TeleBehavioral Health 501 Training Series

Behavioral Health Institute (BHI)
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Northwest Regional
Telehealth Resource Center (NRTRC)
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March 15, 2024

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment.

The BHI brings the expertise of Harborview Medical Center/UW Medicine and other university partners together to address the challenges facing Washington's behavioral health system through:

- Clinical Innovation
- Research and Evaluation
- Workforce Development and Training
- Expanded Digital and Telehealth Services and Training

The BHI serves as a regional resource for the advancement of behavioral health outcomes and policy, and to support sustainable system change.

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

The NRTRC delivers telehealth technical assistance and shares expertise through individual consults, trainings, webinars, conference presentations, and the web.

Their mission is to advance telehealth programs' development, implementation, and integration in rural and medically underserved communities.

The NRTRC aims to assist healthcare providers, organizations, and networks in implementing cost-effective telehealth programs to increase access and equity in rural and medically underserved areas and populations.

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Speaker Disclosures

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Planner disclosures

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DISCLAIMER

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Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.

Please consult with legal counsel, billing & coding experts, and compliance professionals, as well as current legislative and regulatory sources, for accurate and up-to-date information.

We gratefully acknowledge the support from

Washington State Health Care Authority

NRTRC NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

AHEC WW
AREA HEALTH EDUCATION CENTER
FOR WESTERN WASHINGTON AT WHATCOM COMMUNITY COLLEGE

BUILDING TELEHEALTH CAPACITY for BEHAVIORAL HEALTH

Telehealth and SUD Treatment-Unprecedented access without risk?

MARK DUNCAN, MD

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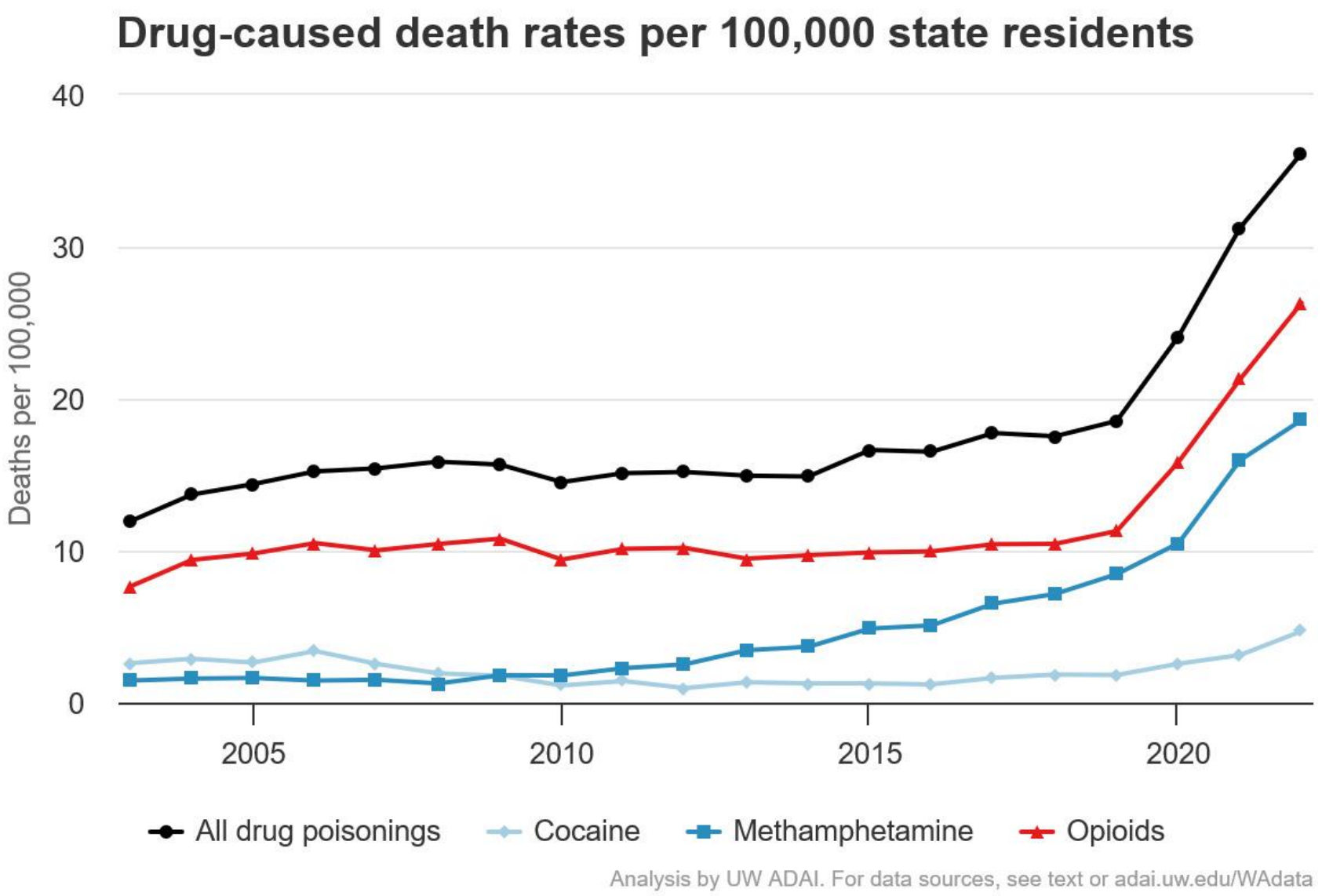
UNIVERSITY OF WASHINGTON DEPT OF PSYCHIATRY & BEHAVIORAL SCIENCES

