NAADAC

COVID-19: Telehealth for Opioid Addiction Interventions
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>> SAMSON TEKLEMARIAM: Welcome to today's webinar on COVID-19: Telehealth for Opioid Addiction Interventions presented by Dr. Marlene Maheu. It's great you can join us today. My name is Samson Teklemariam, director of training and professional development for NAADAC, the association for addiction professionals. Towards the end of this webinar, we will include a 10 minute demonstration on how to use Clocktree telehealth platform. NAADAC receive a 15 percent discount on all telehealth plans for the lifetime of their NAADAC membership, receive more information later on towards the end of the webinar and you'll see some information pop up in your chat box.

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Speaking of your go to webinar control panel, it'll look similar to the one on my slide. You've entered into listen-only mode, microphone muted to prevent background noise. For audio trouble, consider switching to a telephone line which is right next to the orange arrow to your GoToWebinar control panel. You can use that orange arrow to minimize or maximize the control panel. If you have questions, type them into the questions box. Be aware that we may not get to everyone's questions during the live webinar, but our presenter will be able to respond to your questions throughout the webinar, potentially some, maybe all, towards the end of the webinar, depending on time, and any questions that we do not get to, we'll collect from the presenter and post those questions and answers on our website. Lastly, there we go, you'll notice the handouts tab underneath the questions box. You'll see the PowerPoint slides from today's presentation and three slides per page PDF handout, also a quick reference guide, and you'll see additional resources and handouts provided by your presenter. Speaking of your presenter, let me introduce you to today's expert, Dr. Marlene Maheu has been a technologist and pioneer since 1994. She served various organizations with the development of technology focused standards and guidelines, including the American telemedicine association, and the American Counseling association. Dr. Maheu serves as the executive director of the telebehavioral health institute which offers 64 hours of basic and advanced telehealth training online and offers two micro certifications in telehealth. She's the CEO for the non-profit coalition for behavioral science. Five textbooks including telebehavioral health foundations theory and practice for graduate learners the APA published practitioners guide, and career paths in telemental health. Her insights will help you not only get started but thrive with telehealth. NAADAC is delighted to have this webinar presented by this highly experienced presenter and close friend of NAADAC. So Marlene, if you're ready, I will hand this going to you.

>> MARLENE MAHEU: Thank you, Samson. And hello, NAADAC. I'm very happy to be here today. Your organization is light years ahead of many of the other ones because your CEO and your leadership has had the vision of creating an environment for you that they have already vetted. So there are a lot of problems that you don't have to deal with that many other groups do in trying to figure out which technology to use. So what I'm going to do today is by-pass a lot of that information and just try to help you get up to speed quickly with opioid addiction and telehealth as it stands right now in COVID because you'll see I have an unreasonable number of slides. I'm going to be talking very quickly and hopefully you can come back to the slides and look at the handouts because the federal government in the United States has made a

number of resources available to you. They've pulled out Ltd. stops because we've got two emergencies going here in the behavioral world. We have of course COVID but also the opioid emergency that the president announced a couple years ago. So lots of resources have come to play and very clear and helpful materials are available to you right now. They are loaded into your NAADAC platform so you can just download them anytime you'd like. So a little bit about me. What I'm going to do is educational only. I'm a psychologist and MFT. I cannot give you a representation as to the accuracy or sufficiency of the information you'll get from this webinar for your specific circumstance. I will not and cannot offer you legal or reimbursement advice with regards to COVID. Nothing I say is to be deemed as such. What I'm going to do is offer you the information that I've been able to find. And then as responsible clinicians, I encourage you to do your part to seek practice specific advice from your legal entities. And there's no -- there are legal, ethical malpractice groups. So it's good to write a letter, send it out to everybody and say, hey, this is what I'm doing, make sure I'm up to snuff. That way -- they may not respond to you right now, obviously, but you have done it, and you can let them know you're interested in their input and what you're doing.

That also will create more urgency on their part to deal with a lot of these issues that have been very slow to take priority with regard to telehealth.

Now, in terms of maximizing your effort here, I want to encourage you to turn off your phone and text messaging and email because I'm an east coast gal and talk rather quickly and you may miss the very thing you came to get. So just want to encourage you to try to stay with me and start with the to-do list. If you can get something to write on and just make a list of everything you need to do. Unless theoretical things going on out there, if you get a to do list, it's an action item list, and likely you'll be able to start with that. If you just sit and absorb and try to let the theory roll around inside of you when you walk away, tomorrow, the day after, you won't have a really clear thing about what to do. So I'm going to give you a lot of things that you can start doing right now. All right?

Then what I want to encourage you to do first off is just sit back and think about what's going on not only in our country and not only with addiction professionals, but much more broadly. The year 2020 is when the work force for the entire globe is being required to work from home. And use the technology that we've had. Now, there's lots of challenges with that because the system was the internet and technology is not built to all of a sudden in one week carry the entire workload for the planet. But there are many opportunities that come of this. And what I am hoping to help you do today is to help you figure out ways to take care of yourself as we focus on people that we're trying to serve. And then how can we as a community come together and help each other stay balanced in the midst of taking care of a lot of the crises out there? If you've been watching some of the news, you'll see that in some areas things have gotten terrible, just terrible. And in other areas, it hasn't really hit them yet.

Now, I don't know about you, but I'm in Day 15 of self-quarantine. Even at that, it's hard to maintain with people who don't quite get it are all of a sudden at the door. For us to be able to find ways to protect ourselves -- I spoke to a clinician yesterday

who is still meeting in person with her clients because she's afraid to go online, you see. So we are in a continuum here of our colleagues of let's help each other. If you have a colleague not yet online, hasn't figured that out, help them with that. And then also, let me talk to you about how to take care of ourselves in the midst of all this.

Now, what I'm going to do today is kind of giving you the perspective. There are people dying every day and it's not just in our country. But by the end of this week, predictions are it's going to be quite a bit more difficult. More people will die next week and the week after that. What I did hear is I distilled about 800 slides to give you 50 and I'm going to give you 50 out of my normal training deck. So I can't give you what you really need to know to be able to work quickly, but this is an emergency type intervention. Okay? One I'll be giving you is mostly legal and reimbursement changes so you can get a sense of where to go to get accurate information. And I will not do more than point to many of the slides that I have here today so I can come back because I can't fit everything into the time we have here. So I have to prioritize now to help you prioritize. Stick with me, okay? Make a to-do list and then come back, look at my slides, and look at the handouts because I'm not giving you any telehealth handouts. All I'm giving you is handouts about opioids and new changes in the law, but we cannot discuss them. I cannot give you any exercises. I will take questions, but I can't promise the answers. I had people be upset with me because I can't tell them what to do with their several actively suicidal people during this time. And I can't fix the problem for everybody, you see? I'm the messenger here. And what I think is good news is that we can all think about -- in my early days as a clinician, nobody would mention mental health. Nobody would mention substance abuse. Now we actually have government officials who daily stand in the podium and mention mental health and substance abuse. This is a dream, a dream come true for many of us that have been slogging away for years and decades trying to recognize as a health care issue in this country and we're here. So I want us to take solace in the fact that there's been a lot of progress made and now we can have -- we do have materials that can help us, too, that are federally funded.

The other thing I want to say before I get into my content is now is the connect with NAADAC. If you haven't joined and on the periphery, I want you to join NAADAC. They did not ask me to say this. But join the communities that NAADAC has organized for you. If you don't find what you need related to technology, create one. Do some service work here. Help this organization right now because help is needed. There are many clinicians who are down in the mouth and feeling depressed and isolated themselves. How good can they be if they're bleeding, you see, as they help other people? They need support, too. We all need each other's support. Get on mailing lists, share information, and share resources. That's my pitch for NAADAC. If you want to go to the website, I put the URL here for you. They've done a phenomenal job. They are very, very advanced. They have a whole list of resources for you on their website. You can go anytime, a lot of handouts that I'm giving you today, and they're keeping it updated. So go take a look if you haven't been there.

All right. I'm going to refer to some of the NAADAC ethical principles as I give my talk because the leadership at NAADAC has made it their business to address a lot

of this years ago. And you have an ethical code that already talks about how you should approach technology. They called it e-therapy, e-supervision, social media, and the first thing they started with is competency that you have to know what you're doing before you offer yourself as a professional doing that. So we'll be talking about competencies here.

Happens to be one of my favorite topics. I have a group, non-profit that I'm an executive director of and the group was to develop telebehavioral health competencies because nobody had done this. Interesting thing about competency is at the institute of medicine in 2001 said thou shalt not -- I'm paraphrasing -- not make claims that are unsubstantiated about anything that you offer in training. So you can't say Johnny is going to get better if you put peanut butter on his forehead because it's not evidence based. Institute of medicine said if you're going to develop training, which is my thing, you see, the unique competencies. That's when you start looking around and say, well, we don't have competencies. Let's make them. So six, seven years ago, a group of us started and we were across six different behavioral professions. And the addiction was one of the six and we came up with what we thought was a first take on this. So that's the article. You can get that for free, by the way, by coming to my website, telehealth.org/blog. And if someone here with the webinar can type that in telehealth.org/block. I have several articles about competencies. Because I'm the author on that, I can give it to you for free. So you can get it off my website.

