

This is Study Guide 2 of 2026 Course 4TASDP 'Technology Assisted Services for Distinct Populations' sponsored online for CE Credit by CEU By Net. This Guide 2 presents additional information about 1) Southwest ATTC's step-by-step workplan for setup and operation of a Telehealth Program, and 2) instructions for use of AHRQ's Teach-Back Method for use with Telehealth, and 3) SAMHSA's analysis of the effectiveness of Telehealth in various situations.

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South Southwest (HHS Region 6)

ATTC

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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Developed by South Southwest ATTC

Framework for Implementation of Telehealth Services in a Behavioral Health Setting in a Short Time Frame

Original Document - April 2020 -
Currently published online 2026



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South Southwest (HHS Region 6)

ATTC

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

The Addiction Technology Transfer Centers (ATTCs) play a critical role in advancing our nation's health by equipping healthcare professionals and community organizations with effective tools to address individuals, children, and families impacted by alcohol and drug use.

We build local capacity of the behavioral health workforce resulting in treatment that leads to long-term recovery. ATTCs' no-cost services are aligned with national goals to reduce overdose fatalities and combat the opioid crisis while decreasing the burden on criminal justice and social service systems.

Training treatment and recovery providers nationwide saves billions in taxpayer dollars, while also fostering safer and healthier communities.

Purpose and Acknowledgements

The COVID-19 health pandemic accelerated the implementation of behavioral health services via remote technology, including telephone and video conferencing.

The following is an implementation framework for behavioral health care providers that guides organizational leadership through short term practical steps for implementation of remote services via technology while including successful long-term strategies for sustaining telehealth services.

This document resulted from discussions between behavioral health providers from Oklahoma tribal communities, the Oklahoma Department of Mental Health and Substance Abuse Services, the SAMHSA Region 6 Administrator, the Oklahoma City Area Indian Health Service and the South Southwest Addiction Technology Transfer Center in March 2020. Collaborative partners Mountain Plains ATTC and NFAR provided support and input into the development of this framework.

For additional resources to guide the provision of behavioral health services via technology, see the Resources Section of this document. For additional information or comments, contact the South Southwest Addiction Technology Transfer Center.



Action Item 1: Participant Interest and Capacity

Connect via telephone or in-person with individuals on existing caseloads to determine individual preference and ability to participate in telehealth services.

Questions for individual receiving services:

1. Does the individual choose to receive services via their phone or computer at this time?

If no, discuss other options available to individual to support their wellness and/or treatment plan. Provide referrals and connection to alternate services, if applicable.

Encourage them to reach out to organization and other available supports if needed, and provide specific contact information.

Make note to connect at a future time to check in with the individual to support their wellness and ascertain if they have accessed needed services, and to see if the individual has a need for telehealth services at the time.

2. Does the individual have a telephone?

If yes, is it a landline or mobile phone?

If yes, is it their own phone or do they share it with others?

3. Does the individual have access to WIFI services?

If yes, is the WIFI available somewhere private or do they rely on public WIFI (library, coffee shop, school etc.)?

4. Does the individual have a mobile device(s) – tablet or smart phone?

If yes, what kind?

If yes, do they rely on WIFI or a phone data plan to connect their mobile device(s) to the internet?

If WIFI, public or private?

5. Does the individual have a computer?

If yes, what kind?

If yes, do they use it to connect to the internet?

If yes, does the computer have?

- Camera
- Microphone
- Speakers

Next Steps:

Timeline:

Staff Person(s) Responsible:

Action Item 2: Platforms

Compare possible telehealth platforms and decide which will be utilized.

Some options include, but are not limited to:

1. Zoom.us
2. Doxy.me
3. RealPresence
4. Microsoft Teams

Consideration	Platform A	Platform B	Platform C	Platform D
Cost				
HIPAA Compliance				
Business Associate Agreement for HIPAA				
End-to-End Encryption				
Waiting Room Function For Online Session				
Ease of use by participants				
Ease of set up by provider and participant				
Feedback from Other Behavioral Health Providers				

Action Item 3: Patient Safety and Privacy¹

Determine how to best protect your patients if you implement telehealth services in a time of public health crisis, and ongoing in the long term.

Steps:

1. Revise your consents to incorporate changes related to telehealth.
2. Develop procedures and best practices related to safety and privacy that comply with:

HIPAA

Federal confidentiality rules and regulations 42 CFR Part 2

Ethical standards of practice

**CEU By Net note:
There are new
Telehealth Rules. See
the SAMHSA Update
to 42 CFR, Part 2,
most recently 2026 -
in Study Guide 1 of
this Course 4TASDP.**

Some examples might include, but are not limited to:

- Ensure both the staff and patient are trained on using the hardware and the video conferencing system and there are opportunities to practice. Ensure procedures are in place to maintain privacy **prior to the start of the first telehealth session.**
- **Maintain up to date emergency contact information for individuals receiving services.** Identify emergency contacts that are in geographical proximity to the individual.
- **At the start of each session, ask participant for a phone number where they may be reached if the video technology drops or fails.**

¹ Mountain Plains Addiction Technology Transfer Center (2020 **Where to Begin... Essential Tips for Using Videoconferencing to Deliver SUD Treatment and Recovery Services Webinar** Presenters: Sandnes S. Boulanger, LCSW, MCAP, Clinical Director, Operation PAR, Inc. and Maryellen Evers, LCSW, CAADC

- At the start of each session, ask the individual being served to identify the **address** where they are physically located so you can call an emergency contact, crisis team or 911 if needed.
- At the start of each session, ask the individual being served **who else is in the room with them**.
- Develop a **safety phrase** the individual being served can use to let you know now is not a time where they can participate in a session, “The grocery stores have been really busy this week.” Staff can then respond with “I have had an emergency come up and I need to reschedule our session today.” **Utilize a different phrase to indicate if they need you to send help.**
- Establish policies and procedures for use of text messaging and email with individuals being served.
- Consider use of **patient portal systems** designed to protect communication with patients.
- **Never record or upload a recording of a telehealth session.**

Next Steps:

Timeline:

Staff Person(s) Responsible:

Action Item 4: Staff Preparation and Training

Survey staff to determine types and extent of support needed from leadership for implementation of telehealth services and prepare staff for the transition.

Questions:

1. What are staff needs and concerns about telehealth implementation and how will we address them?
2. When and how will we prepare staff to implement telehealth services?
3. What specific training and ongoing support do they need to build skills and comfort with the new processes and technology?
4. How will we maintain ongoing feedback and communication with staff as the new processes are implemented?

