the background.

How do I control that, and I mean really control that, and not let people come in? All of a sudden the child is in the room, the husband is in the room. Banging going on on the other side of the door, kids are screaming. All this stuff is happening. And if things are in the background that are not supposed to be there, that then can over time influence that relationship.

So in any case, there's telephone, email, text, apps, wearables are coming. Remote patient monitoring does you now have CPT codes, as of last year, 2019, that you can get paid to work with people that are connected to certain devices in their home. And that would be a blood-pressure cuff. That could be more heart rate variability. There are a number of different things, cardiac monitors for people that are working with patients that are ill that are trained to be able to deal with that. So there's a lot more that are actually are billing codes that can be used.

Now not all insurers cover all these things. Medicare covers that, but you may be working with a third-party carrier who doesn't. In which case you have contact them. There's no easy way.

There's no easy rule about that. But right now with the COVID emergency, a lot of the state rules are getting published through the Center for Connected Health Policy. And you can see, wait, all the third-party carriers are now allowing this or that, you see, like telephone, that I mentioned earlier, OK? So anyway, a little more detail about some of these.

Videoconferencing platforms can enable addiction specialists and other behavioral health experts to deliver treatment consultation and aftercare solutions nationwide. So it's not just for the treatment. It can be follow up. It can be relapse prevention. There are billing codes for it, you can do it, OK? Digital messaging platforms also are available, especially right now.

There's a thing called the eVisit that is a way that you can screen people using a digital messaging platform that–it can be written, it can be on the phone–that will help you identify those patients that really do need to keep their appointment this week or next week, or they are really OK. They don't need to come in. And so you can give some time to people that really need to come in if you're swamped, you see? So that is an eVisit.

And if you look at the American Psychological Association, they have an article about this and all the billing codes that you can use. And it can be by a licensed clinician, and don't quote me on this, but I think it's five minutes or more. When you just do a little, quick check in, you get paid for that. Why? The government wants you to do it, OK? Don't give a seat to somebody who doesn't need it. Just a little phone call will do. Well, then, but they will give you a CPT code that you can bill for that time.

Mental health apps these days are very popular. I've been addressing apps for about 10 years now and there are lots of ins and outs, but it's not as easy as it may seem. How you introduce it, how you follow up with this, which apps to pick, these are complex issues. And I encourage you to not do it willy-nilly. Get yourself some training before you just jump in and start delivering services through any technology. Make sure you understand what can go wrong.

I think the best analogy I can give for that is anybody over the age of 10, depending on how long their legs are, can drive a car, OK? Not hard to step on the gas and make the thing go forward. But if you've got to back that thing up, or if there's something coming at you, or you have to park, things get hairy really quickly. And with what we do, people's lives depend on our professionalism.

I encourage you to make sure that you know what you're doing and you've been exposed to all the things that can go bad. And then you can shut that door. You don't have to worry about all that stuff. You find a way that works and you're in. Then you do that.

A lot of these things are very exciting, but I think people overwhelm themselves. And all of a sudden they don't know what to do, and they don't know who to talk to about it. Because their colleagues also don't know what to do. And so they've gotten in over their heads. So I just encourage everybody to pay attention.

We have one rule, one basic rule in health care, and that is do no harm, right? So safety comes first. Even though we have all these capabilities, it doesn't mean we should do it. Our legal and our ethical mandate is to think through and make sure we're not hurting people. That's the main stance to take.

Now when we look at who these people are in our professions, there are nine professions of behavioral professionals in our country. Most of us don't know that. Most of us are so used to working in our little silo with our colleagues, and maybe one or two other professions. We don't stop to think of the big community of people out there that really are actively working to help people with substance use and mental health disorders, which now SAMHSA is calling behavioral disorders. And that we could reach with, that we can work...

Well, technology allows us to do that. There are CPT codes that were approved in 2019 that actually pay for us to talk to clinicians in other professions about a particular patient. So that type of–that's called professional collaboration. The name is exactly what it is. And so you can get paid to speak with the primary care doctor or the psychiatrist, whoever is involved, the nurse, addiction professional, OK, get it paid. Now it's not a gazillion dollars. It's, I think, $14, $15. But hey, before 2019 we couldn't get paid for that. So there's CPT codes you can look for that as well.

Now I'm going to quote some of the bullets from NAADAC, the Association for Addiction Professionals, because they've done a really good job. And I thought, well, it's relevant to what we're talking about here today, substance use disorder. So one of the things they talk about within the context of e-therapy, e-supervision, and social media is the need for competency. Which is basically what I've been telling you is you can't just willy-nilly pick something up and start doing it. You have to be able to consider yourself competent, as in any other field, right?

Any other aspect of the work we do, you have to establish minimal competency. How do you do that? The litmus test for competency is supervised experience. Well, a lot of people don't have that in telehealth and they don't know where to get it. A lot of times the supervisors don't know how to supervise in telehealth. So how do you do it? You participate in an activity like you're participating in today.

And that certificate that you're going to get after this hour and a half is what you keep. And I encourage you to put all that in a file in your desktop, or if you want to print this stuff out, put it in a paper file. And everything you do related to telehealth, you print it up and you build it in there.

Now if something goes wrong, will an hour and a half get you off the hook and in court if somebody dies on your watch? No, right? Just as it wouldn't if you were doing any other aspect. Say you decide to work with ADHD teens, OK? That doesn't mean an hour and a half training is going to defend you, but it is something that you could start with. And once you have this experience, maybe you can start looking around for more so you can really build up your competency.

Now I'm a very big advocate of competency. I chaired a committee that established competencies, and we pulled together professionals from six of those professions that I mentioned earlier. We worked for four and a half years to come up with a competency statement. We can hardly see it here, but An Interprofessional Framework for Telebehavioral Health Competencies.

So we use the term that CFC uses, and that is behavioral health, as opposed to mental health, or substance use. Because it's a newer term, and so our institute is called Telebehavioral Health Institute. And all the documents that we produce, the research we do, we call it telebehavioral health.