Oops a little trigger happy there. Let me back up [chuckling]. If we look at competencies, I want to give you a big picture on this. Typically, the way this system is structured is that bad things lapin out there and law makers or legislators decide this is a bad thing and we're going to do something about it. So they propose bills. And normally, that takes a year or two and the bills get voted on, torn apart, put back together. And if they survive, then that becomes a law. Now, out of the law, let's say a law from a state, then the regulatory boards in that state will look at the law and say, okay, with respect to us, social work board, or psychology board or medical board or whatever, addictions board, whatever it is, we're going to interpret that law in our land, in our state to mean these things. And they roll out regulations. Now, lot of these regulations are the same within a state, but some states are not. As a matter of fact, some states are opposed. One board can be diametrically opposed to another and the boards across states, so the -- let's say the social work board in another state could be different on some aspects. Not all of it, obviously. But a lot of it. This can be confusing when you go across state lines. These issues come up if you're not familiar with what the rules are in your state and other states and all of a sudden you're practicing with other states or you're practicing with people of various professions on a team. Then this can get confusing. Let's go on with the diagram here.

Regulations, ethical standards. Ethical standards are what groups like NAADAC, typically a national group will look at all the regulations as best they can. And they will built on top of the law a higher order for people in their associations. They'll say, okay, ethics stands on top of law. So it'll say, all right, if you're going to abide by, let's say a regulation for privacy, here's how we want you to do that as an addictions person. Out of that, some groups come up with guidelines related to technology. But nobody came

up with competencies. So that's why we decided to do it as a non-profit. Coalition technology for science, go take a look. We tried to organize things like this across professions because we don't believe in siloed professions anymore. We want to help people cut to the chase and get on board with technology in a responsible way. We developed these competencies. Out of these competencies should come training, training that we offered our institute is competency based, and if people haven't published their competencies and they claim they're competency based, ask them for the research to show that what they say holds any water. A lot of people claim that but it's another one of those words that they use to enhance their marketing. But really, not based on competencies. And then training and professional service delivery. We help people understand how the system is wired because if you go ask the wrong party or you go to the wrong set of documents for what you need, you may not get it. You asked the wrong question. You get the wrong answer. So we want to help you understand some questions go to boards. Some questions go to ethical groups like NAADAC's ethical as a board, but regulatory board, licensing board is different than an ethical board. Guidelines are put out by associations, competencies are getting adopted by a number of groups. Okay? And out of all of that should come training so that when you learn something, you are sure it's based in fact and not folklore or hypo, like peanut butter will save Johnny.

So out of that, we came up with -- all of that background, we came up with competencies that identified seven domains. And we'll look at just a few of those here today.

So we're going to look at legal regulatory primarily because that's where a lot of domains are coming from for opioids. We'll talk about clinical, technical a little bit -- and the rest we can't deal with today. But seven areas there.

First issue is if you're going to any board, licensing, ethical, looking for what word to use, what our colleagues defined 27 terms across not research but across licensing boards. Okay? So in one state, you're going to have a board use a term like behavioral telehealth, telemental health, telepsychology, cell nursing online, counseling, online counseling with two L's. That's British. A lot of English speaking countries in the world. We're not the center of the universe, the United States. And as matter of fact, some have been doing telehealth ten years prior to us. Some people still call it online therapy. Distance counseling. Although there's a movement away from all of this. If you go ask a question and you get an answer like oh, no there's no rules like this in this state, I want to encourage you to use the term that SAMHSA's used, which is the federal arm that oversees what we do in health care, in behavioral health care. They're part of health and human services. A lot of people don't understand the system. It's a branch of the U.S. government that deals with health care. Under health care, there's SAMHSA, substance abuse, mental health services administration. If you go to their website, you'll see they have done away with the words mental health and substance abuse. They're calling everything -- it's going to refer to substance, substance use, and they tried to combine the whole thing, mental health and substance use in one term called behavioral. It's much less negative. People are more likely to admit the

behavioral problems than they would a mental health issue or addiction, a substance abuse issue. So the whole thing is called behavioral.

Now, what we saw happen with our president a couple weeks ago was to use the word telehealth. That happens to be the term that is at the root of all of this before we had different professions decide they're going to call it telemedicine, call it this or that. Telehealth is all of health. We have health care in this country. It's the generic term. So telehealth is a generic term, so I'm glad to see the president used that term. A lot of law flowing out now uses that particular term. Be aware there's telebehavioral health in our world and there's telehealth. Okay? A lot of people still use telemental health, but I think with the president taking a stand on telehealth and the laws reflecting that, the new initiatives in COVID, we can see change. Everyone's trying to coin a term, get it all right. Why not call it one thing? It'll save a lot of fooling around.

These are the nine professions in our field. I know that NAADAC is a hub for people that are interested in working with addictions. So we probably have some of these in the books that we work with at NAADAC. But I want you to see most of us don't know that there are nine groups. Most of these groups operate as if they are [indiscernible] once. Unfortunately, some of that still exists. But the truth is behavioral health care is the largest unmet need in our country. Frankly, worldwide. Right? We need to come together to form teams. And that was all integrated care, ObamaCare, professionals to go to care settings, all of that. Coming together, we need sort of a common rule book. For trainers, what we do is come up with competencies that would work in this way. For all of us to talk about the same thing.

So I want to give you that picture. I want to give you some of the definitions when you look at materials so you understand what's going on. Distant site in the telehealth literature is where you're located. Now, it's counterintuitive because distant, you think that's far apart from us. Telehealth, the originating site is the center of it, where the patient is. If you reflect back on the new terminology, new for a decade now, patient centered health care, it would make sense that the originating site would not be us but where they are. It's an important distinction bah the law also flows from where they are any time we contact them. They're the hub, the originating site.

If we go back to the competencies, I'm going to give you some of my slides about this. So competency, the 5th one is legal regulatory. What we've seen -- and many probably already know HR 6, support for patients and communities act. It did have to do with opioids, and it makes changes to Medicaid programs, so suggest opioid substance use disorder. I'm that going to read all these slides for you. No. 1, you can read as well as I can. I've taken the bulk of really important material and put them on slides for you, so you can come back and take a look at this later. I'll read the high points for you so we can go through the material and you can see it for yourself. SAMHSA has a tip called the rural behavioral health: Telehealth challenges and opportunities, and in that tip, this is a few years ago that they published this, fall of 2016. A fair amount of information about -- the next slide, actually, boss it gives this -- yeah, assessment treatment, medication management, continuing care education, and collaboration. There's something out there for you related to telehealth that has already

been put out by SAMHSA. And this is setting down a lot of the rules and makes it okay for us to work online, you see. It goes into what the details are. It's 2020 now, so things have gotten more specific, but I want you to see there's material out there that's been around for a while to do telehealth because some people think telehealth's the wild west, everybody's making it up. Not at all. Telehealth started in 1959 in this country for psychiatry in 59. That's in our behavioral world and it has been growing like crazy ever since, but it's not been in the mainstream literature and fortunately not trained -- not had a whole lot of this in training. That's why we wrote the textbook that Samson mentioned in the beginning for graduate learners.

So you see another group here, agency for health care research and quality. They published another document for opioids in their group. And once again, this is a couple years old -- at least a couple years old. So there's a lot going on, big on telehealth in particular, but also in rural areas, which has been a big focus for telehealth.

Now, what we've seen just this month is a dramatic change in protocols and SAMHSA has published this in the treatment of opioid use disorder.

And you have a handout for this. I also give you an URL to an article. This handout is in the packet that I gave to NAADAC for this event. No. 1, allows the patient -- my finger is on the button and keeps moving. Sorry. Allows some patients in opioid treatment programs to take home their medication. This is available today. States may request blanket exceptions for all stable patients in an outpatient treatment program to receive a 28-day supply of take-home doses of medications. So please go take a look at that, look at the handout, SAMHSA's hand out.

You'll see there's another handout about 42 CFR dealing with COVID-19. And so once again, I'm going to let you take a look at that. They're available to you online, free. The Ryan Haight Act, limited the ability of prescribers to prescribe over state lines. The DEA was missed its deadline. In March 2020 this month, there's a waiver that allows for the prescribing of controlled substances via telemedicine, and the issue here is over state lines. So this is now approved to deal with COVID. Let me see if I can get through the right slide here.

