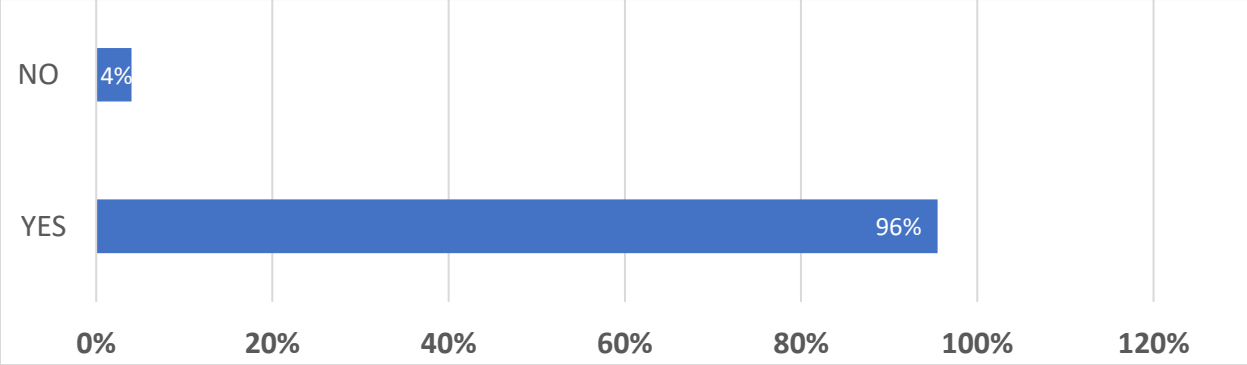
118th Congress

PRIORITY ISSUE:
TELEHEALTH AS A TOOL FOR SUD TREATMENT

Telehealth use soared early in the COVID-19 pandemic amid lockdowns and social distancing. While telehealth utilization has gone down for substance use disorder services, it is still being used significantly more than during pre-pandemic times, across the healthcare system. With this paper, we hope to shed light onto the use and practical applications and best practices of telehealth in the substance use disorder (SUD) field to date, explore future directions for telehealth policy, including challenges facing its expanded use, the impact on client care, and effects on the United States healthcare system.



96% of Treatment Community of America (TCA) members agencies reported utilizing some form of telehealth i.e., audio only, video conferencing and/or both. When surveying them, five barriers to providing telehealth services were identified: connectivity issues and wi-fi access, having privacy for sessions; electronic literacy of our patients and clients, resources and access to telehealth technology, and payment parity.

Treatment Communities of America (TCA) founded in 1975 as a non-profit, member-led association, represents over 800 community-based program sites across the United States and its territories. TCA members are dedicated to serving individuals with substance use disorders, co-occurring and mental health problems. TCA member programs are predominately publicly funded and serve substance use disorder clients many of whom have multiple barriers to recovery such as co-occurring mental illness, the homeless, adolescents, pregnant women, criminal justice involved individuals, the elderly, veterans, as well as persons with HIV/AIDs and Hepatitis C.

Treatment Community of America's members provides the full continuum of care including services such as assessment, detoxification, residential care, in-prison programs, case