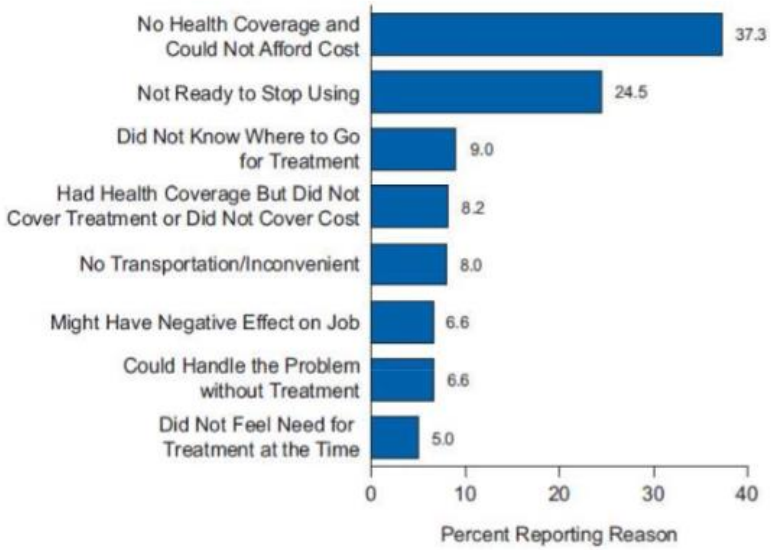
MARCH 15, 2024

Objectives

- Describe how telehealth is used for SUD treatment
- Highlight what the evidence says about using telehealth for SUD treatment
- Discuss lessons learned from using a phone app to deliver CM for Methamphetamine use
- Summarize some of the strength and weaknesses around using telehealth to treat SUDs


Drug-caused death rates per 100,000 state residents
Deaths per 100,000
40
30
20
10
0
2005
2010
2015
2020
All drug poisonings
Cocaine
Methamphetamine
Opioids
Analysis by UW ADAI. For data sources, see text or adai.uw.edu/WAdata

Why are OUD treatment rates so low?



(SAMHSA, 2017)

Lin, A AAAP 2023

Promise of Telehealth

- Remove barriers
  - Geography
  - Local resource availability
  - Transportation
  - Disabilities
  - Competing employment and family responsibilities
  - Stigma
- Improve Care
  - Remote monitoring
  - Revenue/Cost Savings
    - More patients
  - Efficiency
  - Better care to more people

https://www.whitehouse.gov/wp-content/uploads/2022/06/Telehealth-and-Substance-Use-Disorder-Services-in-the-Era-of-COVID-19-FINAL.pdf

Changes in SUD Care with Pandemic

ASAM American Society of Addiction Medicine

Pandemic	Non-Pandemic
Telemedicine widely available	Telemedicine not available
Initial in-person visit for Buprenorphine not required	Initial in-person visit for Buprenorphine required
Limited Urine Drug Testing	Baseline urine drug testing
Refills without in-person visits	In-person visits for refills
Consideration for delivery of meds (if quarantined)	N/A
More frequent check-ins by phone	Regular frequency

https://www.asam.org/Quality-Science/covid-19-coronavirus

How is telemedicine used for SUD treatment?

Direct patient care

- Medications
- Psychotherapy
- Intensive outpatient programs

Remote monitoring

- Measurement based care
- Drug testing

Technology based stand-alone treatment (apps, computer based)

Augment in-person treatment

Mutual Help Groups

Does Telehealth work for SUDs?

Is it acceptable?

Is it effective?

Does it increase access?

Unintended consequences?

Do patients find telehealth for SUD acceptable?

- Yes

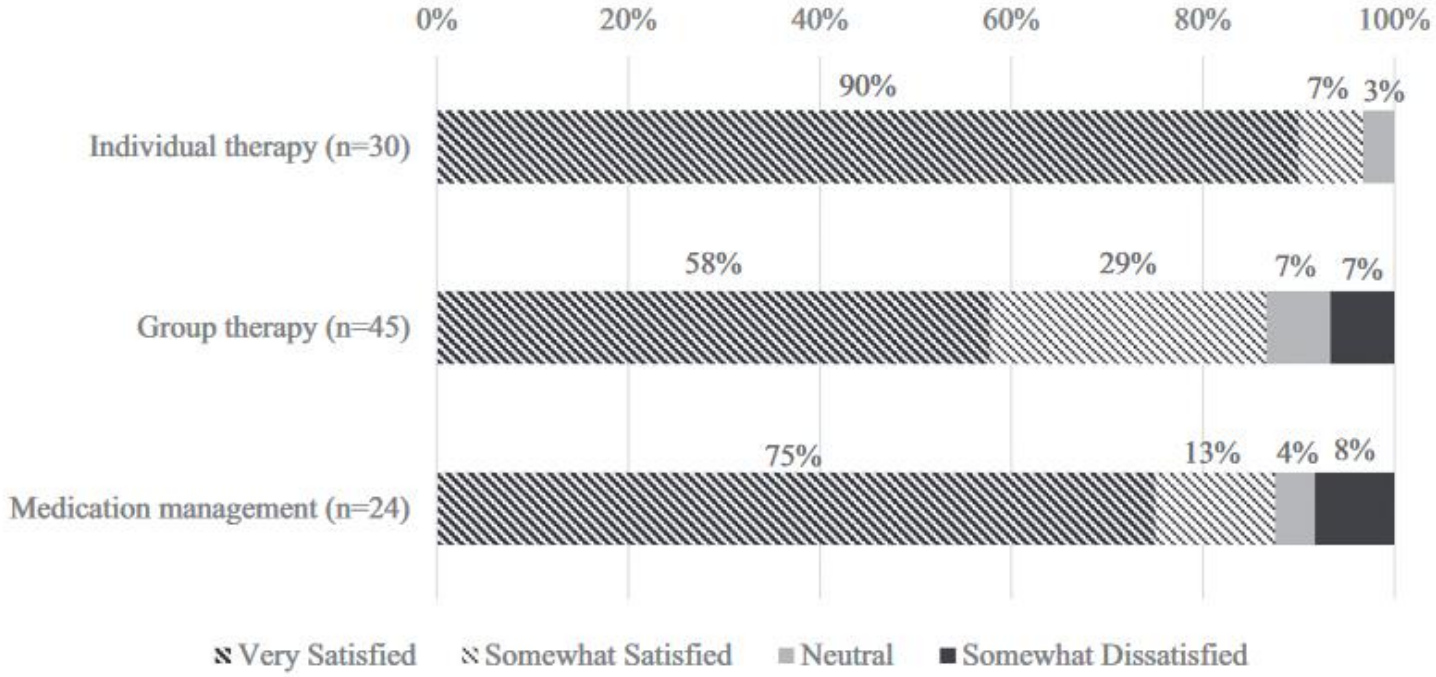


FIGURE 1 Telehealth satisfaction by treatment type

SUD Specialty Clinic-Groups, Med management

N=58 (mostly white, male, well educated)

