Frequently Asked Questions

From March 31 to April 29, 2020, the Addiction Technology Transfer Center (ATTC) Network, the Center for Excellence on Protected Health Information (CoE-PHI), the National Consortium of Telehealth Resource Centers, and the Center for the Application of Substance Abuse Technologies (CASAT) at the University of Nevada - Reno (UNR) facilitated eight national online discussion and resource sharing opportunities for substance use disorder (SUD) treatment providers and peer support specialists faced with transitioning their services to the use of telephone and videoconferencing methods in response to COVID-19 social distancing guidelines.

Each session invited attendees to ask any questions related to telehealth generally and in the content of the pandemic. Panelists and attendees responded to questions and shared key resources.

Panelists also offered ten-minute presentations "5 key tips" focused on one key topic at the end of each session:

Best Clinical Practices for Treatment with Telehealth
Privacy Considerations for Telehealth During COVID-19
Groups via Telehealth
Billing and Reimbursement
Tips for Engaging & Interacting in a Virtual Session
Tips for Successful Telehealth Implementation
Tips for Recovery Community and Recovery Support Services
Self-Care: Hope Matters

All materials shared during these sessions can be found on the Telehealth Learning Series page and the Resource page. These materials include podcasts, recordings and transcripts from each session, the key tips shared during each session, and a targeted selection of tools (webinars, toolkits, fact sheets, and other documents) to support implementation.

After analyzing the questions asked across the eight sessions, we found key issues people wanted additional information for in response to COVID-19 and the rapid implementation of telehealth, in addition to understanding the need for longer-term implementation planning if telehealth is to become a sustained part of their healthcare approach. The following summary of frequently asked questions (FAQs) is focused on supporting those rapidly seeking to implement telehealth and also highlights external documents we have found useful during this time. Each section provides a summary of

key questions asked, collates responses, and shares examples/templates of documents that may be adapted to be useful to your current and future organizational needs around telehealth. All of this is with the caveat that things are rapidly changing and your organization should stay updated by reviewing any policies and changes on SAMHSA's COVID-19 Guidance and Resources page as well as the U.S. Department of Health and Human Services (HHS) Telehealth resource page.

The FAQs are divided into the following topics:

1. **What is considered telehealth and why is it important to implement?**
2. **We have to do this now! Where do I start?**
    a. Rapid capacity assessment
    b. Know the policies
    c. Organize billing and reimbursement
    d. Rapid planning, preparing, and testing
    e. Building initial telehealth workforce capacity
3. **What are HIPAA compliant ways to communicate with patients and protect health information?**
    a. Recommended technology
    b. Consent to treat vs consent to share information
    c. Importance of documentation and storage
    d. Engaging across state lines
4. **Can you share best practices around…?**
    a. Planning and preparing to conduct individual and group sessions?
    b. Creating safe spaces and establishing boundaries?
    c. Engaging patients and making sessions interactive?
    d. Recovery strategies and ways to engage peers?
    e. Conducting assessments?
    f. MAT?
    g. Intensive outpatient programs (IOPs)
    h. Working with youth and those in college?
    i. Telehealth in rural and remote communities?
    j. Making telehealth culturally responsive?
5. **How can we continue to build staff capacity and offer professional development opportunities?**
    a. Free online learning
    b. Continuing Education (CE) Accredited Online Learning
    c. Technology Based Clinical Supervision
6. **How do we practice self-care and build a culture of wellness and resilience in our organizations?**
    a. Role of leadership
    b. Individual action
7. **How do we plan for the future and think about building our long-term capacity to sustain telehealth?**

1. **What is telehealth and why is it important to implement?**

   Telehealth uses computers, phones, and internet-supported mobile devices to deliver healthcare services, including mental health and substance use disorder treatment and recovery. The COVID-19 pandemic and the need for physical distancing accelerated the shift toward telehealth and reduced many of the barriers to providing telehealth, including administering medications such as buprenorphine. This is causing many healthcare organizations to rapidly implement new protocols and policies to address the organizational, clinical, technological, financial, and workforce changes needed to effectively manage this change process and minimize direct contact between patients, providers, and other staff. Many healthcare organizations are starting this process in response to COVID-19 with a focus on better understanding where telehealth and services delivered virtually will integrate into their sustained services post COVID-19.

2. **We have to do this now! Where do I start?**

   First of all, take a deep breath! This situation is unprecedented and so is the available training and technical assistance support to make this happen. While there is an emergent demand for you to continue to provide treatment and recovery services during COVID-19, public health emergency practitioners and clinics will need to address the organizational, clinical, technological, financial, and workforce changes needed to effectively manage this change process and successfully implement services using telehealth. If you or your clinic/center are still familiarizing yourself with the concept of telehealth and looking for resources and support during COVID-19, four great resource and technical assistance (TA) places to start include:
   - The Telehealth Learning Series Resource page.
   - Center for Excellence on Protected Health Information (CoE-PHI)
   - Center for the Application of Substance Abuse Technologies (CASAT) at the University of Nevada – Reno
   - National Consortium of Telehealth Resource Centers

KEY RESOURCE: SAMHSA's 2015 TIP 60: Using Technology-Based Therapeutic Tools in Behavioral Health Services offers a comprehensive overview of implementing and sustaining technology-assisted care and shares templates of forms.

ONCE YOU ARE READY TO GET STARTED, THERE ARE SOME KEY THINGS WE RECOMMEND:

Conduct a rapid capacity assessment

Is the shift to telehealth a short-term goal to respond to the pandemic and mitigate exposure for your staff and patients or an opportunity to explore how telehealth could improve and/or support your patient outcomes? Being clear on what you are trying to accomplish and why enables you to decide how much time initially to spend on planning and preparation. A great way to assess where you are in the start-up process is to have a small team including a clinical champion and/or leadership conduct a rapid capacity

assessment to identify next steps and start to engage staff. A rapid assessment will clarify your goals, identify where you are in organizational readiness, staff engagement, and patient readiness as well as define financial and operational logistics. If your focus is only short-term (to respond to COVID-19 needs) then your small team can work with your information technology (IT) staff to examine options and select a telehealth strategy and platform that supports your program model and clinic flow, rapidly train your workforce and educate patients, and establish basic protocols and policies to start offering telehealth in compliance with the emergency pandemic guidance. If you are seeing this as a potential longer-term opportunity to integrate and sustain telehealth, then we recommend a more inclusive and in-depth planning and assessment, preparation, implementation, and evaluation approach.
Example of Rapid Capacity Assessment: Maryland Healthcare Commission Telehealth Readiness Assessment (TRA) Tool
Example of Checklist: Mid-Atlantic Telehealth Resource Center Telehealth Essentials Checklist
Example of Telehealth Capacity Assessment Tool (TCAT): National Frontier and Rural Telehealth ATTC: TCAT

Know the policies

Policies around telehealth are rapidly changing and knowing where to find and learn about updated federal and state policies is critical.

- Federal: At the federal level, SAMHSA's COVID-19 Guidance and Resources and HHS telehealth and COVID-19 resource page outlines the most recent updates. These include changes around HIPAA flexibility, telehealth waivers for the Centers for Medicaid and Medicare Services (CMS), and details around cost-sharing for patients in federal healthcare programs. TA and resource centers such as CoE-PHI and the National Consortium of Telehealth Resource Centers offer webinars and brief guides to help understand these policies and guidelines.

