Telehealth Service Recommendations

Clinical guidance for outpatient behavioral health providers

January 2023

OREGON HEALTH
LEADERSHIP COUNCIL

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INTRODUCTION

Purpose & Intent

The recommendations in this document were developed by members of Oregon Health Leadership Council's (OHLC's) Telehealth Workgroup (see Methods section for more information). They are meant to provide **guidance to behavioral health providers in determining whether a patient may be clinically appropriate for outpatient telehealth care**. They were developed from available evidence-based literature and expert opinion, but do not guarantee successful outcomes, nor set a medical or legal standard.

Evidence pertaining to the effectiveness of telehealth is not yet available for some health conditions and patient populations. This document is meant to provide information to assist practitioners in developing their own practice standards. They are not prescriptive and are not intended to be used in a regulatory manner. Providers should continue to exercise their own clinical judgement in determining whether telehealth services are appropriate on an individual patient basis.

Organizations providing telehealth services must abide by all local, state, and federal laws and regulations, including privacy and security requirements.

Position Statement

We advocate for the continued use of telehealth as an effective platform to deliver high quality behavioral health care services for children, youths, adults, and families. The hope is that these recommendations help facilitate safe and effective remote care and build strong patient-provider relationships, while maintaining patient privacy and adequate communication with all parties involved.

We appreciate that telehealth facilitates improved access to behavioral health services through increasing provider options in rural areas, reducing stigma for those who do not wish to be seen at a behavioral health facility, eliminating transportation barriers, and relieving childcare needs. We believe that telehealth offers an opportunity to grow and diversify the behavioral health care workforce, as well as increase patient and provider satisfaction.[1]

We also recognize that significant inequities in accessing telehealth care exist among different sociodemographic populations.[2] It is recommended that a high priority is placed on ensuring access to vulnerable patients, to prevent furthering already existing health inequities. Therefore, we support the expansion of affordable broadband and video-capable devices to rural and low-income populations, as well as appropriate interpreter services, disability accommodations, and technical assistance for all patients.

Lastly, we support permanent reimbursement for all modes of telehealth delivery, which is essential to the development of an innovative and stable telehealth infrastructure.

INTRODUCTION

Telehealth Definitions

"Telehealth" is a mode of delivering healthcare services or medical information from one physical location to another through the use of telecommunications technologies. Services may be delivered asynchronously or synchronously, via audio, visual, and/or written communications.

This document focuses on visits with a patient located in their home or other non-clinical setting, and uses the following definitions for telehealth platforms:

Video: Synchronous audio and video communication, through smartphone, tablet, or computer
Telephone: Synchronous audio-only communication
E-Visit: Asynchronous communication between a patient and provider through a secure online messaging portal

Telehealth Principles

It is recommended that organizations abide by the following standards, adapted from the telehealth principles of the West Coast Compact:[3]

1. **Access:** Telehealth will be used as a means to promote adequate and equitable access to health care.
2. **Confidentiality:** Patient confidentiality, including interactions and patient records, will be protected; and patients should provide informed consent verbally or in writing about both care and the specific technology used to provide it.
3. **Equity:** Telehealth will be available to every patient, regardless of race, ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, immigration status, nationality, religious belief, language proficiency or geographic location. Telehealth services will comply with civil rights law.
4. **Standard of Care:** Standard of care requirements will apply to all services and information provided via telehealth, including quality, utilization, cost, medical necessity, and clinical appropriateness.
5. **Stewardship:** Providers will employ the use of evidence-based strategies, deliver quality care, and will continue to take steps to mitigate and address fraud, waste, and abuse.
6. **Patient choice:** Patients, in conjunction with their providers, should be offered their choice of service delivery mode. Patients will be made aware of the limitations of virtual visits and retain the right to receive health care in person.

Payment and Benefits

Benefits for telehealth vary by type of service and health plan. **These recommendations pertain to clinical use of telehealth services, regardless of benefit coverage.** We attempted to align recommended services with those that are currently covered by Medicare (CMS) and the Oregon Health Plan (OHP). However, coverage should always be confirmed prior to the provision of any telehealth services.

ESTABLISHING A TELEHEALTH RELATIONSHIP

Behavioral health providers of all types, including case workers, counselors, psychiatrists, psychologists, and more can use telehealth to connect with patients. While the content of the visit is similar to in-person meetings, there are some additional steps that should be taken upfront to align expectations and identify any additional needs of the patient. **These recommended foundational steps can help promote success and engagement in telehealth care:**

1. Provide the patient/caregiver **telehealth instructions and technical assistance** materials in their preferred language, prior to the first visit. If possible, provide the opportunity to test and practice use of the technology prior to the first visit.[4]

2. **Identify any barriers** to telehealth that need to be addressed prior to the visit, such as interpreter needs, disability accommodations, technology limitations, or privacy concerns. <u>Note:</u> Insurers may be able to help patients pay for a smart phone or tablet for telehealth visits. Patients can contact their insurer to ask if they qualify for any assistance programs.
   ➤ Click here and here for more information on improving telehealth accessibility for patients with disabilities

3. Obtain and document **informed consent** for telehealth prior to or during the first visit, including an explanation of telehealth, its benefits, possible harms or risks, alternative options, the ability to withdraw consent, and anticipated cost.[5]
   a. Risks can include: technical challenges, privacy challenges, limitations of the provider to comprehensively assess the patient, and limitations to intervene if a patient experiences intense emotions or rapid dysregulation
   b. Benefits can include: increased accessibility for those in rural areas or with transportation limitations, transportation time and cost savings, reduction of stigma, reduction of disease transmissibility potential, and ability to assess the patient's home environment
   ➤ Click here for a sample consent form and instructions on how to conduct a consent discussion

4. The provider should state their name and credentials at the beginning of the visit and confirm the patient's identity. They should ensure that room the patient is in, as well as the room they are in, offers **privacy and safety**.[6]

5. The provider and patient should develop an **emergency plan** together.[6]
   a. Providers should be aware of the location of the patient during each visit, understand emergency management protocols and have documented emergency contacts in each location (police, fire, crisis, urgent care, and emergency department)
   b. Ask patients to identify a support person nearby them that could be called for assistance in the case of a crisis or emergency
   c. Collect contact information for the patient's primary care provider and other healthcare team members
   d. Plan for what will happen if the visit is disconnected during an emergency or if the patient unexpectedly misses an appointment
   e. Determine what events will set the emergency plan into action and what events will prompt a referral to in-person or in-patient care
   ➤ Click here for a list of emergency plan questions to ask your patients

GENERAL TELEHEALTH RECOMMENDATIONS

Telehealth has proved to be an effective and accepted means to deliver behavioral health care for a wide variety of patients and conditions.[7] **No population or diagnosis is inherently appropriate or inappropriate for remote care.** The following patient, provider, situational, and diagnostic considerations should all be weighed to determine the most appropriate type of visit for each individual at any point in time.

1. Patient Status

A patient's medical history, treatment needs, and presenting symptom severity should be used to inform whether telehealth may be an appropriate method of care delivery.

Consider the following patient status factors when determining if an in-person visit will be needed:

1. Current medical status and treatment needs. For example:
   - Need for hands-on physical examination or office administered medication
   - Subtle nuances of verbal and/or physical communication need to be evaluated and are not evident via virtual visit
   - Elevated risk of harm to self or others
   - Recent significant decline in behavioral health status/function
   - Hallucinations that interfere with aspects of virtual care delivery
   - Experiencing paranoia or anxiety and may not trust telehealth platforms
   - Limited tolerance or ability to pay attention during telehealth visits
2. Patient history. For example:
   - At high risk for acute physical and/or mental decompensation
   - Previous violent or self-injurious behavior
3. Cognitive capacity
4. Availability and adequacy of patient's support system

Patients in acute crisis should be referred to emergency or inpatient care. For example:

- Dangerous, assaultive, or other uncontrolled behavior
- Acute deterioration in mental health functioning causing an exacerbation in other medical conditions
- Active psychosis

In the event of a behavioral health crisis or emergency during a telehealth visit, the provider should contact emergency services directly and make their best efforts to provide hand-off information verbally and in writing, including the provider's contact information. If possible, the provider should remain connected to the patient until emergency personnel have arrived and remain available during the emergency to communicate with first responders.[4]

2. Situation

Outside factors unrelated to the patient's condition can also influence the effectiveness or feasibility of a remote visit.

Situations that may necessitate an in-person visit:[8-10]

- Patient does not have the requisite telehealth technology or technical skills
- Privacy cannot be ensured during a remote visit, particularly if the visit will include sensitive topics such as assessment of substance use disorder or sexual history, or if the patient is experiencing domestic violence or other abuse in the home
- A trusted adult is not available to support or assist children, adolescents, those with limited cognitive capacity, or with other caregiving needs
- Need to assess patient safety
- Poor audio or video connection interferes with proper assessment or communication
- Patient's cultural beliefs are not aligned with virtual care
- As required by patient's insurer
- As required by licensing, state, or federal laws or regulations

Other situational factors to consider:

- Access or distance to nearest the emergency facility
- Potential for disease exposure
- Time elapsed since last in-person visit

Note: **Telehealth can be appropriate for new and established behavioral health patients.** The need to establish care alone does not necessitate an in-person visit.

3. Patient and Provider Choice

The patient's choice of in-person, video, or phone visit should be accepted whenever (1) privacy, safety and care quality are not compromised, (2) the provider agrees it is an appropriate fit for the patient, and (3) the provider feels competent using the selected modality.