2021, Sugarman DE, et al, Am J on Addictions

Preferred mode of treatment delivery

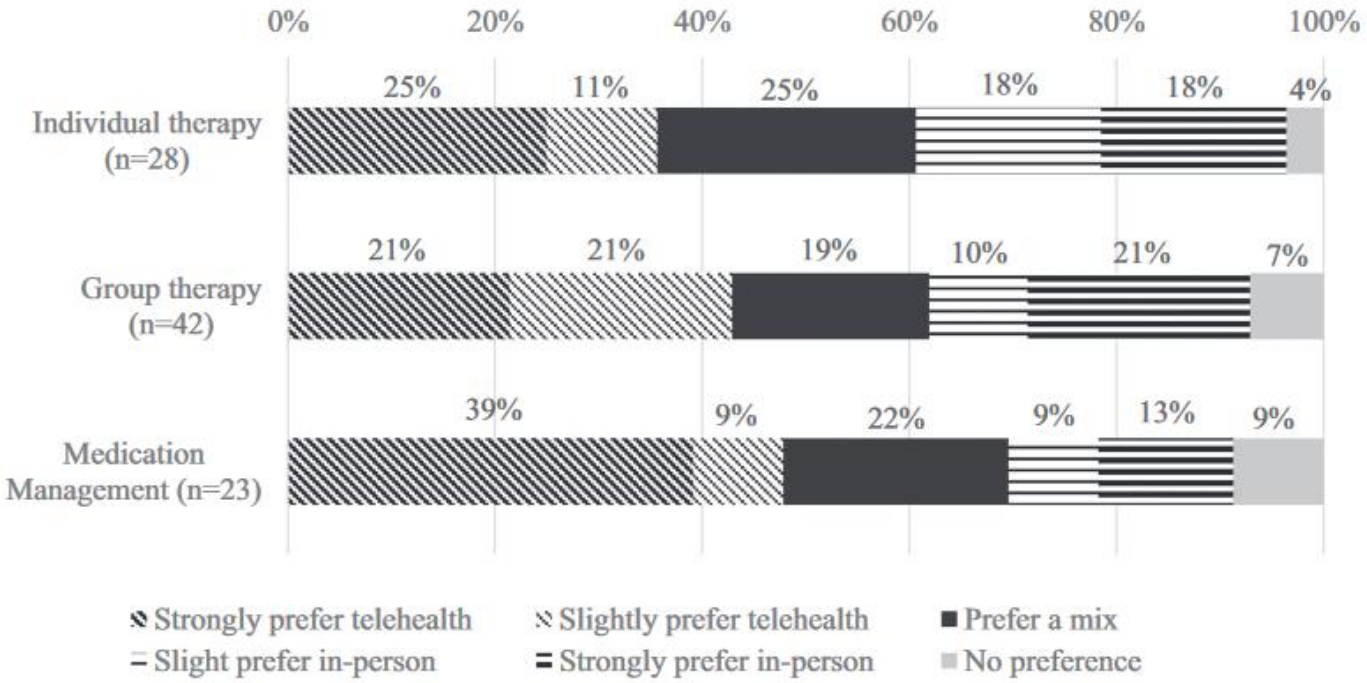


FIGURE 2 Preferred mode of treatment delivery by treatment type

SUD Specialty Clinic-Groups, Med management

N=58 (mostly white, male, well educated)

2021, Sugarman DE, et al, Am J on Addictions

Do patients find telehealth for SUD acceptable?

Did Not Like about Telehealth	Did like about Telehealth
Don't connect well with other group members (28%)	I can do it from home (40%)
Potential for interruptions at home/work (26%)	I don't have to commute (83%)
Like going to clinic and getting out of the house (19%)	I don't have to sit in a waiting room (45%)
More likely to discuss difficult topics in person (17%)	I don't have to leave work (35%)
Don't connect as well with therapist (16%)	It is easier to find an appointment time (33%)
Privacy concerns at home (14%)	It makes childcare responsibilities easier (22%)
	It is easier to talk with therapist (16%)
	It is more confidential (12%)

2021, Sugarman DE, et al, Am J on Addictions

It is effective?

Is telehealth a replacement for in-person therapy?

- 1 Randomized Controlled, n=32
- In-person therapy + meds prn **VS** online therapy + meds prn
- 12 month follow-up
- Results
  - No difference in days of any or excessive alcohol use
  - Dropping out of therapy

In-person	Online
44%	17%

Tarp K, Bojesen AB, Mejldal A, et al. Effectiveness of optional videoconferencing-based treatment of alcohol use disorders: randomized controlled trial. **JMIR Ment Health**. 2017;4:e38

Can you use computer-only CBT with no therapist?

- 2 Randomized controlled trials for Alcohol Use Disorder
- Trial 1: Computer-based online CBT vs in-person CBT
- Trial 2: Computer-based online CBT vs online CBT therapist

- Results
  - No difference between groups in overall abstinence from alcohol
  - No difference in days of any alcohol use
  - No difference in quality of life at 8+ weeks

Kiluk BD, Devore KA, Buck MB, et al. Randomized trial of computerized cognitive behavioral therapy for alcohol use disorders: efficacy as a virtual stand-alone and treatment add-on compared with standard outpatient treatment. **Alcohol Clin Exp Res**. 2016;40:1991-2000.
Sundström C, Eék N, Kraepelien M, et al. High- versus low-intensity internet interventions for alcohol use disorders: results of a three-armed randomized controlled superiority trial. **Addiction**. 2020;115:863-874.

Addiction Treatment and Telehealth
Review of Efficacy

- 8 Studies (5 RCTS, 3 retrospective obs)

Telehealth vs In-person

- Individual and Group Counseling
  - **No difference in**: treatment adherence, retention, excessive alc consumption, drug positive tests, treatment satisfaction, therapeutic alliance

- Medication Management for OUD
  - Can be effective and better in some cases

Mark TL, Treiman K, Padwa H, Henretty K, Tzeng J, Gilbert M. Addiction Treatment and Telehealth: Review of Efficacy and Provider Insights During the COVID-19 Pandemic. Psychiatr Serv. 2022 May;73(5):484-491.

How does telehealth impact outcomes?

- VA Retrospective Study from 2008-2017
  - N=28,791 across all VA sites, 93% male, 81% white, 50% between 25-44yo
  - 73% also had diagnosis of depression, 40% PTSD
- Diagnosed with OUD and treated with Buprenorphine
- Telehealth visits included med management and counseling

- **Results**
  - Engagement in telehealth was associated with a lower risk of treatment discontinuation (aHR 0.69)

Vakkalanka JP, Lund BC, Ward MM, et al. Telehealth Utilization Is Associated with Lower Risk of Discontinuation of Buprenorphine: a Retrospective Cohort Study of US Veterans [published online ahead of print, 2021 Jun 22]. *J Gen Intern Med*. 2021;1-9. doi:10.1007/s11606-021-06969-1

How does telehealth impact outcomes?

