Telehealth Learning Series Top 5 – Episode 1

NARRATOR: Hello, and welcome to top telehealth tips and lessons learned, part of the telehealth learning and discussion series for substance use disorder treatment and recovery support providers.

This project is brought to you by the Addiction Technology Transfer Center Network, the Center for Excellence on Protected Health Information, The National Consortium of Telehealth Resource Centers, and the Center for the Application of Substance Abuse Technologies at the University of Nevada Reno in response to the COVID-19 pandemic.

Today's speaker is Maryellen Evers a registered tele-behavioral health clinician for mental health and addiction services and a tele-behavioral health trainer for the Center for the Application of Substance Abuse Technologies. Ms. Evers discusses the top five best clinical practices for treatment for telehealth. Welcome to the show and let's get started.

PRESENTER: So you know, we're looking what's the main five things we got to do clinically to have the most sound and ethical practices right now as we're going through this situation. Number one is not necessarily a clinical skill in this modality. It's the front end. But it is really important to be sure that you are in compliance with your licensing board.

And having the proper informed consent, as I alluded to earlier. You know, the language is different in the informed consent when it comes to tele-behavioral health. Again, I refer everybody to SAMHSA tip 60. That is a wonderful starting point.

If you're new to telehealth and you don't know where to go, that's a great place to at least kind of get some groundwork. But the biggest thing I learned when I learned about telehealth some years ago was your malpractice insurance has to [INAUDIBLE] tele-behavioral health.

Every insurance is different. Some are already including it within their policies. But if you're going to be providing professional practices, LPCs, LCSWs, make sure your malpractice insurance includes covering you for tele-behavioral services.

Checking about your folks online life. People walk in, we see them face to face. But many folks that we work with also have what we call online life. Those who are probably under 35, we consider a digital native. While those of us who are older from another generation, we are considered digital immigrants.

So we have to be mindful of what generation really and what comfort level the person has that we're going to be suggesting the use of tele-behavioral services to. It's very, very important to understand that tele-behavioral health therapy or services is not cookie cutter.

There are some clinical diagnoses where this modality of treatment may not be beneficial. As a matter of fact, it could be more harmful. So you've got to be mindful that you just don't go through your caseload and automatically make everybody go tele-behavioral health.

You've got to be careful with looking at what issues they're dealing with. You've got some folks who are dual-diagnosed. Quite frankly, I've got a few of my patients who have a history of ongoing suicidal and homicidal ideations. You know, for me in my practice, tele-behavioral therapy is not appropriate for them.

We've had to come up with alternatives. You also need to consider medication and the work that the folks you're dealing with or working with may have when it comes to psychiatry. So again, it's not cookie cutter.

You really have to kind of parse out who would benefit from and who is the safest to do tele-behavioral health with from the clinical perspective. This is real important, patient safety, because I can't control the environment. And by the click of a button, someone can leave my session.

So I have to plan for emergencies. One of the mottoes is, we plan for the worst and hope for the best. And usually, the best is what happens in your telehealth sessions. But it is really important to come up with a safe word, a safety plan, and make sure you get a proper emergency contact.

So just to kind of go over kind of a broad kind of safety plan that I use, quite frankly, I let someone know that I'm going into a telehealth session. And I do this, you know, before my session even occurs. I throw a do not disturb sign on my door. I make sure I can see a clock. Because depending on the program you're using to do your sessions, you may lose sight of the little timepiece at the bottom right corner of your screen.

It's really important to make sure all of your own distractions and computer programs are shut down. You've got to make sure you've got a good microphone, a good camera. And then, you invite your patient into the practice through whatever means, platform, you're using.

But when I start a session, I check out where the patient is. Now 99% of the time, they are at the address that they provided me in my informed consent. But if I do notice that they're someplace different, I need to check in with them to find out where they physically are, and I need to make sure I have a decent phone number where I can reach them and they can reach me.

And I go over that with them in the first couple of minutes of our clinical session. I ask them, are you there alone? Is anyone with you? Again, Santos made the point before that they have the right, it's their information. So they very well may say, well, my daughter is here in another room and I'm OK with that.

And then, we just kind of go over this idea of a safe word. A safe word is really handy. Because personally, I use the word coffee with all the people I work with. So if my patient says, I need a cup of coffee. I stop talking.

This way, if somebody is around them or in earshot of their computer, it's kind of the secret way of letting me know that they don't want the person to hear me speaking. But more times than not, my patient and I come up with the safe word that they're comfortable using.

Honestly, you know what? It sounds simple. You just click end the session. But it's not always so simple, because it does happen. You might think you're ending a session and you don't. You've got to be really mindful that when you do end the session, that you, you know, end the session. You disconnect your headset and you let others know that you're off that telehealth session.

You would be surprised at the things you hear when you think you're unplugged when you're not really unplugged or the things that they could hear if you don't completely sign-off. So, you know, just kind of going back to that safe word, I use it when, with the folks when they're unable to talk.

I also use it when my folks are feeling unsafe. Once I hear, again, that word coffee, which is the one I use, you know, I'll wait a few minutes. And very often, they'll say to me, OK. I got my coffee or they'll say I need more coffee.

And we come to this safety plan where we will end the session and then, I have their phone number to be able to follow-up with them. It's really important also to have a safety plan. You know, and don't rely on 9-1-1 at any means right now and don't necessarily rely on, oh, you can just go to the hospital.

Because of this pandemic, a lot of rules and regs of normalcy that we used to, you know, take for granted are changed now. It's also really important to make sure you have an in case of emergency contact number in the emergency plan.

But here's the piece. Most people will put their significant other or parent on the paperwork that they'll fill out in my office. That may not be their emergency person when it comes to tele-behavioral health.

Real quick example. If I have kids who are in college, they have to identify somebody at the college as their emergency person. And I clinically have to make sure that I have a release of information so that if something does happen, I can reach out to that emergency contact.

And finally, you know, the number five kind of clinical best practice is just be prepared. You're going to hear different verbalizations. Teletherapy is exhausting. Quite frankly, I would do six or seven patients in a row when I do face to face sessions.

Right now, I do two hours on, one hour off. So two sessions on, one hour to catch a breather, two more sessions. You speak differently. You observe differently. You listen more intensely. And also keeping in mind that, at a click of a button, anything can happen.

The patient could leave the session, a family member could walk in, you might have technological problems. So it's just, you know, really being prepared to kind of navigate whatever comes your way. I've had people sign on the telehealth sessions with just boxer shorts on, quite frankly.

I've had somebody log-in at Walmart because they didn't want to miss their session. And they were fearful that they were going to get a no-show charge. So they logged into their telehealth session while pushing a cart at Walmart.

It's knowing how to best handle those situations, because you just never know. So we expect the unexpected when it comes to tele-behavioral health.

NARRATOR: Thank you so much for joining us today. For a transcript of this podcast, presentation slides, and other related resources, please visit our website site at www.telehealthlearning.org. This podcast is supported by funding from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, and Health Resources and Services Administration.

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We encourage all listeners to reflect on the context discussed during the series and to take that information to colleagues and/or supervisors for further discussion, especially in the context of state rules and regulations.

In addition, content related to privacy and security and 42 CFR part 2 presented during these sessions should not be construed as legal advice and listeners are directed to discuss recommendations with their agency’s legal counsel.

Finally, listeners should consult SAMHSA resources that provide additional information regarding delivery and services virtually. Once again, thank you to our listeners for tuning in today. We hope that you'll join us again.