It is recommended to choose the most comprehensive telehealth platform feasible. Telephone visits should be used when audio/video platforms are unachievable or declined by the patient. E-visits should be primarily used for established patients, for symptom-specific evaluation, when the condition is of low-acuity, low-risk, and not time-sensitive.[3]

The option to perform an in-person evaluation should always remain available. Keep in mind that an in-person visit may provide information not obtainable during a virtual session.

Providers who do not have a physical location in which to see patients should consider maintaining referral agreements with providers who do have a physical location, to offer timely, low-barrier access for patients in need of an in-person visit.

During the telehealth visit, if it becomes clear to the provider that an in-person visit is necessary based on clinical need or acuity, the provider should ensure there is a feasible plan for scheduling the visit and arranging transportation.

CONDITION SPECIFIC TELEHEALTH RECOMMENDATIONS

4. Diagnosis or reason for visit

Research-guided information on the safety, effectiveness, and acceptability of telehealth for specific behavioral health conditions or diagnoses may also help providers determine if remote care is appropriate for their patients. The following sections provide guidance on treating common coaching topics, mental health conditions, and substance use disorders, and **should be considered in conjunction with the general recommendations in the previous sections**.

Behavioral Health Coaching

Coaching involves working with patients to make individualized lifestyle behavior changes through motivation, collaborative goal-setting, planning, and education. The list below includes telehealth recommendations for common focus areas in coaching. The list is not comprehensive, but is intended to assist behavioral health providers in developing their own criteria for the selected conditions.

Behavioral Health Coaching Recommendations

Coaching focus	Telehealth Candidate?	Platforms	Recommended telehealth services	In addition to general recommendations, consider in-person visits for the following:	References
Chronic illness self-management	Yes	**Video** – preferred **Telephone** – acceptable	• Education, motivational interviewing, medication management, goal-setting, action planning, adherence support, nutrition/diet counseling, provide or link to social/emotional supports, provide encouragement and advice • Remote monitoring may be used as an adjunct to visits to track symptoms, peak flow, blood glucose, blood pressure, weight, physical activity, etc.	• Vulnerable/underserved populations • Patients with low health literacy • Severity of symptoms interferes with coaching effectiveness	11,12,13, 14,15,16,17, 18,19
Depression/ anxiety	Yes	**Video** – preferred **Telephone** – acceptable	• Education, motivational interviewing, care coordination, goal-setting, symptom assessment, medication management, refer to higher level of care if needed • May be accompanied by online or hard-copy self-guided modules for education and skills training	• Severity of symptoms interferes with coaching effectiveness	20,21,22,23, 24

Behavioral Health Coaching Recommendations

Coaching focus	Telehealth Candidate?	Platforms	Recommended telehealth services	In addition to general recommendations, consider in-person visits for the following:	References
Smoking cessation	Yes	**Video** – preferred **Telephone** – acceptable	• Education, motivational interviewing, goal-setting, trigger identification and action planning, medication management, provide or link to social/emotional supports, provide encouragement and advice		25,26,27,28
Weight management	Yes	**Video** – preferred **Telephone** – acceptable	• Education, motivational interviewing, goal-setting, action planning, nutrition/diet counseling, provide or link to social/emotional supports, provide encouragement and advice • May be accompanied by use of food/activity logs, remote tracking of activity/stress/sleep/weight		25,26,29,30, 31,32

CONDITION SPECIFIC TELEHEALTH RECOMMENDATIONS

Mental Health Treatment

Outpatient treatment delivered remotely for mental health conditions may include psychotherapy, medication management, care coordination, group support, etc., and can be delivered by a wide range of mental health professionals. The list below includes telehealth recommendations for common mental health diagnoses. The list is not comprehensive, but is intended to assist behavioral health providers in developing their own criteria for the selected conditions.

Mental Health Recommendations

Condition	Telehealth Candidate?	Platforms	Recommended telehealth services	In addition to general recommendations, consider in-person visits for the following:	References
Attention-deficit/hyperactivity disorder (ADD/ADHD)	Yes	**Video** – preferred **Telephone** – acceptable if video is not possible	• Pediatric ADD/ADHD evaluation, caregiver behavioral training and education, medication management • Pediatric care team conferencing, including patient, family, and school personnel • Adolescent group therapy	• Limited evidence exists for effectiveness of telehealth for adult patients • Limited evidence exists for effectiveness of direct therapy provided via telehealth • Parent/guardian is unable to actively participate or support pediatric patient	33,34,35,36, 37
Anxiety	Yes	**Video** – preferred **Telephone** – acceptable	• Psychotherapy, including cognitive behavioral therapy, exposure therapy, relaxation therapy, and group therapy • Diagnostic assessment, medication management		38,39,40,41, 42,43,44,45, 46
Autism	Yes	**Video** – preferred **Telephone** – not recommended	• Diagnostic pediatric assessment (only if patient is unable to be seen in person) • Parent education and training, functional analysis, patient education, therapy, coaching, follow-up discussions	• Limited evidence exists for effectiveness of telehealth for adult patients • If possible, telehealth should be used to augment, rather than replace in person visits • Diagnostic assessments should be in-person whenever possible	35,47,48,49, 50

Mental Health Recommendations

Condition	Telehealth Candidate?	Platforms	Recommended telehealth services	In addition to general recommendations, consider in-person visits for the following:	References
Bipolar disorder	Yes	**Video** – preferred **Telephone** – not recommended	• Psychotherapy, including social rhythm therapy • Medication management	• Need to more thoroughly assess movement, speech, or affect • Limited evidence exists for reliability of diagnostic assessment via telehealth • Limited evidence exists for effectiveness of pediatric treatment via telehealth	51,52,53,54
Depression	Yes	**Video** – preferred **Telephone** – acceptable	• Psychotherapy, including cognitive behavioral therapy, problem solving therapy, behavioral activation • Diagnostic assessment using validated screening questionnaire, education, medication management, symptom monitoring		38,39,44,45, 46,55,56,57, 58,59,60
Eating disorders	Yes	**Video** – preferred **Telephone** – acceptable if video is not possible	• Psychotherapy, including cognitive behavioral therapy, exposure therapy, family-based treatment, caregiver support groups, group therapy • Education, medication management, food planning, self-weight measurements • Remote monitoring and self-help may be added as an adjunct to treatment	• Increasing or concerning symptomology, need for in-person weight or vital sign monitoring, need for medical evaluation • Limited evidence exists for effectiveness of telehealth for men, older adults, and minority populations • Limited evidence exists for reliability of diagnostic assessment via telehealth	61,62,63,64, 65,66,67,68, 69,70,71
Obsessive compulsive disorder (OCD)	Yes	**Video** – preferred **Telephone** – acceptable	• Psychotherapy for youths & adults, including cognitive behavioral therapy, exposure & response prevention, education, parent support/training • Diagnostic assessment, medication management	• Concern for physical health complications, including weight loss	41,45,46,72, 73,74

Mental Health Recommendations

Condition	Telehealth Candidate?	Platforms	Recommended telehealth services	In addition to general recommendations, consider in-person visits for the following:	References
Panic disorder	Yes	**Video** – preferred **Telephone** – acceptable	• Psychotherapy, including cognitive behavioral therapy • Education, medication management • Diagnostic assessment, only if the patient has been evaluated to rule out physical causes	• Acute panic attack • Need for vital sign monitoring • Other significant or concerning physical symptoms	58,75
Personality disorder	Yes	**Video** – preferred **Telephone** – not recommended	• Psychotherapy, including dialectical behavior therapy, cognitive behavioral therapy, acceptance and commitment therapy, group skills training • Medication management	• Patients with significant dysregulation, unstable or increasing anger, impulsivity, or thoughts/plans of self-harm • Inability to remain engaged or refrain from distracting behaviors during a remote visit • Consider providing new patient/pretreatment visit in person to establish relationship • Limited evidence exists for reliability of diagnostic assessment via telehealth	76,77,78, 79,80,81
Post-traumatic stress disorder (PTSD)	Yes	**Video** – preferred **Telephone** – acceptable	• Psychotherapy, including cognitive behavioral therapy, behavioral activation, prolonged exposure, and cognitive processing therapy, particularly for US veterans • Diagnostic assessment	• Limited evidence exists for effectiveness of telehealth for children and youth	38,44,60,82, 83,84,85,86, 87,88
Psychotic disorders	Yes	**Video** – preferred **Telephone** – not recommended	• Patient assessment (via video) • Psychotherapy, including cognitive behavioral therapy • Medication management, skills training, patient/caregiver education, facilitated support or therapy groups, care coordination • Remote symptom monitoring may be added as an adjunct to treatment	• Delusions, hallucinations, or paranoia that interfere with acceptance of telehealth care delivery • High quality audio-video connection is not available (i.e., difficult to assess affect, movement, attentiveness, etc. due to poor video quality)	89,90,91, 92,93,94,95

CONDITION SPECIFIC TELEHEALTH RECOMMENDATIONS

Substance Use Treatment

Outpatient treatment delivered remotely for substance use may include psychotherapy, medication management, care coordination, group support, etc., and can be delivered by a wide range of mental health professionals. The list below includes telehealth recommendations for common substance use diagnoses. The list is not comprehensive, but is intended to assist behavioral health providers in developing their own criteria for the selected conditions.