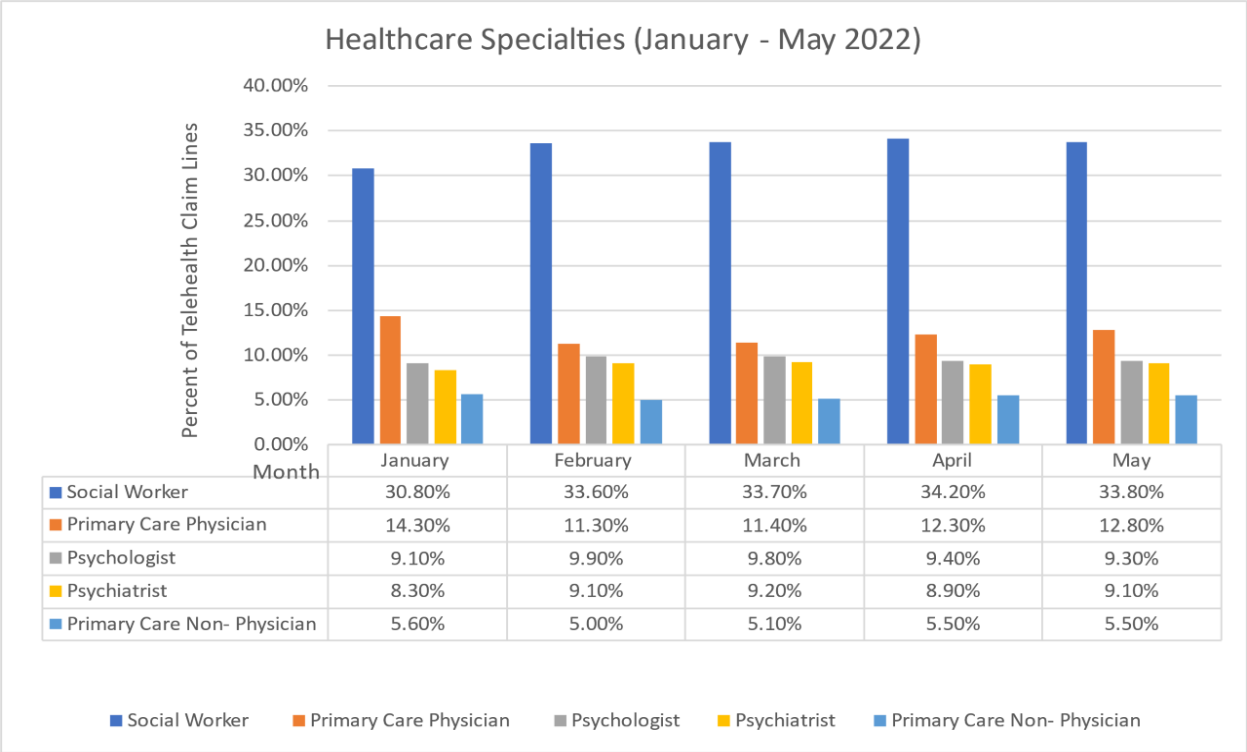
management, outpatient counseling, transitional housing, pharmacologic therapies, education, vocational and employment services, primary medical care, psychological services, family counseling, and unification, to name a few.

As community providers, TCA members' collective experience has allowed them to be flexible and able to provide greater access to care as telehealth (audio, video) options have expanded our ability to serve the community. Telehealth services enhance the options available, especially to people residing in underserved areas. Our experiences with telehealth have taught us to be open-minded and innovative in the ways in which we provide services to our participant's and how we needed to come up with creative ways to keep participants engaged in groups, individual sessions, and activities via telehealth. It has also taught our participants new ways of connecting with the community and services, now that they are comfortable engaging in video and telephonic telehealth services.

At the beginning of the transition to offering telehealth services, the lack of resources and disparities that some of our participant populations faced was brought to the forefront. Many of our participants did not have access to or experience with smart devices, telehealth platforms, and/or the need for "data" for their devices. In addition, some struggled with finding a private space to openly share what they were experiencing in their individual and group sessions. TCA members have continued to work diligently to assist participants with overcoming these barriers, and this practice is what has helped us to be successful. A great example is the creation of Telehealth stations in residential settings allowing participants to stay connected with outpatient community providers.

From a leadership perspective of program oversight establishing new policies to govern the workforce was critical to the success of treatment delivery. Training staff on the use of technology, staff openness to change, staff experience in the use of technology, and managing self-governance of working from home or an offsite location became a priority to ensure quality services were being delivered to our participants. TCA has identified that best practices include policy changes, workflow development, staff and participant trainings, and quality and compliance oversight, to establish a strong foundation for telehealth services.

The data continues to indicate that many providers have embraced a hybrid model (in person, telehealth audio, video) of care and that telehealth is here to stay.