What we did in this research was we looked at boundaries of competence and said, how do we establish that? And if you're going to be offering education and training, what are the competencies that need to be taken into account? So good to explain where competencies fit into the big picture. Typically laws get enacted when a legislator says this big, bad thing is happening over here. And we need a law to fix that, and I'm going to champion this. And generally that takes a couple of years.

So the proposals are made, and then things get voted on, and some things become laws. Out of those laws, let's say a state says health care providers need to secure their records, OK, so recordkeeping. Then the regulatory boards for each of the professions will say, OK. For us, for the medical folks, and psychologists, and social workers, counselors, MFTs, the addiction people, for us, we have to keep records in this certain way in this state. So you say that rolls down from the law to the regulations.

Then professional associations who are not the regulators say, well, we're going to develop ethical standards that are above the higher order from the law, OK? So it's more specialized. If you're going to be in our group, then you need to follow these ethical codes, OK? And out of that are some guidelines. And guidelines are more specific.

Let's say the recordkeeping in the state would say, all right, you have to keep records. The regulatory boards would say, well, for psychologists, those records have to be in a locked cabinet, OK? The guideline for telehealth, for telepsychology would say, it's got to be in a locked cabinet. Or if you're keeping your records in a digital format, your laptop has to be in a locked cabinet. Or your desktop has to be in a locked room. It can't be in your den, for example, OK? So you see how it rolls down.

Below that are competencies. That's even more specific, OK? I like to think of these as the amino acids of what we're supposed to do, the building blocks. And from competencies come training, which is what we're doing right now. What I'm giving you right now is competency based, OK? Because there's tremendous research on competencies.

There are books written on how to develop competencies, OK, for trainers. And then once you've gotten that training, it's professional service delivery. So every single thing you do in

your practice should be based on the competency that hopefully you would have a certificate, a course completion certificate like you'll get here. That's based on competencies to provide the guidelines, and standards, regulations, and laws. So this whole hierarchy goes both ways up and down, OK?

You are the–I'm assuming–at the delivery side of it. So that's how things should be stacking up. If you're doing things that there is no evidence base for, go get some. Go to literature. I explained those three steps. Go find the research. Put it through your head as a clinician and say, this makes sense to me. Or you know what? This doesn't really make sense how I understand human behavior. And this person in front of me–and I'm going to talk to them about it. Are they OK with this? Maybe they don't want to do this thing, so we don't do it. So you see, so that truly is competency-based work.

Now what we did in coming up with this framework was we identified 7 domains and 149 competency areas, all right? These are the domains. I can't give them all to you today. If you want that paper you can get it from me by coming to telehealth.org/blog. Maybe someone could put that in the chat room, the blog. So telehealth.org/blog. If you look for framework you'll see there are, I think, four or five.

The first one on the top, you can get a free copy of this. Why? Because I'm the lead author. I can give away free copies if you come to my website. Otherwise you have to pay quite a bit to get it if you want to get it through the publisher. But I do have that right to give it to you and I'm happy to do that.

OK, so then you'll see the back end of that article is a grid, a table of all the things that if you–let's say you're an administrator in an agency. All the things your clinicians really need to be thinking about, or you need to have in place for your clinicians to deliver competency-based telebehavioral health, OK? So we develop it for the novice, or the trainee person, the intern.

The proficient person is a licensed person. And the authority is more somebody like me who's an advanced practitioner, a specialist, a trainer, or a researcher. So that's maybe not something you need to attend to right way if you want to have that kind of personnel.

Now all of this stuff I'm going to bring back to what's happening in the bigger world. There are certified community behavioral health clinics, and if you look at what the CCBHCs are asked to consider for telehealth, there is a publication for that. I actually took a screenshot here. And once again, it's too small for you to read, but hopefully you can read the red line, fundamental telehealth/telemedicine considerations. And you can go get that for yourself if you're involved in one of these clinics, OK? Now they do a nice job of laying out how is it supposed to be structured according to the decision makers in the government, OK?

Another tool I want to give you, another resource is a book that I was asked to write for the APA. And I found a couple clinicians to work on it with me. Dave Luxton was the first author. It's called A Practitioner's Guide to Telemental Health, How to Conduct Legal, Ethical, and Evidence-

Based Telepractice. This is a bare-bones, 100-page look at the literature, basically what is out there that you can go to.

And we submitted about 150 pages' worth of material, and they took 50 out. All the examples they took. I said, this is dry. But that's what they wanted, so they're the publishers, they did it. But just know, there's a lot more that is related to how to bring this to life. This is 200 pages of the research summarized for you, OK?

The newest publication that we have that my team put out is for graduate learners. So for people in school that want bare-bones fundamental of how do you even think about this? And it took us two and a half years to write this book because we put ourselves not in the position of a licensed professional, which is the group that we were used to addressing, the vocabulary, the conceptual framework. It was kind of a higher order in all the other writing.

We thought we really want to write one for graduate learners. So even if they don't know anything about telehealth, we can start them from the ground up and move in, even if they don't know anything about behavioral health. So it's pretty basic stuff, and that was all through the Coalition for Technology and Behavioral Science.

Now we're going to get into more of this evaluation and treatment issues for you today. So I told you before we had some domains and their objectives, and then we get down to the nitty-gritty amino acids, which are the competencies. I'm just going to show you a little bit about the first thing, which is, we have a first objective. We had seven of these for the first domain, all right? It was, is the client and patient appropriate for telebehavioral health? That includes if they want to do it.

Do they have the device? Let's say it's a phone. Do they have the thing? Are they able? Do they have the finger dexterity to use it, right? Do they have the cognitive ability to understand it? Now those are fundamental things that a lot of people will think, yeah, well, of course.

But no, some people don't. And so to be inclusive we need to step back and say there may be reasons that they don't want to use this thing. Let's not push it on them. Remember I talked to you about preference earlier on. So it's this kind of thing where it's a step-by-step look at what really is appropriate here.

