NAATP

WEBINAR SERIES

Telehealth Gone Viral: Practical Tips for Virtual Integration

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Telehealth Gone Viral: Practice Tips for Virtual Integration

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Learning Objectives

- Attendees will be provided the ***subjective account*** of one provider's transition into telehealth applied throughout Intensive Outpatient Programs (IOP).
- Attendees will gain an increased knowledge into the suggested ***technical/procedural*** barriers for an organization to consider before implementation.
- Attendees will review the ***administrative*** considerations that our leadership team found to be most critical for implementation.
- Attendees will examine the ***clinical practice*** guidelines that have been developed within our health system.

Presentation Outline

- Technical/Operational: Nick (15 min.)
- Administrative: Randal (15 min.)
- Clinical Practice: Bonny (15 min.)
- Q&A: All Presenters (15 min.)

Setting the Stage

What changes in our culture support telehealth practices?

- The iPhone was released on **June 29, 2007**.
- Netflix began online streaming on **January 16, 2007**.
- From (2010-2019), the overall proportion of U.S. adults who own a Smartphone **increased from 35% to 81%**.
- From (2010-2019), the overall proportion of U.S. adults who use **Social Media increased from 51% to 72%**.
- In 2018, Social Media platforms became the **primary news source** for the largest proportion of U.S. adults.

Although a "majority" of U.S. adults have hardware access (e.g. tablet), equitable access to technology will offer some groups significant financial challenges.

Pew Research Center (2019)

Telehealth Research

Several meta-analyses have demonstrated *complimentary effectiveness between traditional psychotherapy and telehealth delivered interventions* for SUDs.[1, 2, 3, 4]

Telehealth services have shown effectiveness in SUD populations across broad delivery systems *(e.g. Telephonic, Video, SMS, Smartphone Application, Web-based Intervention, and Virtual Reality).* [5, 6, 7, 8, 9, 10]

Common predictors of SUD telehealth treatment outcomes include: therapeutic alliance, craving, and proficiency in technology use. [11, 12, 13]

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Benefits of Telehealth

Benefits:

- Flexibility in ***Facility Management***
- Broaden ***Access***
- Increased ***Patient Contact***
- Reduced ***Patient Cost***

Limitations:

- Perceived Decrease in ***Quality***
- Payment ***Parity***
- Ambiguous ***Regulation***
- Technology ***Infrastructure***

Telehealth *Technical / Operational* Overview

- Hardware Infrastructure
- Software Platforms
- Billing
- Documentation
- E-sign

Hardware Infrastructure

Equipment

- Step one in our conversion centered on identifying which of our 45 IOP clinicians needed additional hardware.
- (Action Step): Perform a system-wide inventory of all hardware (e.g. cameras, microphones, etc.).

Bandwidth

- Different software platforms have different bandwidth requirements to operate properly. Depending on the current plan with your internet service provider (ISP), your user experience (UX) could be impacted significantly resulting in dropped sessions and poor quality.
- (Action Step): Consult with your integration specialist at the company you've chosen to determine if the data speeds are sufficient for current and potential expanded future use. Review the fine print before selecting your telehealth platform to ensure they will assist you with this.

Software Platforms

Software

- Many platforms offer web-based video communications solutions. We chose Zoom primarily due to the UX and BAA.
- (Action Step): Network with existing providers and inventory their software selections.

Data Privacy / BAA

- Data Privacy is of significant concern for all providers. Given that we are all bound by HIPPAA/CFR 42, significant caution should be placed in selecting your telehealth software platform.
- Business Associates Agreement (BAA), outlines agreement between two entities that outlines security of data assets.
- (Action Step): Ask your potential vendor for a copy of their HIPAA compliant BAA.

Billing

Payer Contracts

- Our organization maintains contracts with commercial payers. As part of rapid responses to COVID-19, several announced temporary approval for telehealth delivered IOP as billable service.
- (Action Step): Reach out to your payer contacts and explore temporary contract waivers for expanded telehealth services.