Yeah. This is where you can go. If you're interested in that waiver, you can go to the department of justice, drug enforcement administration, the DEA, diversion control division, part of the DEA that is in charge of this, and I'm going to show you just some pages. I did some screen shots here so you can see the actual page and when you get there, you'll know what it looks like. You'll not be able to read all the little words on this on the printout of your slides, but hopefully you can catch the title. Diversion control division. And I'll give you a couple slides of questions and answers on these next couple slides.

Well, this is kind of the summary of it, okay? The waiver is in -- secretary of department of health and human services -- other slide. This is the questions they had. I put it on the slide because it was way too little to talk about it. You have the code section and can you use it? And basically over state lines? Yes. And it goes into some

of the details here. If the permission is given over the internet, then there are exceptions and the exception that they're going to be talking about is the public health emergency, so that's the exception to the code that says you can't. And it goes into more detail about exactly what can happen. Okay? As March 16, it continues as long as the public health emergency remains in effect. DEA practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, providing some conditions are met.

And so once again, I'm not going to read all this for you, but there are conditions to it, and then you'll see that they have to satisfy all of the requirements and they tell you how to do it electronically, fall into the pharmacy. And then they talk about the practitioner, who is it? Physician, dentist, or otherwise licensed registered prescriber. So that was remarkable news.

Then they have other, you know, caveats about this. So it goes on. I'm just going to give you those slides so you can take a look at those when you can go more slowly. Okay?

Now, HB 6074, the coronavirus preparedness and response supplemental appropriations act is different. It gives the secretary of health and human services the right to waive various Medicare. So those of you working with Medicare -- and this applies to you if your client or patient is not on a Medicare beneficiary, then they does not apply to you. Medicare, this is pretty substantial. Now, can you practice over state and international boarders in this time of emergency?

Typically, going back to the NAADAC ethical code, it says you got to be compliant with relevant licensing laws in the jurisdiction of where your -- where the client is located. Okay? What's happening now with COVID is licensing laws are in flux. If the law changes, then it's okay to do what the law says because then you'll be in compliance with the ethical code, basically all it says, be in compliance with the law. Okay?

Now, you may need to check with your state board's website because there are differing rules that apply to different people. And you're a pretty big audience here. I don't know exactly who your board is or what they're saying, but you can get on to your state board's website. They have the notification service. Ask them to tell you if something changes. And there are other resources I'm going to show you in particular for telehealth.

One is the Center For Connected Health Policy. I gave you the URL down there at the bottom of the slide. They are one of 14 telehealth resource centers federally funded in this country and have been for maybe a decade, a long time. These people sit there 40 hours a week. Hopefully they're at home, too, these days, and they answer questions like getting set up for telehealth. They're not particularly focused on behavioral. They deal with a lot of the medical world, but they are including a lot more

behavioral information and they certainly have the larger system wired in, and they have some remarkable resources for you. So I'm going to show you some of these.

If you go to their website, you'll see they have a page related to COVID-19 related state actions. Once again, what do these people talk about? Only telehealth. All right? These are the telehealth related laws. And what you may want to do is check with your state before you start practicing over state lines. What I talked about earlier was that prescribers can practice anywhere. Okay? Medicare recipients, you can serve them pretty much anywhere. What I would encourage you to do is to look at the law before you just take Marlene Maheu's opinion about anything. I'm not a lawyer. But I'm giving you the tools. I pride myself on giving you the right information so you can go look up what you need to look up. Now, what they issued yesterday I thought was remarkable and I asked Samson to get us a couple screen shots on this. But before I get to that, I just want to explain licensing boards may differ in the same [indiscernible] if they are adjoining states, even. You cannot assume that what one board decides is the same as the other. When you work with work with people over state lines, the rule of the road is generally go with the more restrictive. Right now, that is getting waived. So the more restrictive code is not what you need to follow. You need to get people help. So that's what all the changes of COVID are focusing on.

And this includes everything. So let's say you work over state lines but now you bump into an abuse situation. Does that mean you don't report it? No. You're still responsible to your ethical code. So even though the law may be changing, there are parts of the law across all 50 states. You have to report abuse. Who do you report abuse to if you find abuse in a foreign state? Your board can't do anything about that. Okay? You have to go to the foreign state's board. So this is not all in free, recess time, everybody run around and do what you want. But be aware of the law because practicing over state lines does not involve being able to talk to somebody wherever they are. It involves being compliant to all of the laws and these abuse laws apply to us because we're all mandated reporters. If we have any suspicion of abuse, we are still mandated to report it. It's tough when somebody's online and you're going to tell them you're going to report them. They can click you off. There are complications you can think of ahead of time. My job is to show you some of these areas so you can start thinking about it and if you're not proficient on telehealth, get yourself more proficient. I'm giving you the California business code. It's elder abuse, child abuse. In some states, it's spousal abuse. That might be going on more now that people are cooped up with each other.

HIPAA, HITECH and your state law, those are three different things. So law is a little complicated. HIPAA is being relaxed. HITECH is the enforcement of HIPAA. Let's get into this HIPAA information here because HIPAA, as you know, has to do with privacy and security and transmissions. There's three rules in HIPAA.

The privacy one is the one that they've loosened. Okay? We're not mandated to keep things as private as we were right now. It's a temporary relaxing. Okay? You see, it's being relaxed. It's not being put aside forever. It's just like if we were let's say in a flood zone and the flood zone of a tristate area, the local government officials would

say, geez, get out there and help people. If you're one state or the other, doesn't matter. Just get out there and help people and we don't have to follow all the same rules because it's an emergency situation. That's what has happened. We're told to relax things, but it's not going to stay that way. One of the main things is okay to speak to other professionals without explicit release form. That was part of the original HIPAA in 1990 anyway. The original HIPAA safety rules were very well done. They will return. Don't think this is willy-nilly now, you can just go do anything. But here's the actual URL. And I believe I gave that document to you folks as well in your handouts.

I want to go through some of this in fair amount of detail but I'm not going to real every word for you. Okay? So there are penalties in place, just not going to enforce them. You can use any non-public facing remote communication product. What does that mean? We'll come back to that. You can use audio or video that applies to telehealth for any reason, not just COVID. So if you're dealing with someone suffering a heart attack, doing stress management, you can still work with them. Any reason now. Get the help out to your people. Okay?

You have to tell your people that some of these applications do pose privacy risks. They can be exposed and this can come back to bite them a month from now, six months from now, two years from now. So your job as a professional is to be smart about how you choose these things and not just jump on whatever's easy for you. Roll up your sleeves and put a little time into doing this the right now. NAADAC's made it easy for you, like I told you. They've already gotten a video platform that they're working for. Vetted it. If something goes wrong for you, you can be sure they're going to step in there and straighten that situation out. So you've really got a good group that you're working with here. You don't have to figure out all the details of technology. But if you've been jumping out of the sky and jumping on some of these other platforms, be aware that there are limitations and there are possible privacy problems.

Now, what is -- this is a document that I gave you the URL to. I'm not adding this on myself. I'm taking words right out of the document. Turn on the options that are available because sometimes, there are options available. Skype for Business is different from Skype. Microsoft made those names sound remarkably the same. But Skype is not particularly the same as Skype for business. You pay for Skype for business. When you pay for something and they tell you about compliance, you have more protections for you and the people you serve. Here's names they actually put in the document. I was floored that they actually put names of the documents. And they actually listed names of things not to be used. Facebook live, switch, TikTok and similar video communication applications are public facing and should not be used. Now, if you remember a few slides back, they said you can use communication applications that are not public facing. And here they gave you some examples of some that are public facing, meaning the public can see this. It's not really that private. Be careful what you use.

There are ones that are not public facing and definitely Facebook live, TikTok, whatever was on the back slide. Let me get this out of year.

There's a temporary relaxing. A summary slide of HIPAA and privacy requirements. Only release what you must release. I mean, think about it. All the nitty-gritty of what's going on with your client being typed into an interface. If you go to Skype, you can type stuff in, okay? They can be typing things as you see people online, on the video. Where does all that typed stuff go? You see, the regular Skype does not tell you anything about that. All right? If you go to their privacy policy, they'll tell you, we're not responsible, weir are not HIPAA compliant. Use a system that is. Why complicate things? It's not that complicated if you practice with each other. In an hour, you'll have tested everything you need to have tested. Work out the kinks. Or your family, colleagues, whoever wants to test it with you. Just know these precautions, and we don't want anything to come back to bite you or your client, more importantly. All right?

So what does this mean for you? You have to make some decisions. It's sort of a risk benefit analysis, you know, of is it really worth it? Is it absolutely essential? The person can't do anything more? How can I deal with this? You know, I'm noticing I don't have questions coming through. If you have questions as I'm talking, please send them threw because if you want to know something, I'm happy to tell you [chuckling]. I've done a week of Johns Hopkins lecture. I can tell you stuff, but you have to tell me what you want me to tell you. And I can point you in the right direction.