- Medicare Cohort study

	Before COVID 9/2018-2/2020	During COVID 9/2019-2/2021
Number	105,240	70,538
Receipt of OUD Telehealth	593 (0.56%)	13,829 (19.61%)
Received Buprenorphine	4566 (4.3%)	3184 (4.6%)
80% Bup adherence	31.07%	33.26%
Treated overdose	19,491 (18.5%)	13,004 (18.4%)

- In Pandemic group
  - If received OUD telehealth services→increased odds of better retention (aOR 1.27)
- Takeaway: as good as in-person

Jones CM, Shoff C, Hodges K, et al. Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. *JAMA Psychiatry.* 2022;79(10):981–992. doi:10.1001/jamapsychiatry.2022.2284

How does telehealth impact outcomes?

- Medicaid Claims from Kentucky and Ohio, 2019-2020
  - Kentucky: 41,266 individuals
  - Ohio: 50, 648 individuals

- Telemedicine
  - better odds of 90-day retention with buprenorphine in both states in a regression analysis adjusting for patient demographic and comorbidity characteristics.
    - Kentucky: adjusted odds ratio, 1.13 [95% CI, 1.01-1.27];
    - Ohio: adjusted odds ratio, 1.19 [95% CI, 1.06-1.32]) Takeaway: as good as in-person

Hammerslag LR, Mack A, Chandler RK, Fanucchi LC, Feaster DJ, LaRochelle MR, Lofwall MR, Nau M, Villani J, Walsh SL, Westgate PM, Slavova S, Talbert JC. Telemedicine Buprenorphine Initiation and Retention in Opioid Use Disorder Treatment for Medicaid Enrollees. JAMA Netw Open. 2023 Oct 2;6(10):e2336914. doi: 10.1001/jamanetworkopen.2023.36914. PMID: 37851446; PMCID: PMC10585416.

How has telehealth impacted access to SUD treatment?

Does telehealth increase access?

- Cohort study, Commercial insurance or Medicare Advantage
- Compared
  - **Before COVID 3/2019-3/2020** vs **During COVID 3/2020-3/2021**
    - **Low Telemedicine providers** vs **High Telemedicine providers**
- **<u>Results</u>**
  - No change in total visit volume
  - No change in MOUD initiation

***<u>Implications</u>*: Increased telehealth options DID NOT lead to providers providing more OUD treatment.**

Telemedicine as answer to rapid MOUD expansion?

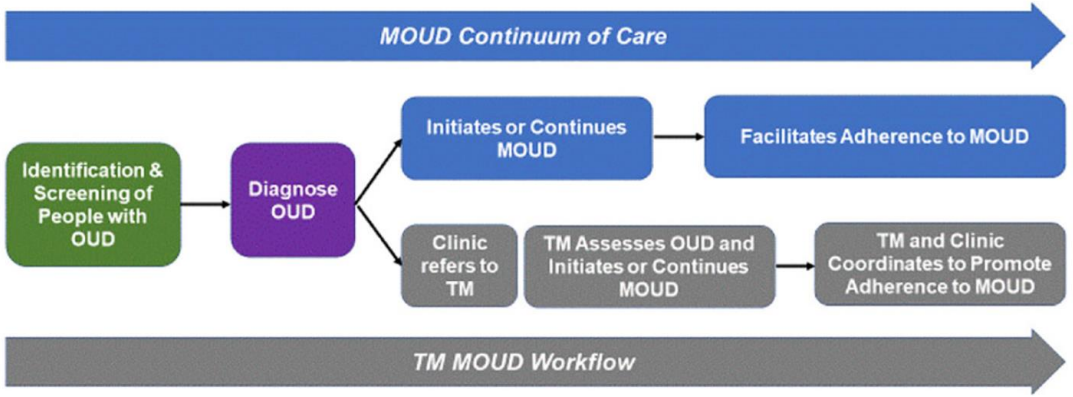
- "Plug-and-play model"
  - Outsourcing SUD care to pre-existing telemedicine program

- Potential benefits
  - Address work-force shortages/scaleability
  - Skilled clinician work-force
  - Share burden of care
  - Rapid expansion of services

Hser YI, Ober AJ, Dopp AR, Lin C, Osterhage KP, Clingan SE, Mooney LJ, Curtis ME, Marsch LA, McLeman B, Hichborn E, Lester LS, Baldwin LM, Liu Y, Jacobs P, Saxon AJ. Is telemedicine the answer to rural expansion of medication treatment for opioid use disorder? Early experiences in the feasibility study phase of a National Drug Abuse Treatment Clinical Trials Network Trial. Addict Sci Clin Pract. 2021 Apr 20;16(1):24. doi: 10.1186/s13722-021-00233-x. PMID: 33879260; PMCID: PMC8056373.

Telemedicine and rapid expansion of MOUD

- Feasibility study-prospective, single arm
- 7 rural primary care clinics (Maine, Washington, Idaho)
- 1-external, nation-wide telemedicine MOUD specialty program
- 6 months (7/2020-2/2021)



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Results

- N=582 patients
- Medicaid-57.4%, Medicare-9.8%
- Co-occurring conditions
  - Anxiety 67.3%
  - Depression 32.0%
  - Chronic pain 44.4%
- Mean drive time to clinics: 35min
- 16% started MOUD during intervention
- 68 patients were referred to telemed OUD providers
  - No difference in drive time between those referred and those not referred

Results

- Overall, 4.2% increase in patient-days on MOUD over the 6 sites.
- TM referral rate: 11.7% over 6 months.
- Co-occurring stimulant use disorder→referred more often

- Site 2 Pre-intervention
  - Only 1 MOUD provder
  - 4 patients
- Site 2 Intervention
  - 19 patients
  - 17 referred to TM
- Site 2 advertised services
- Site 6 started 49 new patients

Number of patient-days on MOUD during the 6-month preintervention period and the 6-month intervention period

Site	Pre-intervention	During-intervention	Change	Change per 1,000 patients*	Mean change per 1,000 patients (95% CI mean change) *P*-value	Cohen's *d*
Site 1[a]	1,086	1,307	221	86	132 (−24.4, ∞) $P = .08$	0.55
Site 2[a]	20	476	456	149		
Site 3[b]	1,310	1,379	69	6		
Site 4[b]	2,977	3,028	51	31		
Site 5[c]	39,580	38,540	−1,040	−80		
Site 6[c]	25,855	29,062	3,207	597		
Total	70,828	73,792	2,964	789		

Open in a separate window

Abbreviation: MOUD, medication treatment for opioid use disorder.