RECOMMENDED RESOURCE: CoE-PHI: Understanding the New SAMHSA/OCR Guidance for Telehealth SUD and MH Services
Recommended Resource: Mid-Atlantic Telehealth Resources for COVID-19

- State: In addition to changing federal guidelines, providers need to ensure they comply with all state requirements, especially around privacy and consent to treat. COVID-19 has further created a situation where patients may have received treatment in one state and then moved to a different state for quarantining. This is especially relevant to those working with college students who have left campus and returned home. While CMS announced a waiver allowing telehealth across state lines, permissibility to practice telehealth across state lines may vary depending on your state. Two other key areas include the duty to warn and child abuse reporting mandates.

RECOMMENDED RESOURCE: The American Psychological Association (APA) Telehealth Guidance by State
RECOMMENDED RESOURCE: The University of Texas and Penn State State-by-state guide to the rules/laws about telehealth services across state lines
COMPREHENSIVE RESOURCE: State Telehealth laws and Reimbursement Policies

Organize billing and reimbursement

Billing and reimbursement may be the largest barrier to implementing telehealth, so we have to just acknowledge; it's complicated! During the Telehealth Learning Series, there were a lot of questions around types of facilities that can be reimbursed, geographic locations around provider versus patient location, eligible services, which clinical providers can get reimbursed and whether interprofessional consultation is included, billing codes, and how all this is changing in response to COVID-19 across different payers. Medicare Fee-for-Service (FFS) rules are the same nationwide, while Medicaid FFS rules are different for each state. The good news is that emergency pandemic guidance for Medicaid has expanded billable services, lifted restrictions on location of services, expanded reimbursed providers to include federally qualified health centers (FQHCs) and rural health centers (RHCs), and allowed for reimbursement for telehealth using the telephone. The challenge is this means rapid changes are being made across Medicaid, Medicare, and private payers, which feels like a continuous process of adding new codes, modifiers, protocols, and policies. Substance use professionals should stay on top of state guidance by reviewing their state emergency management COVID-19 site, which links to any state Medicaid changes and policy waiver changes and provides the most up-to-date information. If healthcare organizations are billing to different private payers and working across state lines, this means reaching out to every private plan and reviewing guidelines for each state to ensure compliance.

A recommended place to start is to review your patient profiles by payer mix, identify the majority group, and then begin with the rules for that group before moving on to the next. An initial task is to organize your billing and reimbursement around your virtual clinic flow and outline the flow of services, professionals reimbursed for those services, codes available for telehealth and how to integrate those CPT codes into your electronic health records (EHR), and note any changes from telehealth policy pre-COVID-19. Example: Caravan Health: Virtual Care and Care Management Services (services, codes, who can bill, and details).

RECOMMENDED RESOURCE: CMS: Medicare Telemedicine Fact Sheet
RECOMMENDED RESOURCE: CMS Telemedicine Toolkit
RECOMMENDED RESOURCE: Center for Connected Health Policy Quick Glance State Telehealth Actions in Response to COVID-19 and COVID-19 related state actions
RECOMMENDED WEBINAR: Medicare Coverage and Payment of Virtual Services

Can you provide some examples of how CMS billing codes have changed, how we can bill for telephone appointments, and what reimbursement we can expect?

With the preface that you should always refer to your state emergency management site for updates, one example is that CMS Telehealth codes now use the same CPT codes as for an in-person appointment, but the Place of Service (POS) on the 1500 claim form should include the modifier 95 to indicate a telehealth appointment. As far as telephone care codes:

- On April 30, 2020, new ruling from CMS permits audio only telephone care for the following psychiatry codes: 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90853. The

psychotherapy add-on codes are to be used with the E/M telephone codes, 99441,99442, and 99443. CMS will increase payments for these E/M codes to match payments for similarly timed office and outpatient visits.
Payments for these services have increased from the current range of about $14-$41 to the higher range of about $46-$110, and these payments are retroactive to March 1, 2020.

Example: American Psychological Association (APA) Sample CMS-1500 forms with case examples for Medicare beneficiaries

What about billing for texting?

There are no current CPT codes to reimburse for texting, though asynchronous communication may be covered as part of an eVisit conducted through a portal. The Office of Civil Rights still prefers audio and video conferencing to unencrypted texting, though guidance may change.

How do we bill and get reimbursed for clinical supervision (tele-supervision)?

The interprofessional consultation codes (also called e-consults or internet consults) existed prior to COVID-19 and provide a workaround to reimbursing for tele-supervision with Medicare. If you have a supervisory relationship with a clinical psychologist billing for telehealth services, then the interprofessional codes should allow both providers to get reimbursed. If you are a primary care provider (PCP) consulting with a licensed clinical social worker (LCSW) or licensed professional counselor (LPC) to engage a patient around substance use issues, you can both bill through interprofessional codes. Examples of codes:

99446 - Interprofessional telephone/internet/electronic health records assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review.

99447 - Interprofessional telephone/internet/electronic health records assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review.

99448 - Interprofessional telephone/internet/electronic health records assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review.

99449 - Interprofessional telephone/internet/electronic health records assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review.

Is there a way to bill for virtual peer support?

This varies across states and we recommend checking with state behavioral health policies and guidance.
Examples: NC Modified Enhanced Behavioral Health Policies; NY State COVID-19 Coding and Billing Guidance

Rapid planning, preparing, and testing

Telehealth is new to many organizations. The extensive time and resources usually dedicated to plan for implementation has been significantly reduced as healthcare organizations rapidly respond to the pandemic and the need to mitigate exposure and ensure their workforce and patient's safety. This ramp-up to telehealth implementation can add stress to a challenging time, so finding ways to make this process manageable and setting yourself and/or your organization up for success involves planning, preparing, pilot testing, and refining your protocols.

BEST PRACTICES:

Planning:

Being clear in your goals for telehealth will help identify the staff and resources needed for implementation. If your only goal is to respond to the virus and mitigate exposure in the short-term, then this is the driver for your planning phase and can be clearly articulated to both your workforce and patients. Clinical and non-clinical staff (including IT and front desk staff) can then be engaged in intensive planning and preparation to define your program model (groups, individuals, families, and/or children) and select a telehealth strategy and platform that works best for your short-term needs.

If your goal is longer-term and you want to take this opportunity to explore how telehealth could improve and/or support your patient outcomes, then a small group of staff (that includes a clinical champion, other frontline staff, and IT) should assess how telehealth could benefit clients and staff, and support your existing program model. Sharing these results early on in the planning process with all staff engages stakeholders and helps build consensus and readiness for the changes to come. It also reinforces the need to take time to identify a telehealth strategy and platform that supports patients access to technology, your clinic flow and program model, and meets ongoing expectations for HIPAA compliance.

Preparation:

Regardless of short or long-term goals, the success of your telehealth program is correlated with staff and patient support and buy-in, establishing clearly written protocols and policies that outline expectations, roles, and procedures for both patients and staff, and ensuring you communicate all of these changes during a telehealth training phase. All staff need to be included in this phase to ensure changes are communicated consistently throughout your program and clinical and non-clinical staff can clearly outline the new protocols and policies to patients. Other considerations

beyond billing and reimbursement include ensuring your malpractice insurance covers telehealth, validating all clinicians are licensed to provide telehealth care in the state they are providing services (or a waiver exception currently exists), and ensuring you have access to the appropriate space and technology needed to sustain telehealth. Many insurance companies will include telehealth in their coverage without any extra payment, but there are some that will require you to get a special rider. Often times, it's at no extra cost or very low cost.

Pilot Testing:

As part of the preparation phase, these protocols and policies need to be pilot tested within your organization and/or with willing family and friends to refine and practice as needed before you go live. Written protocols should include a pre-checklist for clinicians, a “what to expect” for patients, along with clearly written guidelines to set boundaries and expectations for telehealth visits. Pilot testing should include a variety of scenarios to test the technology, including “patients” being at home, in a car, and breaching protocols so you can direct any changes needed.