Substance Use Recommendations

Condition	Telehealth Candidate?	Platforms	Recommended Telehealth Services	In addition to general recommendations, consider in-person visits for the following:	References
Alcohol use disorder	Yes	**Video** – preferred **Telephone** – acceptable	• Psychotherapy, including cognitive behavioral therapy, group therapy, motivational enhancement therapy • Assessment, brief intervention, Medication Assisted Treatment (MAT), medication monitoring, coaching support	• Signs or symptoms of withdrawal are present • Need to assess for detox program	96,97,98,99, 100,101,102
Opioid use disorder	Yes	**Video** – preferred **Telephone** – acceptable	• Psychotherapy, including cognitive behavioral therapy, group therapy • Assessment, Medication Assisted Treatment (MAT), medication monitoring, counseling	• Need to complete urine drug screen • Signs or symptoms of withdrawal are present	103,104,105, 106,107,108
Tobacco/nicotine use disorder	Yes	**Video** – preferred **Telephone** – acceptable	• Assessment, individual and group counseling, motivational interviewing, education • Medication management		109,110,111, 112,113
Other drug abuse, dependence, or illicit use	Yes	**Video** – preferred **Telephone** – acceptable	• Use provider discretion as evidence is limited	• Limited evidence exists for efficacy of telehealth treatment for cannabis, hallucinogen, sedative, anxiolytic, or stimulant use	60

SPECIAL CONSIDERATIONS – Pediatric Patients

Current Support

The American Academy of Child & Adolescent Psychiatry **(AACAP) supports the delivery of psychiatric, mental, and behavioral health services via telehealth for pediatric patients,** noting that "psychotherapy, behavior training, and pharmacotherapy have all been provided successfully" using telehealth, and it is "feasible, acceptable, and as effective as care delivered in person".[7]

The **American Academy of Pediatrics (AAP)** endorse behavioral health principles which state, "telehealth – particularly for mental health and substance use care – can maintain and even improve the quality and comprehensiveness of patient care while expanding access to evidence-based care for children" in a medical home.[114]

Legal Considerations & Consent

- Providers should follow all state and federal telehealth regulations including those pertaining to privacy, confidentiality, security, and informed consent, such as HIPAA, HITECH, and FERPA.[7]
- **In Oregon, minors 14 years or older may consent to outpatient mental health, drug, or alcohol treatment without parental consent.** However, the parent is expected to be involved to some extent prior to the end of treatment. Minors may consent to medical services without parental consent at the age of 15. Access to birth control, as well as STI testing and treatment is allowed at any age without parental consent.[115]
- Remind patients that mandatory child abuse reporting requirements and the permission to report intent to commit certain crimes applies to telehealth visits as well as in-person visits.
- Advise youth that although visits are confidential, parents may see billing information related to the visit from their insurer.

Parent/Guardian Involvement

- Parents or legal representatives that will be participating in visits should be **pre-screened** for ability to safely and effectively participate in telehealth and support the patient if needed.[8]
- Arrangements should be made to ensure that the patient has **access to a private space** during confidential portions of the visit, or the entire visit if appropriate.
- Even if not participating in the visit, a trusted, **responsible adult should be on-site** and able to intervene if needed.[8]
- To facilitate communication, providers should confirm that they have **contact information** for the parent/guardian prior to the telehealth visit,[7] and that the parent has access to the patient's online medical portal if appropriate.

Tips for Engagement and Rapport[8,116]

- Encourage the use of headphones or the chat feature if privacy is a concern
- Younger children or those with attention difficulties may benefit from shorter, more frequent sessions
- Limit distractions – remove phones/tablets, turn off the tv, ask anyone who is not participating in the visit to leave the room
- Younger children may need a larger space in which to play and engage in activities
- During your first session, give the patient a virtual tour of your space and ask them to give you a tour of their space
- If possible, utilize interesting features of your videoconferencing software, such as sharing worksheets, creating drawings together, picking fun virtual backgrounds, etc.

SPECIAL CONSIDERATIONS
Integrated Behavioral Health

Behavioral Health Integration & Telehealth

Integration of behavioral health services with physical health services can help improve behavioral health care access, care coordination, and patient and provider satisfaction. Although behavioral health care is an essential element of comprehensive primary care, the shortage of behavioral health providers, funding limitations, and cultural differences can make integration challenging.[117]

The use of technology, including telehealth, to deliver appropriate behavioral health services can help address some of these challenges while providing patients and staff the benefits of integrated care as well as the benefits of telehealth, such as decreased no-show rates, expanded services to rural populations, and reduced stigma.

Integrated behavioral health care models span a continuum based on the resources and needs of each organization.[118] Telehealth can be leveraged to enhance any integration model, whether the behavioral health provider is co-located with primary care or located remotely. Integrated behavioral telehealth can be particularly valuable for small and/or rural clinics, as it allows for multiple clinics to utilize a single behavioral health provider, who may be located off-site.

Recommendations[118,119]

- Use a common or integrated electronic record system that allows sharing of screenings, assessments, non-confidential chart notes, collaborative care plans, etc.
- Establish a process for teleconsultation between the primary care and behavioral health care providers
- For patients that prefer not to attend their behavioral health visit from home, offer private rooms and PCs/tablets at the primary care clinic for use during visits with off-site providers
- Establish processes for regular (in-person or virtual) communication between the physical and behavioral health care teams, including care team conferences for appropriate patients
- Provide virtual warm-handoffs, using videoconferencing platform to introduce patients to the behavioral health provider whenever possible
- Appointment times should be left available on the behavioral health provider's schedule daily, to accommodate unforeseen warm hand-offs

Additional Behavioral Health Integration Resources

- American Medical Association: Accelerating and Enhancing Behavioral Health Integration Through Digitally Enabled Care
- National Academy for State Health Policy: Improving Behavioral Health Access & Integration Using Telehealth & Teleconsultation
- Agency for Healthcare Research and Quality: Telehealth and Behavioral Health Integration

SPECIAL CONSIDERATIONS
Group Visits & Support Groups

Professional-led therapy, support, and educational groups conducted through videoconferencing have been shown to be an effective and acceptable way of delivering care.[120-122] However, group telehealth can also present some unique challenges. **The recommended tips below can help facilitate an efficient and engaged group experience**.[104,123-126]

1. **Preparation before the meeting**
   - Pre-screen participants: assess each person for alignment with telehealth (see p.6-7) as well as developmental and behavioral ability to appropriately participate in a group setting.
   - Identify and address any barriers and obtain informed consent for telehealth (see p.5)
   - Provide participants with an option to test the software
   - Send instructions and materials to each participant
   - Send a meeting reminder with the link and password one day to several hours prior to the meeting

2. **Meeting logistics**
   - Use a secure videoconferencing platform (synchronous audio and video)
   - Enlist a co-facilitator to monitor the chat, handle technical issues, attend to any emergencies, etc.
   - Maintain security:
     - Require a password to access the meeting
     - Utilize a "waiting room" feature and manually admit pre-screened participants only
     - Do not record the meeting
   - Lock the room after meeting begins to minimize disruptions
   - Leave extra time for questions and troubleshooting
   - Have a backup plan: share a telephone call-in number to be used if technical issues arise

3. **During the first meeting**
   - Provide an overview of how to use the features of the videoconferencing platform
   - Share the emergency plan
   - Outline rules and expectations including:
     - Privacy (e.g., all participants must join from a private space without children or housemates present, use of headphones is encouraged, use first names only). Remind participants that privacy cannot be guaranteed.
     - Engagement (e.g., cameras should remain on, refrain from distractions such as cell phones or TVs)
     - When and how to share (e.g., remain on mute, use raise hand feature to speak, private chat is disabled)
     - Behavior (e.g., appropriate language)

4. **Cultivating positive group dynamics**
   Some studies show lower therapeutic alliance ratings when using telehealth versus in-person groups. To promote engagement:
   - More time may need to be spent on fostering group cohesion than with in-person groups
   - Use eye contact, body language, and hand gestures to keep participants attentive
   - Consider using break-out rooms or pair discussions to encourage interaction between participants
   - Encourage and elicit feedback from participants regularly

OPERATIONAL CONSIDERATIONS
Resources for successful telehealth integration

How can I implement telehealth in my practice?

- Substance Abuse and Mental Health Services Administration (SAMHSA) [Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders](#)
- Health and Human Services (HHS) [Telehealth for Behavioral Health Care: Best Practice Guide](#)
- American Psychiatric Association [Best Practices in Synchronous Videoconferencing-Based Telemental Health (March 2022)](#)
- American Psychiatric Association [Telepsychiatry Toolkit](#)
- American Psychological Association [Guidelines for the Practice of Telepsychology](#)
- American Telemedicine Association [Practice Guidelines for Telemental Health with Children & Adolescents](#)
- Pacific Southwest Mental Health Technology Transfer Center [Telehealth Clinical and Technical Considerations for Mental Health Providers](#)

What telehealth services are covered by insurance?

- Medicare & Medicare Advantage
    - Centers for Medicare and Medicaid Services (CMS) – 2023 Physician Fee Schedule
      https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched
    - Centers for Medicare and Medicaid Services (CMS) – List of Telehealth Services
      https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- Medicaid
    - Oregon Health Authority, Ancillary Guideline A5, Telehealth, Teleconsultations, and Online/Telephonic Services
      https://www.oregon.gov/oha/HPA/DSI-HERC/SearchablePLdocuments//Prioritized-List-GN-A005.docx

Can I provide care to an out-of-state patient?