[a]Site with 0–1 prescribers.

[b]Site with 2–3 prescribers.

[c]Site with 3 or more prescribers.

*To adjust for the site's patient population size and derive the patient-days on MOUD per 1,000 patients for each site, the clinic site's number of patient-days on MOUD for each time period was divided by the site's total patient population size and multiplied by 1,000.

Plug-and-Play MOUD Treatment

- Low utilization of TM
  - TM already used + long acting injectables→increased access already?
  - Few new patients
  - TM referral not always offered
  - Patients declined referral to new provider
  - Implementation efforts need more time

Takeaway

TM Plug-and-Play intervention can increase access to low MOUD capacity clinics and high capacity clinics to assist with patient load.

Telemedicine can't address all barriers

- Low rates of identification of new patients with OUD
  - Screening and diagnosis problems
  - 4000 screened→no new patients
- Low referral to telemedicine specialists
  - Initial referral rate: 6% (of 450 pts with OUD)
  - Stigma?
  - Lack of trust in new program
  - Pts liked visiting clinic in-person
  - No place to do telemedicine visits? (bus visits, neighborhood tour visits, elevator visits!)

Device and internet access problems

Rural Opioid Initiative Survey N=3,026 71% used heroin, and 76% used meth

- White (84%), Male (57.3%), Mean age 36, Houseless past 6 months (53.7%), h/o incarceration (41.4%)
- 81% accessed internet in past 30 days, 35% had NO phone

Cell phone & internet: increased days of MOUD use

(aIRR 1.29 95% CI 1.11-1.52)

No Cell phone or internet: decreased days of MOUD

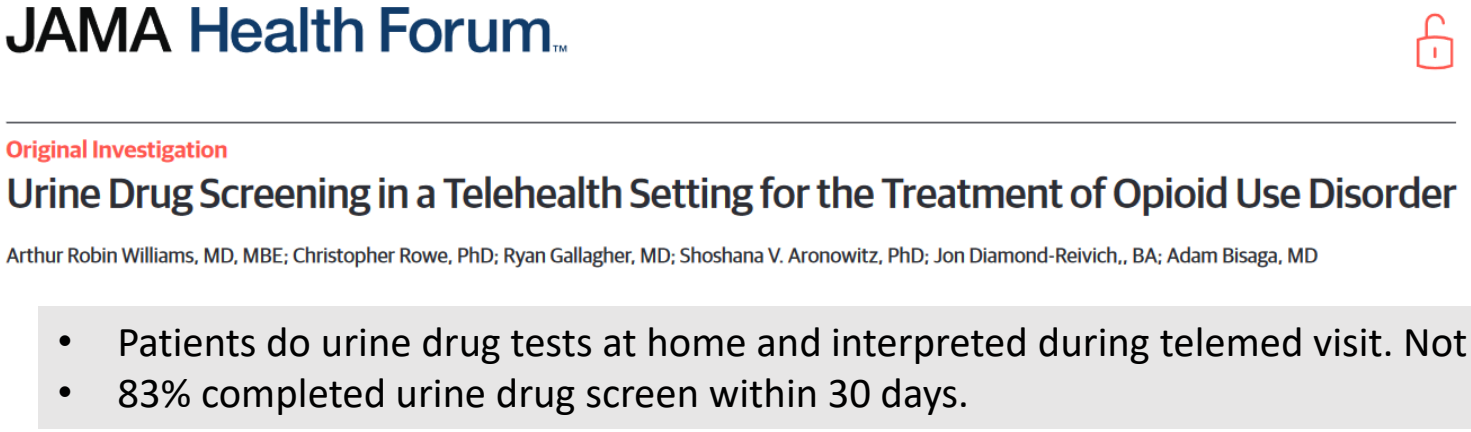
(aIRR 0.77 95% CI 0.66-0.91)

And lower likelihood of prior 30 day SUD counseling (aIRR 0.77 95% CI 0.62-0.94)

Hser YI, Ober AJ, Dopp AR, Lin C, Osterhage KP, Clingan SE, Mooney LJ, Curtis ME, Marsch LA, McLeman B, Hichborn E, Lester LS, Baldwin LM, Liu Y, Jacobs P, Saxon AJ. Is telemedicine the answer to rural expansion of medication treatment for opioid use disorder? Early experiences in the feasibility study phase of a National Drug Abuse Treatment Clinical Trials Network Trial. Addict Sci Clin Pract. 2021 Apr 20;16(1):24. doi: 10.1186/s13722-021-00233-x. PMID: 33879260; PMCID: PMC8056373.
Button D, Levander XA, Cook RR, Miller WC, Salisbury-Afshar EM, Tsui JI, Ibragimov U, Jenkins WD, Westergaard RP, Korthuis PT. Substance use disorder treatment and technology access among people who use drugs in rural areas of the United States: A cross-sectional survey. J Rural Health. 2023 Sep;39(4):772-779. doi: 10.1111/jrh.12737. Epub 2022 Dec 27. PMID: 36575145; PMCID: PMC10293469.

Limitations to use of telehealth

- Security
- Privacy
- Remote drug screens?



JAMA Health Forum

Original Investigation

Urine Drug Screening in a Telehealth Setting for the Treatment of Opioid Use Disorder

Arthur Robin Williams, MD, MBE; Christopher Rowe, PhD; Ryan Gallagher, MD; Shoshana V. Aronowitz, PhD; Jon Diamond-Reivich,, BA; Adam Bisaga, MD

- Patients do urine drug tests at home and interpreted during telemed visit. Not billed.
- 83% completed urine drug screen within 30 days.