And then are they comfortable? You introduce it. Do they want to do it? Are they scared by it? They're afraid people are going to see them. That violates the number one reason people are frightened of telehealth is they think it's being recorded. They think that they're going to see this on YouTube, or their brother is going to see it on YouTube next week. So they don't know, so we have to address that with them in our informed consent, right? So you make them comfortable with it. And they focus, and it goes a long way there.

And then, how do you adapt in-person care requirements to telebehavioral health? Well, if you're doing CBT work, then you need to find an app that's related to CBT. Don't find an app

that's related to other things, because the concepts are going to confuse people So this is just some of the stuff. I've written book chapters on this, and a lot of presentations.

There's a lot of material there, but you have to focus on what is going to slip into the treatment plan right now? Not two months from now, but is this app geared to this population and my orientation–which, let's say, it's CBT–and the stage of the treatment for this person right now? So that's your job as a clinician and to figure that stuff out.

Now there are a few things I just want to give you some tips on doing through telehealth. One is gait analysis. And especially for substance use patients or clients, you need to be able to see, are they able to maintain their balance, you see. Because that's one of the tips that we use in diagnosis.

And when we go to the waiting room and they're seated in the waiting room, they may get up and then stumble into the office. You may see them trip over the doorjamb, or their arm hits the case on the door. And they may have trouble navigating the chair. The hips don't quite work, but they overshoot it, and they land on the arm and slide down in the chair. These are all tips that as a trained clinician you look at it and you say, I need to talk to this person about intoxication today. Or maybe it's medication, they're overmedicated.

Or maybe they need medication. Maybe they're having a balance issue, and maybe they need a prescription. There's something like that. This is all a part of our assessment we don't really stop to think about. But how do you do that through a camera? Because it's an essential part of what we do. The telehealth communities come up with lots of solutions for this kind of thing. It's called the gait analysis. In the medical world they call that a gait analysis, but in the behavioral world of allied health professionals there really isn't a term for it. You just do it and you know to do it.

Or the front office, the admin will say someone's acting up in the waiting room here. You may want to know that, right? So the way you do it is you ask the person to turn the device, the camera to the far end of the room. If it's a phone, and the phones are OK on their end. It's your end you got to worry about the phones, because you're going to get really tired doing very intense work on that phone all day.

But get yourself the biggest monitor that you could possibly afford. And a lot of times a 52-inch old TV monitor is what you can use one little cord and plug it into your laptop. You get this big, huge screen, a high-def screen. And you see people bigger than life. Now you can really see what's happening. So don't bother with the phone.

But in any case, if you turn the thing around–and they do–and you ask them to go back and forth to the far end of the room. And it might be a teeny room. Maybe they get to do it 5 feet, probably 8 feet, probably 10 feet, maybe 12 feet. You watch them on the turns. Have them spin around and walk back and forth five, six, seven, eight times until you really get a sense of it.

OK. If they're able to maneuver those turns without tipping over or taking a step extra or two, they pass the gait analysis. You document it as that. Telehealth gait analysis, that kind of thing. Put it in your notes. You're good.

Hygiene check is the same kind of thing. Telehealth procedure for that is you ask the person who comes in. And you suspect something might be going, hey, could you put your fingernails up to the camera for me? Just hold them there for one minute. I just want to see. Yeah. So everything's fine. Great.

Just let me document that. I just have to do this stuff. So give yourself an explanation there. And don't be going into all the details about it. I just have to do this. It's kind of required.

Then if their nails are cracked and dirty and they don't mention it, all right. What's going on? We can't smell people like we do in our waiting rooms, but maybe there's something going on that you need to make a primary focus here.

If they don't mention it, why don't they? Because most of us have a social norm built in. And if someone were to ask that you put your fingernails up to the camera and you don't comment on it when they're dirty, a lot of alarm bells are going to go off inside. So for you not to say something about it, like, jeez, I'm really embarrassed. I was out moving the trash around and my hands got dirty, or I was gardening, or whatever, right?

Then you know, OK, this person understands the bounds of where they should be. But if they're not, that leads to a whole other set of questions. Just like if someone came into your waiting room and you could tell they hadn't showered for two weeks. It'd take you a nanosecond.

Then your questions are going to start focusing on what is going on with this person? Are they sleeping in their car? Do they have access to food? Do they need emergency health care? And so it helps you sort out what are you going to address right now with this person. Of course, in a video you could ask somebody to lean forward, let you see their eyes a little more closely.

If somebody has been drinking, their decibel level will tend to go higher, right? You could say, hey, could you lower your volume just a little bit there? And then if they lower it, OK, now they're speaking in a normal–OK, because they lowered it on their end. And give them a minute to do it, because this is an analysis that you're doing.

Oh, you don't know where the volume is? Well, there's nothing you could do about that. You see that. But most people know where the volume button is on a phone, or on a keyboard, right? So let them put it down, and if all of a sudden they're talking really loudly again, OK. They're not in check with their decibel levels, you see? So that is part of a mental status exam through a camera, OK?

And you can ask them, and ask questions, or whatever other substance use quick questionnaire. Maybe they can't write it out for you, but they can answer questions back and forth. And then you fill out the form on your side, OK?

So a good book that talks about a lot of this that's evidence-based approaches to administering a variety of tests, and it's a relatively new book, Tom Parsons, highly recommend it. But what I'm trying to say here is conduct a formal intake. There's no shortcuts. You don't just throw this together. OK, we're doing video, blah, blah, blah. Yeah, how are the kids?

This is professional. You need to have a formal introduction. No shortcuts on your intake. Check for all the stuff you would check normally. And then identify, diagnose or document a diagnosis if that's appropriate OK?

NAADAC talks in their ethical code about the need for you to be aware of missing cues. We just went through a bunch with those things, but no, ethical codes actually say that you should do this. Now some associations have done a better job of this. I think NAADAC did a really good job. I've not seen this one this clearly stated in other groups.