- Physicians and Physician Assistants: https://www.oregon.gov/omb/Topics-of-Interest/Pages/Telemedicine.aspx
- Advanced Practice Registered Nurses (NP/CNS/CRNA): https://www.oregon.gov/osbn/Documents/FAQ_APRN.pdf
- Psychologists: https://www.oregon.gov/psychology/Pages/COVID-19.aspx
- Licensed Professional Counselors and Therapists: https://www.oregon.gov/oblpct/Pages/COVID-19.aspx
- Social Workers: https://www.oregon.gov/blsw/Pages/LicenseDescriptions.aspx
- QMHA, QMHP, CADC, CGAC, CPS, CRM, CGRM: https://www.mhacbo.org/en/forms-info/faq/#reciprocity

Is there telehealth reciprocity between Oregon & Washington?*

The easing of telehealth licensing rules made conducting virtual visits easier during the COVID-19 public health emergency (PHE). However, as of October 31, 2022, Oregon and Washington's state PHEs have ended, although the Federal PHE remains in place. This has caused some confusion, as each licensing board has its own rules governing the provision of telehealth between the states. Below are the current rules for MDs, NPs, PAs, and PsyDs. Please note that they are subject to change, as this is a prominent and dynamic issue.

As of December 2022:

- **MDs, DOs, and PAs**
  - **Those who are licensed in Oregon** can provide care to **established** patients via telehealth for patients located in Washington at the time of the telehealth visit for the purposes of maintaining **continuity of care**
    - Oregon licensed clinicians **can no longer see NEW patients** via telehealth if the patient is not physically located in Oregon, unless the provider has a Washington license
  - **Those who are licensed in Washington** can provide care to **established** patients via telehealth for patients who are physically located in Oregon at the time of the telehealth visit for the purposes of maintaining **continuity of care**
- **NPs**
  - **Those who are licensed in Oregon** cannot provide care (in-person or telehealth) to patients located in Washington, unless they carry a Washington license
  - **Those who are licensed in Washington** cannot provide care (in-person or telehealth) to patients located in Oregon, unless they carry an Oregon license
- **PsyDs**
  - **Those who are licensed in Oregon** must have a temporary or permanent Washington license to serve patients physically located in Washington
- **All other licenses**
  - Refer to policies in place for your licensure (links on page 17), or contact your licensing board for clarification

*Information gathered by Providence Medical Group via communication with state licensing boards

METHODS

These recommendations were developed by the members of Oregon Health Leadership Council's (OHLC's) Telehealth Workgroup, with the guidance and support of OHLC's Best Practice Committee. These groups are comprised of providers, clinical leaders, and telehealth experts representing health systems, clinics, and health plans throughout Oregon. More information about the Best Practice Committee can be found here: http://www.orhealthleadershipcouncil.org/ebbp/.

The information in this document was collected via evidence-based literature searches, as well as expert opinion from Telehealth Workgroup members and their colleagues. The conditions listed within each condition specific guideline section were derived from the most common reasons for visits in the behavioral health setting, as well as input from behavioral health clinicians.

The recommendations provided in this document reflect information available to the OHLC Telehealth Workgroup at the time of its development. However, research on the safety, quality, and effectiveness of telehealth is ongoing. We encourage organizations to use these recommendations as an aide in building their telehealth procedures and continue to refine their processes as new research becomes available.

REFERENCES

1. Reese, J. B., & Ramtekkar, U. (2022). Telebehavioral health: Workforce, access, and future implications. *The Psychiatric Clinics of North America*, *45*(2), 313–319. https://doi.org/10.1016/j.psc.2022.03.008
2. Eberly, L. A., Kallan, M. J., Julien, H. M., Haynes, N., Khatana, S., Nathan, A. S., Snider, C., Chokshi, N. P., Eneanya, N. D., Takvorian, S. U., Anastos-Wallen, R., Chaiyachati, K., Ambrose, M., O'Quinn, R., Seigerman, M., Goldberg, L. R., Leri, D., Choi, K., Gitelman, Y., Kolansky, D. M., … Adusumalli, S. (2020). Patient characteristics associated with telemedicine access for primary and specialty ambulatory care during the COVID-19 pandemic. *JAMA network open*, *3*(12), e2031640. https://doi.org/10.1001/jamanetworkopen.2020.31640
3. CareOregon. *CareOregon telemedicine technical assistance guide*. http://careoregon.org/docs/default-source/covid-19/cor-covid-19-telehealth-ta-guide.pdf
4. American Psychiatric Association and the American Telemedicine Association. (2022, March). *Best practices in synchronous videoconferencing-based telemental health (March 2022)*. https://marketing.americantelemed.org/hubfs/Best-Practices-in-Synchronous-Videoconferencing-Based-Telemental-Health-March-2022.pdf
5. Agency for Healthcare Research and Quality. (2020, September). *How to obtain consent for telehealth.* Health literacy improvement tools. https://www.ahrq.gov/health-literacy/improve/informed-consent/obtain.html
6. Health Resources & Services Administration. *Preparing patients for telebehavioral health.* Best practice guide: Telehealth for behavioral health care. https://telehealth.hhs.gov/providers/telehealth-for-behavioral-health/preparing-patients-for-telebehavioral-health/
7. American Academy of Child and Adolescent Psychiatry. (2017, June). *Delivery of child and adolescent psychiatry services through telepsychiatry.* https://www.aacap.org/AACAP/Policy_Statements/2017/Delivery_of_Child_and_Adolescent_Psychiatry_Services_Through_Telepsychiatry.aspx
8. American Telemedicine Association. (2017, March). *Practice guidelines for telemental health with children and adolescents.* https://www.americantelemed.org/resources/practice-guidelines-for-telemental-health-with-children-and-adolescents/
9. Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (2013). Guidelines for the practice of telepsychology. *The American Psychologist*, *68*(9), 791–800. https://doi.org/10.1037/a0035001
10. American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues (2017). Clinical update: Telepsychiatry with children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *56*(10), 875–893. https://doi.org/10.1016/j.jaac.2017.07.008
11. Hanlon, P., Daines, L., Campbell, C., McKinstry, B., Weller, D., & Pinnock, H. (2017). Telehealth interventions to support self-management of long-term conditions: A systematic metareview of diabetes, heart failure, asthma, chronic obstructive pulmonary disease, and cancer. *Journal of Medical Internet Research*, *19*(5), e172. https://doi.org/10.2196/jmir.6688
12. Kelly, J. T., Reidlinger, D. P., Hoffmann, T. C., & Campbell, K. L. (2016). Telehealth methods to deliver dietary interventions in adults with chronic disease: A systematic review and meta-analysis. *The American Journal of Clinical Nutrition*, *104*(6), 1693–1702. https://doi.org/10.3945/ajcn.116.136333
13. Guo, Y., & Albright, D. (2018). The effectiveness of telehealth on self-management for older adults with a chronic condition: A comprehensive narrative review of the literature. *Journal of Telemedicine and Telecare*, *24*(6), 392–403. https://doi.org/10.1177/1357633X17706285
14. Parker, S., Prince, A., Thomas, L., Song, H., Milosevic, D., Harris, M. F., & IMPACT Study Group (2018). Electronic, mobile and telehealth tools for vulnerable patients with chronic disease: A systematic review and realist synthesis. *BMJ Open*, *8*(8), e019192. https://doi.org/10.1136/bmjopen-2017-019192
15. Agastiya, I., Kurianto, E., Akalili, H., & Wicaksana, A. L. (2022). The impact of telehealth on self-management of patients with type 2 diabetes: A systematic review on interventional studies. *Diabetes & Metabolic Syndrome*, *16*(5), 102485. https://doi.org/10.1016/j.dsx.2022.102485
16. Hwang, N. K., Park, J. S., & Chang, M. Y. (2021). Telehealth interventions to support self-management in stroke survivors: A systematic review. *Healthcare* (Basel, Switzerland), *9*(4), 472. https://doi.org/10.3390/healthcare9040472
17. Lin, N. Y., Ramsey, R. R., Miller, J. L., McDowell, K. M., Zhang, N., Hommel, K., & Guilbert, T. W. (2020). Telehealth delivery of adherence and medication management system improves outcomes in inner-city children with asthma. *Pediatric Pulmonology*, *55*(4), 858–865. https://doi.org/10.1002/ppul.24623
18. Pekmezaris, R., Nouryan, C. N., Schwartz, R., Castillo, S., Makaryus, A. N., Ahern, D., Akerman, M. B., Lesser, M. L., Bauer, L., Murray, L., Pecinka, K., Zeltser, R., Zhang, M., & DiMarzio, P. (2019). A randomized controlled trial comparing telehealth self-management to standard outpatient management in underserved black and Hispanic patients

living with heart failure. *Telemedicine Journal and e-health : The official journal of the American Telemedicine Association*, *25*(10), 917–925. https://doi.org/10.1089/tmj.2018.0219

19. Lau, S. C., Bhattacharjya, S., Fong, M. W., Nicol, G. E., Lenze, E. J., Baum, C., Hardi, A., & Wong, A. W. (2020). Effectiveness of theory-based digital self-management interventions for improving depression, anxiety, fatigue and self-efficacy in people with neurological disorders: A systematic review and meta-analysis. *Journal of telemedicine and telecare*, 1357633X20955122. Advance online publication. https://doi.org/10.1177/1357633X20955122

