TeleBehavioral Health 501 Training Series

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Northwest Regional
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December 13, 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/University of Washington 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

None of the series speakers have any relevant conflicts of interest to disclose.

Planner disclosures

The following series planners and team have no relevant conflicts of interest to disclose:

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DISCLAIMER

Please be aware that policy changes may take place after the original date of this presentation.

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

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TeleBehavioral Health 501

Diving deeper into facilitating virtual groups.

ERIKA M. SHEARER, PHD

VA PORTLAND HEALTH CARE SYSTEM

DECEMBER 13, 2024

Learning Objectives

1. Describe adaptations needed to facilitate behavioral health groups via video-based modality.
2. Discuss privacy and confidentiality-related considerations for virtual groups.
3. Identify strategies to improve virtual group facilitation.

Virtual groups vary by…

Location

- At participant's local clinic
- At participant's home
- Hybrid groups: Some combination of participants at their local clinic, home, and/or in-person.

Type and Intensity

- Psychoeducation groups
- Evidence-based therapy groups
- Support groups
- Process groups
- Intensive Outpatient groups
- Residential/inpatient groups

Virtual group examples (from VA)

Health and wellness groups:

- Qigong/Tai Chi/Yoga
- Mindfulness
- Exercise/nutrition/gerofit
- Diabetes management
- Chronic pain management
- Cooking/gardening classes
- Tobacco cessation
- Sleep/insomnia

Support/symptom management groups:

- Korean War PTSD support
- Peer support
- Aging with grace
- Wise Warriors
- Women's groups
- LGBTQ+ support
- PTSD symptom management
- Caregiver support

Skills/transdiagnostic groups:

- Coping skills
- Anger Management
- Race-based stress and empowerment
- Values clarification/Whole Health
- Communication skills

Family/marital therapy groups:

- Gottman's 7 principles
- Helping Endure Infant Loss
- PTSD 101 for families
- Healthy Relationships
- Motherhood and Mood: pregnancy and postpartum

Evidence-based psychotherapies:

- Cognitive Processing Therapy
- Dialectical Behavioral Therapy
- Problem-Solving Therapy
- ACT
- CBT
- Nightmare processing

Intensive outpatient programs:

- Psychosocial Rehabilitation and Recovery Centers
- Substance Use Disorder treatment programs
- Posttraumatic Stress Disorder (PTSD) treatment programs
- Dialectical Behavioral Therapy & PTSD

Residential/domiciliary programing

- Program of psychotherapy, educational, and recreational groups.

The current literature base:

- Feasible
- High acceptability/satisfaction
- Equivalent to in person care/positive behavioral health outcomes
- Safe
- More recent studies found equivalence in therapeutic alliance/group cohesion variables.
- Challenges related to:
  - Technology resources
  - Technology-related training

Banbury, Nancarrow, Dart, Gray, & Parkinson, 2024; Bean, Aurora, Maddox, Mekota, & Updegraff, 2021; Ernstzen et al., 2022; Fortier et al., 2021; Gentry et al., 2018; Gerhman, Shar, Miles, Kuna, & Godleski, 2016; Herbert et al., 2017; Jennings et al., 2020; Khatri, Marziali, Tchernikov, & Shepherd, 2014; Marton & Kanas, 2015; Morland, Hynes, Mackintosh, Resick, & Chard, 2011; Scriven, Doherty, & Ward, 2019; Spencer, Kelly, Langston, 2020; Yuen et al., 2019; Zayde et al., 2022; Zubatskey, Berg-Weger, & Morley, 2020

Virtual group components

- Participant set-up
- Privacy & consent
- Disseminating group materials
- Planning for emergencies
- Facilitating the group

Getting participants set up for virtual groups

- Defer to facility regarding supported platforms and procedures
  - Ensure HIPAA-compliant option for meeting via video-based teleconferencing
  - Explore potential additional features
    - Chat, view settings, sending materials, sharing screens, camera tracking and presenter options, muting, disconnecting participants, reactions, emergency-related applications

When inviting a participant to group (1)

- All participants must agree to participate in the virtual group.
- Whenever home-based patients are included, there is greater potential for breach of privacy.
  - Not all participants may be in a private setting, someone may attempt to take a screen shot, record the session, etc.
  - Some platforms may have technology to prevent on-screen recording; however, this is not yet common.
- Agreement can be obtained over the phone; however, a virtual visit is ideal to assess privacy, appropriateness, and quality.
- Consider sending participants a copy of a 'Intro to Groups'/'Group Telehealth Agreement' document for their records. This letter should additionally be saved into the Veteran's electronic health record to document agreement.