Next Steps:

Timeline:

Staff Person(s) Responsible:

Action Item 5: Policies and Procedures

Review and modify agency policies and procedures.

Questions:

1. What existing policies impede immediate implementation of telehealth services?
2. How will we modify them?
3. Will changes have an expiration date?
4. **What policies and procedures are missing and need to be added?**
5. **How will we update staff on policies and procedures?**

Next Steps:

Timeline:

Staff Person(s) Responsible:

Action Item 6: Work Flow

Review workflow of specific programs and adjust details of workflow as needed.

Steps:

1. Determine *which services will be provided via telehealth*, by which staff and to which individuals.
2. Document steps currently taken to interact with individuals being served using each of these services.

How will we modify these steps to utilize telehealth?

Will changes have an expiration date?

What policies and procedures need to be modified or added to support this work flow?

3. *What community and cultural considerations need to be taken into account and how will they adjust the workflow?*
4. What are the agency procedures for *supervision of staff providing telehealth* services?
5. *How will staff document the remote services? NOTE: SEE new HIPAA documentation rules in Study Guide 1 of this course*

Next Steps:

Timeline:

Staff Person(s) Responsible:

Action Item 7: Staff Resources

Inventory and augment staff resources needed for telehealth.

Steps:

1. Do staff have needed equipment?
 - Mobile devices
 - Access to WIFI or data plan
 - Computer with camera, microphone and speakers
 - IT support for when things go wrong

2. How much will it cost to provide all needed equipment and support?

Next Steps:

Timeline:

Staff Person(s) Responsible:

Action Item 8: Reimbursement

Determine how program will receive payment for telehealth services.

Questions:

1. Will current funders pay for services delivered via phone or videoconferencing?
In the short term due to any public health crisis? In the long term?
2. What are the billing procedures/codes for billing telehealth?
3. **What documentation is required by funders for billing services provided via telehealth?**
4. Does your program collect fees or co-pays from individuals receiving services?
If yes, how will you do so virtually?
Is the payment platform secure/HIPAA complaint?

Next Steps:

Timeline:

Staff Person(s) Responsible:

CEU By Net notation: Not all online payment methods are secure and HIPAA compliant, as was noted by this ATTC. Recent 'high profile' data breaches in the healthcare IT industry have prompted improved security and compliance, and individual online payment systems are evolving accordingly. 'Cloud services' which transmit much of the Internet activity is also undergoing major security and compliance reworking. However, multiple variables can affect the security and HIPAA compliance of a payment platform. Therefore, your IT department or Internet System Administrator MUST specifically check the CURRENT security and HIPAA compliance status of ANY online payment system you use for your clients' payments.

Additional Resources

Tips for Using Videoconferencing to Deliver SUD and Treatment and Recovery Services <https://attcnetwork.org/centers/mountain-plains-attc/tips-using-videoconferencing-deliver-sud-treatment-and-recovery>

Pacific Southwest Virtual MHTTC Learning Guide for Virtual Learning Facilitators
<https://pttcnetwork.org/center/pacific-southwest-pttc/>

National Frontier and Rural Telehealth Education Center (NFARtec)
<https://www.nfartec.org/>

National Consortium of Telehealth Resource Centers
<https://www.telehealthresourcecenter.org/resources/>

SAMHSA's NEW Telehealth Resource Guide

https://library.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf

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Agency for Healthcare
Research and Quality

CEU By Net
notation: The
Teach-Back
Method published
here by AHRQ is
widely
recommended for
use in multiple
online
TELEHEALTH
training
publications,
including
HIPAA.

The Teach-Back Method in Telehealth

'Background and objectives: The rapid expansion of telehealth during the COVID-19 pandemic has created new challenges in patient-provider communication due to the absence of in-person interactions and visual cues. Teach-back, a method where patients repeat information to confirm understanding, is a promising tool for improving communication in virtual care.'

- Elsevier Patient Education and Counseling Journals - 2026



Learn about AHRQ's Teach-Back Approach for use in Telemental Health, below, from AHRQ Health Literacy Universal Precautions Toolkit - Second Edition.

AHRQ Health Literacy Universal Precautions Toolkit

- Second Edition



**Agency for Healthcare
Research and Quality**

"AHRQ has invested in research and shared information on the benefits of telehealth for several years, through its Digital Healthcare Research Program and Effective Healthcare Program. Use of telehealth has expanded through advances in technology, availability of training, and improvements in safety. During the COVID-19 pandemic, telehealth continued to broaden training, mentoring, diagnosis, and treatment opportunities that benefit healthcare providers and consumers alike." - August 2026

AHRQ Health Literacy Universal Precautions Toolkit

- Second Edition

This Teach-Back content was last reviewed in May 2023 by the Agency for Healthcare Research and Quality, Rockville, MD.

Use the Teach-Back Method

Overview

Regardless of a patient's health literacy level, it is important that staff ensure that patients understand the information they have been given. The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understand. The related show-me method allows staff to confirm that patients are able to follow specific instructions (e.g., how to use an inhaler).

- The teach-back and show-me methods are valuable tools for everyone to use with each patient. These methods can help you:
 - Improve patient understanding and adherence.
 - Decrease call backs and cancelled appointments.
 - Improve patient satisfaction and outcomes.

Fact

Studies have shown that 40-80% of the medical information patients are told during office visits is forgotten immediately, and nearly half of the information retained is incorrect.

Practice Experiences

“I decided to do teach-back on five patients. With one mother and her child, I concluded the visit by saying ‘so tell me what you are going to do when you get home.’...She could not tell me what instructions I had just given her. I explained the instructions again and then she was able to teach them back to me... I had no idea she did not understand... I was so wrapped up in delivering the message that I did not realize it wasn’t being received.

- **Keep in mind this is not a test of the patient’s knowledge.** It is a test of how well you explained the concept.
- **Plan your approach.** Think about how you will ask your patients to teach back the information. For example:
 - “We covered a lot today and I want to make sure that I explained things clearly. So let’s review what we discussed. Can you please describe the 3 things you agreed to do to help you control your diabetes?”
- **“Chunk and Check.”** Don’t wait until the end of the visit to initiate teach-back. Chunk out information into small segments and have your patient teach it back. Repeat several times during a visit.
- **Clarify and check again.** If teach-back uncovers a misunderstanding, explain things again using a different approach. Ask patients to teach-back again until they are able to correctly describe the information in their own words. If they parrot your words back to you, they may not have understood.
- **Start slowly and use consistently.** At first, you may want to try teach-back with the last patient of the day. Once you are comfortable with the technique, use teach-back with everyone, every time!
- **Practice.** It will take a little time, but once it is part of your routine, teach-back can be done without awkwardness and does not lengthen a visit.
- **Use the show-me method.** When prescribing new medicines or changing a dose, research shows that even when patients correctly say when and how much medicine they’ll take, many will make mistakes when asked to demonstrate the dose. You could say, for example:
 - “I’ve noticed that many people have trouble remembering how to take their blood thinner.