Matthews EB, Lushin V, Rzewinski J. Patterns & Predictors of Telehealth Utilization Among Individuals Who Use Substances: Implications for the Future of Virtual Behavioral Health Services. Community Ment Health J. 2023 Jul 6. doi: 10.1007/s10597-023-01166-2. Epub ahead of print. PMID: 37410213.
Gajarawala SN, Pelkowski JN. Telehealth Benefits and Barriers. J Nurse Pract. 2021 Feb;17(2):218-221. doi: 10.1016/j.nurpra.2020.09.013. Epub 2020 Oct 21. PMID: 33106751; PMCID: PMC7577680.
Williams AR, Rowe C, Gallagher R, Aronowitz SV, Diamond-Reivich J, Bisaga A. Urine Drug Screening in a Telehealth Setting for the Treatment of Opioid Use Disorder. JAMA Health Forum. 2023 Jul 7;4(7):e232247. doi: 10.1001/jamahealthforum.2023.2247. PMID: 37505489; PMCID: PMC10383010.

Telehealth Access Highlights

- On-Demand, Audio Only Buprenorphine Telehealth
  - Grant funded
  - Rhode Island
- 24/7
  - Staffed by 6 providers
  - Care navigators
- Bridge clinic
- Buprenorphine Initiation
- Does not bill for visit

Samuels EA, Clark SA, Wunsch C, et al. Innovation During COVID-19: Improving Addiction Treatment Access. *J Addict Med*. 2020;14(4):e8-e9. doi:10.1097/ADM.0000000000000685

On Demand Phone Bup Clinic

- 60% male, mean age 40
  - Majority of callers in opioid withdrawal (66%): SOWS-26.8 (4-57)
  - 17% reported overdose in preceding 12 months

- Majority of callers have prior addiction treatment experience
  - 7.6% in treatment at time of call

- 2/3 of callers had taken buprenorphine previously – prescribed and/or non-prescribed

Wunsch C, Lum L, Wightman RS, Pratty C, Jacka B, Hallowell B, Clark S, Samuels EA. On-Demand, Audio-only Buprenorphine Initiation During Covid-19. Accepted abstract ASAM 2022.

On Demand Phone Bup Clinic

- 134 calls

- 103 Buprenorphine prescriptions
  - Not prescribed: no OUD (4), declined Rx (1), already in care (2), triaged to higher level of care (1), unable to participate in interview (4), not listed (11)

- 94 new prescriptions
  - 65 filled ***subsequent*** buprenorphine prescription in 30 days

- Other notes
  - Advertised on social media and late-night TV

Wunsch C, Lum L, Wightman RS, Pratty C, Jacka B, Hallowell B, Clark S, Samuels EA. On-Demand, Audio-only Buprenorphine Initiation During Covid-19. Accepted abstract ASAM 2022.

UW Pilot Study: Phone App for Contingency Management

Contingency Management App for Meth

DynamiCare https://www.dynamicarehealth.com/

- UW Psychiatry Department Garvey Grant Pilot
- Goal N=30
- Study lasts 3 months (after patient enrolls)
- Patient eligibility:
  - Patient within UW Medicine system
  - Age > 18
  - Self-report methamphetamine use (5-9 days out of last 30) and desire to reduce use

No phone or data plan?

- One-time phone/data plan can be provided by study
- Limited number

Study Flow

Clinician will provide flyer and brief study summary to patient*

Pt. will call study phone, if interested

Research coordinator (RC) to complete screening and informed consent with patient (via phone)

RC to connect pt. to DynamiCare enrollment specialist

*alternative: EPIC dot phrase sent to research team

DynamiCare App

- Enrollment specialist to assist with:
  - Downloading app
  - Receiving testing materials
  - Facilitating connecting with “recovery coach”
- ~Weekly meetings with “recovery coach”:
  - Peer/therapeutic, but non-clinical support
- Financial rewards for:
  - Negative methamphetamine tests (saliva-based test)
  - Meetings with recovery coach
  - CBT modules
  - DynamiCare Surveys