So let's see, telephone. There are different types of issues to address. And once again, look up some of that. If you don't know where to go, go to Google Scholar. We have all the references. I told you before, telehealth.org/bibliography. Google Scholar or PubMed is online if you get PubMed. Or a typical university library. If you have academic privileges you can get that, or if you're a student you can get it. But ask for, let's say, telehealth mental status.

Just a keyword just to see what's out there, and then summarize some of that stuff. And in this case, telephone. Telephone mental status. Come up with your own keywords to look around for things. You want studies that are replicated, and you would get that from the intro, all right?

Because it'll say, oh, well in 2015 you published an article on blah, blah, blah, on substance use, telehealth. And now we're replicating it with another population. Different age group, because we're trying to prove that this thing is valid, right? So you need two studies for something to be validated.

If you start looking around at studies, even for things like text therapy, OK? Look at some of that data within your populations, different assessments. Well, for an assessment tool to be validated, that means more than one tried that. And look at the population. For a mixed population–mixed, what does that mean?

OK, look at the literature and make sure that if your supervisor were reading this with you that it would really pass muster, OK? Cultural competence is a big thing more traditionally for telehealth when we're not in an emergency situation like right now. A lot of people are dealing with people they've dealt with for years, or months at least, weeks perhaps. When we're dealing with a new population, telehealth can catapult you into the other part of the state.

And you may not be aware of local factors. You may be dealing with someone from another ethnic background, so another religious background. Your job to be all of the cultural competence things that you learned, all the principals need to be applied to telehealth. You need to use interpreters if you don't speak someone's language.

I know here in California the Department of Mental health is required to provide an interpreter to people in their language. And through telehealth it's quite possible, OK? There are companies that do that for you. They will offer interpretive services. You work with them at times, you get trained on that, and then you can move forward with it.

So documentation. Informed consent, your primary document, right? It's a legal issue. It's required by the ethical codes, and there are two kinds of informed consent. One is partly due at first, and then there's a dynamic, and there's static.

Now I'm going to introduce an app. We're 15 sessions in with somebody, we're going to introduce an app, and I'm going to go into some detail about the app. That's dynamic informed consent. You label your documentation. And in informed consent we talked about with our app, OK?

Now just to go back to informed consent. It's a discussion. It's not a piece of paper. It represents a meeting of the minds, and that is the clinician. It's a reasonable assumption that the client or patient knows what's being explained to them. And I've said to the text messaging companies, how do you do that? How do you have a discussion with somebody through text messaging about informed consent? I haven't seen a single way anybody can do that.

I'm focused on legal ethical. A lot of those companies are focused on making money and they hire young clinicians, or unseasoned clinicians, let's say, to practice there. And they don't tout their licensure. But the responsibility for that's on the clinician.

If you look in the documentation, a lot of those companies make you sign. We literally accept all that responsibility, and they wash their hands of it. Because you're a licensed person. You're supposed to know what you're doing. You say you're a licensed person. By golly, that's your job if you mess up with that.

I don't think you can do informed consent through text messaging and do a good job of it, OK? Because you don't know who's on the other side, or if there's 10 people there, or just one. There's a lot of stuff you don't know.

But in any case, you have to have the ability to communicate with somebody and make sure that they understand what you're saying. And the document represents that you–it's the legal representation that that experience happened. And the trick there is to get them to sign they understand it, you see? So you've got to have a bunch of stuff in that document. Now informed consent, a whole other area that NAADAC went into. Identify yourself... So I'm going to have to leave that and move on.

Opening protocol and documentation. Identify yourself and your geographic location. So you set a frame at the beginning of every session. Hi, this is Marlene. I'm in San Diego, OK? Ask them to do the same as needed. You already know that I'm just going to have to ask them who they are. Well, where are you? That's crucial, because they may not be in the state right now that you're licensed to practice in. And right now the laws are in flux, but if you have to be licensed to do what you're doing, you need to find this out from the get-go.

And if they are not, you don't just cut them off. You ask them if there's an emergency. If there is an emergency, give an emergency protocol, stabilize them. Is there somebody there to help them? Do they need to get to the hospital, that kind of thing, right? And then you stop. You don't do the Tuesday afternoon at 3:00 appointment, OK? And then there's other things in the opening protocol that you have to attend to. So there's a bunch of them.

OK, legal regulatory. There's about 27 terms in the behavioral regulatory code. So even the states can't agree. This is what's being called behavioral telehealth by SAMHSA. But they'll call it all kinds of things. They'll call it electronic health care, or digital health care, or connected health care, or telepsychology. They all have their own–distance counseling from counselors. So you need to call your state and find out what they're doing, or go to the website and see what they call telehealth.

I think the president, two weeks ago, when he identified the state of emergency for the country, used the term telehealth. Now a lot more people are using the term telehealth, which I think is great. Because these distinctions, frankly, don't need to exist.

And HIPAA, I'm going to bypass some of this, and there's a lot of HIPAA stuff that now is getting changed, and I'm going to get to that. They've loosened it, and you have a handout as to what's possible for HIPAA. But I'm going to refer you to the handout.

Now let's get into issues like Skype. Right now, in the state of emergency, Skype is allowed, OK? But all this time it has not been allowed, all right? There are a number of reasons for that. Just know that temporarily this is allowed. When we get on the other side of this emergency, unless they change, they don't allow audit trails. They don't allow a number of things that you, who are the covered entity, are required to use. You need, as a covered entity, to choose a device that meets HIPAA standards.

And so right now it's getting loosened. Use what you can just to address the emergency, but the truth is you can't be doing that willy-nilly, OK? HIPAA does require that you do a risk assessment. If you haven't done that, type it in. They give you a tool. Office for Civil Rights gives you a tool to do risk assessments. And so you can go do that.