Can you show me how you are going to take it?”

10 Elements of Competence for Using Teach-back Effectively

1. Use a caring tone of voice and attitude.
2. Display comfortable body language and make eye contact.
3. Use plain language.
4. Ask the patient to explain back, using their own words.
5. Use non-shaming, open-ended questions.
6. Avoid asking questions that can be answered with a simple yes or no.
7. Emphasize that the responsibility to explain clearly is on you, the provider.
8. If the patient is not able to teach back correctly, explain again and re-check.
9. Use reader-friendly print materials to support learning.
10. Document use of and patient response to teach-back.

What is Teach-back?

- A way to make sure you—the health care provider—explained information clearly. It is not a test or quiz of patients.
- Asking a patient (or family member) to explain **in their own words** what they need to know or do, in a caring way.
- A way to check for understanding and, if needed, re-explain and check again.
- A research-based health literacy intervention that improves patient-provider communication and patient health outcomes¹.

¹ Schillinger, 2003

Coaching

Giving staff knowledge on teach-back and its effectiveness is important. However, to change from a long-standing patient education habit of asking yes/no questions like “Do you have any questions?” to one of using teach-back to confirm understanding via the patient’s own words, takes coaching.

Changing providers’ behavior and building new habits also take time. Coaching can help staff be successful by enhancing their skills in moving away from long-standing habits and integrating new habits.

Here are tips to help you coach staff to the new habit of always using teach-back.

Coaching Tips

Build motivation.

- Encourage use of the new habit by focusing on patient-centered/ideal care.

Honor the current work through observation.

- Establish relationships through observing those seeking to build the new habit (teach-back).

Understand that change is hard and uncomfortable.

- Use active and reflective listening.
- Use open-ended **what** and **how** questions to determine individual barriers.
 - ◆ “What worries you about using teach-back?”
 - ◆ “How did using teach-back with your patient make you feel?”
 - ◆ “Tell me more about...”

Resistance to change is natural. Resistance comes from fear of change.

- Confront the problem, not the person.
- Resistance is a signal to change the response and approach.

Promote new skill development.

- Promote each individual's belief in their ability to change.
- Focus on previous successes.
- Focus on skill development.
 - ◆ Set goals: "I will use teach-back with every patient today."
 - ◆ Develop a change plan. Habit change happens with conscious planning.
 - ◆ Mentally rehearse:
 - "What is the most important thing I want to be sure the patient understands?"
 - "How would I ask this question?"
 - ◆ Embed cues to use teach-back in already-established habits.
 - "After each interaction, I will ask an open-ended question to elicit understanding."

Build confidence to integrate the new habit into work patterns.

- Rate your confidence in using teach-back on a scale of 1 to 5... "What might help you increase your confidence from a 3 to a 4?"

Build reliability.

- Even when people have goals they often need reminders and support to be successful.
 - ◆ Create standard work: content, sequence, timing, and outcome.
 - ◆ Build in job aides and reminders.
 - ◆ Take advantage of pre-existing work and habits.
 - ◆ Make the desired action the default rather than the exception.
 - ◆ Create redundancy.
 - ◆ Group related tasks.

Manage relapses.

- Make a plan for follow-up coaching to reinforce the new habit.
- Share questions and problems. Develop program improvements.
- Recognize, reward, and celebrate!

Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders

What Research Tells Us

SAMHSA

Photos are for illustrative purposes only.
Any person depicted in a photo is a model.

Publication No. PEP21-06-02-001
First released 2021

SAMHSA
Substance Abuse and Mental Health
Services Administration

What Research Tells Us

Telehealth is the use of two-way, interactive, video and/or audio technology to provide health care to individuals experiencing serious mental illness (SMI) or substance use disorder (SUD). The goal of this chapter is to present the evidence for specific telehealth-delivered treatments for individuals with SMI, SUD, and co-occurring disorders (CODs). **While telehealth modalities for SMI or SUD may be synchronous (real-time) or asynchronous (non-urgent electronic communication between clients and providers - e.g., text messages or email), the evidence review in this chapter focuses on synchronous interventions to treat SMI or SUD.** In addition to treatments via telehealth modalities, this chapter also provides information on ways programs can provide telehealth-delivered services along the continuum of care for SMI and SUD, which includes screening and assessment, medication management, case management, recovery support, and crisis services.

Telehealth is effective across the continuum of care for SMI and SUD, including screening and assessment, treatments, including pharmacotherapy, medication management, and behavioral therapies, case management, recovery supports, and crisis services.



The evidence for use of telehealth across the continuum of care for SMI and SUD is included below, with the detailed evidence review results (i.e., causal evidence level ratings) including avioral therapies

When implemented using the same core steps and components as in-person services, synchronous telehealth treatments can be comparably effective to Medication Assisted Treatment (MAT) and in-person services.