Billing Codes

- Most payers have instructed use of specific telehealth modifier codes to include on claims. Internally, the use of these modifiers changed workflows and processes.
- (Action Step): Reach out to your payer contacts and inquire suggested modifier codes for use on claims.

Documentation

Documentation Requirements

- In response to COVID-19, many regulatory bodies have waived or altered existing documentation standards as related to patient consent. On March 13, 2020, the TN Department of Mental Health and Substance Abuse Services (TDMHSAS) announced “increase flexibility” in documentation. Guidance for new documentation standards were also released highlighting, “All services delivered via expanded telehealth services should be clearly documented in the client’s record, including the reasoning telehealth was used as a service delivery method”.
- (Action Step): Reach out to your organization’s licensing body for clarity on telehealth related adjustment in service delivery practice.

Electronic Signature

- Technology accelerants offer unique opportunities to engage patients digitally. Our EHR partners (Sunwave), began immediate work in developing these technologies integrated directly into our web-based EHR system.
- (Action Step): Reach out to your EHR representative to explore for unique collaborations with electronic signature capabilities.

Research

Measurement/Outcomes

- Measurement Based Care delivery system severed. Losing in-person interaction decreased our opportunities to measure our patients (i.e. Kiosk to SMS).
- (Action Step): Engage your technology partners or research staff in troubleshooting interruptions in scheduled measurement practices.
- (Take-Away): Our experiences with COVID-19 offers our practices an increased opportunity to examine the effect of this pandemic on patient well-being and longitudinal outcomes (i.e. quasi-experimental design).

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Telehealth *Administrative* Overview

- Admission Criteria
- Informed Consent
- Crisis Management
- Toxicology Screening
- Training: Technical & Clinical
- Supervision & Quality Management

Admission Criteria

- Patients with identified risk factors, compromised immune systems, age concerns, or family at home in those categories
- Patients discontinuing treatment due to fear of exposure for self and family
- Patient preference
- Individuals previously not served because bricks-and-mortar sites are not convenient
- Technology Access, Bandwidth, and Comfort Level

Informed Consent

- Verify if informed consent must be obtained in person
  - Is there temporary relaxation of federal or state guidelines?
  - Consult accrediting agency, state licensing and other regulators, and payor requirements
- Specify risks and benefits of telehealth
  - Transmission interruption or clarity problems
  - Potential misunderstandings
- Wellness checks, duty to warn, and other crisis possibilities
- Disclose who has access to the record or to the platform

(See also SAMHSA Tip 60)

Informed Consent (Continued: Agency Specifics)

- Hour-long Telehealth orientation for each patient:
  - 1 x 1 with primary therapist
  - Practice with the platform
  - Review of informed consent
- Temporary permission for verbal consent for the following:
  - Consent to Treat
  - Releases of Information (ROIs)
  - Treatment & discharge planning and discharge planning
  - (Check local rules and regulations)
- EMR partner added e-signature for vital documents

(See also SAMHSA Tip 60)

Crisis Management

- Attention to Suicidal Ideation, threats of harm to self or others, and mandatory reporting responsibility
- Crisis Management starts with verifying identity of the patient and their location
- Cell phone participation decreases ability to know patient's location and available resources

TIP:

- Assign a counselor to identify local resources for each patient

ORC LOCATION	MOBILE CRISIS NUMBER	WHO THE COUNSELOR GENERAL CALLS LOCALLY IF THERE IS A CRISIS	HOSPITALS	PSYCH/CRISIS HOSPITALS
CHATTANOOGA	855-274-7471	911	Erlanger East Hospital	Parkridge Valley Hospital
CLARKSVILLE	931-648-1000	Centerstone Mobile Crisis in Clarksville: 931-920-7200		None-Refer to Nashville hospital(s)
COOKEVILLE	615-244-7444, 800-704-2651	Chad Hughes, then emergency contact, then go from there	Cookeville Regional Medical Center	Ten Broeck (attached to CRMC)-Lori said "unsure they will open back up. They do continue to have PHP, IOP and Sr. Perspectives at this time."
COOL SPRINGS	615-726-0125, 855-274-7471	Call supervisor to get thoughts or direction	Saint Thomas West	Rolling Hills, Vanderbilt, Mental Health Cooperative crisis stabilization unit
CROSSVILLE	800-704-2651	Cumberland Mountain Mental Health	Covenant Health/Cumberland Medical Center	None in Cumberland County
HERMITAGE	855-274-7471	Crisis Intervention Center: 615-244-7444	Summit Hospital, Skyline Hospital, Vanderbilt Hospital, St Thomas – midtown and Centennial Hospital	Skyline Madison Campus, Vanderbilt Psychiatric Hospital, Centennial Parthenon Pavilion
JACKSON	731-541-8200, 911	731-541-8200, 911	Jackson Madison County General Hospital, West TN Healthcare North Hospital	Pathways
KNOX CENTRAL (PAPERMILL)	865-539-2409, 855-274-7471	Amanda Lewis and/or 911	Children's, Ft. Sanders, Parkwest, Tennova North, Tennova Turkey Creek, UT	Blount Memorial Emotional Health & Recovery Center, Peninsula Hospital (Division of Parkwest)
KNOX WEST (FARRAGUT)	865-539-2409, 855-274-7471	Amanda Lewis and/or 911	Children's, Ft. Sanders, Parkwest, Tennova North, Tennova Turkey Creek, UT	Blount Memorial Emotional Health & Recovery Center, Peninsula Hospital (Division of Parkwest)
MT. JULIET	855-274-7471	Chad Hughes, Mt. Juliet Police 615-754-2550	Tri-Star Mt. Juliet	Panacea Psychiatric Hospital
MURFREESBORO	855-274-7471	Mobile Crisis	Trust Point, St. Rutherford	Trust Point (Murfreesboro, TN), Rolling Hills (Brentwood, TN), Vanderbilt Psych (Nashville, TN)
MUSIC ROW	615-726-0125	Cindy Spelta for directions	St. Thomas Midtown, Vanderbilt, and	Vanderbilt Behavioral Health/ Vanderbilt Psychiatric Hospital

Toxicology Screening

- ASAM (American Society of Addiction Medicine) recommended (specific to MAT providers) considering suspension of drug testing during contagion window and stay-at-home orders.

- Oral fluid testing is a consideration. Patients self-swab and seal in an envelope while on camera, and submit for mail-in results. Some payors will not approve this.

- Lab partners may set up collection schedules at brick-and-mortar locations and/or at their collection sites.

Training: Technical & Clinical

- Train/practice setting up appointments and problem-solving tech issues
- First Month: daily debriefings/check-in session with counselors on implementation of the new processes
- Second Month: twice per week peer-led user group for sharing tips and concerns
- Implementation of Clinical Supervision group (“PROS”) for licensed and unlicensed practitioners

Supervision & Quality Management

- Transference, Countertransference, Affirmation, Affection, Rescuing, Scapegoating, Otherizing, Fraternizing, and every imaginable group dynamic still occurs
- While stronger initially, counselor preference for in-person services can fade quickly; many patients will still desire in-person interaction.
- Myth: “This is just like being there.”
  - Telehealth vs in-person differences occur in the following areas:
  - crisis response, informed consent, confidentiality, and new forms of testing limits (dress, posture, distraction, unwanted others in the room)

Telehealth *Clinical Practice* Overview

- Preparation
- Confidentiality
- Co-Facilitating vs. Solo
- First Week of Telehealth Sessions
- Group Norms
- Basic Session Structure
- Building Cohesion & Rapport

Preparation

- Double check group member’s emails and verify their privacy, internet, and tech options. Send platform invite to group several days in advance.
- Contact group members and make announcements:
  - Behavioral and confidentiality expectations/limitations & risks
  - How to access the group
  - Initial session opened 1 hour prior to group. Log on at least 15 minutes in advance to trouble shoot tech issues.
- Send patients secure emails: orientation packet, treatment work, assessments, treatment plans. Review on platform.
- Practice utilizing platform features with other practitioners. Goal is to navigate platform seamlessly.
- Create plan for crisis interventions on the new platform.
- Create plan for addressing violations of group norms.