Practicing over states and international borders, NAADAC. Every single ethics code says you've got to abide by the law, OK? And these borders have been a really big deal. States have not been able to change things even though many have tried. They're still feuding with the

neighboring states. The neighboring state is not adequate and they don't want those inadequate people to come and practice in their state.

So hopefully this all will get sorted out now. Because people are getting, in some cases, the right to go over state lines to deal with this emergency. And in some cases with opioids as well, OK? So I gave you some resources. Go check the resources for those details.

Safest practice, aside from the emergency is, first, right now, read the links, updates from your own licensing boards about this licensure issue. But don't trust other people's comments about licensure. People ask me this stuff all the time. I say, I'll give you my opinion, but you know what? I'm Marlene Maheu, right? I am not your licensing board, and these boards are changing the rules a lot. What I know–first off, I don't know all the rules for all the boards for all the professions that we serve. Could you imagine what that would mean at any given time?

You're responsible to your board. So I can teach you the terms, and I can teach you, don't call them and ask them. Put it in writing so you get a written confirmation of this and it's clear. Ask them for the code section, but don't trust anybody, not even the attorneys that say they know this stuff. They're only interpreting the law. Think what the attorneys do. They all fight what the interpretation of this stuff is all the time. That's how they get their earnings. So go to your board. They're going to tell you what you're supposed to be doing.

Realize you're a mandated reporter no matter what. You have to report every single thing that you have to report in person, OK? I just gave you a sample here of California law about child-abuse regulations, and that there are penalties for your not reporting child abuse.

If you see something in someone's home now, it doesn't mean that, well, now it's telehealth so you don't have to report it. Now you have a better window into the home. You may know when those children, or those older people, whoever that you're dealing with may need your help. So this is a little bit about apps, and you have to be able to determine that your person is able to do things. So I'm just giving you more about apps.

There are some references, here I've got a book chapter on finding, evaluating, and using smartphone applications and many resources now. So I'm just going to give you one of the ones that I have. But I'm going to move on to just some general principles about how to identify them.

Here's another article I wrote, The Interactive Mobile App Review Toolkit. Once again, with apps, the same principle, safety first. And we're going to just shift now, because I know we're winding down on time, and I can see a ton of questions coming in.

I'm going to take a few of these just because they're related to HIPAA. If you wanted to find out if a company is HIPAA compliant, just know, they will already tell you that, OK? It'll be on their website. Why? It cost them a ton of money to be able to say that.

And the other thing is they have to give you a BAA, a business associate agreement. No BAA, you cannot use them. It doesn't matter what they say. They can claim anything. You need it, because you're the one mandated to get a company that uses the BAA, OK?

And there's a sample of that given by the Office for Civil Rights. Why? Because the companies will give you one, but it's written by their attorney. Who are they protecting? They may be protecting you. I don't know, but the Office for Civil Rights has a sample.

So you may want to take one from a company, and then compare it to the sample and say, all right. You are lacking these two clauses that the Office for Civil Rights says you need. So double-check that stuff. Also, not in an emergency, but normally you check your malpractice policy for telehealth. Make sure your policy says it covers you for telehealth, right?

OK, so most of us know, mental health is the costliest disorder in the United States. The largest health care problem in the United States is mental health and substance use. So that's why the government is really trying to help us get out there now. But most people will never see a therapist. There are lots of things that we can do, but I want to encourage you to be careful about some of the things that you do.

So people are asking about the protocol I mentioned. We have them for sale at our institute. It's telehealth.org/reports. You can come and see some of that stuff. Let's see–the articles. I think if you just search for the title of the article that you can see on the slides you'll get the get the authors on that. Go to Google Scholar or PubMed if you want any of that.

Now let's go back to cell phones. Let's say somebody tells you that they're feeling suicidal, OK, and in a text message. And you act on that. And they later decide that you've breached their confidentiality and you don't have a formal note. Because you just saw it in your cell phone and that thing got deleted after 30 days depending on your settings. Now what do you have to prove if they want to sue you for breaching confidentiality?

When you get a text message that has clinical material in it, or a phone call that has clinical material in it, or an app message, or whatever you get, document that in your notes. Because you want to be able to say, I got this note. It was based on that that I called the police. Tarasoff, the homicide threat, right? I called up the spouse that the person was threatening to kill, this kind of thing.

So you want your notes to reflect everything, not, oh, that was an app, or that was text messaging. And I'm only going to do my notes for when I have direct contact. Your notes need to reflect all of that. And so there actually are some programs that could help you pull that in.

Or sometimes if you buy a video platform it has all of these services built in. You can text people through the video platform, it's all secured. People know they have to log in to connect and get an unsecured message.

Couple of things on the phones. The program that comes with your phone is not HIPAA compliant, OK? You have to buy that service. Phone calls generally are recognized as being private. It's a one-to-one connection. But if you're using a VoIP line–my phone systems are VoIP, meaning it's a company they uses the internet. So if I unplug my internet, my phone stops, OK? Not my patient phone, because that I carry with me.

But my wall phone, if that unplugs when I unplug my computer, well, that line is running through your computer. That is not secured, you see? So anybody can come and collect the data on that. You don't know who's getting that data. And you're like, eh, never going to catch it.

Well, do you really want to be the person that compromised somebody, and now somebody's dying because of that? Because there have been many reports of patients killing themselves because data got out through telehealth. So just be careful. Download the software.

Pay the $50, $100 a month that you need to pay to have good quality connections and protected communication with your patients. Right now these rules have been set aside because of the emergency. But when this passes, it's not like we trust everybody on the internet.

I have a free newsletter. It's available through telehealth.org/signup, OK? And we have people that go and collect articles, and I'm the one that pick them out. Every week we send out 10 or 12 of the best of the week. We're the only ones that do this in the industry, but we send them to you for free to your desktop through this email newsletter.