20. Thielecke, J., Buntrock, C., Titzler, I., Braun, L., Freund, J., Berking, M., Baumeister, H., & Ebert, D. D. (2022). Telephone coaching for the prevention of depression in farmers: Results from a pragmatic randomized controlled trial. *Journal of Telemedicine and Telecare*, 1357633X221106027. Advance online publication. https://doi.org/10.1177/1357633X221106027

21. Choi, N. G., Marti, C. N., Wilson, N. L., Chen, G. J., Sirrianni, L., Hegel, M. T., Bruce, M. L., & Kunik, M. E. (2020). Effect of telehealth treatment by lay counselors vs by clinicians on depressive symptoms among older adults who are homebound: A randomized clinical trial. *JAMA Network Open*, 3(8), e2015648. https://doi.org/10.1001/jamanetworkopen.2020.15648

22. Fletcher, T. L., Amspoker, A. B., Wassef, M., Hogan, J. B., Helm, A., Jackson, C., Jacobs, A., Shammet, R., Speicher, S., Lindsay, J. A., & Cloitre, M. (2021). Increasing access to care for trauma-exposed rural veterans: A mixed methods outcome evaluation of a web-based skills training program with telehealth-delivered coaching. *The Journal of Rural Health : Official journal of the American Rural Health Association and the National Rural Health Care Association*, 10.1111/jrh.12628. Advance online publication. https://doi.org/10.1111/jrh.12628

23. Salisbury, C., O'Cathain, A., Edwards, L., Thomas, C., Gaunt, D., Hollinghurst, S., Nicholl, J., Large, S., Yardley, L., Lewis, G., Foster, A., Garner, K., Horspool, K., Man, M. S., Rogers, A., Pope, C., Dixon, P., & Montgomery, A. A. (2016). Effectiveness of an integrated telehealth service for patients with depression: A pragmatic randomised controlled trial of a complex intervention. The lancet. *Psychiatry*, *3*(6), 515–525. https://doi.org/10.1016/S2215-0366(16)00083-3

24. Nguyen, P., Heisey, R., Quenneville, C., Goulbourne, E., Khan, R., Rinaldo, E., Chagigiorgis, H., Shields, R., & Townsley, C. (2022). An examination of depression, anxiety, and fear of recurrence among cancer survivors who participated in a virtual cognitive behavioral therapy (CBT)-based telephone coaching program. *Supportive Care in Cancer : Official journal of the Multinational Association of Supportive Care in Cancer*, 10.1007/s00520-022-07148-6. Advance online publication. https://doi.org/10.1007/s00520-022-07148-6

25. Turan Kavradim, S., Özer, Z., & Boz, İ. (2020). Effectiveness of telehealth interventions as a part of secondary prevention in coronary artery disease: A systematic review and meta-analysis. *Scandinavian journal of caring sciences*, *34*(3), 585–603. https://doi.org/10.1111/scs.12785

26. Byaruhanga, J., Atorkey, P., McLaughlin, M., Brown, A., Byrnes, E., Paul, C., Wiggers, J., & Tzelepis, F. (2020). Effectiveness of Individual real-time video counseling on smoking, nutrition, alcohol, physical activity, and obesity health risks: Systematic review. *Journal of Medical Internet Research*, *22*(9), e18621. https://doi.org/10.2196/18621

27. Jolly, K., Sidhu, M. S., Hewitt, C. A., Coventry, P. A., Daley, A., Jordan, R., Heneghan, C., Singh, S., Ives, N., Adab, P., Jowett, S., Varghese, J., Nunan, D., Ahmed, K., Dowson, L., & Fitzmaurice, D. (2018). Self management of patients with mild COPD in primary care: Randomised controlled trial. *BMJ* (Clinical research ed.), 361, k2241. https://doi.org/10.1136/bmj.k2241

28. Burke, M. V., Cha, S., Shumaker, T. M., LaPlante, M., McConahey, L., & Graham, A. L. (2022). Delivery of smoking cessation treatment via live chat: An analysis of client-centered coaching skills and behavior change techniques. *Patient education and counseling, 105*(7), 2183–2189. https://doi.org/10.1016/j.pec.2021.11.030

29. Viglione, C., Bouwman, D., Rahman, N., Fang, Y., Beasley, J. M., Sherman, S., Pi-Sunyer, X., Wylie-Rosett, J., Tenner, C., & Jay, M. (2019). A technology-assisted health coaching intervention vs. enhanced usual care for primary care-based obesity treatment: A randomized controlled trial. *BMC Obesity*, 6, 4. https://doi.org/10.1186/s40608-018-0226-0

30. Schmittdiel, J. A., Adams, S. R., Goler, N., Sanna, R. S., Boccio, M., Bellamy, D. J., Brown, S. D., Neugebauer, R. S., & Ferrara, A. (2017). The impact of telephonic wellness coaching on weight loss: A "Natural Experiments for Translation in Diabetes (NEXT-D)" study. *Obesity* (Silver Spring, Md.), *25*(2), 352–356. https://doi.org/10.1002/oby.21723

31. Silberman, J. M., Kaur, M., Sletteland, J., & Venkatesan, A. (2020). Outcomes in a digital weight management intervention with one-on-one health coaching. *PloS one*, *15*(4), e0232221. https://doi.org/10.1371/journal.pone.0232221

32. Sherman, R. P., Petersen, R., Guarino, A. J., & Crocker, J. B. (2017). Primary care-based health coaching intervention for weight loss in overweight/obese adults: A 2-year experience. *American Journal of Lifestyle Medicine*, *13*(4), 405–413. https://doi.org/10.1177/1559827617715218

33. Spencer, T., Noyes, E., & Biederman, J. (2020). Telemedicine in the management of ADHD: Literature review of telemedicine in ADHD. *Journal of Attention Disorders*, *24*(1), 3–9. https://doi.org/10.1177/1087054719859081

34. Breaux, R., Delshad, M., Shroff, Cash, A. R., Swanson, C. S., Carlton, C., Bertollo, J. R., & Dahiya, A. V. (2021). Telehealth delivery of the RELAX intervention for families of adolescents diagnosed with ADHD: Preliminary treatment outcomes and evidence of acceptability and feasibility. *Evidence-Based Practice in Child and Adolescent Mental Health*. https://doi.org/10.1080/23794925.2021.1970053

35. Valentine, A. Z., Hall, S. S., Young, E., Brown, B. J., Groom, M. J., Hollis, C., & Hall, C. L. (2021). Implementation of telehealth services to assess, monitor, and treat neurodevelopmental disorders: Systematic review. *Journal of Medical Internet Research*, 23(1), e22619. https://doi.org/10.2196/22619

36. Segenreich D. (2022). The impact of the COVID-19 pandemic on diagnosing and treating attention deficit hyperactivity disorder: New challenges on initializing and optimizing pharmacological treatment. *Frontiers in Psychiatry*, 13, 852664. https://doi.org/10.3389/fpsyt.2022.852664

37. Myers, K., Vander Stoep, A., Zhou, C., McCarty, C. A., & Katon, W. (2015). Effectiveness of a telehealth service delivery model for treating attention-deficit/hyperactivity disorder: a community-based randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 54(4), 263–274. https://doi.org/10.1016/j.jaac.2015.01.009

38. Varker, T., Brand, R. M., Ward, J., Terhaag, S., & Phelps, A. (2019). Efficacy of synchronous telepsychology interventions for people with anxiety, depression, posttraumatic stress disorder, and adjustment disorder: A rapid evidence assessment. *Psychological Services*, 16(4), 621–635. https://doi.org/10.1037/ser0000239

39. Bee, P. E., Bower, P., Lovell, K., Gilbody, S., Richards, D., Gask, L., & Roach, P. (2008). Psychotherapy mediated by remote communication technologies: A meta-analytic review. *BMC Psychiatry*, 8, 60. https://doi.org/10.1186/1471-244X-8-60

40. Berryhill, M. B., Halli-Tierney, A., Culmer, N., Williams, N., Betancourt, A., King, M., & Ruggles, H. (2019). Videoconferencing psychological therapy and anxiety: A systematic review. *Family Practice*, 36(1), 53–63. https://doi.org/10.1093/fampra/cmy072

41. Krzyżaniak, N., Greenwood, H., Scott, A., Peiris, R., Cardona, M., Clark, J., & Glasziou, P. P. (2021). The effectiveness of telehealth versus face-to face interventions for anxiety disorders: A systematic review and meta-analysis. *Journal of Telemedicine and Telecare*, 1-12. https://doi.org/10.1177/1357633X21105373

42. Comer, J. S., Furr, J. M., del Busto, C. T., Silva, K., Hong, N., Poznanski, B., Sanchez, A. L., Cornacchio, D., Herrera, A., Coxe, S., Miguel, E., Georgiadis, C., Conroy, K., & Puliafico, A.C. (2021). Therapist-led, internet-delivered treatment for early child social anxiety: A waitlist-controlled evaluation of the iCALM telehealth program. *Behavior Therapy, 52*(5), 1171-1187. https://doi.org/10.1016/j.beth.2021.01.004

43. Nauphal, M., Swetlitz, C., Smith, L., & Rosellini, A.J. (2021). A preliminary examination of the acceptability, feasibility, and effectiveness of a telehealth cognitive-behavioral therapy group for social anxiety disorder. *Cognitive and Behavioral Practice*, 28(4), 730-742. https://doi.org/10.1016/j.cbpra.2021.04.011

44. Palylyk-Colwell, E., & Argáez, C. (2018). *Telehealth for the assessment and treatment of depression, post-traumatic stress disorder, and anxiety: Clinical evidence*. Canadian Agency for Drugs and Technologies in Health. https://www.ncbi.nlm.nih.gov/books/NBK532701/