TIPS:

- Have a co-facilitator or on-call counselor who can facilitate group while primary counselor is addressing crisis.
- Use the “Share Screen” feature during orientation and assessments to make the process smoother and faster.

Confidentiality

- Highlight confidentiality expectations at the beginning of each session during the first week and then periodically throughout treatment.

TIPS:

- Do not use backdrop feature.
- Be in a private, quiet space where no one will or walk through group.

Co-Facilitating vs. Solo

Working with a Co-Facilitator:

- Communication is key.
- Meet every day prior to group to establish the plan for the day and what features will be used and how.
- Talk on breaks to assess the session and patients' needs and adjust accordingly.
- Establish process for dealing with patients who violate group norms or present to group under the influence.

TIP:

- Establish one counselor as the main facilitator during the session. Other counselor will manage troubleshooting, individual patients calls/breakout rooms, and any disturbances within the physical space.

Co-Facilitating vs. Solo (Cont'd)

Working Solo:

- You will probably be more exhausted than usual (Zoom Fatigue). Increase self-care during the first week or two and <u>be extra kind to yourself</u>.
- Navigating tech issues and behavior violations is more challenging alone. Communicate the protocol to the group early and often for how you plan to deal with these issues as they arise.

TIPS:

- Use breaks to move and be physically active (e.g. stretch, walk, etc).
- Schedule longer breaks to meet with patients individually or schedule individual patient needs outside group time so you can recharge on session breaks.

First Week of Telehealth Sessions

- Primary goals:
  - Orient group to new platform
  - Establish new groups norms
- Communicate how platform features will be used.
  - Ex: Move patient to waiting room or breakout room in event of behavioral violation.
- Allot 10 minutes at the end of every session to discuss patient experience with platform.
- Communicate throughout group the plan for the session.

TIPS:

- Communicate with group the exact time that you want them to return from breaks.
- Keep plan for first session simple and flexible.

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Group Norms

- Establish norms to mitigate confusion and drowning others out.
- Keep video on at all times except on breaks.
- Appropriate attire (must wear both a top and bottom).
- No activities during group that do not pertain to group.
  - Suggestions:
    - Do not cook a meal during group.
    - Do not use other devices or watch TV while in session.
- Disable chat feature unless messaging everyone or group leader.

Questions to ask when creating tele-norms:

- Do you want to allow patients to eat while in session?
- Will you allow group members to smoke during session or only on breaks?
- How do you feel about patients lying down while in sessions whether on couch or bed
- Do you want phone users to hold their phone or have set spot for it?

TIPS:

- ❖ Utilize the chat feature to communicate when you need to step out of group & why.
- ❖ Keep microphone muted unless speaking to help reduce white noise.

Basic Session Structure

- Do not create structure based on in-person models. Ask:
  - What is necessary for the session and what is possible in the platform?
  - Can some needs be better served by scheduling separate or individual appointments?
- Identify what overextends your energy and mental sanity. Creatively navigate around those issues.

TIPS:

- People tire more easily through a tech platform. Consistent, regular breaks mitigates screen fatigue.
- Utilize other mediums (e.g. whiteboard, ppt, videos, etc.) to break up the visual monotony.
- Palate cleansers break up the session content.

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TELE-IOP Basic Session Structure

9:00am – 9:10 am

Announcements
Group Expectations
Basic Plan for the day
Answer Questions/Address Concerns

9:10am – 10:10am –

Check-In (share screen of white board or Word doc with check-in points)
Daily Meditation or reading (can be displayed on the white board)

Prior to a break, communicate with patients about what to expect in the segment following each break and if any new platform features will be used.