Refining protocols:

“Don’t let perfect be the enemy of good.” Telehealth is a learning process and you should expect to be learning and refining your protocols as you pilot and start to implement. Identifying 2-3 key metrics (such as improved or equal patient outcomes, more patients engaged in treatment, or increase in the number of patients seen) will support your implementation process, reinforce what is important, and provide data for any future grant or funding proposals to support sustaining telehealth services.

Building initial telehealth workforce capacity

Against the backdrop of the pandemic, any organizational changes can increase anxiety and workplace stress and ensuring staff feel engaged, supported and receive sufficient training is key to successful implementation. If you engage staff in the planning and preparation phase, there is less likely to be resistance during the testing and implementation phase. Building initial telehealth workforce capacity requires creating a space to provide intentional support to staff and patients, conducting training and coaching activities that allow staff to practice using telehealth technology and any new protocols, and routinely communicating how telehealth supports the existing program model focused on patient care.

While the platform or medium of communication is different, it is critical to reinforce to the workforce that the focus on patient care and general organizational principles (staff roles and clinic flow, boundaries, patient confidentiality, consent to treat, goals of treatment, and organizational mission) remain largely unchanged. Administratively, there may be changes to EHR forms and providers will need to secure verbal or written confirmation from patients to receive telehealth-based care, but the process of care should employ the same standard of care as office-based visits. Small changes may be needed to ensure clinicians are fully and completely documenting interactions with patients, clinical findings, medical decision-making, and other necessary variables to support billing codes.

Taking time to schedule regular routine meetings for staff to communicate any anxiety and successes around telehealth, providing space and resources for all staff to be trained in protocols and policies, and ensuring there is a key contact that can provide telehealth support will strengthen ongoing staff competency and sustainability of telehealth services.

RECOMMENDED RESOURCES: National Frontier and Rural ATTC Telehealth Capacity Assessment Tool webinar and infographic.
COMPREHENSIVE RESOURCE: American Medical Association (AMA) Telehealth implementation Playbook.

3. **What are HIPAA compliant ways to communicate with patients and protect health information?**

   A large amount of questions from each session focused on better understanding the guidance and changes for HIPAA and the SUD privacy law, 42 CFR Part 2. Presenters clarified that consent to treatment and care is a state law, whereas HIPAA and Part 2 are federal privacy laws and impose requirements for obtaining consent to disclose protected information. This distinction is critical as we review appropriate technology platforms, create processes for informed consent for treatment and/or consent to disclose patient information, review issues of liability and documentation storage, and assess guidelines for operating across state lines. While there are currently some more lenient guidelines, it is still best practice to set up your telehealth program to protect patient confidentiality to the fullest extent possible. If you need support, CoE-PHI can provide technical assistance: Request TA from CoE-PHI.

RECOMMENDED RESOURCE: CoE-PHI On demand webinar platform for archived webinars on federal health privacy law
RECOMMENDED RESOURCE: Brief video on HIPAA compliance
RECOMMENDED RESOURCE: Telehealth Resource Center infographic on HIPAA and Telehealth
RECOMMENDED RESOURCE: SAMHSA COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance
RECOMMENDED RESOURCE: FCC COVID-19 Telehealth Program
RECOMMENDED RESOURCE: AOAAM webinar: Telemedicine Getting Started

So how do we select a HIPAA-compliant platform?

We like to use the phrase HIPAA secure rather than HIPAA compliant to reinforce that it is the user that makes the platform HIPAA compliant rather than the platform itself. Generally speaking, the difference between HIPAA secure platforms (such as Adobe Connect, Cisco WebEx, Zoom Pro, and GoToMeeting) and currently allowed non-secure platforms (such as Apple FaceTime, Facebook Messenger video chats, WhatsApp, Google Hangout, Zoom, and/or Skype) comes down to the privacy of information (how it is shared) and the security of information (how it is protected). HIPAA secure platforms make a commitment to record and handle any session information or metadata in a way that complies with HIPAA and gives you the ability to audit. We should reinforce that any “public-facing” platform (such as TikTok, Facebook

Live, Twitch, or public chatrooms), which are designed to be open to the public are not covered by the Notification of Enforcement Discretion regarding COVID-19.

Selecting a platform involves ensuring that platform can support your program model needs and be supported by your IT staff. Are you planning on telehealth with groups, individuals, families, and/or children? Think about your workflow and the features you need to support and wraparound that workflow. Are you doing back to back sessions? Do you need a waiting room? Are you scheduling all your sessions and need this to integrate with your calendar, or do you have a scheduler? Do you need this to integrate with billing? If you have your own EMR, do you want a platform that integrates with your EHR as you are working with your patient? If you're thinking about integrating and sustaining telehealth, you need to reflect on your own business practices and ensure your platform supports increased efficiency and effectiveness for your organization, staff and patients.

Your technology requirements should be defined by your program model and NOT the other way around! We will not recommend one technology over another, but we do advocate learning from colleagues and other healthcare organizations already using telehealth platforms and engaging key clinical staff in the platform selection process. The Telebehavioral Health Center of Excellence, offers a tele-mental health comparison tool, which lists the available features as well as issues related to HIPAA and security and privacy.

RECOMMENDED TOOL: Telebehavioral Health Center of Excellence MATRC Vendor Selection Toolkit

How can we make technology platforms more secure?
Train providers and review key strategies to increase security. Ensure your providers do not use public WIFI, password protect meetings, lock virtual rooms once participants join, and password protect patient folders and files (such as documentation of sessions) if using a home computer. It is often not about the platform, but what providers put in place and reinforce with patients that protects patient confidentiality. Reinforce with patients the need to protect communications, prepare surroundings, and protect devices and provide them with a guidance handout that outlines expectations.
Resource: (For patients) CoE-PHI Tips for keeping your telehealth visit private
Resource: (For providers) CoE-PHI Tips for Telehealth and privacy: Federal guidance for SUD and Mental Health Treatment Providers

What are best practices around securing consent and do you have any examples?
We need to emphasize the differences between securing consent to treatment and care (a state law) versus securing consent to disclose patient information (HIPAA and 42 CFR Part 2 privacy laws). We can start by sharing key differences and examples of forms and then focus on COVID-19-responsive strategies to secure consent and meet current HIPAA and 42 CFR Part 2 guidance.

Consent to treatment and care through telehealth: Prior to engaging in telehealth treatment, you will need to secure and document verbal or written confirmation that patients understand the benefits, risks, and limitations of the platform used to receive

telehealth-based care and outline expectations for the telehealth visit. Verbal confirmation is allowed in most states under pandemic guidance, but best practice is to check state guidelines and secure written consent. This is not a typical in-office informed consent due to the need to include language related to technology and the platform selected.

Example: APA's informed consent checklist for telepsychological services outlines the key elements needed for your informed consent form.
Example: NASW informed consent to treat form can be adapted for your organization.

Consent to disclose patient information: These consents are focused on protecting patient's health information and consents to release of information (ROI) are required to make any disclosures of information for billing and/or medical purposes.

- **Pre-COVID-19:** 42 CFR Part 2 requires a signed, written consent for treatment purposes, payment/billing purposes, and most other types of disclosures.
- **COVID-19 response:** SAMHSA 42 CFR Part 2 guidance expands provider's ability to use the medical emergency exception, which permits a Part 2 program to share protected SUD treatment information with other providers for the purpose of treating a medical emergency. To eliminate any barriers to care during the pandemic, if providers cannot get written consent and the need for services is clearly documented as a medical emergency, providers can record the verbal consent and understanding of the patient as it relates to all interventions, and can make disclosures to other treatment providers. It should be noted that this sharing of information is only to a medical treatment provider and not for the telehealth vendor or for billing purposes.