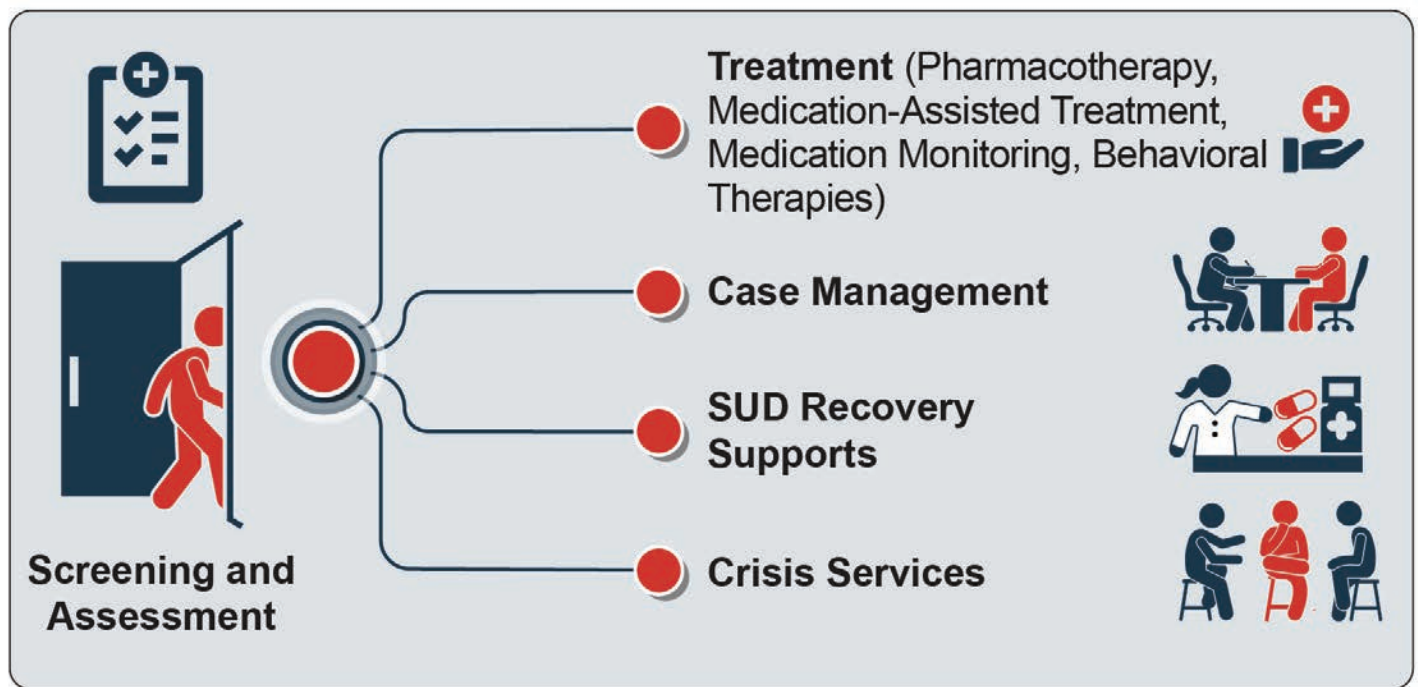
INTERNAL NOTE BY CEUBYNET - DEFINITION OF SYNCHRONOUS vs ASYNCHRONOUS TREATMENT:

Synchronous treatment in mental health and SUD involves real-time interactions between patients and providers, such as video calls, while **asynchronous treatment** allows for delayed communication, enabling patients to send messages or recordings that providers respond to later. Both methods have unique benefits and limitations depending on patient needs and circumstances.

Key Differences Between Synchronous and Asynchronous Treatment
Understanding these differences can help in choosing the right approach.

- **Interaction Timing** — Synchronous treatment occurs in real-time, requiring both parties to be present simultaneously, while asynchronous treatment allows for communication over time with delays between responses.
- **Flexibility** — Asynchronous treatment offers greater flexibility for patients, as they can engage at their convenience, which can be particularly beneficial for those with scheduling conflicts or anxiety about live interactions.
- **Clinical Outcomes** — Studies suggest that asynchronous telepsychiatry can achieve similar clinical outcomes to synchronous methods, making it a viable alternative for many patients.
- **Patient Satisfaction** — Research indicates varying levels of satisfaction between the two methods, with some patients preferring the convenience of asynchronous communication, while others value the immediacy of synchronous sessions.





Screening and Assessment

Screening and assessment for SMI and SUD are the first steps to effective treatment and can be effectively conducted using synchronous and asynchronous telehealth modalities.

- **SMI:** Synchronous screenings and assessments for mental disorders conducted via videoconferencing modalities have similar reliability and accuracy to in-person screening and assessment.
- Asynchronous tools that are completed by a client and later reviewed by and discussed with a provider can increase access to screening and assessment when no clinician is available.¹
- **SUD:** Providers can administer screening tools to assess risk of SUD using telehealth.² Early evidence suggests computer-based assessment tools for SUD may increase engagement in the screening process, as well as response accuracy.³

CEU By Net Note: Assessment and Diagnosis can now be performed for SUD and OUD through Telehealth, which is a change from the 2008 Ryan Haight Online Pharmacy Consumer Protection Act, which, prior to the COVID-19 pandemic, required in-person evaluations before providing medication-assisted treatment (MAT). Assessment and MAT can now be performed through Telehealth prior to in-person visits per SAMHSA, which will help assess effectiveness. See Guide 1.

Telehealth modalities can be used to connect clients, care teams, and support systems during the creation and implementation of an individualized care plan by:

1. Increasing the diversity of specialists (in terms of clinical specialty and geographic location) that can be consulted for diagnosis, assessment, and treatment
2. Engaging administrative staff (via patient portals), clinicians, and providers (via electronic health records and videoconferencing consultations) and support networks such as friends and family (via videoconferencing and social media) in various components of treatment^{5,6}

Once a diagnosis is made, clients and providers can determine together the appropriateness of various telehealth modalities and identify when telehealth, in-person, or a hybrid approach will best meet the client's treatment goals. Appropriateness of telehealth may depend on several factors, including the:

- Nature and complexity of the intervention and the client's condition
- Client's comfort with technology and telehealth appointments
- Ease and preferences of accessing in-person services or using technology

Designing and updating the care plan is a collaborative and iterative process between client and provider, and involves a conversation on client comfort, preferences, and goals.