Things to consider. What's a diagnosis? There's a road map to the future. Really, you look at all the facts you have in the past and you say, all right, you know, put this diagnosis on it. The benefit of that diagnosis is that it helps point you to what you can expect in the future when you look at their diagnosis. Are they oppositional? Are they going to be difficult to manage? You know, do they -- are they manipulative? Do they threaten suicide when it's not really an urgent situation? These are things to watch out for. Watch out for the people you [indiscernible] clients with. You show up, they have three people in the background. Now you have to spend 20 minutes getting them out of there. Those are people that need help to set up the environment and invite them to come into a place.

Consider video conferencing. They may want to consider any other channel. And if you do perceive any of these, advise your clients and patients that rules have been lifted temporarily. Don't say this is how we're going to go because if you build their expectation for all time, you're going to have trouble getting them to not do that in the future. Don't promise the farm here. Just promise what you need to do, and you can do it week by week. And if you look at what the president is doing, I think on Sunday, he said they're going to extend this out for another two weeks. Well, we have the worst [indiscernible] of COVID. How can it only be two weeks? It doesn't make sense. Let's not promise what is unreasonable.

In terms of giving access to things, how we're going to work with people. Let's say you're going to send an email blast to a list of all your clients. If you do that email, the blind CC your recipients so they don't see each other's email on the TO: Line. If you do group text messaging, you can see each other's numbers and maybe they recognize somebody. Be careful. Think about what you're doing and then write it down.

I'm going to violate HIPAA in these three ways for these purposes for COVID. Temporarily, I'm going to try this for a couple weeks and there's your statement, you see? Why did you do it? Because of COVID. I want you to take all the handouts you get here, any other important document you get, of course the completion certification for this course, your CEs, your CME's, and put them in a file on your desktop. Throw everything you have in that file. It'll give you organized, keep your own anxiety down.

Once again, make a little statement. I'm relaxing these rules for these reasons. And when you write stuff down, it forces you to look at exactly what you're doing. Otherwise, you may not think about it, and all of a sudden you're doing things you shouldn't be doing.

Now, some of the questions are, has 42 CFR been relaxed during COVID? Michelle, I want you to look at the handout I gave you. There's a slide on that. There's a picture of a document that says that. Go look at that and read it for the details because I can't give you blanket answers as to everything has been relaxed. That's why I'm giving you the documents. Like I said, I can only give you the high tops.

And use Zoom if Zoom is not for health care. The government document said you can use anything that's not publicly facing. As far as I know, Zoom is not publicly facing. It is, you know, when you go into the Zoom room, the world doesn't see it. This is not through social media. So no. But once again, I am not your legal advisor here. I'm just giving you the documents, and I want you to encourage you -- if you exercise your right to Zoom, say hey, are we okay for using you if you're not Zoom for health care? So ask -- my senses -- this is Marlene Maheu speaking -- but each of you need to act as a professional, do your homework. When you get your letter from Zoom, not Zoom for health care, and saying it's okay to use as far as they know, you can relax with it. Don't relax because I say something. Certainly don't relax if your colleague says something. When you get your license, you don't get a license to think -- a group think with your colleague. You have a license to stay on your own two feet and act as a professional because you've proven you can do that. You took the test, act as a professional, making decisions based on the facts in front of you. So I'm trying to give you the facts.

Couple other things here, beyond video conferencing, unencrypted text messaging, when you look at your cell phone, iPhone, android, whatever you got, text messages reside on your SIM card, the card you take out when you take it out of your old phone when you get your new one, that has circuitry on it. And the circuitry in some phones as well that can carry your -- all of your text messages. So all the stuff you thought you deleted, if the court subpoenas your phone, it can end up as, you know, part of the public documents out there. Be smart about this. Okay? They may be relaxing things now, but if you stand back and you're texting a bunch of things you're not texting, don't think that just deleting it from what you see is going to cover it or that your client deleting it is going to cover it. Be careful, all right? Careful what you say, what you encourage people to do. Relaxation, this is not a total advocation of the rules. When you're texting, another thing to think about is to avoid abbreviations like LOL, emoticons, the memes, video clips you can share in text messaging. Avoid that with

clients. I mean, I really want to encourage you to do it with each other because frankly, I do a lot of that. I pass them around to friends, that's 10, 15 minutes I do to connect with my friends. People thank me to give them a few chuckles. So certainly use it for that. But don't be sending that to your clients. This has to do with an issue of professional boundaries. Lot of the licensing board complaints has to do with emails, text messaging, has to do with poor boundaries. Clinicians are sharing jokes, sharing abbreviations and things that when that's held up in front of a licensing board, it makes you look really bad. That paired with whatever accusation somebody's making of you is about to take you down. Don't do it. Hold your stance. Be professional. When you get to see people again, hanging out with them, doing video conferencing, you crack jokes during your session, that's different. But don't leave a paper trail of that kind of stuff because that's what people use to hang you when they want to press charges against you. Okay?

So I'm going to give you a summary again. Consider diagnosis, risk analysis, risk benefit analysis, history of the person. Are they alone? How is their physical health? And make your determination for each person individually. Some people for whom telehealth is not going to work, they need more structure in their lives. But when you look at telehealth and the evolution of it starting back in 1959, telehealth was done with people who are on locked units because they were unmanageable otherwise. It's not the person that needs to change. It's the environment. Controlled environment, if they're incarcerated, jail cell, prison, they're not going to hurt themselves or anybody else, so yeah, you can use telehealth. It's an issue of environment. ? You stop to think about telehealth, it's all about the setting, isn't it? If you've been working through telehealth last couple of weeks you know, as soon as you lay eyes on your client or they lay eyes on you, you're connected through video now. And that relationship continues. Yes, it's being carried through technology, but it's the, you know, energy between the two of you gets transmitted through the technology and that's where you do your work. The rest of this, be careful about it. Okay?

You have to decide it one by one, and then give them what we call dynamic of informed consent of risk benefits. Let's say they're completely overwhelmed. The only thing they can work with is unpaid Skype. The government says, okay, you can use unpaid Skype. All right. You use it. But you inform them. You know, this could be a little risky. There's benefits, obviously. We can connect here. They may not be able to understand downloads, whatever else, click here, click there. They have Skype, it's working. Their adult child set up or something. You let them know and you document in your notes, I gave them dynamic informed consent about the risks and benefits of this. Other people might find a record of what you type in. You want to be careful what you type into this interface, stuff like that.

Rationale for using that, and they were completely overwhelmed, couldn't do anything else. Move on. Do the contact, deliver the care you need.

So I'm going to shift here to reimbursement. Let's see. Medicare. You know, it's the biggest insurance in the United States. You need to pay attention to this. They have a website. Right? It's called Medicare and coronavirus. If you're Medicare, go

there. Read stuff there. Take screen shots, put it in your file. Or if you have something to download, download it. There's one book that I found, psychological association had a summary of changes because of COVID. Go check it out. Use resources from any group you can find. NAADAC has done a wonderful job on their page. There might be other things you find, too. And if you do, send them to NAADAC. I'm sure they'll put it on their page. Like I said, do some service work here. Help NAADAC get things organized for you folks.

Changes that have come about that affect Medicare and Medicaid in some states. Medicaid is state based. It's not a nationwide thing. But some of the things affect Medicaid as well as Medicare and some third party payers coming along with it. See the handout that you have in your packet from the center for Medicare and Medicaid services. And just to give you a little, so far, equipment that they're going to pay for is two-way live interactive video. Telephone for Medicare is not yet paid. So lots of groups pushing for that. Medicare is holding firm, at least anyway.

Here's more from the APA website that summarizes a lot of this that I'm going to let you read on your own. It's available to people all over the country. Patients don't have to be in an originating site that was pre-approved by Medicare. You have to be in rural areas, professional site. But now they're saying you can serve people from their home, stuff like that that has change. You get the same amount of money for in-person and video.

Now, you use the same CPT code as you would in personal care. One of the things -- but I also want to have you pay attention to that some states are including telephone. This is the California rule that was released I believe last week, and it said that, once again, that it's the same money as face-to-face. Generally, those of us in the field call that in-person because really when you're in video, you're face-to-face, facing the other person. So in-person is more of a fitting term. And you see the little red arrow down here says telephone. So some states have included telephone, not for Medicare, but for third party carriers.

What do you do with all this information? Go back to the center for connected health policy and look for updates regarding Medicaid. Right? They have a state by state thing having to do with jurisdictional issues that we just talked about. But they also have a lot do to do with Medicare and Medicaid. They update this every week. Just last week, I found something that replaced [indiscernible] at 3:30, general handouts that we just did. The one I had was dated March 23rd. This is March 30th. These things are getting updated and you can go to the health policy, go to the NAADAC website. I'm sure they're putting those up there, too. If you look at the codes, these are the same ones we use all the time. Just enough different. So don't think you don't know how to bill. You've been billing this way all along. You know how to bill.