Example: Client is receiving SUD services remotely due to COVID-19 and requests a referral for mental health treatment. SUD provider determines that the client's need for mental health services constitutes a medical emergency for purposes of 42 CFR Part 2 and cannot obtain written consent because client does not have technology to sign consent form remotely. SUD provider asks client for verbal consent to share protected SUD information to mental health treatment provider. Client consents, and verbal consent is documented. SUD provider may then disclose protected SUD information to mental health provider without obtaining written patient consent for disclosure; information should be limited to the minimum necessary to make referral.

BEST PRACTICE:

Check your state guidance as your Part 2-compliant consent forms may need to be updated to reflect any state law requirements (for example, if your state has stricter privacy laws for SUD information).

Example: LAC sample forms regarding substance use treatment confidentiality
Example: LAC consent to disclose patient information to individual form
Example: LAC consent to disclose information to third-party payer form
Example: Sample notice prohibiting re-disclosure of substance use disorder treatment records
Example: LAC form to disclose information to non-treatment provider entity with participants (e.g., health information exchanges)

COVID-19-responsive virtual strategies to secure consent and meet current HIPAA and 42 CFR Part 2 guidance: While COVID-19 guidance allows for verbal consents in cases of medical emergency, best practice is to secure a signature, which includes e-signatures and even a photocopied signature. Part 2 does not require a wet, in-person signature and providers can obtain an e-signature, a photocopied signature, or you could mail the form and ask the patient to mail this back (or take a picture of a signed form and text/email that back). As long as you are not prohibited by state law or by another applicable law, you can use an e-signature. There is no current list of e-signature platforms that are acceptable and Part 2 only states that the consent form authorizing disclosure needs to be signed. A lot of session attendees reported successfully using DocuSign, DigiSign, the Notes app on an iPhone, and Adobe. Assuming a BAA is obtained, any of these can be considered a HIPAA compliant eSignature service.

The most important part to consider is "how are you sending that form (or any information) securely in ways that comply with Part 2 and HIPAA?" If you are using email, you must ensure you are using an encrypted email address. Standard email (Hotmail, Apple, and other web-based emails) are not considered encrypted and are not compliant as far as HIPAA and protected health information. This means you could potentially violate HIPAA by sharing a link to a form or a telehealth session as protected health information includes IP and patient email addresses.

BEST PRACTICE:

Encrypted emails with consent forms attached can be sent through accounts on ProtonMail (free) and Doxy.me (free/paid) or Hushmail (paid). Patients can sign using a signing platform such as DocuSign, DigiSign, or Adobe. This is where knowing what features you want in a telehealth platform can help select the best platform. Platforms such as Doxy.me integrate a variety of features to allow you to securely send and receive information. If telehealth is s short-term strategy and all of this seems overwhelming, then mailing forms to a patient to sign with a stamped return envelope is always an option!

What should I be documenting and how do I ensure I store any data securely?
The importance of documenting (especially for emergency waiver to use verbal consent to treat and/or share information with a medical provider) cannot be overstated. In light of COVID-19 restrictions, if you do not document, it did not happen! It can be efficient for behavioral health providers to document in writing their policies and procedures for COVID-19 and outline standard operating procedures (SOPs). Once you have documented SOPs, you can document in the patient record that SOP was used and if anyone questions it, you have something dated that you can show.

BEST PRACTICE:

Providers should document any verbal consents and outline why the patient is unable to sign, outline any information needed to support billing, and take detailed notes of any patient treatment plan changes, especially if they are related to prescribing.

Record any and all patient communication (email, text, calls, video chats), patient location, updates and changes, and if there is information you cannot

get as you are not face to face, then record that also to document what you can and cannot do through this modality.

Any technology issues (no video, audio not working, sound quality) should also be documented.

If you are not using a log-in EHR system, then any files and folders should be in "locked" (password protected folders) to limit access just as you would expect in a physical office space.

How do I stay compliant if I am operating across state lines?
The variation in state guidelines around how patients can consent to treatment means reviewing the state guidelines for every state you are operating in (based on where you and your patients are located). Part 2 is a federal law and is generally the most protective privacy law, but state guidelines should still be reviewed for cases where the state imposes stricter guidelines around privacy.

RECOMMENDED RESOURCE: State-by-state guide to the rules/laws about telehealth services across state lines
RECOMMENDED RESOURCE: Waiving State Licensing Restrictions for Telehealth Helps Combat COVID-19
RECOMMENDED RESOURCE: Alliance for Connected Care: State Telehealth Expansion by Governor's Orders

Are the CARES Act amendments to the SUD privacy law a permanent change or temporary during this time of emergency?

The Coronavirus Aid, Relief, and Economic Security (CARES) Act permanently changed the SUD privacy law, 42 USC § 290dd-2, and directed the U.S. Department of Health and Human Services to amend the SUD privacy regulations, 42 CFR Part 2, within the next 12 months. The CARES Act changes will go into effect on March 27, 2021. Visit CoE-PHI for more information about the CARES Act amendments, including up-to-date resources about changes to the law.

4. **Can you share best practices around…?**

   A key part of many sessions revolved around better understanding how providers are conducting sessions, creating safe virtual spaces and establishing boundaries, engaging virtually to address different needs and populations, and ensuring virtual approaches are culturally responsive. Session attendees and panelists shared examples of how they are planning and preparing to effectively conduct individual and group sessions, addressing patients' receiving medications for addiction treatment (MAT), including recovery strategies and engaging peers, meeting requirements around intensive outpatient programs (IOPs), working with youth and college students, offering tele-supports for residential facilities, and working with rural and remote populations to ensure access to technology. An important message that panelists and attendees continually reinforced is the need to establish guidelines and expectations in the same way as in a physical setting and ensure all the same rules apply when people attend virtual sessions. Simply put, if you or your client would not behave

that way in your office, treatment setting, and/or recovery group, please do not do it in the virtual setting.

How do we best plan and prepare to conduct telehealth sessions?

Plan, prepare, and practice, practice, practice! Key things are organizing your space and equipment, being clear on guidelines and expectations and communicating them ahead of time and at the beginning of the session, ensuring clients can access any technology being used BEFORE the session, establishing location (of provider and/or co-facilitator, as well as patient/client), knowing the type of appointment or group and what protected health information may be shared to create appropriate safety protocols, preparing ways to engage and make sessions interactive, and having clear procedures in place for any technical or safety challenges that arise. The main differences in working with groups vs. individuals revolve around enhancing patient/client safety in groups, being able to manage the number of people in a clinical vs. psychoeducational group and establishing protocols for both open and closed groups.

Plan ahead:

Use a co-facilitator for groups: Effective telehealth sessions include everything you would do in a live session (engaging clients, intentional and reflective listening, asking questions, watching body language and cues, ensuring group safety) PLUS managing chat, looking for raised hands, being a tech support person, and being prepared for emergency calls to/from clients if a safety issues arises.

Ensure you have the right equipment: If you are doing anything other than phone sessions, you need to ensure you have a microphone and camera that work well with the platform you select.

Get a key contact for technology and emergency support: At a minimum, you need a technology support person. In larger organizations, you should have a key emergency contact such as a telehealth program manager or clinical supervisor that can advise you.

Build in breaks when you schedule sessions: Most people are amazed how exhausted they feel running virtual sessions and cannot sustain the 6-8 hours of back to back appointments and sessions in their office. Recommendations included two sessions on, one off, or creating more space between sessions to practice self-care and be more effective.