45. Orsolini, L., Pompili, S., Salvi, V., & Volpe, U. (2021). A systematic review on telemental health in youth mental health: Focus on anxiety, depression and obsessive-compulsive disorder. *Medicina (Kaunas, Lithuania)*, 57(8), 793. https://doi.org/10.3390/medicina57080793

46. Venturo-Conerly, K. E., Fitzpatrick, O. M., Horn, R. L., Ugueto, A. M., & Weisz, J. R. (2022). Effectiveness of youth psychotherapy delivered remotely: A meta-analysis. *American Psychologist, 77*(1), 71–84. https://doi.org/10.1037/amp0000816

47. Juárez, A. P., Weitlauf, A. S., Nicholson, A., Pasternak, A., Broderick, N., Hine, J., Stainbrook, J. A., & Warren, Z. (2018). Early identification of ASD through telemedicine: Potential value for underserved populations. *Journal of Autism and Developmental Disorders*, 48(8), 2601–2610. https://doi.org/10.1007/s10803-018-3524-y

48. Stavropoulos, K. K., Bolourian, Y., & Blacher, J. (2022). A scoping review of telehealth diagnosis of autism spectrum disorder. *PloS one*, 17(2), e0263062. https://doi.org/10.1371/journal.pone.0263062

49. Gibbs, V., Cai, R. Y., Aldridge, F., & Wong, M. (2021). Autism assessment via telehealth during the Covid 19 pandemic: Experiences and perspectives of autistic adults, parents/carers and clinicians. *Research in Autism Spectrum Disorders*, 88, 101859. https://doi.org/10.1016/j.rasd.2021.101859

50. Parmanto, B., Pulantara, I. W., Schutte, J. L., Saptono, A., & McCue, M. P. (2013). An integrated telehealth system for remote administration of an adult autism assessment. *Telemedicine Journal and e-health : The official journal of the American Telemedicine Association*, 19(2), 88–94. https://doi.org/10.1089/tmj.2012.0104

51. Sankar, A., Panchal, P., Goldman, D. A., Colic, L., Villa, L. M., Kim, J. A., Lebowitz, E. R., Carrubba, E., Lecza, B., Silverman, W. K., Swartz, H. A., & Blumberg, H. P. (2021). Telehealth social rhythm therapy to reduce mood symptoms and suicide risk among adolescents and young adults with bipolar disorder. *American Journal of Psychotherapy*, 74(4), 172–177. https://doi.org/10.1176/appi.psychotherapy.20210011

52. Bauer, M. S., Krawczyk, L., Miller, C. J., Abel, E., Osser, D. N., Franz, A., Brandt, C., Rooney, M., Fleming, J., & Godleski, L. (2016). Team-based telecare for bipolar disorder. *Telemedicine Journal and e-health : The official journal of the American Telemedicine Association*, 22(10), 855–864. https://doi.org/10.1089/tmj.2015.0255

53. Burgess, C., Miller, C. J., Franz, A., Abel, E. A., Gyulai, L., Osser, D., Smith, E. G., Connolly, S. L., Krawczyk, L., Bauer, M., & Godleski, L. (2020). Practical lessons learned for assessing and treating bipolar disorder via telehealth modalities during the COVID-19 pandemic. *Bipolar Disorders*, 22(6), 556–557. https://doi.org/10.1111/bdi.12969

54. Farrell, A., George, N., Amado, S., & Wozniak, J. (2022). A systematic review of the literature on telepsychiatry for bipolar disorder. *Brain and Behavior*, *12*(10), e2743. https://doi.org/10.1002/brb3.2743

55. Osenbach, J. E., O'Brien, K. M., Mishkind, M., & Smolenski, D. J. (2013). Synchronous telehealth technologies in psychotherapy for depression: A meta-analysis. *Depression and Anxiety*, *30*(11), 1058–1067. https://doi.org/10.1002/da.22165

56. Mohr, D. C., Ho, J., Duffecy, J., Reifler, D., Sokol, L., Burns, M. N., Jin, L., & Siddique, J. (2012). Effect of telephone-administered vs face-to-face cognitive behavioral therapy on adherence to therapy and depression outcomes among primary care patients: A randomized trial. *JAMA*, *307*(21), 2278–2285. https://doi.org/10.1001/jama.2012.5588

57. Choi, N. G., Marti, C. N., Bruce, M. L., Hegel, M. T., Wilson, N. L., & Kunik, M. E. (2014). Six-month postintervention depression and disability outcomes of in-home telehealth problem-solving therapy for depressed, low-income homebound older adults. *Depression and Anxiety*, *31*(8), 653–661. https://doi.org/10.1002/da.22242

58. Durland, L., Interian, A., Pretzer, I., & Dobkin, R. D. (2014). Effect of telehealth-to-home interventions on quality of life for individuals with depressive and anxiety disorders. *Smart Homecare Technology and Telehealth*, *2014*(2), 105-119. https://doi.org/10.2147/SHTT.S45044

59. McCall, T., Bolton, C. S., 3rd, Carlson, R., & Khairat, S. (2021). A systematic review of telehealth interventions for managing anxiety and depression in African American adults. *mHealth*, *7*, 31. https://doi.org/10.21037/mhealth-20-114

60. Bellanti, D. M., Kelber, M. S., Workman, D. E., Beech, E. H., & Belsher, B. E. (2022). Rapid review on the effectiveness of telehealth interventions for the treatment of behavioral health disorders. *Military Medicine*, *187*(5-6), e577–e588. https://doi.org/10.1093/milmed/usab318

61. Sproch, L. E., & Anderson, K. P. (2019). Clinician-delivered teletherapy for eating disorders. *The Psychiatric Clinics of North America*, *42*(2), 243–252. https://doi.org/10.1016/j.psc.2019.01.008

62. Maglia, M., Corello, G., & Caponnetto, P. (2021). Evaluation of the effects of telepsychotherapy in the treatment and prevention of eating disorders in adolescents. *International Journal of Environmental Research and Public Health*, *18*(23), 12573. https://doi.org/10.3390/ijerph182312573

63. Waller, G., Pugh, M., Mulkens, S., Moore, E., Mountford, V. A., Carter, J., Wicksteed, A., Maharaj, A., Wade, T. D., Wisniewski, L., Farrell, N. R., Raykos, B., Jorgensen, S., Evans, J., Thomas, J. J., Osenk, I., Paddock, C., Bohrer, B., Anderson, K., Turner, H., … Smit, V. (2020). Cognitive-behavioral therapy in the time of coronavirus: Clinician tips for working with eating disorders via telehealth when face-to-face meetings are not possible. *The International Journal of Eating Disorders*, *53*(7), 1132–1141. https://doi.org/10.1002/eat.23289

64. Anderson, K. E., Byrne, C. E., Crosby, R. D., & Le Grange, D. (2017). Utilizing telehealth to deliver family-based treatment for adolescent anorexia nervosa. *The International Journal of Eating Disorders*, *50*(10), 1235–1238. https://doi.org/10.1002/eat.22759

65. Raykos, B. C., Erceg-Hurn, D. M., Hill, J., Campbell, B., & McEvoy, P. M. (2021). Positive outcomes from integrating telehealth into routine clinical practice for eating disorders during COVID-19. *The International Journal of Eating Disorders*, *54*(9), 1689–1695. https://doi.org/10.1002/eat.23574

66. Gorrell, S., Reilly, E. E., Brosof, L., & Le Grange, D. (2022). Use of telehealth in the management of adolescent eating disorders: Patient perspectives and future directions suggested from the COVID-19 pandemic. *Adolescent Health, Medicine and Therapeutics*, *13*, 45–53. https://doi.org/10.2147/AHMT.S334977

67. Cooper, M., Reilly, E. E., Siegel, J. A., Coniglio, K., Sadeh-Sharvit, S., Pisetsky, E. M., & Anderson, L. M. (2022). Eating disorders during the COVID-19 pandemic and quarantine: an overview of risks and recommendations for treatment and early intervention. *Eating Disorders*, *30*(1), 54–76. https://doi.org/10.1080/10640266.2020.1790271

68. Mitchell, J. E., Crosby, R. D., Wonderlich, S. A., Crow, S., Lancaster, K., Simonich, H., Swan-Kremeier, L., Lysne, C., & Myers, T. C. (2008). A randomized trial comparing the efficacy of cognitive-behavioral therapy for bulimia nervosa delivered via telemedicine versus face-to-face. *Behaviour Research and Therapy*, *46*(5), 581–592. https://doi.org/10.1016/j.brat.2008.02.004

69. Couturier, J., Pellegrini, D., Miller, C., Bhatnagar, N., Boachie, A., Bourret, K., Brouwers, M., Coelho, J. S., Dimitropoulos, G., Findlay, S., Ford, C., Geller, J., Grewal, S., Gusella, J., Isserlin, L., Jericho, M., Johnson, N., Katzman, D. K., Kimber, M., Lafrance, A., … Webb, C. (2021). The COVID-19 pandemic and eating disorders in children, adolescents, and emerging adults: Virtual care recommendations from the Canadian consensus panel during COVID-19 and beyond. *Journal of Eating Disorders*, *9*(1), 46. https://doi.org/10.1186/s40337-021-00394-9