Hello [participant name],

Here are some reminders about the GROUP NAME, as well as the materials you will need for the group.

Group dates/time:
Group leader(s) name & contact information:

Please contact group leaders if you cannot attend a session (via phone--listed on first page of packet; or via secure messaging). You may use this link to register for MyHealtheVet secure messaging if you haven't already— https://www.myhealth.va.gov/mhv-portal-web/home.

Please note that a new VA Video Connect link will be sent to you over email for **each** VA Video Connect appointment.

When you join the VVC session, be sure to enter your **current address** for where you are located when joining, and only your **first name and last initial**.

Please keep your microphone on "mute" when you are not speaking as this will help to reduce noise.

If the VA Video Connect call unexpectedly disconnects, please close out of your browser, go back to your email and try rejoining the VA Video Connect link. If this is not successful, a group leader will follow up with you by phone or secure messaging.

Prior to your first VVC Group, please be sure to read over the Group Telehealth agreement & Guidelines for VVC. Please reach out to me if you have any questions.

For additional information on VA Video Connect go to:
https://mobile.va.gov/app/va-video-connect
https://www.youtube.com/watch?v=HqhVlt4az-Q

Please complete a VVC test call if you have not previously used VA Video Connect; click here: test site.

Conduct a speed test using your device: http://www.speedtest.net/ (ideally: download speeds of at least 10 and upload speeds of at least 3).

I look forward to working with you.

Sincerely,
NAME
CONTACT INFORMATION

Group Telehealth Agreement

1. **Confidentiality**: I understand the laws that protect the confidentiality of my medical information also apply to telehealth, including group treatment conducted over video telehealth. I understand that the VA has instituted procedures and policies to protect my privacy and confidentiality. The provider will lock the virtual medical room to ensure no unauthorized person will enter the session or listen. I understand that everything said and done in group is confidential. I agree to protect the group confidentiality, by not revealing the names of other members of the group, nor what is said and done in the group. I understand that if I violate this confidentiality, I will be removed from the group. I understand that there is an exception to this confidentiality that applies to the group provider. The one exception to confidentiality is when the provider believes that I may be a threat to myself or others.

2. **Risks and Consequences**: The VA does not record telehealth sessions, including group telehealth sessions, without prior approval. I understand that I will not audio or video record any portion of the treatment session. I acknowledge that while this session will not be audio or video recorded by the VA, there is a risk that the session could be audio or video recorded and disseminated by a group member without knowledge or approval from VA or other group members. The consequence for any member audio or video recording any portion of the treatment session will be the removal from the group for violating confidentiality, as well as referral for prosecution to the full extent of federal and local laws. Applicable local laws may include the location of the provider and all members.

3. **Privacy**: Participation in this group is voluntary, and I have the right to withdraw from the group at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I am otherwise entitled. No group member is ever required to answer any question, to participate in any activity, or to say anything. If I am asked questions or asked to participate in an activity that makes me feel uncomfortable, I understand that I have the right to decline, and I agree not to pressure any other group member to participate if they are uncomfortable. I agree to be in a quiet, private location during my session.

4. **Dignity**: I agree that I will be tolerant, respectful, and supportive of other group members. I will avoid language that stereotypes or is derogatory to others and will provide only helpful feedback. I will be considerate of others who are talking, will give others a chance to talk, and will not engage in side conversations.

5. **Behavior**: Safety is of the utmost importance. Violence or intimidation toward other group members is not tolerated. Gossip and grudges can be very destructive in a group. I agree that if I have something to say to another group member, I will say it to the member directly and in a respectful way rather than talk about him or her with others. I understand that if the provider believes that I am under the influence of alcohol or other drugs, I will be asked to leave the group.

I have read the agreement for group sessions and agree to follow it. The provider will note in my medical record that I have received, read and acknowledged this agreement.

When inviting a participant to group (2)

Orient all patients to group rules and how to join prior to first session:

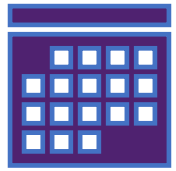
- Respect confidentiality of group members (e.g., privacy, headphones).
- Group etiquette (e.g., treating virtual group like in-person group).
- Emergency planning – determine where the participant will be physically located during the group in case of behavioral or medical emergency.

Ideally conduct this orientation over a video call so that you can assess the privacy of their surroundings and troubleshoot audio visual issues.