Determine appropriate numbers for group sessions: For clinical groups, we recommend no more than 8-9 clients. If your group is psychoeducational, you can include more people but smaller is more manageable and allows you to navigate the technology and adapt to group dynamics as needed. You should also be aware of if there are insurance caps for telehealth groups, such as Medicaid.

Organize your physical and virtual space:

Maximize professionalism: Your physical and virtual space, appearance, and behavior should all maximize professionalism and legitimize telehealth as a treatment modality. If you would not dress or behave that way in your office space, then it should not be acceptable in a telehealth environment.

Prepare your physical and virtual environment: Both your physical and virtual environment are important. If you are not using your usual office space, your private physical space (at least what can be seen on camera) should be clean, uncluttered, and minimize distractions. Be aware of what will be seen around you when you switch on your camera, including any personal items. Plan ways to ensure privacy so that you will not be disturbed if working from home. For your virtual environment, assess your platform and how all the features look. If there are optional features that may be distracting, eliminate or minimize them for each session. If your computer is being used for personal and professional activities, close out any unneeded programs, turn off any email, direct message, and social media alerts, and have any documents you may screen share accessible for your session.

Organize and know your equipment: In addition to having a mic and camera that work well, you will need to play with camera angles, lighting, and your location. This helps you find the right backdrop and ensure you can be seen well, that the camera is approximately eye-level, so you have good eye contact and seem engaged, and that you are neither too close nor too far away when on camera. You also need to explore what your available platform can do so you can assess how to engage clients and make the session more interactive: Do you need to share documents? Will you use breakouts? Is there a whiteboard and/or other way to annotate? Will you use polls? Thinking through this helps you decide how to keep sessions interactive and plan activities to support your session goals.

Practice, practice, practice:

Record yourself: If this is a new modality for you professionally, you can record yourself talking, role-playing, sharing documents and/or your screen, and practicing listening. When you review the recording, be aware of the tone/volume of your voice, your environment, eye contact and whether you seem to be looking at the camera or distracted, body language (hands, fidgeting, staying seated or standing), and any on-screen/off-screen distractions or distracting behavior. Adjust accordingly.

Ask a friend/partner to role-play: Once you have worked out your environment and technology, invite a friend/partner to join you in a practice session and role play. Specify key feedback you need from them to ensure you are maximizing professionalism and minimizing distractions/distracting behavior. If you are trying new features like polling, sharing slides/documents, or other interactive features, be sure to pilot them in your practice session.

Communicate guidelines and expectations for both behavior and technology usage:

Create safe spaces and identify safety code words for individuals and groups: Questions around creating safe spaces and strategies to manage these spaces were of paramount concern to attendees and panelists. Newer in-home listening devices, plus children and families being isolated together, make clarifying and establishing safe spaces critical. Strategies for creating privacy include asking clients to use headphones, go for a walk, use chat to engage and share, use cars/bathrooms/closets for therapy space, and/or negotiating private space with roommates, family members, and loved ones.

- **Code words for privacy:** Panelists and attendees suggest that individuals and groups have quick and easy code words (coffee/water) or phrases for identifying if someone has entered their space and they cannot talk or need to close out: Example: "I need coffee" or "I'm grabbing a glass of water" or the provider could ask "Do you need coffee?" if they are sharing their screen and need to blank out any documents.
- **Code words for emergency:** Intimate partner and domestic violence organizations are advocating the use of code words when working with domestic violence survivors to identify that the perpetrator is in the room. One example shared is using the code word "Walmart." Example: "For instance, if you've met with a client and…you would notice a behavior change or start the session with a conversation. If I was the clinician, I would ask, "have you gone to Walmart today?" and the client would say, "yes," or "no." If the client responds yes, then you would know that the perpetrator is present in the room. If the client responds no, then you know it's all clear. If the person is in the room, the next question could be, "did you find what you needed?" and if everything is okay, the answer would be yes. If the client responds no, then the provider would know to possibly call 911, that the client is not safe."

RECOMMENDED RESOURCE: Futures without Violence: Telehealth, COVID-19, and Intimate Partner Violence

RECOMMENDED RESOURCE: Supporting Survivors' Access to Substance Use Disorder and Mental Health Services During the COVID-19 Emergency

Establish (and Re-establish) Boundaries:

Just as you would set boundaries for in-person sessions, it is critical to adhere to those same boundaries as much as possible in virtual sessions and reinforce them repeatedly with clients (before, during, and after visits as needed). Clients may feel a stronger sense of intimacy receiving treatment when providers are in their home space and it is essential to reinforce professionalism and boundaries quickly and consistently to derail any expectations of a more social and less formal relationship. Clothing and language use should not change, clients should still adhere to updated cancellation and rescheduling policies, and the types of interactions and what is permissible remain in effect. Panelists suggest adapting existing treatment documents to add in any telehealth language and changes and adhering to the language used as much as possible to reinforce telehealth as a legitimate treatment modality. During sessions, providers can model appropriate

behaviors and language, reinforce boundaries, and maximize professionalism.

Develop group and individual agreements:

Just as providers would communicate guidelines and expectations for in-person sessions, it is critical to ensure that any established in-person guidelines are adjusted for telehealth and communicated clearly to clients. Existing guidelines should be amended to include telehealth expectations, including being in a space free of distractions so as to speak freely and not be disturbed, wearing appropriate clothing as if they are attending group in person, expectations around technology needed and whether they can use a phone or need to be on video, wearing headphones, and other ways to reinforce privacy. If these agreements extend to groups, then group-established protocols are needed to further protect client safety and reinforce expectations for the group. Do the group feel comfortable with people calling in? How will a breach in confidentiality be handled (such as a non-member witnessing the group or walking into a room)? Are there exceptions to these policies (such as young children and babies being in the room and on camera)?

Pre-session check-in: Panelists and attendees suggested peer recovery specialists and other staff have been helpful in supporting providers and session facilitators by reaching out to clients prior to their appointment to conduct a quick pre-telehealth session check-in. This reinforces the expectations for the session, assesses both the privacy of the space and that clients can access and use any technology, and gathers key information including:

Location: Address where the client will be for the appointment (including zip code in case practitioner needs to send emergency personnel to the site)
Phone number: In case technical difficulties and/or get cut off
Emergency contact: If the client is documented as a domestic violence survivor, it is recommended this is someone outside of the home
Privacy of space: Who else will be there? Do you have any listening devices (such as Alexa and Google home) and can you shut these off? Could you use your camera to show me your space? (To ensure space is appropriate and safe)
Suggested safe word: Identify and document a safe word for needing privacy (if someone enters the room) or for emergencies (if in danger).
Reviewing individual and/or group guidelines: Asking clients to verbally consent or sign individual and/or group agreement.

Can you provide a script/template for reaching out?

Example 1: "Hi Joe, just checking in before tomorrow's group. Wanted to be sure you will at your home [address previously obtained]. Now I have your phone number and your emergency contact's number if there is a problem, are all of those numbers going to be good for tomorrow? Great, now, remember to be in an area where you feel comfortable to speak openly. I wanted to just remind you that its important no one else is around when you're in session. Even if you wear a headset people can still hear what your saying - even Alexa - so be mindful that any home listening devices are unplugged

too. Now we will still use the group chosen safe word "Coffee" if you need privacy for some reason like someone walking in. Finally, just a quick review of the group rules and I ask you to verbally consent when I am done reading them."

Example 2: “Hello [patient]. Can you see and hear me clearly? [Adjust for lighting, sound.]
As you know, I’m [Provider]. Can you confirm your name and date of birth for me, please?
Can you confirm your location, please?
Are you in a private place? Is anyone else in the room or within earshot?
Do you have any questions about the privacy of this call or anything else before we begin?
If we get disconnected, please reconnect using the same link. If that fails, I will call you at _____. Is that the correct number?”