SMI and SUD Treatment

Pharmacotherapy, Medication-Assisted Treatment, and Medication Management

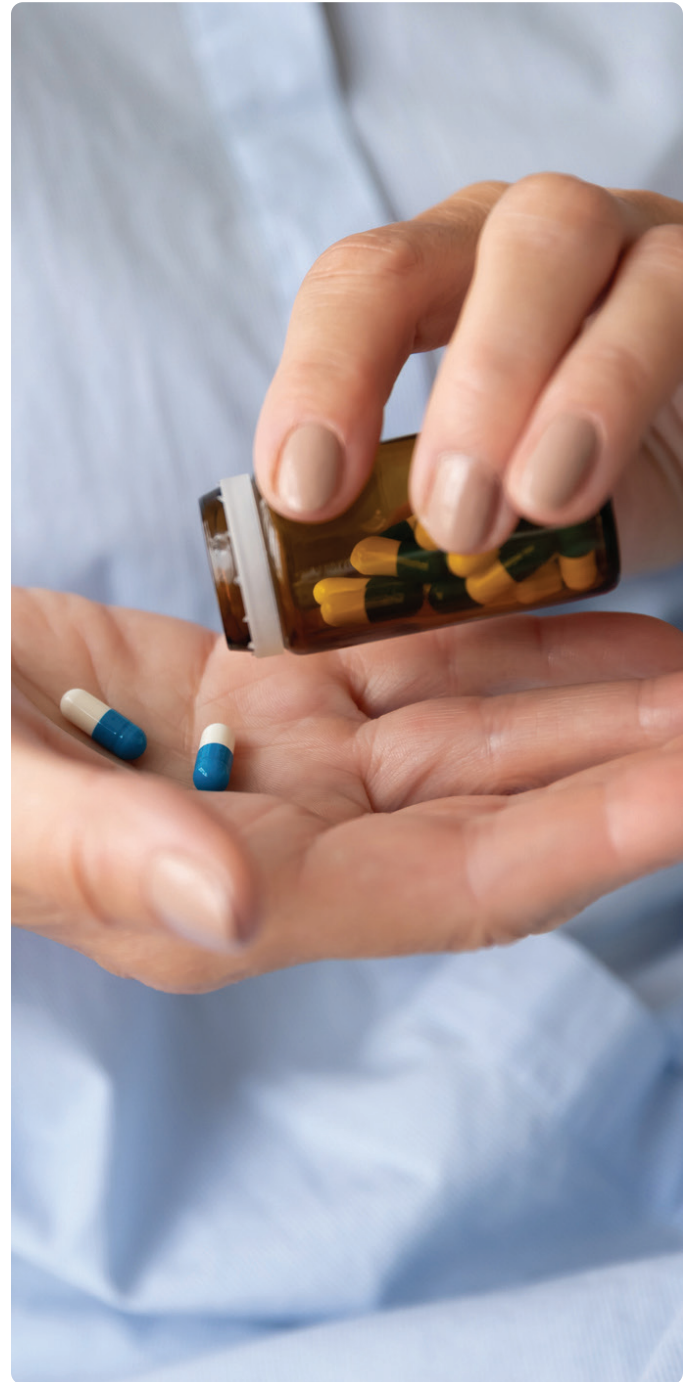
Pharmacotherapy can be implemented using synchronous telehealth for SMI. Prescribing and monitoring medication using telehealth can lead to reduced length of hospitalization and symptomology, and improved medication adherence.^{7, 8} There are also limitations to prescribing and monitoring medication that should be noted, such as evaluating movement disorders and the ability to test muscle tone (e.g., in order to gauge rigidity as a side effect of a medication).

Medication-Assisted Treatment (MAT) uses pharmacological medications in combination with counseling and behavioral therapies to treat diagnosed SUD.⁹ MAT involves multiple components tailored to meet individual clients' needs,¹⁰ including initiating medication, monitoring adherence, and providing access to counseling and psychosocial supports.¹¹ MAT includes FDA-approved treatments for opioid use disorder (using methadone, buprenorphine, and naltrexone),¹²⁻¹⁴ and alcohol use disorder (using naltrexone, disulfiram, and acamprosate).^{15,16} Currently, there are no FDA-approved medications to treat stimulant or marijuana use-disorders.¹⁷

MAT is regulated by the Drug Enforcement Administration (DEA). Prior to the COVID-19 pandemic, practitioners could not provide certain components via telehealth.^{18, 19} [**CURRENT 2026 EDIT:** Due to temporary changes for COVID-19 that have now become permanent per SAMHSA 42 CFR Part 2, in 2026, there are several models for using a hybrid in-person and telehealth approach to delivering MAT.²⁰]

For example, a physician may perform an initial assessment and prescribe medication via videoconference, while local clinicians provide counseling and follow up in-person; or, a physician could prescribe medications and monitoring during in-person visits and the client then receives counseling via telehealth.²¹

As a result of changing regulations, evidence for the provision of MAT solely through telehealth modalities is limited. Studies included in the review (below) examined multiple components of MAT, some of which are provided via telehealth modalities and others through a hybrid approach (combination of in-person and telehealth approach).



SEE THE NEW 2026 REGULATIONS FOR SUD TELEHEALTH TREATMENT AND INFORMATION RELEASE, IN STUDY GUIDE 1.

Medication-Assisted Treatment using a hybrid telehealth and in-person approach



Strong Evidence

Health outcomes	Reduction in rates of positive urine drug screens over course of study²² and no significant difference in positive urine screens between in-person and telehealth groups^{22, 23}
Telehealth-specific outcomes	When compared to in-person treatments: - No significant difference in retention²² and counseling attendance rates²³ - No significant difference in and high level of client satisfaction²³ - No significant difference in client and provider ratings of therapeutic alliance²³
Populations that benefit from the treatment	- People living with opioid use disorder^{22, 23} - Pregnant women living with opioid use disorder²²
Providers who can offer intervention services	A range of providers can implement MAT activities depending on both the specific activity they conduct, the location of the prescriber and treatment program, and the type of medication offered. The care team can include: - Waivered prescribers at buprenorphine^{18, 24} and opioid treatment programs²⁵ - Social workers, peer recovery counselors, addiction counselors, outreach workers, and nurses - Pharmacists²⁶
Technology used	Videoconferencing and web-based applications^{22, 27}
Intensity, duration, and frequency	- MAT is designed to meet clients' clinical needs, so there is no protocolized model for the intensity and duration of the program - Clients may vary in the types of supports they need and those needs may change over the course of treatment and recovery¹¹ - MAT begins with treatment initiation, followed by weekly urine drug screens, medication monitoring, and counseling sessions that taper to monthly depending on response to treatment^{22, 23} - Medications are often administered gradually, and providers work with clients to appropriately adjust the dosage between initiation and stabilization²⁸
Lessons learned from transitioning from in-person care to telehealth	- Telehealth can be used to integrate care and extend the reach of specialty providers to make MAT available to underserved populations²² - Although some clients experienced technical problems, most enjoyed the convenience of telehealth services²³ - Providing MAT via telehealth is limited by regulatory constraints and practitioners should consult state and federal prescribing laws prior to initiating telehealth MAT programs²⁹

Four studies met criteria for review (one RCT, two QEDs, and one single sample pre-post), resulting in a rating of Strong Support for Causal Evidence.