Planning for emergencies

- Emergency plan: contact 911 and request relevant services to be dispatched to the participant's physical location.
- Remind group participants of emergency plan when going over group rules and expectations when inviting them to group and during the first group session.
- Options for handling an emergency during group:
  - If you have a co-facilitator have one facilitator work with the participant outside of the group while the other facilitator continues the group.
  - Contact a colleague/suicide prevention coordinator type via instant message to assist
  - End the group and disconnect everyone except for the person having the emergency; follow up with group members

Facilitating the group (1)

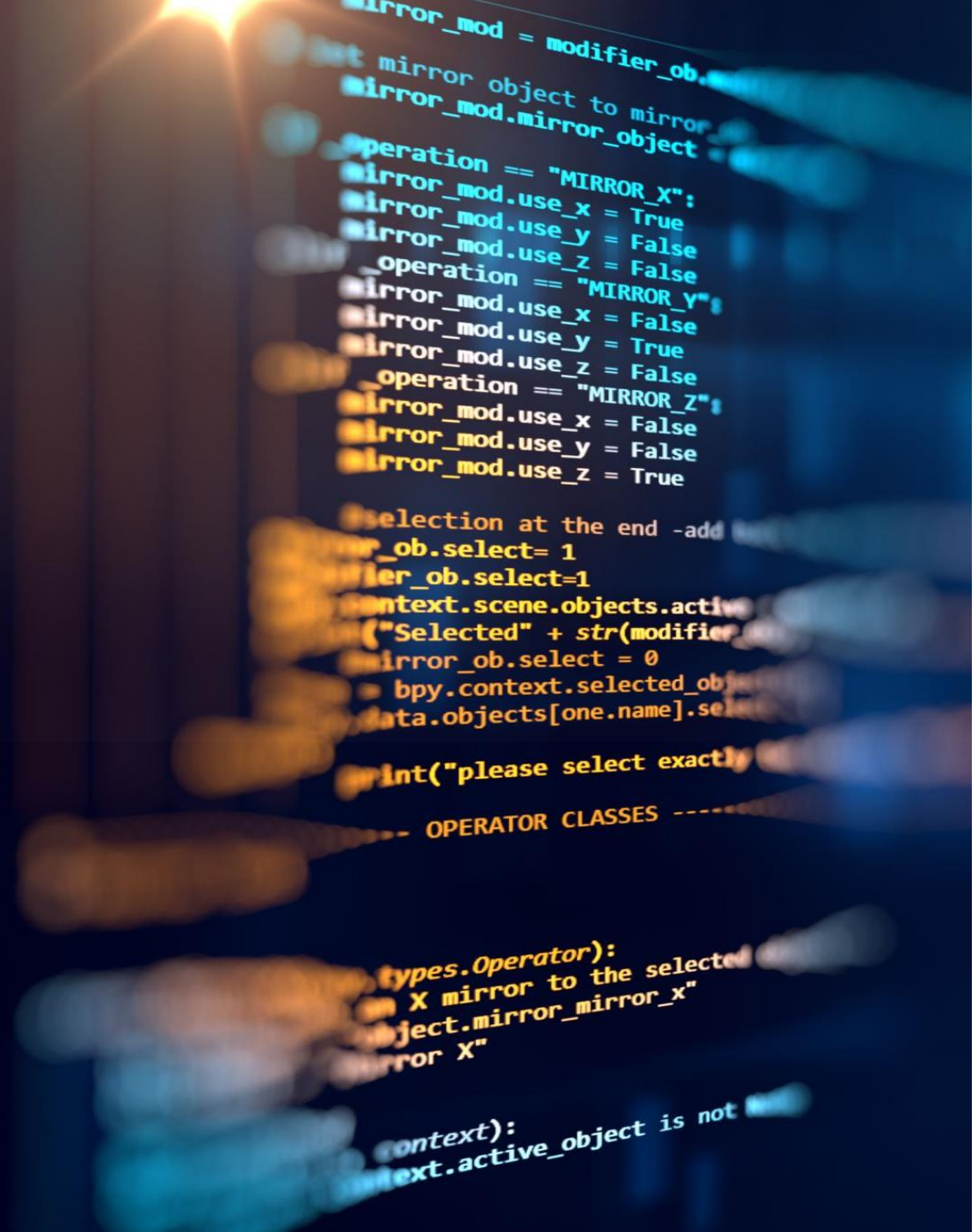


Plan for problems on the first day.

Keep telephone numbers handy for easy access during the group.

Co-facilitator can be helpful so that one person can troubleshoot while the other continues with the group material.

Consider having an audio option as a back up for technology failure.