Month	January	February	March	April	May
Social Worker	30.80%	33.60%	33.70%	34.20%	33.80%
Primary Care Physician	14.30%	11.30%	11.40%	12.30%	12.80%
Psychologist	9.10%	9.90%	9.80%	9.40%	9.30%
Psychiatrist	8.30%	9.10%	9.20%	8.90%	9.10%
Primary Care Non- Physician	5.60%	5.00%	5.10%	5.50%	5.50%

The Benefits of Providing Telehealth Services:

1. **Access to Integrated Care-** substance use disorder/mental health /primary care access for participants residing in rural/urban areas – For people who live many miles from the nearest treatment facility, telehealth provides a way to meet with a provider quickly. Also, this saves time, saves gas money, and allows people to stay off the road when driving conditions are less than optimal, such as during a snowstorm or hailstorm. Telehealth has allowed therapeutic care to start or continue for people experiencing stress, anxiety, depression, and other mental health issues. People experiencing mental health emergencies, including those who are at risk for self-harm, can quickly connect with a therapist or psychiatrist at any time of the day or night. Telehealth reduces barriers to care during the initial phase of treatment- Telehealth has provided us the opportunity to decrease any backlog of participants in the intake process due to the doctor not being able to be on-site. Allowing part of the intake process to utilize telehealth keeps the process moving.
2. **Infection Control** - Reduced exposure to pathogens – Being in waiting rooms with other participants can contribute to the spread of COVID-19, the flu, and other viruses and illnesses. Telehealth allows participants to be at home, avoiding potential exposure to viruses and germs. This also helps to protect medical and SUD professionals as well by decreasing traffic in the programs.

3. **Workforce Flexible Schedules (Hybrid Model)-** Child care, telehealth removes the need for the cost and task of finding childcare arrangements for participants who are the primary caregiver for their families.

4. **Prescriber Flexibility**– Telehealth has allowed providers to engage in clinical assessments and if deem appropriate prescribe take home medication (methadone).

5. **Treatment Engagement** Group size, our experience has shown that smaller group sizes (10-12) keep clients most engaged and allow the counselor to better gauge the client's attentiveness.

6. **Treatment Expansion**: We have been able to expand our treatment services via telehealth to additional states because of the licensing waivers currently in place.

Best practices for implementation of telehealth for both client and providers.

1. Identify telehealth feasibility and risk factors.
2. Evaluate the features of the telehealth platform you are using.
3. Develop policies and procedures & workflows related to telehealth service provision inclusive of privacy regulations.
4. Pilot the service as a test drive, start small then scale up.
5. Track data related to the visit to ensure successful outcomes.
6. Engaged your target population i.e., satisfaction surveys post visit.

The Challenges of Providing Telehealth Services:

1. **Toxicology & Labs** – Telehealth sessions do not allow providers to take blood or urine samples. For people with chronic conditions who take medications, this can hamper necessary changes to dosages and may prolong the time before a new diagnosis can be made.

2. **Visual Assessment & Risk Management** – With in-person sessions, providers rely on visual assessments, which may be harder to perform via telehealth.

3. **Reimbursement** – Insurance coverage varies from state to state and from payer to payer.

4. **Human Connection** - Some participants prefer face-to-face contact.

5. **Zoom Fatigue**- Being back-to-back on Zoom and/or any other virtual platform can result in burn out.

6. **Technical Issues**- Time flexibility/appointment spacing: many front-line staff have indicated that they quickly noticed the need to block extra time in appointments to 1) allow for each client to have their own experience with the doctor while not feeling rushed and 2) to account for possible technology issues. Putting appointments back-to-back too closely resulted in issues with the schedule if client appointments lasted longer or the site experienced technology issues.

Successful stories collected from TCA members:

1. William is a 60-year-old male with a 40+ year history of alcohol abuse, severe. He is self-employed and with no history of mental health issues. He had one previous history of residential substance abuse treatment from 2012 – 2013 but relapsed sometime after treatment. His last alcohol use was in March of 2020 when he reports drinking half a bottle of scotch a night. He was referred to treatment by Mt. Sinai Hospital following a liver transplant in April of 2020, however, was unable to enter inpatient or residential treatment due to the fact that he developed kidney failure following his transplant, and ultimately needed to receive dialysis 3x per week. William reported that his medical team was clear with him that any return to his patten of alcohol use would be life-threatening. He requested outpatient telehealth services due to his desire to not use alcohol, but in consideration of being immunocompromised, and in addition, consented for his outpatient SUD team and his medical team to collaborate around his care. His dialysis team conducted regular testing for ethanol, and he attended weekly group and individual sessions via telehealth. He continued receiving telehealth services exclusively for his treatment episode, which ultimately led to a successful completion.