And I have as many breach reports as news items. It is shocking to me. Out of, let's say, 30 or 40 that I get every week, at least half are this company got breached, this company got breached, that company got breached. Unbelievable, so don't take it for granted. Get some HIPAA training. We have some at our institute. But make sure you know what you're doing with HIPAA.

And I'm not talking five people getting breached. I'm talking 10,000, 20,000, 50,000, 2 million, 6 million. There's big-time breaches going on, so be careful about it. You don't want to be the person, right, that they caused something.

Now there's all kinds of new tools where people can check their blood pressure on their phones. You don't have to be connected to somebody's home, their remote monitoring device, to be able to read it. Get them to put their blood-pressure cuff on their finger, OK, and use an app. And have them show it on the screen, right? You read it from the screen.

You don't have to get fancy about this stuff. Learn to work with this camera. There's a lot of stuff. Maybe for little kids you can say, OK, I'm going to give you that hug now. And you go and you–put your finger out there. OK, thank you, right? You can do all kinds of creative things with a screen. Start thinking about that. Share what you learned with each other, OK?

I'm only telling you these things because I've been studying this literature and developing it for the last 26 years. There's lots of little adaptations that you can make that are really very, very beneficial. People want a hug, give them a hug. You don't have to get fancy about it, OK? But there are lots of devices available for sleep monitoring now that we give people all kinds of readings that are helpful. Have them show you that on their wrist.

We have a buyer's guide for this kind of thing, and I see we have questions about technology coming in. I've gotten a ton of these. I don't own these companies that we have listed. We have a buyer's guide, and I'm giving you the link here, telehealth.org/buyersguide. You can come here. It's free to you. We have a bunch of video things. I don't go check under the hood for these people.

Let me just give you my disclaimer. If they tell us they're HIPAA compliant and we can verify it on their website because they say it on their website site, then we will list them here. But we do not take responsibility for what you decide to do with these people, OK? We're just trying to offer a free community service. And we develop this, we pay for this. We maintain it for your benefit.

So If there's some group that you don't like, come and rate them negatively. We have a star rating. Come tell us that you don't like that, and tell your colleagues, OK?

Text messaging. There's a lot of positive outcomes for that, but for alerts. Not just, hey, how you doing? I'm terrible. What do you mean you're terrible? I mean I'm really terrible. But what does that mean? You see, you can get caught in all kinds of things with that. I would encourage you that if you want to do it that you make sure that you can address all the safety concerns that might come up with this group you're text messaging.

The confidentiality you're not using whatever's on your phone, but you've been using a device that gives you a business associate agreement. Just realize you're missing a ton of information, OK? So what evidence base are you using to say that what you're doing is appropriate? You really need to cite some articles.

Go to Google Scholar, PubMed, or whatever. Look at whatever your population is, let's say it's opioid, OK? Then opioid and telehealth, look at the sample part of that. Who was this? Go to discussions section. What do these people say to do? As a result of all the stuff we did over here, we recommend blah, blah, blah. This is in the discussion section at the end, OK?

Say, OK, I'm finding that Peterson and Johnson 2018 said to do ABC. For this patient I'm doing C. Why? Because Johnson found this research. I'm citing the literature. Do that in your notes. You're going to sleep better. You're going to deliver better care. And if anybody looks at what you've done–because their audits are rolling around now to see if you're doing appropriate note taking since ICD-10. If you haven't been hit by that, just know it is nasty. I encourage you to get your documentation in order. Get some literature that you're citing to do telehealth, and then you won't have to worry about it.

Another thing about it is emotional reasoning. Just because you like an emoticon and you want to–later you're text messaging and all of that, little smiley faces, and LOLs, and abbreviations. Ixnay on that, OK? That is not professional behavior. Actually some ethical codes have banned that for at least a decade.

So just know, this is where people get themselves in trouble. If someone wants to prove that you violated their boundaries, the easiest way to get to that is to show how you were doing laughing out loud, sending them memes, little jokes, little songs through YouTube and things. Well, you're not maintaining your professional stance.

So maintain your stance. You'll be able to interact professionally and hold that boundary, especially in telehealth. If you want to joke around in your office, that's a whole different thing. But all this stuff can be used against you when you try to defend yourself if anything goes wrong.

And I'm not here to try to dampen your energy about this. Look, I'm the biggest fanatic you could ever meet, all right? But I made it my business to find out how to do this legally and ethically, and that's what I'm trying to share with you, OK? So do it, do it, do it, do it. Just be smart about it, OK? Document what you're doing.

Now this was a handout that I had given before I submitted my slides to SAMHSA for approval. So I don't have other ones to stick in here, but I'm going to show you this one. The traditional way to bill for Medicare and Medicaid services is to put 95 in the modifier code next to the CPT box.

So you have CPT code box on the 1500 form. And it's probably five digits, OK? Then there's a dash, and there's two digits. In there is where you're supposed to put 95.

I've seen some doctors say, don't bother with the modifier code. Why not? Use it. Do it now. Teach your billing staff. Do it the right way. That used to be -GT and all of that, but that is not the way it is anymore. And this is a handout that says that these are the current billing codes. I'm trying to see the date on this. I can't quite see it myself.

But look for the title, Revisions to Telehealth Billing Requirements for Distant Site Services. Distant site is the patient. Because telehealth billing follows the patient, you see? You've got to bill where the patient is, because telehealth is generally considered to have happened where the patient is.

And that's why if your patient is in Iowa and you're working out of California, like I am, they are in an area–that's OK for them to be there, yet you cannot be there. You can't join them there because now technically you're in their state to deliver care. And Iowa law may have something to say about that, all right?

Now your licensing board, depending on your licensure, may have something to say about that. Mine does. My licensing board says, here's a license. Thou shall not leave this state with that license without formal written recognition by the foreign state. You see?

Now like I said earlier, we're in a state of emergency. Things may have changed. Check with your board. Don't believe your colleagues. Check with your board. You want it straight from the board, OK?

The other thing is the place of service code because the activity is happening where the patient is. The distant site is a term for that. It is 02 for that place of service code, OK?