Facilitating the group (2)

- It may be helpful to “share screen” to show a word doc with instructions (see next slide) at the start of group while you mute yourself and turn off video. This will allow participants to filter into group while you may or may not need to troubleshoot technology with others.
- You may also be able to share links for participants to complete measures while waiting for the group to begin.

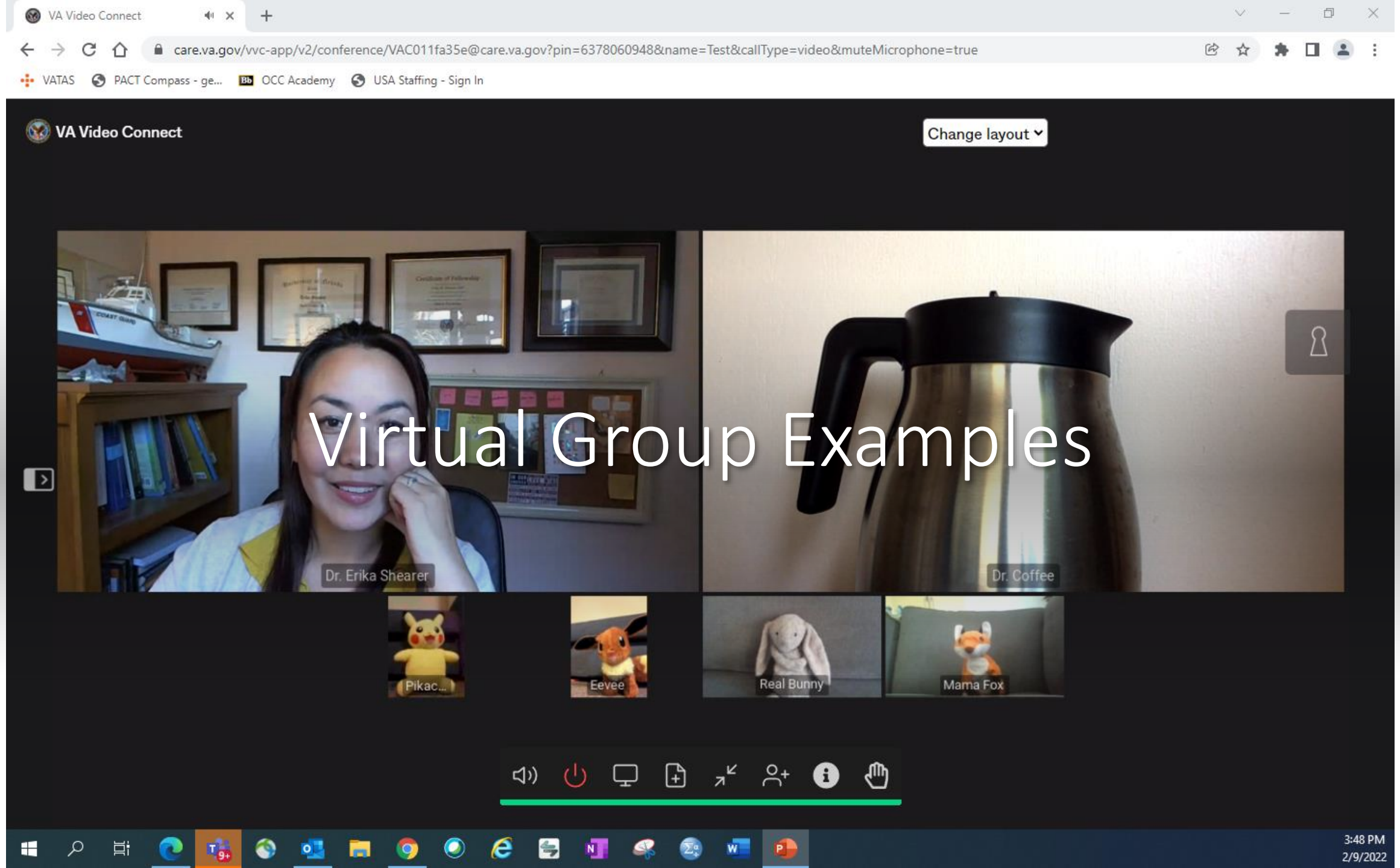
Welcome to the Healthy Sleep class. We are working to get everyone connected to the class. Please stand by. Thank you for your patience!

Facilitating the group (3)

- ‘Lock’ group session once participants have joined.
- You may need to use names/call on group participants directly more frequently than you would in-person.
- Budget more time after questions to allow participants to unmute and respond.
- Test how you will review materials in group prior to first session – whether by using a shared presentation on the computer or zooming in to a whiteboard or flip board. Enlist colleagues to test the call and shared screen capability. Have a back up plan for sharing materials.

