NASHP and Mercer: State Strategies to Support Telehealth Infrastructure

April 7, 2022

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

nashp.org

Logistics

- Your lines will be muted during the webinar.
- To ask a question or make a comment, please use the Q&A function.
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience.
- Thank you!

Welcome & Introductions

Jodi Manz, MSW

Project Director; Behavioral Health, Aging, and Disability

NASHP

Speaker Introductions

Kathy Nichols, LCSW, CPH

Kathy is a Senior Government Behavioral Health Consultant in Mercer's Government Human Services Consulting practice. Kathy has experience with both Medicaid and Substance Abuse and Mental Health Administration (SAMHSA) block grant funding, and has worked extensively with design of Medicaid managed care for behavioral health, including community-based services. She has designed and implemented 1915 (b) and (c) and 1115 waivers and has worked on maximizing federal funding across federal payers within the government system.

Pete Liggett, Ph.D., Licensed Psychologist

Pete Liggett, Ph.D. is a principal and licensed psychologist in Mercer's Government Human Services Consulting practice. Since joining Mercer, Pete has worked with projects in Pennsylvania, Kansas, Arizona, Delaware, Connecticut, Missouri, and New Jersey involving value-based purchasing (VBP), behavioral health benefits design, telehealth policy, crisis intervention services, LTSS, and evidence-based service delivery models.

Speaker Introductions

Sara Goldsby, Director, South Carolina Department of Alcohol and Other Drug Abuse Services
A native of Wyoming, Sara Goldsby was confirmed as Director of South Carolina's Department of Alcohol and Other Drug Abuse Services (DAODAS) by the South Carolina Senate on February 8, 2018, after being appointed Acting Director by Governor Nikki Haley in August 2016, then nominated as Director by Governor Henry McMaster in May 2017. As Director, she has led South Carolina's response to the opioid crisis and currently serves as co-chair of the State Opioid Emergency Response Team. Under her leadership, DAODAS has been instrumental in helping local law enforcement agencies employ the use of the emergency overdose antidote naloxone.

Sarah Dearborn, Chief for the Behavioral Health Unit with the Department of Health and Human Services, Division of Health Care Financing and Policy, also known as Nevada Medicaid. In this position, Sarah supports and oversees the policy development and program management for all behavioral policy benefits for recipients receiving insurance coverage through Nevada Medicaid. These policies and programs include outpatient mental health, rehabilitative mental health, substance use prevention and treatment, targeted case management, applied behavior analysis, Certified Community Behavioral Health Centers, services specific for youth in specialized foster care, inpatient psychiatric services, as well as psychiatric residential treatment centers/facilities. Before entering the State of Nevada workforce, she earned her master's degree in Marriage and Family Therapy from the University of Nevada, Reno in 2006. Following graduation, Sarah gained experience in the field of mental health through her work with children, families, and adults as a Qualified Mental Health Associate. She grew passionate about mental health community-based and in-home services; she was promoted to manage the rehabilitative mental health program at a local behavioral health agency while supporting the experiential development of other mental health professionals in the field for many years. Sarah has over 16 years of experience in the field of mental health.

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welcome to brighter

Making the Case: Research on the Efficacy of Telebehavioral Health

Summary of Findings and Recommendations

Pete Liggett, PhD, Licensed Psychologist
Kathy Nichols, LCSW, CPH

A business of Marsh McLennan

Childhood post-traumatic stress and trauma-focused cognitive-behavioral tele-therapy

Heightened family stress combined with lockdown conditions and little community contact likely resulted in increases in child maltreatment

Provision of trauma treatment via telehealth improves access and availability but brings with it engagement challenges

- Attention and emotion regulation skills among this population
- Ability to identify dissociative symptoms
- Available private space for sessions and lack of adequate technology
- Reluctance to process trauma in the absence of a safe environment

"Not all child trauma cases will be appropriate for tele-mental health."[1]

[1]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. *Integration*, 30, 274-289.