Study Results

- Enrollment

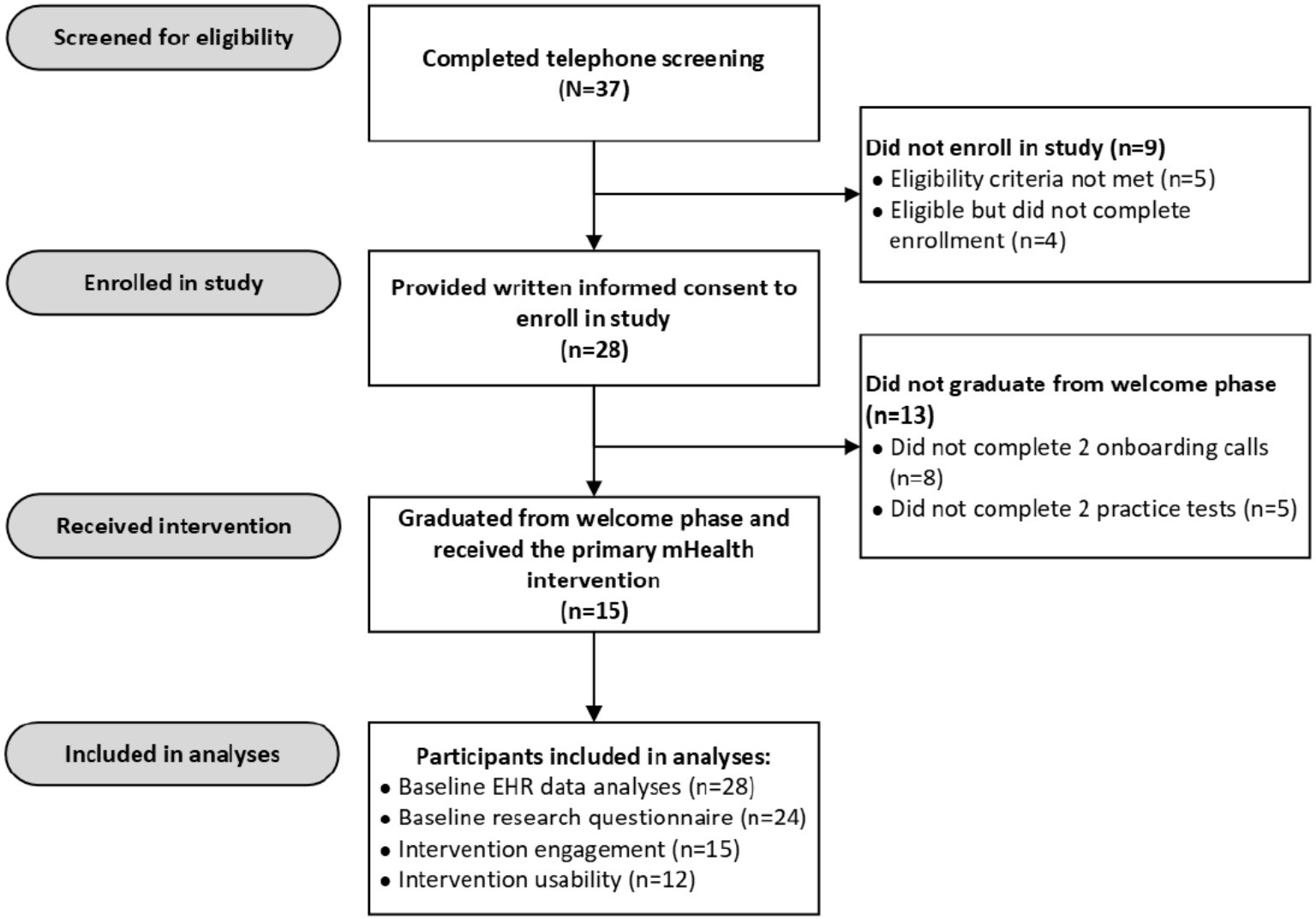


Table 1. Characteristics of the 28 participants who enrolled in the study.

		N (%)
Age	18-29	5 (18%)
	30-45	9 (32%)
	46-64	14 (50%)
Gender	Woman	5 (18%)
	Man	23 (82%)
Race	American Indian or Alaska Native	1 (4%)
	Black or African American	3 (11%)
	Hispanic, Latinx, or Spanish Origin	4 (14%)
	Middle Eastern or North African	1 (4%)
	White or Caucasian	16 (57%)
	More than one race	3 (11%)
Marital status	Single, divorced, or widowed	22 (79%)
	Married or committed relationship	3 (11%)
	Other or unknown marital status	3 (11%)
Past 30-day methamphetamine use	5-9 days	4 (14%)
	10-14 days	4 (14%)
	15-20 days	7 (25%)
	21-30 days	13 (46%)
Methamphetamine goal	Abstinence	21 (75%)
	Non-abstinent reduction	7 (25%)
Prescribed medications for opioid use disorder		17 (61%)
Prescribed amphetamine medication		1 (4%)
Co-occurring non-amphetamine SUD (per EHR)		22 (79%)
Co-occurring mental health disorder (per EHR)		24 (86%)

Study Results

- Easily adopted by both primary care and specialty clinics
  - Cardiology
  - HIV
  - SUD

- Free smart phone availability was challenging

Table 2. Engagement with intervention, among the N = 15 patients who received the intervention.

		N (%)
Substance tests completed[a]	10-33%	9 (60%)
	34-66%	3 (20%)
	67-94%	3 (20%)
Substance tests showing recent (meth)-amphetamine abstinence[a]	0-33%	14 (93%)
	34-66%	0 (0%)
	67-100%	1 (7%)
Coaching calls completed[b]	0-4	8 (53%)
	5-8	4 (27%)
	9-24	3 (20%)
CBT modules completed[c]	0-11	9 (60%)
	12-23	4 (27%)
	24-35	2 (13%)
Rewards earned[d]	$37-$107	8 (53%)
	$108-$177	5 (33%)
	$178-$246	2 (13%)

Note. [a]Percentages are calculated based on the number of substance tests prompted by the app: M=24.9, SD=4.0 tests prompted per patient. [b]Participants were encouraged to complete 1 coaching call per week for the 12-week program but could complete additional coaching calls as desired. [c]35 CBT modules were available. [d]In total, participants could earn ~$465 if they completed all intervention components and had complete (meth)amphetamine abstinence. CBT = cognitive behavioral therapy. Response categories reflect the ranges observed across participants who received the intervention (e.g., no participants completed <10% or >94% of substance tests).

Table 3. Intervention usability ratings, as reported on the Modified mHealth App Usability Questionnaire (MAUQ) at intervention week 6 (n = 12).

Modified mHealth App Usability Questionnaire item	Strongly agree	Agree	Some-what agree	Neither agree nor disagree	Some-what disagree	Disagree	Strongly disagree
Ease of use questions							
The program was easy to use.	5	6	1				
It was easy for me to learn to use the program.	4	7	1				
I like the program.	6	6					
The program was well organized, so I could easily find the information I needed.*	3	7	1				
I feel capable of using this program.	7	4	1				
Satisfaction questions							
I would use this program again.	7	4	1				
Overall, I am satisfied with the program.	6	5	1				
The program is an acceptable way to receive help with substance use.	5	5	2				
The program does what I expected it to.	3	8		1			
Usefulness questions							
The program would be useful for my health and well-being.	5	7					
The program improved my access to healthcare services.	3	2	3	4			
The program helped me manage my substance use effectively.	2	4	3	3			
I felt confident that any information I sent to my recovery coach using the app would be received.	7	3	1	1			
I felt comfortable communicating with my recovery coach using the app.	5	4	2	1			

	Much too short	A little too short	Just right	A little too long	Much too long
Additional items					
On a day-by-day basis, the amount of time it takes to participate in the program is:		1	10		
The three-month duration of this program seems:	1	4	5	1	

Study Summary

- Participants had variable rates of engagement with the intervention, potentially due in part to co-occurring SUDs, mental health conditions, and socioeconomic factors.
- More hands-on, human-to-human connection may be needed to increase engagement, especially during early phases of the intervention.
- Participants who received the intervention found it easy to use and satisfactory.
- Impressions were slightly more mixed regarding the intervention's usefulness.
- Modifications to the intervention may be warranted to increase the perceived usefulness of the intervention.
- Future studies could utilize a longer intervention period with greater financial incentives to potentially improve engagement and clinical outcomes.

How do you best use telemedicine for SUD treatment?

- **Flexibility**
- **Rapid expansion of treatment options**
- **Creative ways to supplement treatment**

Summary

- Telehealth is acceptable and as effective as in-person care
- Telehealth can take many forms and has the ability to increase access across clinical settings
- Flexibility related to telehealth is valued
- Telehealth is not a replacement for in-person care
- We do not know how helpful it could be

Thank You

UW Psychiatry and Addiction Case Conference

Online webinar

Monthly OUD related topic

Reviews spectrum of substance use and mental health issues

Free, Thursdays, online, all providers

https://ictp.uw.edu/programs/uw-pacc

UW Provider Consultation Line

Free 24/7 hotline for prescribers and non-prescribers for psychiatry and addiction questions.