Session preparation:

Get creative and be experiential: Panelists recommended providers employ the same creativity as they would in planning a regular session and use experiential exercises (meditation, breathwork, stretching) to support treatment and recovery. In preparation for the session and to ease any anxiety around telehealth, suggestions included doing the same 1-3 minutes of mindfulness, breathing, stretching, and other relaxation exercises that providers will do with clients at the beginning of sessions.

Emergency plan and contact: Having an emergency plan in place and available ensures you can efficiently respond to any situation rather than react. Ensure you have your key contacts handy in case of any technical or clinical emergencies.

Key things to remember when you are facilitating sessions:

Drive the bus! Safety is paramount and you are in charge of ensuring safety so this may require being directive as needed and using mute or even removing people if clients are being distracting or disruptive. In addition to modeling appropriate behaviors and minimizing distractions, you can ask people to share their surroundings if you feel there are any privacy violations or triggers which could impact the group. Example: “When we are providing group or individual group counseling sessions and this a formal session, even though we're doing this in people's homes, would we allow someone to have a beer when they come into a session? Of course not. When people use the word "confrontation," we think that sounds harsh, but it's not. It's saying, "Hey, it looks like there's a bottle of beer there. Is that yours? Can we talk about that? Have you been having difficulties using or drinking again?" I think you address it, not in a confrontational manner, but in a way that you would if it happened in your facility.”

Review session guidelines and gain consensus for any exceptions:

Even if guidelines and expectations are sent out and reviewed pre-appointment, it is still best practice to review any guidelines and expectations and not make assumptions these have been read. When you open the group, it is critical to do a run-down of the guidelines and

expectations and note any exceptions by asking the individual or group members and documenting any responses and consensus. Refer to the emailed/mailed guidelines for anyone calling in, but also have the document posted on the screen as a reminder. This review should include and outline any potential impacts of specific behaviors on the individual or group and also outline expectations for how people can engage using the technology (sign-in using chat or provide a link; use headphones for privacy; engage through chat or raise hands, unmute and speak; if parenting and/or taking a bio-break, do you leave the session open but go off camera or stay on camera and close out if needing a bathroom or other break? Emphatically reminding clients they cannot take photos, record, or use any screenshots on social media). People are at different stages of using technology and creating an open space to review rules and expectations for the session and any technology used will reinforce this as a therapeutic space.

Addressing behavioral triggers: In a virtual environment, tools like motivational interviewing, recovery management plans, and building recovery capital are critical. Clients are exposed to triggers through engaging more closely with family members and environmental stressors. We recommend using peers and finding other ways to support clients in setting boundaries, practicing self-care, and maintaining their recovery.

Language Matters: The increased anxiety surrounding the pandemic, combined with the stress of using a new treatment modality like telehealth and not having full access to body language and cues means clients need their providers to employ all their evidence-based strategies to support their treatment and recovery.

- Ask for descriptive language: If a client makes a vague emotional statement, such as “I am sad,” ask them to define this with more description to better understand the extent of their emotions.
- Increase reflective and intentional listening: Ensure clients feel heard, validate this with feedback, and actively listen.
- Be empathetic in statements. There is a vulnerability in inviting you into their private home so acknowledge that and thank them for allowing you into their home, while maintaining professional boundaries.

Conduct post-session check-ins/evaluation/feedback: Peers and other staff can support between visit check-ins, ask for feedback on telehealth appointments, and/or share any evaluation tools related to sessions and key metrics to improve telehealth quality.

Can you share some strategies for recovery and engaging peers in virtual recovery activities?

Recovery Support Services:

Attendees and panelists shared a variety of strategies that are sustaining recovery services and providing recovery support that includes virtual meetings, family support,

fitness and wellness activities, social media groups, online chatrooms and discussion boards, and phone, text, and virtual crisis support.

- **Parking lot support meetings:** People stay in cars but face others so they have visibility but can use a conference line to communicate keeping everyone safe.
- **Online support groups:** A large number of virtual recovery meetings are available 24/7. Examples: SAMHSA Virtual Recovery Resources; Mountain Pains ATTC Online Support Groups
- **Online crisis and "on demand" virtual support:** Examples: SAMHSA's Disaster Distress Helpline; Crisis Text Line
- **Online social hours:** Example: SMART Recovery
- Facebook community groups for sober living: Example: ROCovery
- **Online global communities with chat rooms and message boards:** Example: Soberistas (women-only international online group), SMART Recovery
- **Online fitness activities to support recovery:** Example: Sober living community ROCovery Fitness
- **Phone check-ins:** To ensure recovery is inclusive of those who may not have access to a computer/smartphone and/or have a barrier to using technology.
- **Virtual communities focused on youth or specific populations:** Collegiate recovery groups are hosting a variety of online recovery meetings (social and support) for their members. Example: University of Denver Collegiate Recovery Community.

Engaging Peer Recovery Specialists

Peers are a vital part of the connection and outreach that needs to happen during this time of isolation and peers can do any activity virtually that is within their scope of work. Panelists and attendees outlined a number of ways organizations and providers have been engaging peers to support telehealth implementation and regularly check-in with those in recovery. Before sending peers out virtually, it is critical to ensure that peers are trained and prepared for using telehealth and that there are regular virtual check-ins for the peer's own self-care and wellness during this pandemic. Peers need to safeguard themselves, so they know the best practices when they go into virtual settings.

Best practices for engaging peers:

- **Motivating people to treatment:** Peers continue to reach out by phone, text, and/or video calls to connect people to services and recovery supports.
- **Providing ongoing phone support**: One example shared was having organizations send out a flyer with the photos of peers and their phone numbers to reinforce clients could reach out for recovery support during COVID-19.
- **Technology needs and access:** Peers have been especially helpful in identifying technology needs and available access for those in recovery. This helps inform providers about the types of platforms that will be most helpful and ensuring there is a "call-in" option when appropriate to be inclusive of those without access to a computer, internet, or smartphone.
- **Troubleshooting and co-facilitating groups:** As people engage virtually and employ telehealth, there are a number of technology challenges (loading apps, making apps work, getting online, logging in, connectivity and audio/visual settings) and peers have been supporting providers and people in recovery by

providing support. Peers may also be great co-facilitators for group sessions, managing chat, supporting any technology issues that arise, and making emergency calls to clients if there are safety issues.

- **Navigating telehealth landscape:** Peers have also played key roles in supporting people in recovery (and providers) as they navigate the telehealth landscape and doing phone check-ins to review changes.
- **Wellness and mental health check-ins:** Peers have been regularly checking in with clients in recovery and offering wellness activities, connecting them to online resources and mental health apps, offering "facts not fear" approaches to ensure clients are accessing reputable media sources, offering skills groups, and other types of recovery support on the phone and through Google Hangouts, Zoom, and other online platforms.

RECOMMENDED RESOURCE: COVID-19 Office Hour Session – Opportunities for Peer Support Workers, Supervisors, and Programs

How are people conducting clinical reviews and assessments in an online environment?

Assessments can currently be done via phone or video conferencing. If you have a standardized assessment tool you can either screen share that or review the questions over the phone. This is the same for counselors doing longer assessments, such as for intensive outpatient programs. Follow the safety plan, share the screen with the assessment, and review together. It may take longer as people are learning the technology. Physical exams are not possible to the same extent, though it is permissible to ask someone to show you "close-ups" of eyes, arms and skin, and any other features you want to document.

How are people approaching MAT?