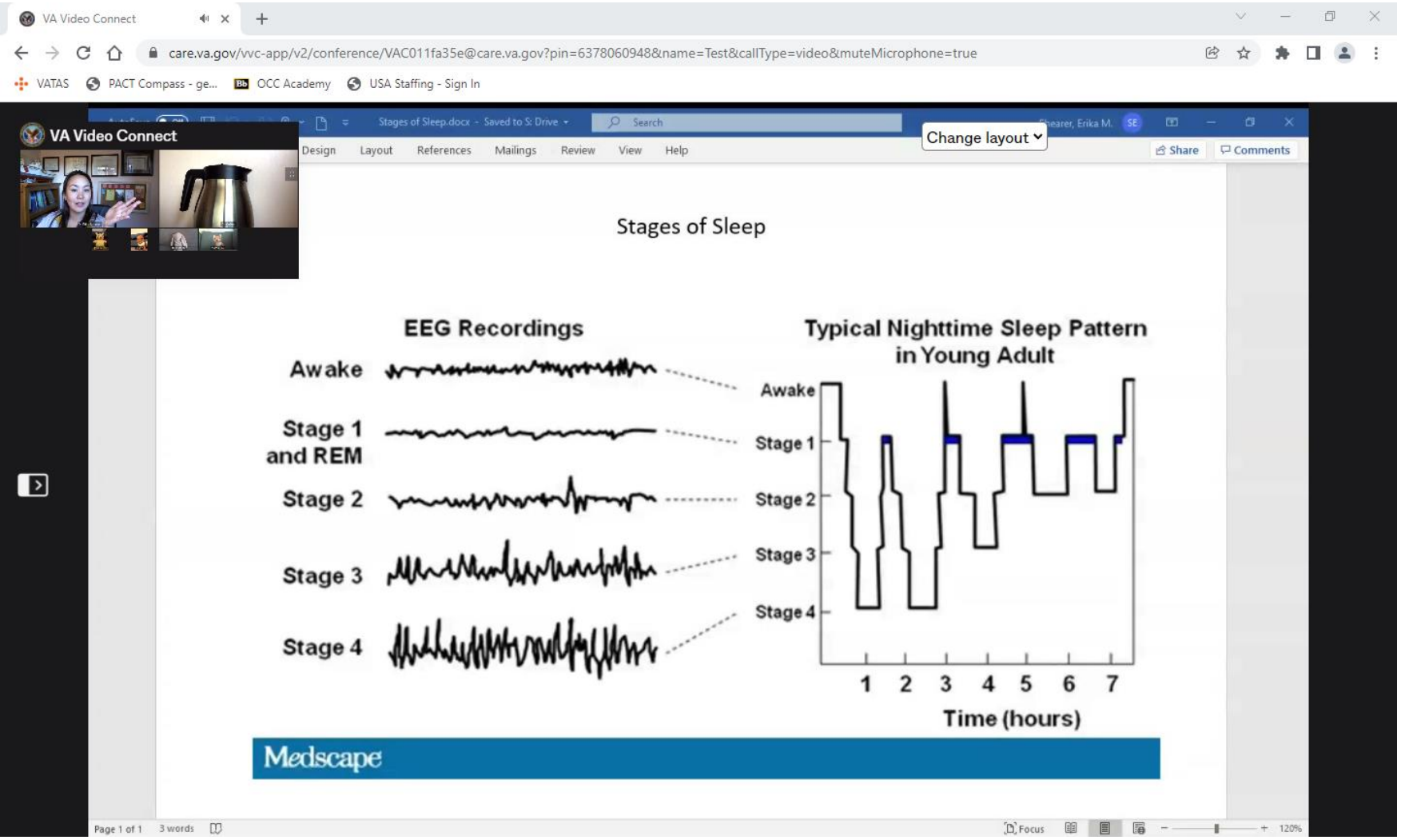
Facilitating the group (4)

- Review group rules:
  - Treat virtual group as you would in-person group.
  - Mute microphones unless speaking to limit distracting background noises. Headphones can be helpful to minimize feedback.
  - Be mindful of moving around with the device or moving out of the frame of view.
  - Provide orientation/coaching related to nonverbal communication (e.g., nodding, shaking head, thumbs up or down, etc.)