70. Ahmadiankalati, M., Steins-Loeber, S., & Paslakis, G. (2020). Review of randomized controlled trials using e-Health interventions for patients with eating disorders. *Frontiers in Psychiatry*, *11*, 568. https://doi.org/10.3389/fpsyt.2020.00568

71. Aardoom, J. J., Dingemans, A. E., Spinhoven, P., van Ginkel, J. R., de Rooij, M., & van Furth, E. F. (2016). Web-based fully automated self-help with different levels of therapist support for individuals with eating disorder symptoms: A randomized controlled trial. *Journal of Medical Internet Research*, *18*(6), e159. https://doi.org/10.2196/jmir.5709

72. Lenhard, F., Andersson, E., Mataix-Cols, D., Rück, C., Vigerland, S., Högström, J., Hillborg, M., Brander, G., Ljungström, M., Ljótsson, B., & Serlachius, E. (2017). Therapist-guided, internet-delivered cognitive-behavioral therapy for adolescents with obsessive-compulsive disorder: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *56*(1), 10–19.e2. https://doi.org/10.1016/j.jaac.2016.09.515

73. Herbst, N., Voderholzer, U., Stelzer, N., Knaevelsrud, C., Hertenstein, E., Schlegl, S., Nissen, C., & Külz, A. K. (2012). The potential of telemental health applications for obsessive-compulsive disorder. *Clinical Psychology Review*, *32*(6), 454–466. https://doi.org/10.1016/j.cpr.2012.04.005

74. Maye, C. E., Wojcik, K. D., Candelari, A. E., Goodman, W. K., & Storch, E. A. (2022). Obsessive compulsive disorder during the COVID-19 pandemic: A brief review of course, psychological assessment and treatment considerations. *Journal of Obsessive-compulsive and Related Disorders*, *33*, 100722. https://doi.org/10.1016/j.jocrd.2022.100722

75. Bouchard, S., Allard, M., Robillard, G., Dumoulin, S., Guitard, T., Loranger, C., Green-Demers, I., Marchand, A., Renaud, P., Cournoyer, L. G., & Corno, G. (2020). Videoconferencing psychotherapy for panic disorder and agoraphobia: Outcome and treatment processes from a non-randomized non-inferiority trial. *Frontiers in Psychology*, *11*, 2164. https://doi.org/10.3389/fpsyg.2020.02164

76. Zimmerman, M., Ward, M., D'Avanzato, C., & Tirpak, J. W. (2022). Telehealth treatment of patients with borderline personality disorder in a partial hospital setting during the COVID-19 pandemic: Comparative safety, patient satisfaction, and effectiveness of in-person treatment. *Journal of Personality Disorders*, *36*(3), 277–295. https://doi.org/10.1521/pedi_2021_35_539

77. Dharwadkar, N. P., Broadbear, J. H., Heidari, P., Cheney, L., & Rao, S. (2021). Psychotherapy via telehealth during the COVID-19 pandemic in Australia–Experience of clients with a diagnosis of borderline personality disorder. *Global Journal of Health Science, 14*(1), 29-35. https://doi.org/10.5539/gjhs.v14n1p29

78. Landes, S. J., Pitcock, J. A., Harned, M. S., Connolly, S. L., Meyers, L. L., & Oliver, C. M. (2022). Provider perspectives on delivering dialectical behavior therapy via telehealth during COVID-19 in the Department of Veterans Affairs. *Psychological Services, 19*(3), 562–572. https://doi.org/10.1037/ser0000571

79. Zalewski, M., Walton, C. J., Rizvi, S. L., White, A. W., Gamache Martin, C., O'Brien, J. R., & Dimeff, L. (2021). Lessons learned conducting dialectical behavior therapy via telehealth in the age of COVID-19. *Cognitive and Behavioral Practice*, *28*(4), 573–587. https://doi.org/10.1016/j.cbpra.2021.02.005

80. Lakeman, R., King, P., Hurley, J., Tranter, R., Leggett, A., Campbell, K., & Herrera, C. (2022). Towards online delivery of dialectical behaviour therapy: A scoping review. *International Journal of Mental Health Nursing*, *31*(4), 843–856. https://doi.org/10.1111/inm.12976

81. van der Boom, B., Boumparis, N., Donker, T., de Beurs, D., Arntz, A., & Riper, H. (2022). Internet-delivered interventions for personality disorders - A scoping review. *Internet Interventions*, *28*, 100525. https://doi.org/10.1016/j.invent.2022.100525

82. Acierno, R., Gros, D. F., Ruggiero, K. J., Hernandez-Tejada, B. M., Knapp, R. G., Lejuez, C. W., Muzzy, W., Frueh, C. B., Egede, L. E., & Tuerk, P. W. (2016). Behavioral activation and therapeutic exposure for posttraumatic stress disorder: A noninferiority trail of treatment delivered in person versus home-based telehealth. *Depression and Anxiety*, *33*(5), 415–423. https://doi.org/10.1002/da.22476

83. Fortney, J. C., Pyne, J. M., Kimbrell, T. A., Hudson, T. J., Robinson, D. E., Schneider, R., Moore, W. M., Custer, P. J., Grubbs, K. M., & Schnurr, P. P. (2015). Telemedicine-based collaborative care for posttraumatic stress disorder: A randomized clinical trial. *JAMA Psychiatry*, *72*(1), 58–67. https://doi.org/10.1001/jamapsychiatry.2014.1575

84. Morland, L. A., Wells, S. Y., Glassman, L. H., Greene, C. J., Hoffman, J. E., & Rosen, C. S. (2020). Advances in PTSD treatment delivery: Review of findings and clinical considerations for the use of telehealth interventions for PTSD. *Current Treatment Options in Psychiatry*, *7*(3), 221–241. https://doi.org/10.1007/s40501-020-00215-x

85. Peterson, A. L., Mintz, J., Moring, J. C., Straud, C. L., Young-McCaughan, S., McGeary, C. A., McGeary, D. D., Litz, B. T., Velligan, D. I., Macdonald, A., Mata-Galan, E., Holliday, S. L., Dillon, K. H., Roache, J. D., Bira, L. M., Nabity, P. S., Medellin, E. M., Hale, W. J., & Resick, P. A. (2022). In-office, in-home, and telehealth cognitive processing therapy for posttraumatic stress disorder in veterans: A randomized clinical trial. *BMC Psychiatry*, *22*(1), 41. https://doi.org/10.1186/s12888-022-03699-4

86. Stewart, R. W., Orengo-Aguayo, R. E., Cohen, J. A., Mannarino, A. P., & de Arellano, M. A. (2017). A pilot study of trauma-focused cognitive-behavioral therapy delivered via telehealth technology. *Child Maltreatment*, *22*(4), 324–333. https://doi.org/10.1177/1077559517725403

87. Racine, N., Hartwick, C., Collin-Vézina, D., & Madigan, S. (2020). Telemental health for child trauma treatment during and post-COVID-19: Limitations and considerations. *Child Abuse & Neglect*, *110*(Pt 2), 104698. https://doi.org/10.1016/j.chiabu.2020.104698

88. Litwack, S. D., Jackson, C. E., Chen, M., Sloan, D. M., Hatgis, C., Litz, B. T., & Marx, B. P. (2014). Validation of the use of video teleconferencing technology in the assessment of PTSD. *Psychological Services*, *11*(3), 290–294. https://doi.org/10.1037/a0036865

89. Donahue, A. L., Rodriguez, J., & Shore, J. H. (2021). Telemental health and the management of psychosis. *Current Psychiatry Reports*, *23*(5), 27. https://doi.org/10.1007/s11920-021-01242-y

90. Santesteban-Echarri, O., Piskulic, D., Nyman, R. K., & Addington, J. (2020). Telehealth interventions for schizophrenia-spectrum disorders and clinical high-risk for psychosis individuals: A scoping review. *Journal of Telemedicine and Telecare*, *26*(1-2), 14–20. https://doi.org/10.1177/1357633X18794100

91. Sharp, I. R., Kobak, K. A., & Osman, D. A. (2011). The use of videoconferencing with patients with psychosis: A review of the literature. *Annals of General Psychiatry*, *10*(1), 14. https://doi.org/10.1186/1744-859X-10-14

92. Gaebel, W., Großimlinghaus, I., Kerst, A., Cohen, Y., Hinsche-Böckenholt, A., Johnson, B., Mucic, D., Petrea, I., Rössler, W., Thornicroft, G., & Zielasek, J. (2016). European Psychiatric Association (EPA) guidance on the quality of eMental health interventions in the treatment of psychotic disorders. *European Archives of Psychiatry and Clinical Neuroscience*, *266*(2), 125–137. https://doi.org/10.1007/s00406-016-0677-6

93. Miu, A. S., Vo, H. T., Palka, J. M., Glowacki, C. R., & Robinson, R. J. (2021). Teletherapy with serious mental illness populations during COVID-19: Telehealth conversion and engagement. *Counselling Psychology Quarterly*, *34*(3-4), 704-721, https://doi.org/10.1080/09515070.2020.1791800

94. Lynch, D. A., Medalia, A., & Saperstein, A. (2020). The design, implementation, and acceptability of a telehealth comprehensive recovery service for people with complex psychosis living in NYC During the COVID-19 crisis. *Frontiers in Psychiatry*, *11*, 581149. https://doi.org/10.3389/fpsyt.2020.581149

95. Joseph, H. L., de Andino, A. M., & Wood, K. (2021). Group cognitive-behavioral therapy via telebehavioral health for those with psychotic spectrum disorders: A case series. *Cognitive and Behavioral Practice*, *28*(4), 716–729. https://doi.org/10.1016/j.cbpra.2021.06.007