Medication management via telehealth ranges from automated, non-specific text messages to adherence counseling conducted over the telephone.^{7, 30} Examples of telehealth modalities for conducting medication management are described below:

- **Text message** interventions, designed to remind clients to take their medication, have been found to be effective for people experiencing SMI even if the messages were not customized or specific to the dosage, timing, or medication prescribed.^{31, 32}
- **Smart pill containers** remind clients to take their medication, provide alerts about taking the wrong medication, and are linked to programs for the client to report side effects to providers. Used together with telephone support, smart pill containers have shown statistically significant improvement in medication adherence.³³
- **mHealth apps** have been used in combination with smart pill containers, in-home dispensing devices, or other systems to dose medications. These apps remind clients to take medications and communicate medication use information to their healthcare provider through a client portal.³⁴
- **Treatment support over the phone** from case managers, nurses, or other health professionals offers clients prescribed medications for SMI and SUD information and adherence support. These approaches have shown statistically significant improvements on medication adherence rates.³⁵⁻³⁷

Medication monitoring, including both support for medication adherence of the prescribed treatment and prevention of non-prescribed or illicit substance use that may cause dangerous interactions, is an essential component of MAT. Clinics or other agencies without a local, trained MAT provider have used telehealth to link clients to a remote MAT provider. The local clinic and agency can provide in-house medication monitoring and urine toxicology screening while providing space for the client to meet with the MAT provider using telehealth technology.²⁵ In some treatment models, monitoring visits are conducted using telehealth, but the client is required to report in-person for regular urine toxicology screening.^{20, 23, 38}

Behavioral Therapies

Practitioners can implement psychotherapy³⁹ and behavioral therapies through synchronous telehealth modalities while adhering to clinical specifications and producing clinical improvements similar to treatment outcomes from in-person care.⁴⁰

This evidence review identified four interventions that met evidence review criteria (described above and in Appendix 2) and improved health outcomes for people experiencing SMI, including Behavioral Activation (BA) Therapy, Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), and Prolonged Exposure (PE) Therapy. Each behavioral therapy is described below, including associated health outcomes, populations that may benefit, and other important information for implementing these therapies using telehealth.



Behavioral Activation (BA) Therapy via telehealth



Strong Evidence

BA is a treatment component based on **changing behavior to change one's mood**. It involves identifying, scheduling, and completing positive reinforcement activities.^{41, 42} *Behavioral Activation-Therapeutic Exposure (BA-TE)* is an integrated, evidence-based treatment for **Post-Traumatic Stress Disorder (PTSD)** and **Major Depressive Disorder (MDD)**. BA-TE combines BA with exposure-based therapy. It involves weekly BA activities along with situational exposure to clients' avoided stimuli and imaginal exposure to past traumatic events.^{42, 43}

Health outcomes	- Reduction in depression⁴¹ and major depression^{42, 43} symptoms - Reductions in PTSD symptoms^{42, 43} - Reduction in anxiety⁴²
Telehealth-specific outcomes	When compared to in-person treatments: - Reduction in Veteran's Affairs health utilization costs one-year post-telehealth intervention⁴⁴ - Similar rates reduction in PTSD symptoms (e.g., disturbing memories/thoughts about military experience, avoidance of external stimuli, nightmares, and re-experiencing)^{43, 45}
Populations that benefit from the treatment	People experiencing MDD, including: - Older veterans (58+)⁴¹ - Rural veterans⁴¹ - Black/African American veterans⁴¹ - Male veterans⁴¹ People experiencing PTSD, including: - Male and female veterans of Operation Enduring/Iraqi Freedom⁴³ and the Vietnam War, the Persian Gulf War, and Operation New Dawn⁴³
Providers who can offer intervention services	- Master's-level clinicians with over five years of experience who participate in a two-day training and who receive weekly supervision throughout the trial⁴¹ - Master's-level counselors who completed an eight-hour workshop and shadowed a senior-level clinician administering the treatment⁴³ - Mental health therapists who completed a week-long training, shadowed a senior-level clinician, and received weekly supervision⁴²
Technology used	- In-home videoconferencing technology, set up via an analogue telephone⁴¹ - Computer, tablet, or smartphone with encrypted videoconferencing software similar to Skype or FaceTime^{42, 43} - A landline-based videoconferencing program which functions like a typical touch-phone but includes an adjacent video screen^{42, 43}
Intensity, duration, and frequency	Eight 60- to 90-minute weekly sessions^{42, 43}
Lessons learned transitioning from in-person care to telehealth	- Telehealth treatment was effective even though the in-home videoconferencing technology used in the studies has become somewhat obsolete; researchers believe new technology can only improve communication between clients and providers, thus easing future implementation⁴¹ - Home-based telehealth has potential advantages over hub-and-spoke models (e.g., where a client is treated in an office setting by providers at another office setting) for addressing treatment barriers, including cost, stigma, and travel logistics⁴⁶

Four studies met criteria for review (three RCTs and one single sample pre-post), resulting in a rating of Strong Support for Causal Evidence.

Cognitive Behavioral Therapy (CBT) via telehealth



Strong Evidence

CBT is a goal-oriented psychotherapy that seeks to modify an individual's thought patterns, beliefs, and behaviors. CBT programs use a variety of cognitive and behavioral techniques in group and individual settings while remaining structured and time-limited.⁴⁶ Through cognitive restructuring, CBT may be used to help clients re-evaluate their negative thought patterns that include overgeneralizing or catastrophizing negative outcomes.^{47, 48} CBT techniques can be used to help clients address traumatic experiences and develop more effective thought patterns and realistic perspectives on the trauma.⁴⁷	
Health outcomes	• Reduction in severity of depression symptoms^{49, 50} • Reduction in symptoms of PTSD⁵¹ • Reductions in self-reported depressive and general anxiety symptoms⁵¹
Telehealth-specific outcomes	When compared to enhanced usual care (defined as conversations with primary care physicians): • Higher level of client satisfaction^{50, 51} • No significant difference in therapeutic working alliance between provider and client⁵¹ When compared to in-person treatment: • Higher level of treatment completion⁴⁹
Populations that benefit from the treatment	People experiencing major depressive disorder, including: • Primary care clients⁴⁹ • Rural, Latino/Latina clients⁵⁰ • People experiencing PTSD, including: – College women who are survivors of rape⁵¹
Providers who can offer intervention services	• Doctoral-level therapists^{49, 51} • Students working towards master's in social work degree⁵⁰ • Master's-level social workers⁵⁰ • Licensed social workers⁵⁰
Technology used	• Telephone^{49, 50} • Computer-based online program facilitated by a therapist⁵¹
Intensity, duration, and frequency	• Participants were offered 8 to 18 sessions of CBT; sessions (offered in both English and Spanish) were designed to be 45 to 50 minutes^{49, 50} • Through an online, therapist-facilitated CBT program, clients completed nine modules over the course of 14 weeks⁵¹
Lessons learned transitioning from in-person care to telehealth	• Lack of telephones was not a significant barrier to participation⁵⁰ • Providing culturally tailored CBT via telephone has the potential to enhance access to care for Latinas/Latinos living in rural areas⁵⁰ • Providers and clients developed a strong therapeutic working alliance despite the largely asynchronous nature of communication⁵¹ • Future research is needed to assess the effectiveness of delivering similar therapist-facilitated online programs to diverse populations and in multiple practice settings⁵¹
Four studies met criteria for review (four RCTs), resulting in a rating of Strong Support for Causal Evidence.	