2. Hector is a 33-year-old male, El Salvadorian refugee (approved asylum seeker) who has resided in the US for 14 years. He had a 19-year history of alcohol use and 6 years of alcohol abuse, severe, which resulted in multiple DWIs leading to 3 years of incarceration. He has a history of traumatic violence in El Salvador, including family members being kidnapped and held for ransom by gangs. Hector was released from incarceration and as a condition of parole was referred to outpatient substance abuse treatment. He began receiving onsite medication management (naloxone) and group and individual services. As a condition of his parole this client needed to find employment. He obtained his Temporary Protective Status (TPS) license, which permitted him to work legally in the US, however, the employment he found conflicted with his treatment schedule, and therefore transitioned to services via telehealth. Service provision via telehealth assisted this client in meeting his multiple legal and employment obligations and remaining connected with his addiction medication provider and treatment services. This client remains stabilized in treatment, maintaining sobriety and employment.

3. Sara is a 38-year-old female with a 12-year history of alcohol, opiate, cocaine, and cannabis abuse, severe. She has a previous CPS case for her three minor children who are no longer in her custody due to her substance use and has worked intermittently at various entry-level positions. As part of her after-plan following long-term residential treatment, she was referred to an 820-re-integration residence level (community residence) with in-person outpatient treatment services on the same campus. At the start of the COVID-19 state of emergency, this client attended outpatient services via telehealth, including medication management, while remaining in the community residence. She continued to attend and meet treatment plan goals. As restrictions loosened the client transitioned to a hybrid remote schedule of weekly on-site individual sessions and group telehealth sessions. She was able to meet her treatment goals, gained employment, and successfully completed treatment. Shortly after transitioning to

independent living, she had a re-occurrence of alcohol use and contacted the outpatient to re-engage in treatment. She attended onsite services, however, had inconsistent attendance as there was some conflict with working hours. She was shifted to telehealth services again, with periodic in-person contact for toxicology. Treatment attendance stabilized, however, the client still reported struggling with urges to use, which she reported doing intermittently. However, through staying connected with treatment was ultimately referred to the community residence where continues to live. Her recovery has stabilized, and she attends outpatient services via telehealth.

Call to Action

- **Include flexible language in future telehealth legislation that still supports the advantages identified in our paper.**

  TCA supports The Administration/Office of National Drug Control Policy (ONDCP) recommendation to *Permanently Enact and Expand PHE Telehealth Regulatory Changes* including the waiver of certain requirements, such as the originating site requirements for Medicare reimbursement of telehealth services, become permanent. The Drug Enforcement Administration (DEA) should also consider making permanent the SUD treatment and recovery changes implemented as a result of the Public Health Emergency (PHE), including authorizing qualified practitioners to prescribe controlled substances to patients using telehealth without first conducting in-person evaluations (as has been the case during the PHE).

- **Develop a telehealth working group of SUD practitioners designed to advise on matters of telehealth.**

- **Payment parity across all payers.**

- **Funding to support access to technology & education for both clients and providers.** TCA supports the Administration's recommendation to increase funding for Mobile App and Assistive Telehealth Services to help individuals who have difficulty with connectivity and Internet access. This is in addition to the federal legislation already passed (American Rescue Plan Act), which included a multi-billion-dollar appropriation to help expand high-speed Internet access.

  Specifically, Congress should consider increasing funding to:
  - Telehealth Broadband Pilot Program in Health Resources Services Administration (HRSA), which assesses the broadband capacity available to rural health care providers and patient communities to improve their access to telehealth services.
  - Federal Communications Commission (FCC) efforts to address the digital divide and to expand availability of high-speed internet (e.g., Universal Service Fund, Rural Health Care Program, Connected Care Pilot Program).

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