Our institute when we train on reimbursement, there's stuff for telehealth. But you can look like these, for example. These are specifically to describe a bundled episode of care for the treatment of opioid use disorders. So they added these three, GYYY 1, 2, and 3. And generally when it's the same thing like that, longer period time,

this may be X number of minutes, Y number of minutes, that kind of thing. Telehealth Medicare.

It includes overall management, care coordination, individual group and psychotherapy and substance use counseling. Those codes are pretty good for you.

Let me talk about e visits just a little bit. Brief communication. It can be initiated by the clinician or the client, the patient. And basically, it's a check in and if the person tells you they're okay, then they don't need to take -- they don't need to take a chair with the clinician. This is kind of a triaging type visit. And you can charge for this. There are codes for e-visits. There are several codes for e-visits. You can look this up. And I'm going to give you an URL, the American psychological association. It has a whole bunch of codes. Let's say you have a social worker who sits at the desk and coughs everybody in your practice. Hey, Pete, you got an appointment next Monday. Just want to check in with you. How are you doing? You feel like you need to come in? If Pete says now, you can bill for that call, and don't see Pete that day. If you're getting overwhelmed -- e visit is pretty important. If your group, clinic, agency, hospital is getting overwhelmed because too many people are coming in, it's not a good idea to have them come in or fill your calendar if they don't need it. You can triage that way.

Same code as before, but what's different? Typically, on the 1500 form, there are five empty blocks where you put the code. There's a dash and two more empty blocks. 95 has been the standard CPT code for about a couple years now. The previous code that would go in that was dash GT but was discontinued by CMS like I said a couple years ago. 95 is the right one. Don't bother with that, just do it. But I'm telling you, why not code it properly? 95 is a designation for telehealth. That means it happened through technology. And once these things go back to normal, 95 is not going to be the code again.

The one you want to pay attention to is 02, a place of service code. Those of you that use this code know that means the client is in the patient home, not in your office. So place of service fits in with what I was saying earlier about patients that are health care in the telehealth follows the patient if they are a Virginia client and you are Virginia licensed and you've been working with them and now they are in Mississippi, they are the center, they are the originating site. And so you have to code it as if you are in Mississippi. And the code to do that is 02 if you use technology. So just use 02 as the place of service code.

Excuse me. I'm coughing, but I don't have coronavirus. Just bronchitis. Last week, this was signed. It released a lot of money and much of this will go to the state run organizations, federally qualified health centers and rural health clinics. So they're going to be a distance site where they're going to -- station the clinicians. And the clinicians are likely to be in their house. We're giving away free trainings and one of those is how to practice from your home. And in that one, I go into a lot of detail about how to set up your house and all. But the thing is the ability to practice from home has been the big draw for telehealth for most of the people that are already in it. So many, many clinicians that has practiced telehealth has been working from home all along.

Why? There's no rule that says you can't, you see. Some of the old school training, I know when I got one when I was in grad school, it was don't work from your home because peep you don't want to be held responsible particularly of the accusation of sexual impropriety. But it's not likely for video. It's been a big draw for young people coming out of school if they have young families to work from home.

Telehealth resource centers. I mentioned 14 resource centers earlier. Center for connected health policy is the one that is paid to come up with all the policies which is why you have all the documents weekly. That's their thing. But they're geographically located around the country, so those will be more go-to places as well.

A lot of them have not focused on behavioral -- I've been working with a lot of them myself, and there's -- helping groups get on board. But there's a lot there that you can get that's generic information that's not behavioral. Now, there's a $2 trillion relief package that does help with a lot of what we do. So I want to encourage you -- I've giving you the link here.

We can look at the evaluation and treatment. One of the things I want to mention is there are things called certificated community behavioral health clinics. This is what used to be community mental health clinic. When I first started working, I used to be in a mental health clinic. My first job. And now they're called behavioral because of what I told you earlier. The federal government has changed mental health terminology, calling it behavioral.

And then they started going around and establishing some criteria and certifying community behavioral health clinics that met the criteria. So now we have the CCBHCs. And this outline of what these groups should be doing has been around for several years now. So like I was saying earlier, this is nothing new. This is not the wild west. Things in our community have already put in place for us to do telehealth for a long time.

So some all of the fundamentals are not going to change just because COVID. These things are responsible care, does not change no matter what the law is. That remains the same regardless of how we deliver it. In-person, through video, text messaging, email, apps, anything.

The adoption rate is changing because we're under the period of forced adoption. Get over whatever inhibitions we have, get the training you need and get on board. Whatever you use, you're responsible through your legal and ethical codes. It's not the time to be slacking off. And just know if things don't go right, when you operate with integrity, you've got nothing to fear. Document your decisions like I said earlier. Write two sentences down about why you chose to use technology with which person. Put it in their patient file, in their progress note whenever you make that decision.

But think about telehealth in general is a lot like driving a car. It can take a few months of regular practice to learn and remember all the safety things you have to do. To develop your reflexes understand what all the signs mean, how soon you have to

start braking, depending on the zone, the road conditions. This takes time. Telehealth is similar. You may have jumped in it but you may start realizing, geez, some of this isn't working as well as I would like it to. If you start getting overwhelmed, just understand it can take a little bit of time, take a few hours generally. We gauge 15 hours for people who are trying to -- of training, I'm talking about -- that are working in a group or agency where they already have things in place for telehealth. The decision makers, the supervisors, 36 hours to teach them the basics, the rules of the road, if you will so you really have all your documentation in place, everything is right. Right now, everybody jumped in a car and started driving around. Right now, any child, ten year olds, lugs long enough can drive a car. What they can't anticipate are all the problems that might arise, how to deal with an onslaught of traffic, right? A child running in front of a car, all of those things, they're not trained. This is what you may be facing yourself, too.

You jumped on board. You may be realizing you don't know exactly what to do in some circumstances. And it's part of a developmental process is what I'm trying to tell you. I hope you don't shy away from telehealth after this comes down because tremendous benefit for lots of people. But if you go at it systematically like I'm trying to outline for you and your focus is how do I responsibly approach this for each and every person I'm dealing with? I stop and think about them and their needs. Then it does make a lot of sense for a lot of people.

First, of course, do no harm. That's our No. 1 mandate. Don't hurt somebody. Look at the evidence base before you do anything. You look at opioids and telehealth, go to the evidence base, which is literature. But then if you say you're an evidence based practitioner, what does that mean? It means you've read some studies. Let's say you go look up 4, 5, 6, 7, 8 studies. And then you read the first part of it at least, who was in the sample, how do they define the sample. Any studies that define the sample as a mixed population, throw that away? Okay? If they can't specify this is adults or children or people with this disorder or that disorder, they're trying to pull a fast one on you. Throw it away. Get specific. Opioid population, this age, this gender. What's going on here? Get some details to match your population.

And then you sit with a person that is in your practice and you look at them. You think about what the literature said, and then your clinical judgment, you decide. That finding in that article in the discussion section is generally where they have this is irrelevant. Or wow, those researches mentioned three things that are pivotal. And for this patient, I'm going to document it. Peterson and Johnson 2019 said blah, blah, blah, that I should be doing this, and that's why I'm doing this with this patient. That's evidence based care.

Now, the third leg on that is to ask them their preferences and values. Do you want to do this? That's informed consent. Look, I read about this protocol, some people are doing this and that, do you want to try it? And if they agree, that then you can document as evidence based care. Three legs. Not you read articles, low it in a pile, and you do it. That's willy-nilly. Be systematic. That separates the yahoos from the professionals.

Technical, legal, ethical, clinical. Let's go through these. I'm going to get to the home-based things. Watch your own house. Most of us are working out of our houses, I hope. Controlling your children, your spouse, any other people living with you, your room mates, house mates, have a talk with them. Make sure nobody can be seen through class behind you. Their reflection. You might see them, but you don't realize that the big picture behind you with glass on it is reflecting it into the camera and your client is also seeing them. Pick up your stuff in the background. Throw it in the other corner of the room, if you need to. But try to help people focus off your home. Give them a one liner. Make up whatever works for your people, but don't indulge questions about your home, what you're doing. That kind of thing can come back to bite you later if you're not -- the more disordered the somebody is s so is the boundary. Especially when you're working from home, when you show up, if you have a waiting room in the technology office, you can put some pictures, the desk, furniture, chair. Or include in your home background, things in your real office. A vase, picture, something to kind of help situate them. It can be very disruptive for them. You're a professional. You were not hanging out with people.