Now I'm getting questions about licensure, so let me address some of that. If you move to another state and you're still licensed in your original state, can you still see the people you saw in your original state? Yeah. Typically, yes. I don't know of any state right now that says no.

But once again, I am not the licensing board. You need to talk to your board about this. And right now the laws may be changing. Go to your board website and it'll tell you what the emergency situation is. And then later on when this temporary emergency hopefully passes, then the rules will come back into play.

But depending on your profession, OK, and your licensure, for the most part, 99% of the time, it's OK. Why? You're licensed. Why do states want to license you? A state wants to license you to make sure that you don't hurt its citizens, OK? That's how it came about in the 1950s.

So when you stop and think about, OK, Iowa doesn't want me to hurt their people. They don't know me, right? They don't know me. I haven't filed anything with the state of Iowa. They don't want me going there because they don't know who I am. And if I do big, bad things to their people, their citizens, then they have no control over me, you see?

So many states will let you file for registration, is what it's called, in the foreign state. And they'll limit it to 30, 60, 90 days. Most of the time it's 30 days, OK? And you can do that.

What's a visit through telehealth? One day. So they say 30 days, well, that's 30 visits, right? So you can't set up a practice in Iowa and do that all the time with people in Iowa. But you can follow your patient that way.

Now back to your original question. If you live in Arizona and you are serving people in California, and you're licensed in California, yeah, they see you proved to the licensing board in California that you understand their rules. And the truth is, a lot of states have very different rules. It's amazing.

It's amazing how many hours you need to report child abuse, what kind of forms you need to use. What about you and your supervision? Is supervision OK? There's all these things that are

so different. So Tarasoff. Some states are not Tarasoff states. So you go violate somebody's confidentiality, there's no policies.

In California there's insurance that will protect you if somebody complains that you said that they were going to kill somebody. But maybe some other state doesn't have that. So know the state law, and that's why they want you to go pass their exam. And if you do pass an exam, it's a jurisprudence examine in the foreign state. It's not the whole exam you took when you took your licensure, OK?

So there are a few codes I want to know about before we just do question and answer here. And that is that starting in calendar year 2020, CMS approved three codes for treatment of opioid use disorder, specifically this year, OK? So it describes a bundled episode of care. So look for these codes. And the codes apply to overall management, care coordination, individual and group therapy, and substance use counseling. So the government wants you to deliver this care.

Now with that, I'm going to go straight to the questions and see what I can say. We discussed expectations like unauthorized recording or pictures with patients. Yeah. See the truth is, I could've had my phone here the whole time, and you, too, recording all of this. And your patients can do that. There's no way you can control what–in your informed consent, this is why informed consent is so crucial for telehealth.

You need to address that and then have an informed consent document that also addresses that, that there's an agreement. And you establish this as soon as you start doing telehealth that there will be no recording going on. And do they agree that if they decide to record at any point that they're going to tell you, you see?

So I get this question a lot in terms of what if someone is not in their right state and they lie to you? There again, you can only ask them, and you do. See, if you can say, well, you know what? Maybe they were in a different state and I was not compliant with that state. And now they're suing people that they died and the family is suing them, and they want to pull me into this thing.

But you see, this is the opening protocol. And my opening protocol is a checklist, and as I go down the questions I check them off and I stick that in the patient file, or do it digitally. You can have an iPad or whatever, tablet next to you with your assessment things, check, check, check, done! Boom, recorded, you see?

Or if you buy a video platform that includes a lot of this stuff, you can set it up so that you have your opening protocol and as a PDF that you put in the waiting room. And when people come in and they're sitting there waiting for you, well, they can read all that. Please tell me what state you're located in right now.

Did you lock the door? If you have children and you need a sitter, do you have a sitter with them? Tell me this ahead of time. Do you have a tissue box? This kind of thing. Is there anybody else in the room? I want you to tell me if anybody else is in the room. Tell me if you're going to record things.

You put all this stuff at the front. Depending on your judgment of the people you deal with, OK? And you save that as a PDF, maybe put a nice, little picture in there, and that's saved, and there you go. While they're sitting in there, they get to read all that and nothing else. They're just reading that.

So when you come in, you go, oh, is there anything you need to tell me? We're starting, tell me where you're at. So you document that. So you can organize yourself really well very quickly with this.

If they lie to you, you could say, well, I did the opening protocol. They asked me. Look, and here's my checkboxes of what I asked them. Check. They told me they were in, let's say, California they're licensed, right? We are not held responsible for the things that we don't know. What we're held responsible to is what a reasonable professional would have done in a comparable situation to what we dealt with. That's the litmus test when you're brought up on charges of anything.

And if you can prove that you did what you're supposed to do–here's the evidence base for my inventions. Here's my checklist of what I did. Here's the informed consent agreement. See? There's documentation that we did discuss this. Because I have a question on item seven and nine, and I documented they asked me a question, which means we went through this form.

This informed consent process, we went through this and they asked me these three questions. That means that I went through the whole thing. So they only had three questions, but I went through the whole document. There's your proof. Not that they signed the document, but that you put questions that you answered for them during the informed consent process in your initial protocol.

And then, let's say, you're doing dynamic informed consent. I explained an app. We went through dynamic informed consent. Pete asked me this question about safety, and I answered him. Boom, that's it. There's your documentation. OK, so that addresses a number of these that I see coming.

If you're dealing with the VA–let's see, I don't have the name here but I can't help you fight with the VA. That's frustrating, but I think you have to use traditional channels there. Yes, people are Zooming in from their beds right now. Yeah. Part of that problem is that–during this emergency–is that they go to their room and shut the door. I wouldn't make a big deal about that right now under a state of emergency. We just talk to people, OK? Later on it is not a good practice, obviously.

I remember talking with somebody who was not a patient, it was somebody I was working with. Because we run an institute. We have a technology platform running content management and all of that. I was talking with this gal and all of a sudden I saw a guy without a shirt get up from around her. He was in bed with her, OK?