10:10am - 10:25am

Break

Communicate exact time clients should return from break; communicate with clients they can meet with counselor in break out room to discuss personal concerns.

10:25 – 11:45

Education or Treatment Work

Another Break can be taken as needed.

11:45 -12:00

Check Out (Share Plans for the day/weekend)
Process Tele-format
Brief announcement about the next day: share changes in group structure or updates about new admits.

Building Cohesion & Rapport

- Group cohesion and rapport are more challenging to establish via telehealth.
  - Computers and tablets work best. Use phones when patient has no other tech options.
- Brainstorm with co-facilitator about potential options for more focused group interactions.
- Physical activities are recommended.
- Create list of activities that can be done with simple household items or paper & pen. These remove focus from screen and increase engagement.

TIPS:

- Have patients introduce their pets to the group.
- Combine breathing/meditation exercises with a stretching/physical component.

Questions/Inquires

Please do not hesitate to contact our team for additional information.

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References

1. Young, L. B. (2012). Telemedicine interventions for substance-use disorder: a literature review. Journal of Telemedicine and Telecare, 18(1), 47-53.
2. Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: a 2013 review. Telemedicine and e-Health, 19(6), 444-454.
3. Lin, L. A., Casteel, D., Shigekawa, E., Weyrich, M. S., Roby, D. H., & McMenamin, S. B. (2019). Telemedicine-delivered treatment interventions for substance use disorders: A systematic review. Journal of substance abuse treatment, 101, 38-49.
4. Kruse, C. S., Lee, K., Watson, J. B., Lobo, L. G., Stoppelmoor, A. G., & Oyibo, S. E. (2020). Measures of Effectiveness, Efficiency, and Quality of Telemedicine in the Management of Alcohol Abuse, Addiction, and Rehabilitation: Systematic Review. Journal of Medical Internet Research, 22(1), e13252.
5. McKay, J. R., Van Horn, D. H., Oslin, D. W., Lynch, K. G., Ivey, M., Ward, K., ... & Coviello, D. M. (2010). A randomized trial of extended telephone-based continuing care for alcohol dependence: Within-treatment substance use outcomes. Journal of consulting and clinical psychology, 78(6), 912.
6. Keoleian, V., Polcin, D., & Galloway, G. P. (2015). Text messaging for addiction: a review. Journal of psychoactive drugs, 47(2), 158-176.
7. Bush, N. E., Armstrong, C. M., & Hoyt, T. V. (2019). Smartphone apps for psychological health: A brief state of the science review. Psychological Services, 16(2), 188.
8. Gustafson, D. H., McTavish, F. M., Chih, M. Y., Atwood, A. K., Johnson, R. A., Boyle, M. G., ... & Isham, A. (2014). A smartphone application to support recovery from alcoholism: a randomized clinical trial. JAMA psychiatry, 71(5), 566-572.
9. King, V. L., Brooner, R. K., Peirce, J. M., Kolodner, K., & Kidorf, M. S. (2014). A randomized trial of Web-based videoconferencing for substance abuse counseling. Journal of substance abuse treatment, 46(1), 36-42.
10. Ghiţă, A., & Gutiérrez-Maldonado, J. (2018). Applications of virtual reality in individuals with alcohol misuse: A systematic review. Addictive behaviors, 81, 1-11.
11. Giroux, D., Bacon, S., King, D. K., Dulin, P., & Gonzalez, V. (2014). Examining perceptions of a smartphone-based intervention system for alcohol use disorders. Telemedicine and e-Health, 20(10), 923-929.
12. Molfenter, T., Boyle, M., Holloway, D., & Zwick, J. (2015). Trends in telemedicine use in addiction treatment. Addiction science & clinical practice, 10(1), 14.
13. Sawesi, S., Rashrash, M., Phalakornkule, K., Carpenter, J. S., & Jones, J. F. (2016). The impact of information technology on patient engagement and health behavior change: a systematic review of the literature. JMIR medical informatics, 4(1), e1.