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Childhood post-traumatic stress and trauma-focused cognitive-behavioral tele-therapy

Pilot Study

An examination of the feasibility and potential effectiveness of trauma-focused cognitive-behavioral therapy (TF-CBT) delivered via telepsychotherapy

70 trauma-exposed youth in seven underserved communities were used in the study

Results

97% Percentage of treatment completers (9 of 10) who no longer met the criteria for diagnosis

What was learned

- Findings support the preliminary feasibility and effectiveness of TF-CBT with trauma-exposed youth
- No comparison group in this study, but treatment outcomes were comparable with established outcomes for office-based recipients

Stewart, R.W., Orengo-Aguayo, R., Young, J., Wallace, M.M., Cohen, J.A., Mannarino, A.P., & de Arellano, M.A., (2020). Feasibility and effectiveness of a telehealth service delivery model for treating childhood posttraumatic stress: A community-based, open pilot trial of trauma-focused cognitive–behavioral therapy. *Journal of Psychotherapy Integration*, 30, 274-289.

Telehealth psychiatric appointment attendance

Hospital-based IOP services during COVID-19

"Showing up is half the battle"[1]

Study goal

Determine whether rates of attendance of high-risk individuals receiving intensive outpatient treatment (IOP) varied by population group, race, insurance and clinical program

Two groups > those receiving in-person treatment and those who attended via telehealth

Services were primarily group-based psychotherapy; participants were adults and adolescents

Observational data from the electronic medical record at the Yale New Haven Psychiatric Hospital from October 1, 2019 to July 31, 2020

Results

Analyses revealed a statistically significant **higher proportion** of attended appointments for telehealth IOP services of all types (individual, family, medication management, group-based contacts) compared with in-person IOP services of all types for adults

[1]Childs, AW, Bacon, SM, Klingensmith, K, Li, L, Unger, A, Wing, AM, and Fortunati, F. (2021) Showing Up is Half the Battle: The Impact of Telehealth Psychiatric Appointment Attendance for Hospital-Based Intensive Outpatient Services During COVID-19, *Telemedicine and E-Medicine*, p.1-8

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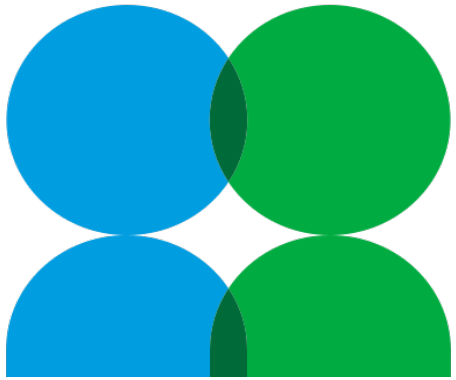
The impact of co-occurring anxiety and AUDs on VTH among rural veterans

- Individuals with co-occurring anxiety and alcohol use disorders (AUDs) tend to have poorer treatment outcomes, which is more problematic for individuals living in rural areas
- Data source was the Corporate Data Warehouse, a large-scale database related to mental and physical health of veterans within the VA in fiscal years 2016–2019
- Findings suggest providing additional approaches such as mobile therapy in reaching the COD population
- Aim of the study is to examine telehealth utilization among rural veterans with anxiety disorders, AUD, and co-occurring mental health and substance use disorders (CODs)
- Populations were divided into three groups: anxiety disorder only, AUD only and COD
- Rate of Video Telehealth Utilization (VTH) visits over time were higher for anxiety disorders group and lowest for the comorbid anxiety/AUD

Ecker, A, Amspoker, AB, Hogan, JB, and Lindsay, JA. (2021). The Impact of Co-occurring Anxiety and Alcohol Use Disorders on Video Telehealth Utilization (VTH) Among Rural Veterans. *Journal of Technology in Behavioral Science*, 314–319, https://doi.org/10.1007/s41347-020-00150-x

Telepsychotherapy and the working alliance
Generalized anxiety disorder

65
participants
in-person
therapy



50
participants
telepsychotherapy

Telehealth and the Therapeutic Alliance

Of the **115** individuals diagnosed with generalized anxiety disorder, research shows that telepsychotherapy does not interfere with development of the working alliance and resulted in a stronger working alliance than in-person therapy

Watts, S., Marchand, A., Bouchard, S., Gosselin, P., Langlois, F., Belleville, G., & Dugas, M.J., (2020). Telepsychotherapy for Generalized Anxiety Disorder: Impact on the Working Alliance. Journal of Psychotherapy Integration, 30, 208-225