The federal government expanded telehealth and MAT access during the pandemic, allowing healthcare providers to use their best judgement to safely initiate buprenorphine at home (without the need for a physical visit which is still required for new patients being treated with methadone), to extend prescriptions for buprenorphine (most are using a 30-day supply) or methadone (up to 28 days of take-home for stable patients), experiment with remote delivery methods, skip the toxicology testing to limit staff exposure, distribute naloxone, and promote harm reduction strategies. Panelists and attendees reported being at different stages of implementation around using these expanded telehealth approaches, though the majority suggested they are engaging patients through telehealth regularly, suspending urine drug screens, using video (if available) to conduct visual "physical" exams and document such things as track marks and ulcered skin, with the understanding that currently phones are also acceptable ways to conduct intake and ongoing assessments.

But what if you are mandated to continue testing?

For ongoing court mandated facilities (such as DUI and drug court programs) and facilities that are continuing testing, panelists recommended decreasing staff and client exposure by reducing testing, using a "color-line" approach in combination with appropriate special distancing and safety protocols, and reporting telehealth group attendance. In a color-line approach, clients are randomly assigned a color and only 1-2

colors are selected per day for testing. Clients come into facilities using appropriate safety precautions, tests are completed, and recorded to the court program site to track program adherence.
RECOMMENDED WEBINAR: Center for Care Innovations: Medications for Addiction Treatment (MAT) Management During COVID-19: 6 Takeaways
RECOMMENDED RESOURCE: AATOD COVID-19 FAQ addresses all changes and federal recommendations for keeping staff and patients safe.
RECOMMENDED RESOURCE: SAMHSA FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency.

How can Intensive Outpatient programs (IOPs) operate using telehealth?

IOPs can include a lot of group services across the week depending on the ASAM Level of Care and groups need to be smaller (around 10 people). If your IOP usually has 20 people per group, then offering two smaller sessions (at least initially) is the best approach. Panelists recommended using a co-facilitator so one person can lead the group and the other can monitor the chat and other needs. ASAM guidelines for IOP differ based on Level of Care so a mixture of individual and group sessions will ensure you meet the hourly requirements and parameters.

Examples: Virginia: SMART IOP, Crestview Recovery Telehealth IOP.

Are people using telehealth with youth and those in college?

Collegiate recovery
There is a lot of collegiate recovery support happening across telehealth platforms and collegiate recovery communities are offering morning meditations and/or wellness activities, recovery support meetings, and social hours. Online platforms, such as private Facebook groups, offer opportunities to connect and inform people about upcoming virtual meetings and activities, plus share positive messages, re-affirm recovery messaging, and share other online support groups and activities.
Recommended Resource: Association of Recovery in Higher Education: Providing Telehealth Recovery Support During COVID-19

Youth and adolescents
Telehealth with youth and adolescents is definitely more challenging due to the parental consents needed, including parents in sessions, and ensuring providers and parents have plans in place to deal with any situations that may arise due to technology and/or behavioral issues. One example of this would be ensuring parents were prepared to deal with any behavioral issues that may arise in child with Oppositional Defiant Disorder (ODD) prone to anger outbursts. Attendees noted the need to keep any treatment or recovery support meetings shorter than usual to ensure adolescents stay engaged and creating and reviewing clear guidelines for both parents and youth. Attendees suggested that virtual platforms work well for groups, but phone/audio may eliminate any security concerns and allow wider access and engagement. One example of this is student assistant professionals in an education service district placed in high schools and middle schools contacting the students from office sites to maintain communication by phone.

RECOMMENDED RESOURCE: UCLA: COVID-19 Tips: Building Rapport with Youth

RECOMMENDED RESOURCE: Mental Health Technology Transfer Center School Mental health Resources
RECOMMENDED RESOURCE: Educational Resources for Virtual School Counseling, COVID-19 School Counseling Emergency Task Force (CASC and WSCA)

Can you outline some ways we can use telehealth strategies to support programs in our residential facilities?

It is great to keep consistency in recovery and treatment and so finding ways to continue activities virtually and continuing to build relationships and trust is key. Panelists and attendees invited people who usually come in to run meetings to run these same meetings virtually to keep the connection and ensure everyone is safe. Other attendees urged people to get creative and find recovery-focused assignments to engage patients. Reaching out to other residential facilities and learning how others are thriving, staying safe, while adhering to state and federal guidelines can be helpful. While physical distancing is in place, inviting family and friends to connect through video chats and providing phones/devices to do that and other activities is important. Also offering expanded wellness activities such as breathing and meditation (virtually or offered by someone in the facility) can be helpful to support both staff and patients.

RECOMMENDED RESOURCE: National Council for Behavioral Health's Guidance for Behavioral Health Residential Facilities, is modeled on the federal guidance from nursing homes.

How can we engage all our patients and clients in telehealth and ensure they can access the technologies needed for telehealth?

There were a lot of concerns expressed about telehealth as a solution that is impacted by health disparities when many communities (rural and remote, people living in poverty and/or homeless/facing housing insecurity, and the elderly) lack access to technology or people are not computer literate. Attendees reported a number of barriers to accessing telehealth services and recovery supports, including problems with available equipment (broken speakers, bad connections, no cameras or video access), lack of WIFI access, and even lack of cell signal or available minutes for telehealth appointments. Panelists and attendees shared strategies and key resources to support access to technology and telehealth services.

Best Practices:

Phones are always an option: Panelists reinforced that phones and landlines (if available) are always an option for telehealth and we should strive to meet clients where they are in terms of preferred technology. Find ways to get phones to people and access funding for technology supports to engage clients.

Use peers to connect to patients and clients: Peers can support people using and accessing technology and try to get them connected to services. They can also provide phone and technology support for clients struggling to navigate telehealth.

Meet people where they are: Sometimes it is not the technology itself, but fears around technology so clients and patients need reassurance that the recovery and/or therapeutic relationship can continue in any virtual way they prefer. Keep reaching out, reinforce to the patient or client that this new way is okay, we can make this work and that although not in person, we can still build a relationship and connect.

Offer or share free available internet access locally: While facilities such as recovery community organizations and other community spaces like libraries are closed, they are offering mobile access or free internet connection in certain locations.

Free/reduced cost access to technology: During the pandemic, some providers are offering free services and/or agreeing not to terminate service due to not being able to pay bills.

Find funding to support telehealth: On April 2, the FCC established a $200 million COVID-19 Telehealth Program to help health care providers provide connected care services to patients at their homes or mobile locations in response to the pandemic. Congress appropriated the funds as part of the CARES Act. The program provides immediate support to eligible health care providers responding to the pandemic by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services. To learn more about eligibility and to submit an application, visit fcc.gov/covid19telehealth.

RECOMMENDED RESOURCE: MATRC have a list of have a list of free/low cost platforms under the "About HIPAA, Telehealth technology, and Vendors" tab on their resource page.
RECOMMENDED RESOURCE: Verizon Wireless COVID-19 FAQs
RECOMMENDED RESOURCE: FCC Keep Americans Connected lists all the government and private company programs that are working to keep America connected.
RECOMMENDED RESOURCE: Telehealth Use in Rural Healthcare

How can we work to ensure telehealth is culturally responsive?

Part of best practice around telehealth is ensuring you are integrating cultural competency and being culturally responsive. Do you have patients that need accessibility features due to being deaf or hard of hearing? Will you be using translators and securing consents around protected health information? Being culturally aware that social determinants (age, socio-economic status, housing status, accessibility, language and literacy) may impact interest in, use of, experience with and access to technology will help providers select the platforms that meet patients and/clients where they are. Asking patients how their culture may impact their use and preferences for mobile and other technologies and finding ways to engage people in the care that best fits their needs will support retention and engagement in care. Recognizing that different patients/clients may need different technologies and adapting to those needs will support communication flow and allow patients/clients to engage in care and providers to improve the quality of care provided to clients from diverse backgrounds.