877-WA-PSYCH

https://psychiatry.uw.edu/clinical-care-consultation/provider-consultation/psychiatry-consultation-line-pcl-faqs/

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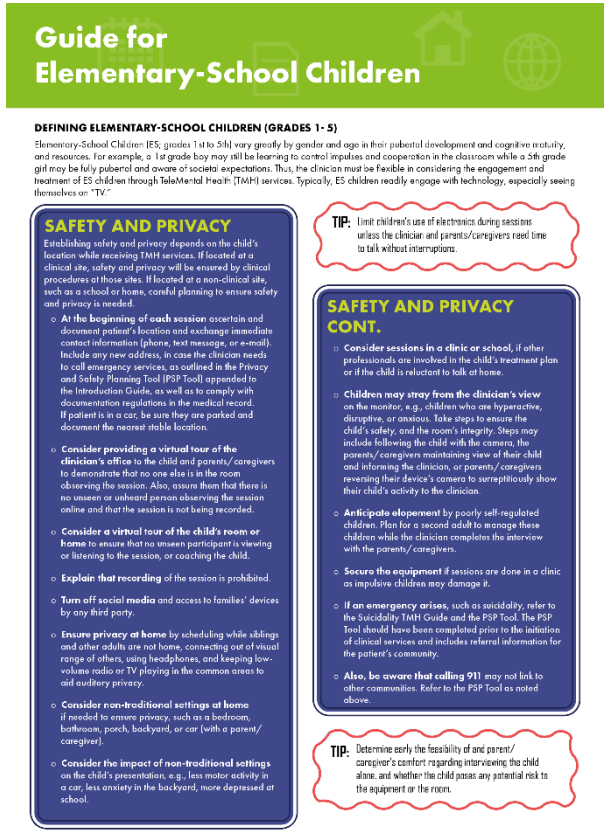
TeleMental Health Guides for Infancy to Young Adults

Guides (8)

- Infancy and Toddlers
- Pre-schoolers
- Elementary School Children
- Middle School Youth
- High School Teens
- Young Adults
- Neuropsychological Testing
- Suicidality



Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1- 5)

Elementary-School Children (ES; grades 1st to 5th) vary greatly by gender and age in their pubertal development and cognitive maturity, and resources. For example, a 1st grade boy may still be learning to control impulses and cooperation in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Thus, the clinician must be flexible in considering the engagement and treatment of ES children through TeleMental Health (TMH) services. Typically, ES children readily engage with technology, especially seeing themselves on "TV."

SAFETY AND PRIVACY

Establishing safety and privacy depends on the child's location while receiving TMH services. If located at a clinical site, safety and privacy will be ensured by clinical procedures at those sites. If located at a non-clinical site, such as a school or home, careful planning to ensure safety and privacy is needed.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patient is in a car, be sure they are parked and document the nearest stable location.
- **Consider providing a virtual tour of the clinician's office** to the child and parents/caregivers to demonstrate that no one else is in the room observing the session. Also, ensure them that there is no unseen or unheard person observing the session online and that the session is not being recorded.
- **Consider a virtual tour of the child's room or home** to ensure that no unseen participant is viewing or listening to the session, or coaching the child.
- **Explain that recording** of the session is prohibited.
- **Turn off social media** and access to families' devices by any third party.
- **Ensure privacy at home** by scheduling while siblings and other adults are not home, connecting out of visual range of others, using headphones, and keeping low-volume radio or TV playing in the common areas to aid auditory privacy.
- **Consider non-traditional settings at home** if needed to ensure privacy, such as a bedroom, bathroom, porch, backyard, or car (with a parent/caregiver).
- **Consider the impact of non-traditional settings** on the child's presentation, e.g., less motor activity in a car, less anxiety in the backyard, more depressed at school.

TIP: Limit children's use of electronics during sessions unless the clinician and parents/caregivers need time to talk without interruptions.

SAFETY AND PRIVACY CONT.

- **Consider sessions in a clinic or school,** if other professionals are involved in the child's treatment plan or if the child is reluctant to talk at home.
- **Children may stray from the clinician's view** on the monitor, e.g., children who are hyperactive, disruptive, or anxious. Take steps to ensure the child's safety, and the room's integrity. Steps may include following the child with the camera, the parents/caregivers maintaining view of their child and informing the clinician, or parents/caregivers reversing their device's camera to surreptitiously show their child's activity to the clinician.
- **Anticipate elopement** by poorly self-regulated children. Plan for a second adult to manage these children while the clinician completes the interview with the parents/caregivers.
- **Secure the equipment** if sessions are done in a clinic as impulsive children may damage it.
- **If an emergency arises,** such as suicidality, refer to the Suicidality TMH Guide and the PSP Tool. The PSP Tool should have been completed prior to the initiation of clinical services and includes referral information for the patient's community.
- **Also, be aware that calling 911** may not link to other communities. Refer to the PSP Tool as noted above.

TIP: Determine early the feasibility of and parent/caregiver's comfort regarding interviewing the child alone, and whether the child poses any potential risk to the equipment or the room.

TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

Abdul is a 10 y/o Afghani refugee boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and falling behind academically. The Mother noted similar difficulties in the home, especially regarding homework. Both parents worked and lived in an urban neighborhood with poor transportation options, so they agreed to home-based TMH. The family used their smartphone for the sessions, with adequate, but not optimal, cell reception. Sessions were held in the parent's bedroom, for privacy. An older sister watched the siblings in another room or took them for a walk.

Abdul was readily engaged over the smartphone and told of his favorite videogame, his love of Legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Even with the spotty connectivity, the clinician appreciated Abdul's good verbal skills, intellect, charming personality, as well his impulsive intrusiveness and mild mid-facial and guttural tic. To assess his gross motor skills, the clinician asked Abdul to do some movements, including some dance movements. He was awkward and had difficulty cooling down once wound up. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, Abdul was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly returned to the smartphone to show his artwork: not an animal, but he enthusiastically told of its meaning, demonstrating his creativity and knowledge.

The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services, and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

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uwcolab.org/tmh-guides

Additional Free Resources for Washington State Behavioral Health Providers

EDUCATIONAL SERIES:

- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO
- UW TelePain series

PROVIDER CONSULTATION LINES

- UW Pain & Opioid Provider Consultation Hotline
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line