Maintain your therapeutic frame. You're there to focus on them. Don't allow distractions. Don't deny someone's reality by lying about what you just did. If they just caught you on the phone banging around the kitchen and they tell you -- ask you that, don't say no. People aren't stupid. They know what the kitchen sounds like. If they see something and you're embarrassed, say that. Be real with people. Just be yourself, own it. And I think you're going to go a lot further if you try to hide things that they're shocked they saw and talking to you about.

Starting a session with an open protocol. That is a formal thing. And I don't know that I included that packet, Samson. If I didn't let me know, and I'll send it to you. These are accepted ways of telehealth to start a session. The first thing is to always -- and I mean always, 100 percent of the time -- ask the person where they are. I mean, if you don't know them, you can ask them to identify themselves. A lot of us are working with people who we do know. So you don't have to go through the first step. Second one, ask them where they are. Third, if you think other people are in the room, don't be afraid to ask to scan the room with the camera. Hey, JoAnne, can you take the laptop and show me the corners of the room here today? I want to be sure you're private. What are you doing Marlene. Sorry, I have to do that. That's what the rule book says. Make a one liner like that that will give you a leeway because if there's a batterer likely to show up in the environment, they can say it, you can't hide in the corner. This is part of maintaining the security of the room, their room. Don't be shy about that. You may actually protect somebody in doing that.

You on your side may have been using poor boundaries in your own house. You may not notify family and friends that you've got a scheduled appointment. They might walk into your room. You may find yourself flustered because now you're dealing with a crisis on video. You did not have all of your patient notes, phone numbers, things to do, emergency room numbers, right in front of you when you started the session. You really should have all of that for each person especially now in this time of crisis. Don't

want to be flustered digging around for 15 minutes on your phone looking for the hospital in their area. If they're not being cooperative, this can really be a problem.

So on your end, develop a non-verbal, fail-proof system. Lock your door. Put a do not disturb sign on the outside of the door. Note on kitchen counter. Text message others. Emergency session. Keep people away from den, wherever you are in the house. No. 1 key. And this one I cannot stress enough. Wherever you're setting up, turn your camera away from the door. Someone coming through the door won't be on camera. I can't tell you how many people have shared with me embarrassing moments where spouse or children come running through the room because they didn't know mom or dad was on camera. Right? Sometimes people are not fully dressed. And there are all kinds of things that can be exposed there. So don't want to have to explain that one and be real with your client if you didn't plan ahead. Turn the camera away from the door and then teach them -- you're going to do this when your client is watching you. Raise a finger, something discreet so you're not screaming at them, get out of here, I'm on camera. Don't want to look flustered when you're trying to calm down your clients with what's going on. Want to keep things calm, keep things cool.

I can't seem to advance these slides. I'm not too sure. Oh, now we have two of them. Screening is kind of important. I'm going to give you some of this material. Look at the evidence base. There again, go to Google scholar, pub med. This is all free stuff online now. Look for some researchers. For the population, let's see, opioid, you know, comma telehealth. Go get information, share it with your colleagues. You can do that through NAADAC. Right? Send some of these resources in, some of these articles in. Do some service work. Help build community over there and resources for everybody. Not that you have to vet the article but say, hey, if you want to look at some articles, here are some articles. You want evidence based care. Just know that almost all groups of people have been treated with telehealth. It's just that every time you use a different type of technology with a different population, there's special things that come up. So when you read an article for opioids and teens and telehealth, you may see in the discussion section, so skip the middle if you have to, but hit that discussion, and they'll give you some recommendations. Oh, didn't think of that, but that makes sense. See? So you start adopting that in what you do.

Treatment to their home is much riskier, because it's much more difficult to control factors in the home. We started a program dealing with these clinical issues, clinical best practices, things like what do you do when your client shows up and they're half-dressed or very scantily dressed? You know they're attracted to you. They told you that and they're sitting on their bed. How do you handle that? What would be appropriate here? What we do is problem solve about these things. And there are other things you can think about like that that will help you get a grip on this if you're struggling. But first stop, go to literature. Lot of mistakes people took the time to document for your benefit.

And understand, there's a difference between treating people in their home versus the hospital or in their car or park bench. Each one of those has its own set of responses that you can come up with. Right? And if they're not compliant, then you

know, limit what you're going to do with them. Systematically assess and identify clinical, diagnostic, setting, population, and other factors that would preempt or complicate the use of a technology with a client. You might decide some something is good this week and something went bad and you don't do it next week. If you can't get someone to comply on video, maybe drop down to telephone. The issue is maybe you can't get paid for telephone. Medicare is not paying for telephone yet. Does it mean you don't deliver the service? I guess that's between you and your conscience, but it's a time of crisis. You need to consider that. Will your state allow you to get paid? Look at it state information I just gave you. You go to center for connected health policy.

If you need somebody to have nor support and they're in an environment, contact the people in charge of the facility, the residential care facility. Ask them to document what they're doing too so they're not throwing stuff together mindlessly, not worrying about something they should be thinking about. Are people able to do what they want? If you give them something they can't do, they're going to shy away from you. You ask them to do something they're not able to do, they're going to be embarrassed and won't come back. A recent article about smart phone apps used just for cell phones. Let me find some of the article here. It's probably in an upcoming slide. Standalone smart phone apps for mental health: A systematic review and meta-analysis. I'm giving you the words of the research. Although some trials showed potential of apps targeting mental health systems using mart phone apps as standalone psychological interventions cannot be recommend said based on the current level of evidence.

Now, every newsletter you see from mental health out there, you're going to see new smart phone apps. Were there being used? This research is recent, but it also replicates a bunch of other studies that has been happening for quite a while now. If you use something with somebody in tandem with telehealth direct care, yeah, it can be helpful, particularly if they know it and they like it. Will it protect them? Who knows? What are other privacy studies? Does the app say HIPAA compliant. If it doesn't say it, it's not. This is like organic food. If it doesn't say organic, just says natural, it's not organic.

If they say they are HIPAA compliant, do they give you a business associate agreement? If they don't, they don't. They're not. Should you not use it? Well, you may need to decide the circumstance, given the emergency, maybe you do. There are levels here of confidence that you can put into phones and smart phones and apps. Think about it. Share this -- discuss these things with your clients. If you're making your to-do list, discuss it with your clients, your colleagues. Get a group together and talk about this stuff. NAADAC is a wonderful help for a lot of that.

What do you do if your client insists that an app is helping them. Again, that's between and your conscious. You talk to your colleagues about it and you document that you consulted them. People grab an app. Yeah, yeah, let's give this to the client. If you give it to the client, and I'll give you one tip on that -- I do a presentation on this. There's a lot of apps -- but No. 1 thing is apps will often ask you to leave a window open to help people -- to help the developer with any bugs. You know what that is? That's one way communication channel to the developer, whoever that is, to see whatever

your client's putting in the app. I encourage you to encourage your client to turn that off. Usually it's a toggle. And to give people the app in your office and help them install it. That's the four hour abbreviated version of dealing with apps so that you know they're doing it and you can follow up with them next week and you don't have to be embarrassing them with things they can't do on their own. That was a 2020 article.

If you're doing telehealth with someone that's at risk, pull in the family. Ask them as part of informed consent where they have identified the name of the person that they want you to communicate it with, informed consent, give permission to speak to that person and tell them what you're going to tell that person. I've been searching for Julie and I can't find her. She missed her appointment with me. Would you please help me find her. Who are you? I am a professional. I've been working with Julie. What are you working with her? I can't give you the details. But please, I can't tell her. I'm worried about her. Could you please ask her to contact me. And that's really tight. Come up with your own. How precise or loose do you want to be? These are the words I'm going to say so they can trust you they're all going to get. They're not going to get the full download, all the ins and outs of what your client told you so they're going to deal with that in the next five years with all the details you threw at the collaborator. This is common practice. You can search for that. Telehealth, comma, collaborator. But it's a very wise thing to do.

And what do you do if you've decided telehealth is not adequate for someone? What are your options? Right now, president said state of emergency. If you decide it's not going to work, write down what the alternatives are and if none, write that done. Just write it down. You can't fix it, but think about it. People are dying in emergency rooms as they speak. They can't fix it. But they can say, there's nothing else we can do. They do document that. So go ahead and document that. So you're probably getting the message here. What I'm telling you is document your decisions. Think about things and then document things. I'm getting some questions from Tiffany asking about the website to see research again. You can go to Google Scholar. If you go to just Google, any search engine, you type in Google Scholar, all it is, is research articles. And then you search my name. You'll see a ton of articles. I tell people I'm a fanatic. I'm not an academic. I'm a fanatic. I've been writing for decades. And books. Put someone's name and search for it. PubMed is a library for medicine stuff. But there's a lot of the stuff there, too.

Capability. What NAADAC is saying here in this ethical code is you've got to take reasonable steps to determine that your client is capable of using e-e-therapy. All right? That doesn't go by the wayside.