Virtual Group Examples

Virtual Psychoeducational Group Example



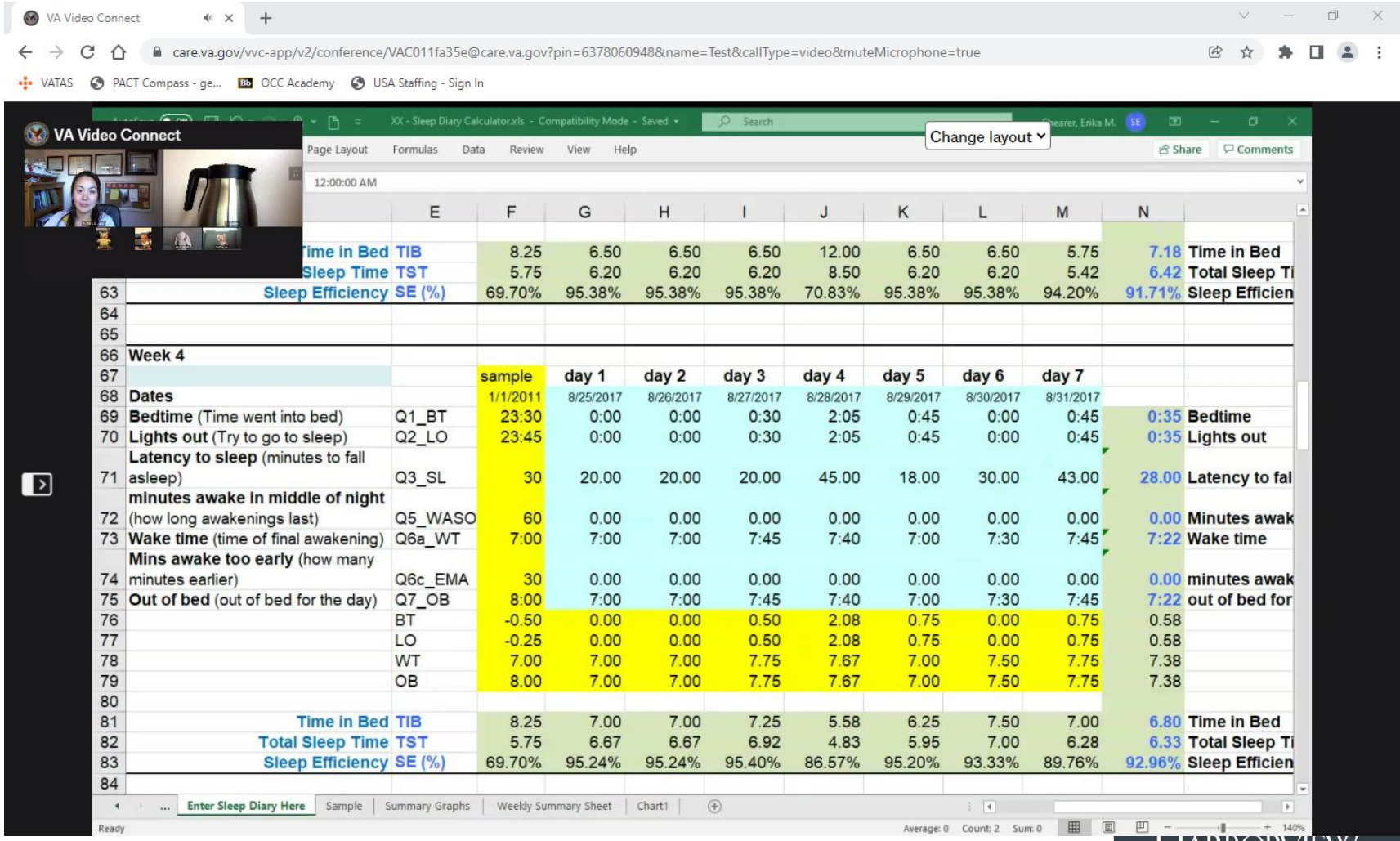
Notes from a Healthy Sleep Orientation class:

- Self-referral.
- Minimal screening (Group Telehealth Agreement + Insomnia Severity Index).
- Assembled letter + handouts for Veterans to reference during and after class.
- If No Show, Veteran could be automatically scheduled for next month.
- Secure Messaging, BHL Touch/MH Check Up ideal.
- Made use of sharing, chat, play with class layout.