Cognitive Processing Therapy (CPT) via telehealth*



Strong Evidence

CPT is a trauma-focused cognitive therapy aimed at reducing symptoms of PTSD. ⁵² CPT has been found to be effective in reducing symptoms of PTSD developed as a result of experiencing traumatic events, such as child maltreatment, sexual assault, and military-related stressors. ⁵³⁻⁵⁵ CPT consists of four main components: 1) Education; 2) Processing; 3) Challenging thoughts about the trauma to restructure thought patterns; and 4) Focus on trauma-related themes of safety, trust, power and control, esteem, and intimacy. ⁵⁵⁻⁵⁷	
Health outcomes	- Greater or equivalent reduction in severity of PTSD symptoms^{55, 58-60} - Reduction in symptoms of depression^{59, 60}
Telehealth-specific outcomes	When compared to in-person treatments: - Increased access to care for underserved rural populations⁵⁸ - No significant difference in client treatment adherence (homework completion) and retention^{55, 58} - No significant difference in client satisfaction^{55, 58} - No significant difference in therapeutic alliance between provider and client^{55, 58, 60}
Populations that benefit from the treatment	People experiencing PTSD, including: - Veterans^{55, 59, 60} - Civilian women⁵⁵ - Male combat veterans living in rural areas⁵⁸
Providers who can offer intervention services	- Licensed psychologists⁵⁹ - Doctoral-level psychologists^{58, 60} - Licensed social workers⁵⁹ - Master's-level and doctoral-level social workers^{58, 60} - Family therapists⁵⁹ Although formal CPT training is not required for practitioners, resources are available, including a program delivery manual and certification trainings⁵²
Technology used	Videoconference^{55, 58-60}
Intensity, duration, and frequency	Participants received CPT over 12 sessions, conducted once or twice a week for approximately 50 to 90 minutes each^{55, 58-60}
Lessons learned transitioning from in-person care to telehealth	- Videoconference is a familiar format for many users⁵⁹ - Participants encountered few disruptions using videoconferencing (e.g., no sessions were canceled due to technological difficulties)⁵⁸ - Smaller technology screens may reduce rapport and communication⁵⁹
Four studies met criteria for review (four RCTs), resulting in a rating of Strong Support for Causal Evidence.	

*Originally, the primary version of CPT was administered with a written account of trauma and cognitive-only CPT was administered without a written account of trauma. Research comparing the efficacy of the two versions found that both versions are as effective, and, notably, the cognitive-only version led to a decrease in dropout rate. As a result, the terminology changed and CPT without a written account of trauma became the primary version implemented. For the purpose of this evidence review, this guide uses the terminology as CPT delivered with or without a written account of trauma.

Prolonged Exposure (PE) Therapy via telehealth



Strong Evidence

PE is a type of CBT that focuses on helping individuals confront their fears from traumatic experiences.⁶¹ First developed as an intervention to treat sexual assault survivors suffering from PTSD, PE has been shown as effective for treating survivors of varied traumas, including combat, accidents, and disasters.⁶² Through weekly sessions of PE, individuals learn how to gradually approach their trauma-related memories and feelings.^{61, 63} Exposure therapy through imaginal exposure (describing the traumatic event) and in vivo exposure (confronting feared stimuli) also helps reduce symptoms of PTSD.^{48,61}	
Health outcomes	- Reduction in the severity of PTSD symptoms⁶⁴⁻⁶⁹ (compared with both no treatment and in-person PE therapy) - Reductions in symptoms of anxiety^{64, 68, 69} - Reductions in symptoms of depression⁶⁴⁻⁶⁹
Telehealth-specific outcomes	When compared to in-person treatments: - Increased access to care for rural veterans⁶⁸ - No statistical differences in client satisfaction, although participants in the in-person group reported a higher level of comfort when communicating with their therapist than participants in the telehealth group⁶⁴ - High acceptability of telehealth modalities⁶⁶ - Reductions in the extent to which PTSD interferes with activities of daily living (including health, diet, and work)⁶⁹
Populations that benefit from the treatment	People experiencing PTSD, including: - Veterans, predominantly male^{64-67, 69} - Rural veterans⁶⁸
Providers who can offer intervention services	- Clinical psychologists^{66, 68,69} - Psychiatrists⁶⁸ - Master's-level therapists and counselors^{64, 65, 67} - Master's-level social workers^{68, 69} - Psychology interns/fellows⁶⁸ - Although formal PE training is not required, practitioners of PE often received training and supervision in the form of: - Weekly supervision from a licensed clinical psychologist who was a certified PE trainer⁶⁴ 32-hour workshop training program in PE⁶⁵ - Observation of a senior-level clinician through a complete course of prolonged exposure, both in-person and via telehealth⁶⁵ - Recordings of therapy sessions for treatment fidelity⁶⁷ - Extensive training and supervision in exposure therapy for PTSD⁶⁹
Technology used	Videoconferencing via computer⁶⁴⁻⁶⁹ or smartphone⁶⁸
Intensity, duration, and frequency	Participants received PE once a week ranging from approximately 60 to 90 minutes;⁶⁵⁻⁶⁹ they were typically offered between 6 to 12 sessions depending on treatment response,^{64, 65, 67-69} and up to 21 sessions in one case⁶⁶
Lessons learned transitioning from in-person care to telehealth	- Clients express general interest and acceptability in using PE delivered via videoconferencing⁶⁸ - Telehealth-delivered PE can help overcome geographic barriers to care and help providers reach underserved populations^{68, 69} - Providers can make small adaptations to telehealth-delivered care to increase adherence to PE; some small, yet useful changes in care include using smartphone calendar reminders, scheduling an initial in-person client meeting to build rapport, and using the PE Coach app to augment and supplement treatment^{66, 68} - During telehealth visits, the quality and positioning of video cameras and monitors can reduce providers' ability to notice and respond to clients' nonverbal communications⁶⁹
Seven studies met criteria for review (four RCTs, two QEDs, and one single sample pre-post), resulting in a rating of Strong Support for Causal Evidence.	

SUMMARY OF EFFECTIVENESS AND USE

While this review focuses on synchronous interventions, providers can use asynchronous tools to complement, support, and reinforce synchronous client-provider interactions. Examples of asynchronous tools can be found through online repositories such as the [M-Health Index and Navigation Database](#) or the [VAApp Store](#).