Safety first. Video conferencing is being used. Running through some text, technology. Text messaging being used. Be careful if it's not HIPAA compliant text messaging. You know, when I started this happening about what's going on right now, how many people are wringing their hands, delighted that all this private information will be running through these networks that clinicians are mindlessly using? And what are they going to do with that data about that patient, that person? Don't minimize the ability of evil doers out there to do damage to you through technology. Use HIPAA

compliant platforms, if you can. That's all I can say about that. I already told you about apps. Careful on that. If you use it in person, step by step, you do it, set it up for them, it can make a tremendous difference. Oh, yeah, here is something on insomnia. Why don't you try it out, uh-huh.

Telephones. You can go to PubMed or Google doc -- Google scholar, and you can search telephone comma teen comma opioid. See what comes up. I can't guarantee there's an article there, but typically, a whole bunch of things. So go look for what you need. And then follow their guides. Write that you followed that in your progress note. I went, looked for this guy. See if I can find something. I wrote it down. Here at the institute, telehealth.org, we have 1200 articles publicly. Inside we have 4400 articles. We have a big database for telebehavioral stuff. Make sure that what you read makes sense. Don't just take anything out there. Some things aren't worth being published.

Medication adherence, there's a lot of the u about medication assisted treatment programs. That can be helped with apps, too. Blind CC, I gave an example if you don't know how to do that. In your email software, you'll see typically there's a Bcc line or right underneath the line. Hit Bcc so everybody you send email out to can be blinded so that they don't get everybody else's names. When you work through technology, NAADAC says be aware of missing cues. Document this, talk about it. Document it.

You can use multiple cameras. You can set up multiple cameras, put a camera in the corner of the room. I'm going to move through some of this because won't have time. But you can use interpreters. Cultural competence is crucial. Right now, if you're working with your usual case load, you probably know your people. If you're taking on new folks, know that in many states in the United States, you need to deliver services in the language of the person, what their preference is for that language. There are interpreters. They will help you with that. That's all I can say.

Documentation, we've been through a lot. We want to talk about informed consent. Legal issue and ethical issue, static, which is beginning of the informed consent versus dynamic, as you go. You need to do something new. Right now, you are introducing telehealth quickly. That's a dynamic thing. You're kind of doing it on the fly. But know it represents a meeting of the minds. It's a discussion. It's not a piece of paper that people sign. It's a discussion that leaves you reasonably assured that their know what's going to happen to them. NAADAC has a whole thing about this, too, informed consent. Make sure they understand in writing and verbally the rights and responsibilities here.

Opening protocol. I mentioned this. This is what I said is an abbreviated version. Identify yourself if you're new to the person. Do you see me? Do you hear me? Is there anyone within ear-shot? Is there anything else I might notice and find of interest? And of course No. 1 important thing is where are you? Because that determines your licensure and if you can build them because some people -- some insurers will let you see them. Really, they have no jurisdiction over that. But they won't pay. And that's dependent on states and the insurance company.

So I'll spend a few minutes talking about self-care and I'll turn it over. If you do telehealth a long time, and your screen is too small, you may be straining your eyes. You may be experiencing some of this. My tip to you is use the biggest monitor possible. If you've got a big TV monitor, 52 inch high definition monitor or an old one sitting in the back room somewhere, fire that puppy up. There's one cord that you can use to plug in a laptop to that kind of eternal monitor. And you can use a TV as a monitor and you'll see that person -- you'll see their head bigger than your head. You can see everything going on in your face. Make it easy on yourself. Don't strain yourself working on a phone or a little laptop or iPad or something like that. Make it easy on yourself so you can sit back and see what you need to see. Close your eyes, occasionally. Make circles with your eyes. Cupping your eyes is leaning forward, putting your eyes in your hands. Make believe your eyeballs are falling into dark, black velvet. Release all the little muscles behind your eyes. Very good for you.

And look out the window and then back at your desk at your screen. Out the window. So you're exercising your pupils. You're not forcing them to be locked all day. You need lighting on your face. Your client needs lighting on their face. Not the computer lighting, but like a nightstand light if they don't have one. They say, oh, yeah, I have -- I might get it next time. No, why don't you get it now. Make sure the next time they show up, they are equipped. If you make them get it now, wait few minutes, they'll make sure they have it next time. Make sure you can be convenient. You can dim your screen. I learned a lot about my eyes. You can dim the amount of light that's pouring out into your eyeballs from the screen. If you do that, it releases reflection on your glasses, if you have glasses, too. You don't have to be on full brightness for your screen. Cut it down. Third of the brightness, you'll be fine. And then you can get glasses with blue lenses. You can also use software that reduces eye strain. A film over the screen that cuts the ray energy. Position your monitor so that you actually are, you know, looking at the top of your monitor. You want your eyes to be at the top part of the screen, not seated down. Imagine the woman to the left. If she were lowered six inches, she would have a ton of space over her head. People feel weird talking to you. This is about telepresence. If you have a sitting desk, standing desk, make sure your eyes are at the top of the monitor. The picture is taken with the person's eyes on the top third of the picture. Do that kind of thing with your monitor as well.

If you start getting neck pains, back pains, look at this woman's chair. This is not orthopedically designed. This is not form fitting. It is not comfortable for her. And I've given you some graphics here. Look at the people on the top. Their elbows, knees are off. Or they're much too forward. Probably cleaning on their well goes. Not good. That's going to get you. Get either the chair on the left. Get yourself some cushions to support your neck and low back. Or get yourself an ergonomically designed chair that will do that for you without having to stick pillows in there. Use the best chair possible. Ergonomic is better. Use wrist guards for your hands. Consider a standing desk. Stagger your appointments. You may find that getting people set up takes more time. You may find that you don't show up on time. So give yourself 15 minutes or 10 minutes between the people. Let them know, I'm delaying, staggering my calendar right now. Give yourself -- you're in charge. Okay? Give yourself the leeway you need to stand up. Do some stretches. Get up, run around your yard, walk around the yard,

whatever you need. Get some oxygen in you. People in their 30's often complain of leg cramps because they sit all day in front of a monitor doing telehealth. If you have a flight of stairs in your house, force yourself to go upstairs to use the restroom. It's going to force you to go up. Going up the stairs is for your health. When we go to the waiting room, get up out of our chair, sit someone down, it's all doing stuff with our body. Telehealth, you may not be doing that. Drink water, push yourself to go up and down the stairs. Go outside.

When you think about when you're flying, the yellow oxygen cup comes down, they say put it on yourself before you put it on your child. This is what I'm talking about. Properly care for yourself so that you can do the work you want to do. Okay? Don't weaken yourself. We as a work force really need to focus on self-care. In terms of modeling, if people see you get frustrated or shout explicatives when your technology doesn't work, they're going to do the same. If you laugh at yourself, you'll be okay when things go wrong, you wait, you have a plan, if things break down, then what are you going to do? You're going to wait for it to come back up. But in the meantime, you're going to call the client. Don't ask them to call you. You stay in charge of your session. You're the professional. You tell them, I will call you. You laugh about it, and then you carry on on the phone. And if your video kicks back up, awesome. If the sound -- forget the sound on the internet. Stay on the phones. Phones work. Use the video, if you can. Even if it's sort of pixilated, doesn't matter, you got a solid voice connection on the phone. If you can watch people on video, that's it. You hope the session is better another day.

>> SAMSON TEKLEMARIAM: This is Samson. Sorry for interrupting. Just a little heads up. Just another minute or two to wrap up and then you we have to transition to Clocktree. Thank you so much.

>> MARLENE MAHEU: Remember that you're doing sacred work. I'm going to take some of the questions. Is there a central place where you can find the regulations? Unfortunately not. I have given you many of the handouts that I found. They are federal government, health and human services. You have a handout from them on their website. SAMHSA oversees us. You can go to CMS for center of Medicare and Medicaid services if you're a Medicare person. Center for connected health policy. I've given you examples for each one here. And I showed you a screen shot of the NAADAC website for COVID resources. That's a big one. We have one at our institute, telehealth.org. We got a lot of resources that we're posting there. We hope you can join us and post things as well. We try to be a central hub for all of these places, all of these documents. If you have trouble finding things, you'll be surprised to see how many you have in your packet.

How many sessions per day is appropriate if they're 30-minute sessions? David, it depends on what your patients need. They can be in and out in five minutes. Generally by telephone. So you see, it really depends on who you're seeing. But you decide what works for you and when you decide it, go to the research and look up some articles to see, you know, what are they suggesting? So you might need to roll up your sleeves for four or five hours, do some studying, talk to your colleagues about it. I wish

there was a quick answer for everybody. That's it. All the questions I have. Samson, I'm going to let you take it away. I'll stick around to answer questions later.