Virtual Evidence-based Psychotherapy Group Example

Notes from a 4-session CBT-I class:

- Referrals from the Healthy Sleep Class – this was a pre-requisite.
- Screening previously completed (Group Telehealth Agreement + Insomnia Severity Index).
- Assembled letter + handouts for Veterans to reference during and throughout (ISI, sleep diaries, etc.).
- If No Show, Veteran contacted by facilitator to determine next steps.
- Secure Messaging, BHL Touch/MH Check Up crucial.
- Make use of sharing, chat, play with class layout, etc.

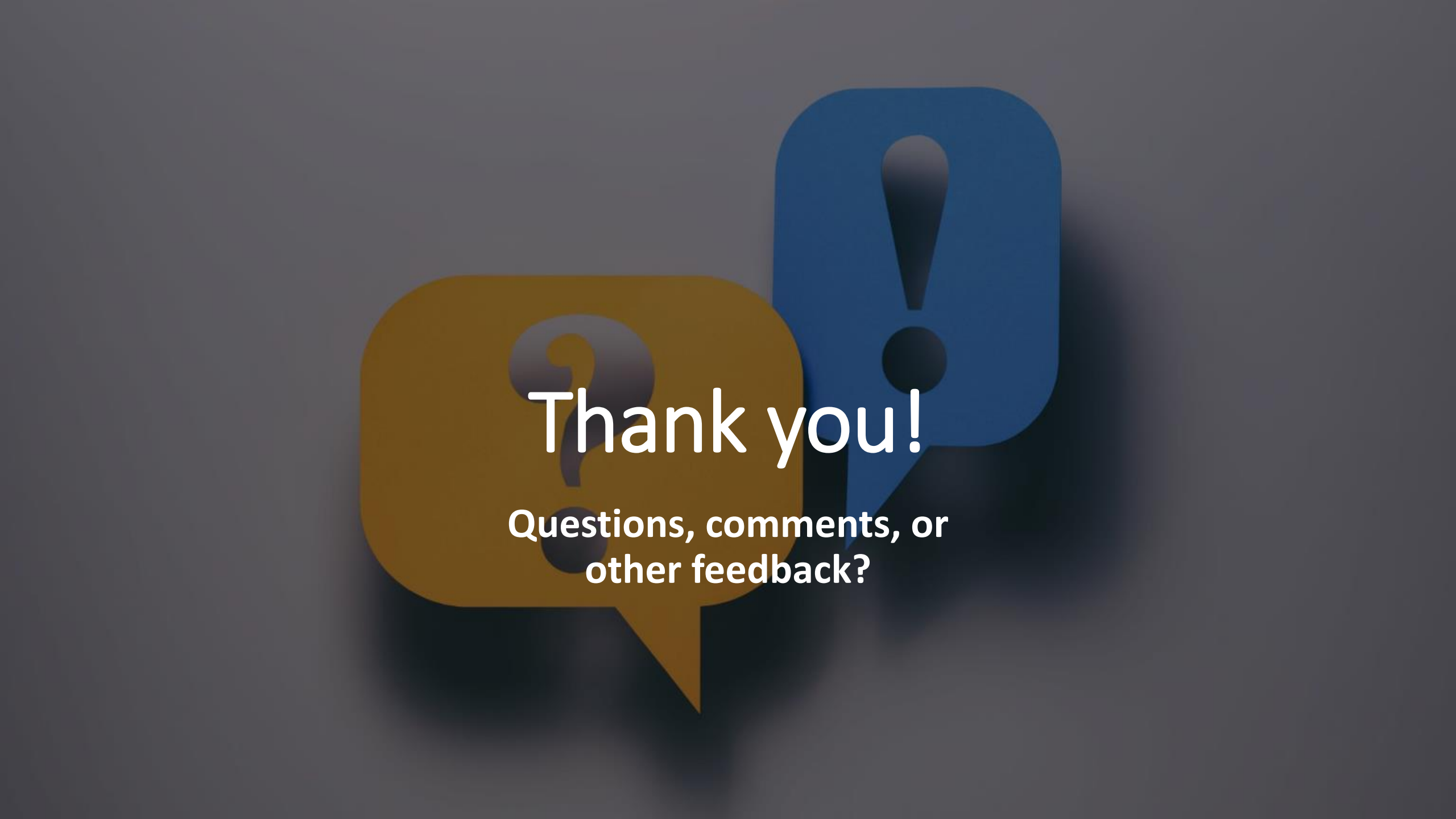


			sample	day 1	day 2	day 3	day 4	day 5	day 6	day 7		
63	Sleep Efficiency	SE (%)	69.70%	95.38%	95.38%	95.38%	70.83%	95.38%	95.38%	94.20%	91.71%	Sleep Efficien
64												
65												
66	Week 4											
67			sample	day 1	day 2	day 3	day 4	day 5	day 6	day 7		
68	Dates		1/1/2011	8/25/2017	8/26/2017	8/27/2017	8/28/2017	8/29/2017	8/30/2017	8/31/2017		
69	Bedtime (Time went into bed)	Q1_BT	23:30	0:00	0:00	0:30	2:05	0:45	0:00	0:45	0:35	Bedtime
70	Lights out (Try to go to sleep)	Q2_LO	23:45	0:00	0:00	0:30	2:05	0:45	0:00	0:45	0:35	Lights out
71	Latency to sleep (minutes to fall asleep)	Q3_SL	30	20.00	20.00	20.00	45.00	18.00	30.00	43.00	28.00	Latency to fal
72	minutes awake in middle of night (how long awakenings last)	Q5_WASO	60	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	Minutes awak
73	Wake time (time of final awakening)	Q6a_WT	7:00	7:00	7:00	7:45	7:40	7:00	7:30	7:45	7:22	Wake time
74	Mins awake too early (how many minutes earlier)	Q6c_EMA	30	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	minutes awak