RECOMMENDED RESOURCE: Cultural competency criteria for telehealth
RECOMMENDED RESOURCE: Video-based accessibility for deaf and hard of hearing patients
RECOMMENDED RESOURCE: The American Psychiatric Association and American Telemedicine Association Best Practice Guidelines include a brief review of cultural competency issues (p5)

5. **How can we continue to build staff capacity and offer professional development opportunities?**

There is variation in organizational needs around training and building staff capacity. Many organizations reported feeling over-extended and wanting to build in opportunities for self-care, while others do not have enough work for full-time staff and see this as an opportunity to build staff capacity around telehealth, technology skills in general, professional or paraprofessional skills, and cultural competency. Attendees also requested strategies and trainings for technology-based clinical supervision.

Free Online Learning:
There are extensive free online trainings available currently and we recommend reviewing resources and trainings available through the Addiction Technology Transfer Center (ATTC) Network, the Center for Excellence on Protected Health Information (CoE-PHI), the National Consortium of Telehealth Resource Centers, and the Center for the Application of Substance Abuse Technologies (CASAT) at the University of Nevada – Reno. Community. The TTC Networks are posting updated resources related to emerging COVID-19 issues, including the ATTC COVID-19 Products and Resources, the Prevention TTC (PTTC) Pandemic Response Resources, and the Mental Health TTC (MHTTC) Responding to COVID-19 Resources.

Continuing Education (CE) Accredited Online Learning:
For organizations and providers looking for CE during this pandemic, there are a variety of available places to receive CE, including community colleges. Most CE-supported training includes a low cost to cover the associated accreditation and resource fees associated with offering CE.

Recommended Resource: HealtheKnowledge, managed by The Collaborative to Advance Health Services at the University of Missouri-Kansas City School of Nursing and Health Studies offers a wide variety of courses in the areas of improving health and healthcare services. Each high-quality HealtheKnowledge course offers a free Certificate of Completion for you to keep once you have passed the course requirements. Continuing Education (CE) credit is available for most of our courses for $5 per credit hour.
Recommended Resource: Mindful Continuing Education offers CE starting at $4 per credit hour.
Recommended Resource: US Health and Human Services: Improving Cultural Competency for Behavioral Health Professionals– up to 5 free CEUs on the topic of cultural competency.
Recommended Resource: Care Courses for Early Childhood Professionals
Recommended Resource: CE4less offers unlimited CE subscription plans for mental health professionals starting at $74.99 annually.

Technology Based Clinical Supervision (TBCS):
TBCS is being done using telehealth and the National Frontier and Rural ATTC (NFAR ATTC) have created resources around this to provide substance use disorder and other behavioral health professional licensing and certification boards with guidelines and associated rationale for policies regarding the implementation of TBCS. All supervision, whether live or audio and video recordings, shall be done in a confidential manner in accordance with the ACA Code of Ethics and any state or federal guidance. Recording sessions is discouraged unless there are strong privacy protections in place and even then, the panelists recommended limiting any information disclosed during activities such as case studies.

Recommended Resource: NFAR ATTC: Technology Based Clinical Supervision Guidelines.
Recommended Resource: NFAR Telehealth Education Center: Webinar on Technology-Based Clinical Supervision

Example of sample supervision plan: NASW's technology supervision standards: Standard 4.12: Social Work Supervision Social workers who use technology to provide supervision shall ensure that they are able to assess students' and supervisees' learning and professional competence. Interpretation Some social workers use technology to provide supervision in a timely and convenient manner. When using technology to provide supervision, social workers should ensure that they are able to assess sufficiently students' and supervisees' learning and professional competence and provide appropriate feedback. Social workers should comply with guidelines concerning provision of remote supervision adopted by the jurisdictions in which the supervisors and supervisees are regulated. Social workers who provide remote supervision should comply with relevant standards in the NASW Code of Ethics, relevant technology standards, applicable licensing laws and regulations, and organization policies and procedures.

6. **How do we practice self-care and build a culture of wellness and resilience in our organizations?**

Panelists and attendees spoke to the challenges of engaging patients and clients in treatment in a therapeutic way while also addressing their anxiety and their own staff's anxiety and how all of this can result in compassion fatigue and secondary trauma stress. Compassion fatigue refers to the emotional and physical fatigue experienced by professionals due to their chronic use of empathy in helping others in distress. Secondary trauma stress describes the process of being traumatized not by directly experiencing a traumatic event, but by hearing about a traumatic event experienced by someone else. Both can result in psychological and physical symptoms including chronic fatigue, inability to listen and engage, feeling helpless or hopeless, hypervigilance, and poor self-care. Avoiding and addressing compassion fatigue and secondary trauma stress becomes more complex when the pandemic adds in learning new ways to work, such as telehealth, which can increase workplace anxiety. Building resilience, having strong support systems, setting boundaries, and practicing self-care is more important now than ever. Self-care focuses on pro-active ways to enhance resilience and well-being and includes exercise, nutrition, sleep, creative and spiritual activities, and social engagement.

BEST PRACTICE:

Role of leadership:

- Modeling self-care
- Providing space for process-oriented supervision, such as virtual check-ins to openly discuss how staff are dealing with any anxiety and changes around COVID-19 and telehealth.
- Building in opportunities for self-care and wellness for clients and staff, such as meditation, mindfulness, stretch breaks, and exercise.
- Encouraging staff to use optimistic language, focus on facts when discussing COVID-19, and intentionally promote hope and community.
- Train staff on applying trauma-informed principles in the workplace

Individual action:

- **Regulate your affect and acknowledge any stress;** optimize self-talk to reinforce you are learning a new process and can do this.
- **Practice, practice, practice:** The more prepared you are, the more confident you will feel, resulting in decreased stress when implementing telehealth.
- **Foster self-compassion**: Intentionally cultivate mindfulness and foster self-compassion; reinforce this is not self-centered but a way to preserve you as a resource for others.
- **Implement a self-care plan:** Just as you would for clients, plan and monitor your nutrition, exercise, sleep, non-work activities, and social engagement. Create a work to home transition plan and boundaries related to your physical and emotional well-being.

RECOMMENDED RESOURCES: Building resiliency and compassion in the workforce: The ATTC offers a variety of compassion fatigue and resilience resources to support behavioral health workers.
RECOMMENDED RESOURCES: MHTTC Responding to COVID-19 resources to support behavioral health workers during these turbulent times
RECOMMENDED RESOURCE: Figley Institute 2012 Basics of Compassion Fatigue
RECOMMENDED RESOURCE: AMA Managing Mental health During COVID-19
RECOMMENDED RESOURCE: Considerations for a trauma-informed response for work settings

7. **How do we plan for the future and think about building our long-term capacity to sustain telehealth?**

We do not currently know what changes related to telehealth will remain in place and what will revert back to pre-pandemic guidance and when this might happen. We do know there is a significant increase in providers providing telehealth and there will be increased data to support the impact of telehealth on treatment initiation, modalities used, and patient outcomes. Establishing clear, consistent, and ongoing policies and protocols for your staff and organization will ensure you are better prepared for any future pandemics and disasters.

While rules for offering telehealth are currently more lenient to reduce barriers to care, we recommend ensuring that patient safety and protecting patient's health information is a priority. If you are not using encrypted platforms and ways to communicate currently, have a plan to do that in case things change quickly. Following best practice when planning, preparing, implementing and evaluating is recommended to sustain your telehealth strategies and set your providers and organization up for long-term success with telehealth implementation.