96. Mitchell, M. M., Mendelson, J., Gryczynski, J., Carswell, S. B., & Schwartz, R. P. (2020). A novel telehealth platform for alcohol use disorder treatment: Preliminary evidence of reductions in drinking. *The American Journal of Drug and Alcohol Abuse*, *46*(3), 297–303. https://doi.org/10.1080/00952990.2019.1658197

97. Kruse, C. S., Lee, K., Watson, J. B., Lobo, L. G., Stoppelmoor, A. G., & Oyibo, S. E. (2020). Measures of effectiveness, efficiency, and quality of telemedicine in the management of alcohol abuse, addiction, and rehabilitation: systematic review. *Journal of Medical Internet Research*, *22*(1), e13252. https://doi.org/10.2196/13252

98. Frueh, B. C., Henderson, S., & Myrick, H. (2005). Telehealth service delivery for persons with alcoholism. *Journal of Telemedicine and Telecare*, *11*(7), 372–375. https://doi.org/10.1258/135763305774472060

99. Staton-Tindall, M., Havens, J. R., Webster, J. M., & Leukefeld, C. (2014). METelemedicine: A pilot study with rural alcohol users on community supervision. *The Journal of Rural Health : Official journal of the American Rural Health Association and the National Rural Health Care Association*, *30*(4), 422–432. https://doi.org/10.1111/jrh.12076

100. Keleman, A., Minarcik, E., Steets, C., & Liang, Y. (2022). Telehealth interventions for alcohol use disorder: A systematic review. *Liver Research, 6*(3), 146-154. https://doi.org/10.1016/j.livres.2022.08.004

101. King, S. C., Richner, K. A., Tuliao, A. P., Kennedy, J. L., & McChargue, D. E. (2020). A comparison between telehealth and face-to-face delivery of a brief alcohol intervention for college students. *Substance Abuse*, *41*(4), 501–509. https://doi.org/10.1080/08897077.2019.1675116

102. Constant, H., Ferigolo, M., Barros, H., & Moret-Tatay, C. (2021). A clinical trial on a brief motivational intervention in reducing alcohol consumption under a telehealth supportive counseling. *Psychiatry Research*, *303*, 114068. https://doi.org/10.1016/j.psychres.2021.114068

103. Ogilvie, C. B., Jotwani, R., Joshi, J., Gulati, A., & Mehta, N. (2021). Review of opioid risk assessment tools with the growing need for telemedicine. *Pain Management*, *11*(2), 97–100. https://doi.org/10.2217/pmt-2020-0064

104. Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Telehealth for the treatment of serious mental illness and substance use disorders.* https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf

105. King, V. L., Brooner, R. K., Peirce, J. M., Kolodner, K., & Kidorf, M. S. (2014). A randomized trial of web-based videoconferencing for substance abuse counseling. *Journal of Substance Abuse Treatment*, *46*(1), 36–42. https://doi.org/10.1016/j.jsat.2013.08.009

106. Zheng, W., Nickasch, M., Lander, L., Wen, S., Xiao, M., Marshalek, P., Dix, E., & Sullivan, C. (2017). Treatment outcome comparison between telepsychiatry and face-to-face buprenorphine medication-assisted treatment for opioid use disorder: A 2-year retrospective data analysis. *Journal of Addiction Medicine*, *11*(2), 138–144. https://doi.org/10.1097/ADM.0000000000000287

107. Eibl, J. K., Gauthier, G., Pellegrini, D., Daiter, J., Varenbut, M., Hogenbirk, J. C., & Marsh, D. C. (2017). The effectiveness of telemedicine-delivered opioid agonist therapy in a supervised clinical setting. *Drug and Alcohol Dependence*, *176*, 133–138. https://doi.org/10.1016/j.drugalcdep.2017.01.048

108. Guille, C., Simpson, A. N., Douglas, E., Boyars, L., Cristaldi, K., McElligott, J., Johnson, D., & Brady, K. (2020). Treatment of opioid use disorder in pregnant women via telemedicine: A nonrandomized controlled trial. *JAMA network open*, *3*(1), e1920177. https://doi.org/10.1001/jamanetworkopen.2019.20177

109. American Lung Association. (2018, September). *Telehealth as a vehicle to support tobacco cessation.* https://www.lung.org/getmedia/0df40b1c-cca4-4f8d-b17f-1c0ef19052a1/telehealth-tobacco-cessation.pdf.pdf

110. Cancer Center Cessation Initiative Telehealth Working Group (2021). Telehealth delivery of tobacco cessation treatment in cancer care: An ongoing innovation accelerated by the COVID-19 pandemic. *Journal of the National Comprehensive Cancer Network: JNCCN*, *19*(Suppl_1), S21–S24. https://doi.org/10.6004/jnccn.2021.7092

111. Richter, K. P., Shireman, T. I., Ellerbeck, E. F., Cupertino, A. P., Catley, D., Cox, L. S., Preacher, K. J., Spaulding, R., Mussulman, L. M., Nazir, N., Hunt, J. J., & Lambart, L. (2015). Comparative and cost effectiveness of telemedicine versus telephone counseling for smoking cessation. *Journal of Medical Internet Research*, *17*(5), e113. https://doi.org/10.2196/jmir.3975

112. Carlson, L. E., Lounsberry, J. J., Maciejewski, O., Wright, K., Collacutt, V., & Taenzer, P. (2012). Telehealth-delivered group smoking cessation for rural and urban participants: Feasibility and cessation rates. *Addictive Behaviors*, *37*(1), 108–114. https://doi.org/10.1016/j.addbeh.2011.09.011

113. Nomura, A., Tanigawa, T., Muto, T., Oga, T., Fukushima, Y., Kiyosue, A., Miyazaki, M., Hida, E., & Satake, K. (2019). Clinical efficacy of telemedicine compared to face-to-face clinic visits for smoking cessation: Multicenter open-label randomized controlled noninferiority trial. *Journal of Medical Internet Research*, *21*(4), e13520. https://doi.org/10.2196/13520

114. American Academy of Pediatrics. (2021, May 7). *Child and adolescent mental and behavioral health principles.* https://downloads.aap.org/DOFA/CAMH%20Principles%202021%20Final%2005-04-21.pdf

115. Oregon Health Authority Public Health Division. (2016, August). *Minor rights: Access and consent to health care.* https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/Documents/minor-rights.pdf

116. Seager van Dyk, I., Kroll, J., Martinez, R., Emerson, N., & Bursch, B. (2020, March). *Covid-19 tips: Building rapport with youth via telehealth.* UCLA Pediatric Psychology Consultation Liaison Service. https://clinicalcenter.siu.edu/_common/documents/telehealth-tip-sheet-covid-child-version-3-20.pdf

117. American Medical Association. (2022). *Accelerating and enhancing behavioral health integration through digitally enabled care: Opportunities and challenges.* https://www.ama-assn.org/system/files/bhi-return-on-health-report.pdf

118. Agency for Healthcare Research and Quality. *Telehealth and behavioral health integration*. Integration Academy: Integrating Behavioral Health & Primary Care. https://integrationacademy.ahrq.gov/about/integrated-behavioral-health/telehealth

119. Townley, C., & Yalowich, R. (2015, November). *Improving behavioral health access & integration using telehealth & teleconsultation: A health care system for the 21st century*. National Academy for State Health Policy. https://nashp.org/wp-content/uploads/2015/11/Telemedicine1.pdf

120. Gentry, M. T., Lapid, M. I., Clark, M. M., & Rummans, T. A. (2019). Evidence for telehealth group-based treatment: A systematic review. *Journal of Telemedicine and Telecare*, *25*(6), 327–342. https://doi.org/10.1177/1357633X18775855

121. Marton, K. & Kanas, N. (2016). Telehealth modalities for group therapy: Comparisons to in-person group therapy. *International Journal of Group Psychotherapy*, *66*(1), 145-150. https://doi.org/10.1080/00207284.2015.1096109

122. Banbury, A., Nancarrow, S., Dart, J., Gray, L., & Parkinson, L. (2018). Telehealth interventions delivering home-based support group videoconferencing: Systematic Review. *Journal of Medical Internet Research*, *20*(2), e25. https://doi.org/10.2196/jmir.8090

123. Kneeland, E. T., Hilton, B. T., Fitzgerald, H. E., Castro-Ramirez, F., Tester, R. D., Demers, C., & McHugh, R. K. (2021). Providing cognitive behavioral group therapy via videoconferencing: Lessons learned from a rapid scale-up of telehealth services. *Practice Innovations, 6*(4), 221–235. https://doi.org/10.1037/pri0000154

124. Health and Human Services. (2021, July 2). *Group teletherapy*. Telehealth for behavioral health care. https://telehealth.hhs.gov/providers/telehealth-for-behavioral-health/group-teletherapy/

125. American Psychological Association. (2020, April 10). *How to do group therapy using telehealth: Group therapists are responding to COVID-19 by rapidly transitioning from in-person to online therapies*. https://www.apaservices.org/practice/legal/technology/group-therapy-telehealth-covid-19

126. Central East Mental Health Technology Transfer Center. (2020, August). *Tip Sheet: Group teletherapy: Best Practices, skills, and strategies for providing virtual group psychotherapy*. https://mhttcnetwork.org/sites/mhttc/files/2020-08/MHTTC_TelehealthInfoSheet2_GroupTelehealth_FINAL.pdf

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