75	Out of bed (out of bed for the day)	Q7_OB	8:00	7:00	7:00	7:45	7:40	7:00	7:30	7:45	7:22	out of bed for
76		BT	-0.50	0.00	0.00	0.50	2.08	0.75	0.00	0.75	0.58	
77		LO	-0.25	0.00	0.00	0.50	2.08	0.75	0.00	0.75	0.58	
78		WT	7.00	7.00	7.00	7.75	7.67	7.00	7.50	7.75	7.38	
79		OB	8.00	7.00	7.00	7.75	7.67	7.00	7.50	7.75	7.38	
80												
81	Time in Bed	TIB	8.25	7.00	7.00	7.25	5.58	6.25	7.50	7.00	6.80	Time in Bed
82	Total Sleep Time	TST	5.75	6.67	6.67	6.92	4.83	5.95	7.00	6.28	6.33	Total Sleep Ti
83	Sleep Efficiency	SE (%)	69.70%	95.24%	95.24%	95.40%	86.57%	95.20%	93.33%	89.76%	92.96%	Sleep Efficien
84												

Virtual Intensive Outpatient/Residential Group Example

Notes from an ACT for Chronic Pain Group :

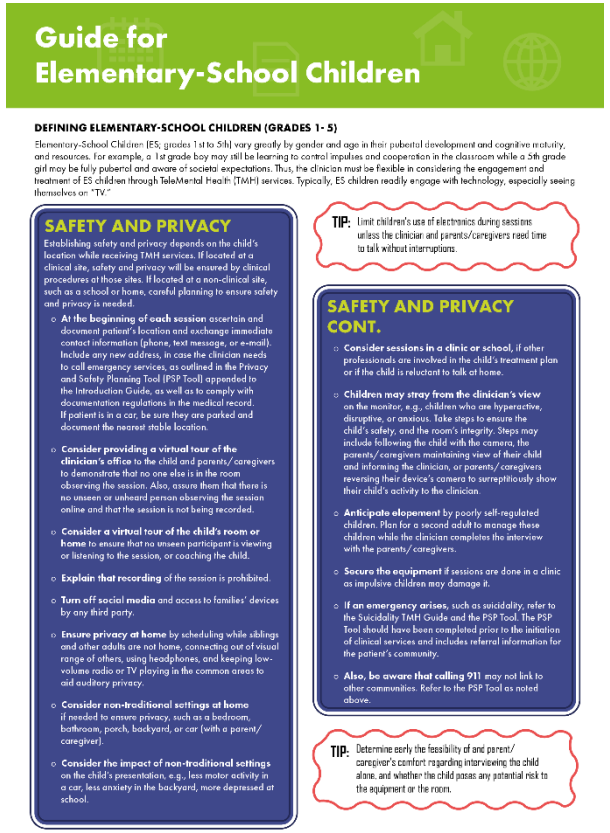
- Met twice a week, 90 mins each, 6 weeks.
- Referrals from Outpatient Mental Health Clinic.
- Minimal screening (Group Telehealth Agreement).
- Assembled letter + workbook for Veterans to use during class.
- If No Show, Veteran contacted by facilitator to determine next steps
- Secure Messaging, BHL Touch/MH Check Up not as crucial.
- Make use of sharing, chat, play with class layout.
- Frequent breaks, active movement, etc.


Thank you!
Questions, comments, or other feedback?

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

UW Medicine
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Washington State Health Care Authority

Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

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