Case Management

Ongoing case management may include routine check-ins and follow-ups, updates and modifications to care and treatment plans, identification of and connections with needed resources, and support in achieving the goals of an individualized care plan. These ongoing conversations are readily adapted to synchronous telehealth modalities and Health Insurance Portability and Accountability Act (HIPAA) compliant asynchronous messaging platforms, including texting and messaging through a clinic electronic health record (EHR) system. Specific studies have demonstrated ongoing case management interventions using telehealth are effective for people with depression^{70, 71} and schizophrenia.⁷²

SUD Recovery Supports

Practitioners can provide ongoing recovery support for people in SUD treatment through synchronous telehealth methods. Peer recovery support services use peers (people who have similar lived experiences as the client, such as someone who is in SUD recovery themselves) to provide support for clients while in treatment and recovery.⁷³ Some peer recovery support services use technology-assisted peer support to engage clients, conducting regular check-ins over telephone or videoconference.⁷⁴

Crisis Services

Telehealth modalities can increase the availability of needed crisis services, ensuring these services are available to anyone, anywhere, at any time, and that there is a “no-wrong-door” approach for entry into services.⁷⁵ Crisis services are an effective strategy for suicide prevention and resolving acute mental health and substance use crises, as well as for reducing psychiatric hospital bed overuse, inappropriate use of emergency departments, inappropriate use of law enforcement resources, and the fragmentation of mental health care.⁷⁵

Cited by the [National Guidelines for Behavioral Health Crisis Care](#) as an essential element of an integrated crisis system, regional crisis call centers provide synchronous telephonic crisis services, text, and online chat technology to triage needs, assess for additional needs and preferences, and coordinate connections for additional post-crisis support. In addition to telephone calls and live online chats or texts, regional crisis call centers can also make use of the following technologies to support an individual’s well-being:

- 24/7 outpatient scheduling
- Crisis bed registry
- GPS-enabled mobile crisis dispatch
- Real-time performance outcome dashboards

Asynchronous tools such as [My Mental Health Crisis Plan](#)⁷⁶ (designed by SAMHSA) can be used to create a personal advance directive, a legal document outlining an individual’s preferences during a mental health crisis should the individual not be able to determine or communicate their own decisions.



Suicide Screening and Assessment

Telehealth modalities provide an effective alternative to in-person suicide screening and assessment.⁷⁷ The following suicide screening and assessment tools can be implemented through telehealth modalities:

- The [Ask Suicide-Screening Question Toolkit \(ASQ\)](#) from the National Institute of Mental Health (NIMH) is an evidence-based, 20-second, four-question suicide screening tool.⁷⁸
- The [Collaborative Assessment and Management of Suicidality \(CAMS\)](#) is an evidence-based intervention to assess, treat, and manage clients with suicidal ideation in a range of clinical settings.⁷⁹⁻⁸⁷
- [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#), also known as the Columbia Protocol, can be used to determine whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support the person needs.⁸⁸

If a client is at risk of imminent harm:

1. **Assess immediate danger.** If the client is in immediate danger and the provider is unable to detain or physically intervene, the provider must contact emergency services.
2. **Identify the client's location** in case emergency services are necessary.
3. **Work with other care providers (e.g., suicide prevention coordinators) when contacting emergency services.** Remain connected with the client as the client connects with emergency services or while arranging hospitalization.⁸⁹
4. **Support clients as they navigate the triage process at an emergency department.** Treatment programs should have safety protocols to mitigate risks and create a workflow to support the client; providers should determine the suicide risk level with criteria that identify the appropriate clinical response.^{90, 91}

Future Directions

This evidence review supported conclusions related to *treatment outcomes*:

- Telehealth is effective across the continuum of care for SMI and SUD, including screening and assessment, treatments, including pharmacotherapy, medication management, and behavioral therapies, case management, recovery supports, and crisis services.
- Evidence-based treatments for SMI and SUD, traditionally provided face-to-face, are also effective when delivered using telehealth and have outcomes comparable to in-person service delivery.
- Therapeutic services provided using telehealth modalities generate positive outcomes for the client, including engagement in treatment, retention in care, and client satisfaction, which in turn lead to improved long-term health outcomes.



- Positive outcomes are dependent on the provider and client having the necessary resources to conduct telehealth well, including training and technology (more information on supporting telehealth implementation can be found in Chapter 3).

Additionally, several conclusions related to *healthcare access* and *utilization* can be made from this evidence-review:

- Use of telehealth modalities increases individuals' and communities' access to trained providers and evidence-based practices that may otherwise be unavailable to them.
- When geographic and other access barriers (e.g., transportation, mobility, and obligations like employment and caretaking responsibilities) prevent individuals from accessing services, telehealth fills a treatment gap and improves health outcomes.
- Some clients may prefer to receive services wholly or partially by telehealth, and any of the treatment practices presented in this chapter may be part of an overall treatment plan that includes a hybrid of telehealth and in-person services.

However, research on the telehealth application of evidence-based practices has been limited for the following reasons:

- *Evidence review limitations.* While there may be innovative behavioral therapies currently delivered via telehealth for specific conditions, this evidence review relies on specific types of published research to determine the strength of evidence.
- Included studies must be either randomized controlled trials, use a quasi-experimental design, or use a pre-post design with a strong counterfactual; therefore, innovative treatments and interventions that have not been studied with such rigorous methods are excluded.

- *Limitations of the literature.* While telehealth has been used for numerous other conditions, individuals experiencing SMI and SUD have traditionally been regarded as having complex conditions and therefore excluded from telehealth research. With limited implementation of telehealth for people with SMI and SUD, it offered fewer opportunities for researching treatment to treat those conditions. Some providers have been reluctant to offer telehealth in the past, in part due to negative views towards the modality and perception of clients' experiences with telehealth,⁹² which has slowed access to telehealth for individuals experiencing SMI or SUD.

- *Need examination of asynchronous forms of treatment.* This evidence review demonstrated strong evidence to support synchronous interventions to support telehealth-delivered, evidence-based treatments.
- However, more research is needed to determine the effectiveness of asynchronous treatments, which can be effective complementary tools to synchronous virtual or in-person treatment by increasing client engagement, promoting healthy behaviors, reducing feelings of stigma, and increasing access to treatment.^{93, 94} Text messages, online chat features, email, and social networking sites can also be used to facilitate ongoing communication outside of face-to-face sessions.⁶

While there are limitations to the research, telehealth is a key strategy to increasing and ensuring access to care for people living with SMI, SUD, or COD. Future research could expand beyond telehealth efficacy and focus on implementation and evaluation considerations, including provider/patient buy-in, necessary technological infrastructure, and methods of quality improvement. Considerations related to implementation and evaluation will be discussed in Chapters 3 and 5, respectively.

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