>> SAMSON TEKLEMARIAM: Thank you so much, Marlene. You can still continue to send in questions in the questions box. We'll have a few minutes at the end to have Dr. Maheu answer some final questions and any questions not answered, we'll put it in a documents and send to t to her and have her answer them and post the document on our website at a later date. Please keep the questions coming into the questions box. I'm going to turn this over in just a moment to Kimberly Bower from Clocktree. She is going to introduce telehealth platform. We've given you clinical information, tips, updated information on policies. Marlene has stepped in as an expert in the field on these topics. And now we want to make sure you also have some practical resources. And maybe even an understanding of another option if you have already chosen your telehealth platform or those of you who haven't, we would like to introduce you or remind you about Clocktree and the NAADAC benefits with Clocktree. Kimberly, the floor is yours.

>> KIMBERLY BOWER: Thank you, Samson and Dr. Maheu. I wanted to introduce you to one of the options when you're looking for a telehealth service to use with your clients, as a lot of people are looking around right now. Clocktree offers a fully HIPAA compliant platform. I know that right now, the HIPAA compliance laws are relaxed, letting you use a non-HIPAA compliant platform for the short term, but that won't always be the case. So we're offering a fully HIPAA compliant platform that you can get started with now that will carry you into hopefully our next phase when we're not in crisis mode but some of your clients will appreciate the convenience of telehealth even after we're not mandated to. So Clocktree is fully HIPAA compliant. We were built from the ground up, designed for health care providers of any kind. Therapists, dieticians, any kind of health care provide. We offer very simple, secure platform. It's easy to use if your clients can use Skype or face time or Zoom, they can use Clocktree. It's that simple. There's no software required to download on their machine. No plug ins, nothing special that they need. You and your client can use any computer or mobile device that has a camera.

So while it's probably, as Dr. Maheu mentioned, a little more professional for the provider himself to be on a desktop or laptop computer, if that's just not possible and your camera that you have is your iPad, Clocktree works just fine. Same with your clients. It's realistic that probably the only camera they might have on their phone is on their iPad or iPhone. It works just great and there's not an app for them to download. It's all browser based, simple. Our video sessions on Clocktree include document sharing that's all secure. None of the documents or information, not even their name ever leaves Clocktree's service. Additionally, Clocktree staff can't even see your client names. It's all encrypted and private to you. So that's nice to know. Definitely in this time we're in right now, but going forward that all of your patient's information would be secure. So I mentioned that document sharing is included as well as text chat during a session. So all of that's right there in the virtual appointment room. Clocktree's platform also gives you a scheduler. Oh, I'm losing the slide control here. Samson, if you can go

back to the slides, my slides -- I'll talk a little bit more about Clocktree's platform. Here, we talked about -- sorry, I lost my place here.

We talked about included scheduling. You can schedule your video sessions in Clocktree in and your clients will get appointment reminders leading up to the session. So that's a nice benefit. There's secure messaging in between sessions. I lost my slides again, Samson. If you can get back to the Clocktree slides again for me, please. In between, you can send secure messages to your Clocktree clients that can contain the intake forms or anything you need to share with them in between sessions. And all of that is secure.

I'm going to talk more about the advantages of Clocktree. It's kind of the differentiators between Clocktree and some of the other platforms such as Zoom or Doxy. Primarily, it's ease of use. It's very simple for both you and your clients to use. You can be up and running with Clocktree with a client within 15 minutes of setting it up. Very simple. Your client won't have a cluttered interface. The only thing they can do is communicate with you via video and text chat. There's not a lot of other bells and whistles there that get in the way of their communication with you. So it's less stressful situation than some other platforms where there's a lot going on in the interface that might detract from just communicating with you. It is designed for an ongoing relationship with the client, not a single appointment. So each of your clients will have their own account to Clocktree, their own log in to the account. You can see their appointment history, their messaging history with you for really a period of seven years. We keep that on file for seven years for them. So it's really not designed for a one-time appointment. In and out. It's to facilitate that ongoing relationship. The other advantage for Clocktree is our pricing model for you. We're priced per practice, not for an individual provider. If you're part of a clinic of five providers, you've got one central pool of video hours available to you to use and one fee. There's not a licensing fee on top of your basic subscription each month.

I wanted to talk to you. Right now, we've opened up at 90 day free trial. Just to give health care providers a simple, easy way to be introduced to telehealth. So 90 days fully unlimited use for three full months from the date you sign up. And then after that, you can choose a subscription plan if you decide to use telehealth going forward. Still very affordable. NAADAC members, so everyone on this webinar today and any NAADAC member gets a 15 percent lifetime discount if you decide to use Clocktree going forward for telehealth had remember the promo code NAADAC, which is easy to remember. Type that in when you sign up and you'll receive a 15 percent discount off of your subscription plan.

To get signed up, it's all online and self-served so you don't need Clocktree representatives to do anything for you. It's all online and self-serve. You go to Clocktree.com, click the Info For Providers tab. The step is high level. It takes about 15 minutes. At high level, you're going to register your practice and invite colleagues to join you on your practice and ready to invite clients. Your clients will need an email address to accept your invitation. They accept your invitation and you're ready to schedule an appointment with them. It is very simple. We've got more information

about all the features in Clocktree at our website. Like I said, Clocktree.com, click Info For Providers. The button is right there. We have a support team if you have questions at all. You would email support at Clocktree.com. Email is also on our website. That's all I have, Samson. If there's any questions, I'm happy to answer questions now.

>> SAMSON TEKLEMARIAM: Thank you so much, Kimberly. And sorry about the technical snafu. Thank you for bearing with us.

>> KIMBERLY BOWER: No problem.

>> SAMSON TEKLEMARIAM: We did get questions in. We'll post the questions in a document after the webinar. But for Kimberly, what would be an example fee for a solo practitioner working part time.

>> KIMBERLY BOWER: After the 90 day free trial, it is $29 per month, and that plan is capped at 10 hours of video time per month. And that's not necessarily ten sessions or ten clients. It's ten hours. So fees go up from there, but $29 is our lowest plan, and that's designed for a part-time solo practitioner.

>> SAMSON TEKLEMARIAM: Thank you so much. And one more, Kimberly, and rest of them, I'm sorry, we'll have to send to the Q&A document. One question for Michael, if our practice decides to discontinue after 90 days, how can we access files after?

>> KIMBERLY BOWER: Good question. Yes, after 90 days or at any time, if you discontinue service, your accounted with go to a read only mode. You'll have full access to your appointment history, any client documentation you've done in Clocktree, you won't have more video sessions with your clients. That's considered medical record so we by law are mandated to keep that available to you and your client for seven years, so we do.

>> SAMSON TEKLEMARIAM: Thank you so much, Kimberly. And thank you, Clocktree. Everyone on your screen right now, you see some information from our presenter, Dr. Marlene Maheu, a close friend of NAADAC, incredible presenter as you saw and heard today. Her organization, telebehavioral health institute is offering 50 percent off all training and micro certifications until May. Free COVID-19 webinars are also available. Telehealth.org. Very easy to remember. You can email Dr. Maheu any time. Contact@telehealth.org. On our slide, you'll see her contact number. The questions that you all sent in, we will add to a Q&A document. We'll email them to Marlene right after this webinar and we'll work to get those up on the web page including the most up to date resources that she referenced through the webinar. Here is the schedule for upcoming webinars. Please tune in. Really interesting topics with great presenters. Also as many of you are turning to health care at this time, we are pleased to offer another free webinar on April 3rd, this fried to provide you all with additional information on how to respond to this current pandemic or epidemic that's happening. Marlene mentioned opioid epidemic but also the telehealth issue we're having as a response to COVID-19. We spoke with Dr. Timothy Legg who originally

been scheduled in September, but he agreed to bump it up to April 3ered t noon eastern to 1:30 p.m. eastern, impact of disaster on recovery: The perfect storm, covering evidence based practices and research on how to help our patients respond to this crisis and deal with some of the disruptions in their routine and how to deal with -- how isolation triggers recovery and also self-practices for the practitioner. You will see the website at the bottom of the screen, NAADAC.org/impact-of-disaster-on-recovery-webinar. As Kimberly mentioned, another benefit you'll see in your chat box, you'll also see that in the thank you letter with a link directly to Clocktree. One benefit of being a member is lifetime as a NAADAC member as long as your lifetime NAADAC membership exists, you will get an additional 15 percent off your account with Clocktree. Please note that a short survey will pop up at the end. Please give us feedback, notes for the presenter and tell us how we can improve. Your feedback is very important to us as we continue to sharpen your learning experience. Thank you again for participating in this webinar. Thank you so much, Kimberly, from Clocktree, and especially thank you to Dr. Marlene Maheu for telehealth. It was encouraging. I want to encourage you to stay connected with us on Facebook, LinkedIn and Twitter. Have a great day, everyone.

[End of webinar].