Now that could happen. That can happen. You don't know who's in that room. If they are in the room, you could say, hey, could you take your laptop and just scroll around the room real quick just so I can make sure nobody's there? Well, you know nobody's there, Marlene. Right. You say, you know what? I'm sorry. I have to document this. This is the rules.

They won't argue with you. Pull that card out. I have to do this. This is my policy, or my agency policy. So all right, just double-check there's nobody there. All right. Now I've seen some people that are barely clothed that are showing up on camera. This is the kind of thing where is it an issue right now that's worth discussing in a state emergency or not? I think at a later point in time, you may want to help them tighten that up, all right?

Again, lots of good questions. Let's see. Can you work with a company that offers an app that's HIPAA compliant? Well, yeah, absolutely. If they tell you, get the BAA, OK, and look at the app and make sure it fits your treatment model. And use it based on what the patient needs right now, not I'm just going to stick this app on everybody. And then introduce it to them in the session. Help them toggle things on.

A lot of the apps will say, hey, is it OK that we report bugs to the developer? No. No, OK? That's creating an open channel. Do you know who that developer is? Do you know what they're doing with that information? What do you think the likelihood is they're selling that information, right? No.

This is secured. If it's HIPAA compliant it really shouldn't let the user communicate with the developer. But if you see that come through, encourage your person to not do it. And then as you are talking with them in the session, like the app, get the phone. Let's see your phone. And if you need 10 minutes to figure that out, take the 10 minutes. Because they're not going to do it on their own more than likely, and they're going to get overwhelmed.

And if you prescribe something that they don't follow up on, it's a little tear in the therapeutic relationship. You didn't know them well enough to anticipate that they couldn't do this. Now they're going to be embarrassed, OK? Or maybe they're not even going to try it, and they're going to feel a little bit of guilt, you see?

The therapy relationship should not be tinged with these kinds of things. If you really want them to do it, practice with your colleagues. Get this little introduction thing down so it's just a few minutes and you don't have to fumble around. OK, you're going to have to fumble with their phone. OK, where are your settings and that kind of thing? And turn it on. There's a little thing about communicating with the developer, turn that off. No, we can't have that.

And then walk them through it. OK, here's a thought record. Here's where you put your thoughts for the day. See, this is by day, time, you can sort it out that way. Take the time to walk them through it, and the next time they come in, go for it, OK? Well, let me see that. Let's look at it together. Hold them accountable that way, or you're wasting your time and you're going to damage your relationship. It may not be a huge tear, but these sort of tears do add up over time. So hopefully that will help you.

OK, here's a question about cultural competence, normal cultural considerations for telehealth use. I was called in by a regulatory board for Alberta, Canada a couple years ago. And they said, hey, can you come up? And they organized people up there to train. And so their licensees came into the big room. A bunch of licensees from neighboring provinces.

And when I was flying in, flying up to Alberta–I love traveling. And so the view is nothing, nothing, nothing, nothing, nothing, then this huge condo development, and then more nothing, nothing, nothing. And countryside, and mountains, and all that, and then a huge condo development. coming in more, huge condo development. It's miles and miles in between them.

And so during the time I was there, I did a day or two workshop there. I said, so what's going on with all this? I don't understand what's going on around here. There's a religious community that decided, Marlene, that they love Alberta. And Calgary was the town, and they decided that they'd settle here. And they get huge condo developments because live in community. There's the rec center, basically, and there's a kitchen. And they all live together.

So this becomes an issue when someone walks in, because members of that community sometimes want to leave the community, you see? And if they try that it can be severely punished. They get excommunicated. They can't talk to their family. They're basically out. And it's very difficult for them to cope.

So see, telehealth allows you to go there. And how do you know if they're in the community, out of the community, some other community, some other religious group that you don't anticipate? You need to have a thorough intake about this in telehealth with new people. Your traditional people it's not an issue.

What's the best way to protect myself and train to assist my three supervisees for Medicaid compliance? Well, I don't know if you're talking about telehealth there or Medicaid. If you want telehealth supervision we have a course about that. We have some things going on for COVID right now that could be of use to you. We have a free course. We have one every Saturday.

We're doing an intense clinical. And all those things that I showed you about gait analysis and all that, we have an intense four-hour clinical workshop for that every Saturday right now through April. We may do it more, it depends on what's happening with this emergency. So if you want Medicaid billing compliance for you and your supervisees, then we don't do Medicaid. We can teach you the codes like we do for telehealth, but that's a separate thing.

But we have group training right now, too, that if you want to come in as a group, then all our training is 50% off. And you can get a super discount at any point. We're trying to just help the community, but we've got to keep our costs covered, too, so we don't go under. So that's why. So hopefully you in the group.

I see another question here about group. Do I have comprehensive telecodes? There are a lot of these available through telehealth right now. We have a three-hour recent reimbursement course for telehealth at the Institute. We give that there. And also, you'll find them on some of the government websites, OK?

So with that, I see our time is up. I'm sorry I have to end. Thank you for being such a good group and being so interactive. My pleasure.

INA RAMOS: Thank you so much, Dr. Maheu. This has been a very enlightening presentation, especially given the state of the country right now, and really of the world. So on the next slide here you see that there are several resources to aid your further research in telebehavioral health. Some were included in the chat box, but it is available as a handout in the Webinar page.

And last, we'd just like to thank everyone for a great question and answer period, and for joining us on the webinar today. We hope that you'll be able to utilize the information presented to strengthen your work. In closing, we'd like your feedback on this webinar. After you close the webinar window, a new window will pop up that includes a brief survey.

You will also receive a follow-up email tomorrow with this survey, and it will include a link to download a certificate of participation for today's webinar. So thank you very much again, and this concludes our webinar. Thank you Dr. Maheu.

DR. MARLENE M. MAHEU: My pleasure.