An international study on mental health clinicians' use of telehealth

25 contributing authors studied 1,206 clinicians from the WHO's Global Clinical Practice Network

Study goal	Observational study	Findings
This large international study examined the impact of the pandemic on mental health clinicians' telehealth use	Clinicians from 100 countries completed the telehealth section of an online survey in one of six languages and were asked about their use, training, perceptions, and concerns	• 90.5% clinicians reported to have started or increased their telehealth services • 49% participants indicated that they had not received any training • Most clinicians indicated positive perceptions of effectiveness and patient satisfaction • Findings in this report suggest that training is associated with clinicians' perceptions of effective telehealth delivery and preparedness

Participants were asked whether they had received training on technological, ethical, legal, and clinical aspects of telehealth service

Citation: Montoya, M.I., et al. (2022). An international survey examining the impact of the COVID-19 pandemic on telehealth use among mental health professionals. Journal of Psychiatric Research, 148 (1), Pages 188-196

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Telepsychology with veterans
A meta-analysis

27
studies including…

25
with pre-post data evaluating outcomes

18
used RCT study design

2,648
respondents

1,667
in treatment conditions

981
in control conditions

Conditions included PTSD and depression

More research needed on other conditions experienced by veterans

Weighted average effect sizes computed from RCT studies suggest telepsychology is similarly effective as services delivered face-to-face

McClellan, M. J., Osbaldiston, R., Wu, R., Yeager, R., Monroe, A. D., McQueen, T., & Dunlap, M. H. (2021). The effectiveness of telepsychology with veterans: A meta-analysis of services delivered by videoconference and phone. *Psychological Services.* Advance online publication.

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An effective alternative to in-person care

Evidence on telebehavioral health

- Is as effective as in-person care for common conditions in adults with depression, anxiety, SUDs, and post-traumatic stress disorder (PTSD)
- Telehealth showed significantly greater improvements for children with attention deficit hyperactivity disorder (ADHD) with decreases in distress among caregivers
- Neither worse than nor harmful in comparison to in-person care for many BH conditions

4½ page issue brief with 55 citations

Lazur, B., Sobolik, L., and King, V. (2020). Telebehavioral Health: An Effective Alternative to In-Person Care. Milbank Memorial Fund Issue Brief, October 2020.

Is videoconferencing just as good?

Meta-analysis of videoconferencing technologies

Review of **57** empirical studies over the past two decades

43 examining intervention outcomes

14 examining assessment reliability

"Videoconferencing Technologies (VCT) consistently produced treatment effects that were largely equivalent to in-person delivered interventions across **281** individual outcomes and **4,336** clients."[1]

Analysis of assessments using VCT ***did not*** lead to differential decisions compared to in-person assessments

This study highlighted the need for **more** RCT studies on VCT

[1]Batastini, A. B., Paprzycki, P., Jones, A. C. T., & MacLean, N. (2021). Are videoconferenced mental and behavioral health services just as good as in-person? A meta-analysis of a fast-growing practice. *Clinical Psychology Review*, 83.

Determining the individual hybrid model

What we know

Telebehavioral health breaks down barriers and offers more privacy than face-to-face mental health care

Additional benefits

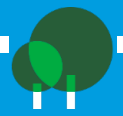
- Connecting patients and providers to a **wider** network regardless of location, while still monitoring privacy risks
- Easier, more convenient **access** to specialists and unique treatments
- Improving opportunities for patients and providers to **connect** with people coming from a similar cultural background or speaking the same language
- Increased patient **confidence** for those typically unwilling to seek out in-person behavioral health treatment, but feel comfortable with telehealth

Businesses need new workflows, procedures and updated business model

Understanding the pros and cons will help decide the correct hybrid model

Factors in deciding on a hybrid model

Understand the **community** you serve



Think about what services your patients need and what the common behavioral health challenges are in your area

Decide which telehealth approach best matches your skills and will be the most effective in your community

Challenges to consider

Increased need for mental health services for health care providers and front line workers who are working longer hours in stressful and often dangerous situations due to COVID-19

Challenges that are unique to your area that could impact the community's need for behavioral health services

How your telebehavioral health services can be easily accessed by a diverse group of patients with different needs

Determine **budget** for technology and customer support

Review your budget to understand if you have the financial resources to invest in ongoing maintenance and tech support

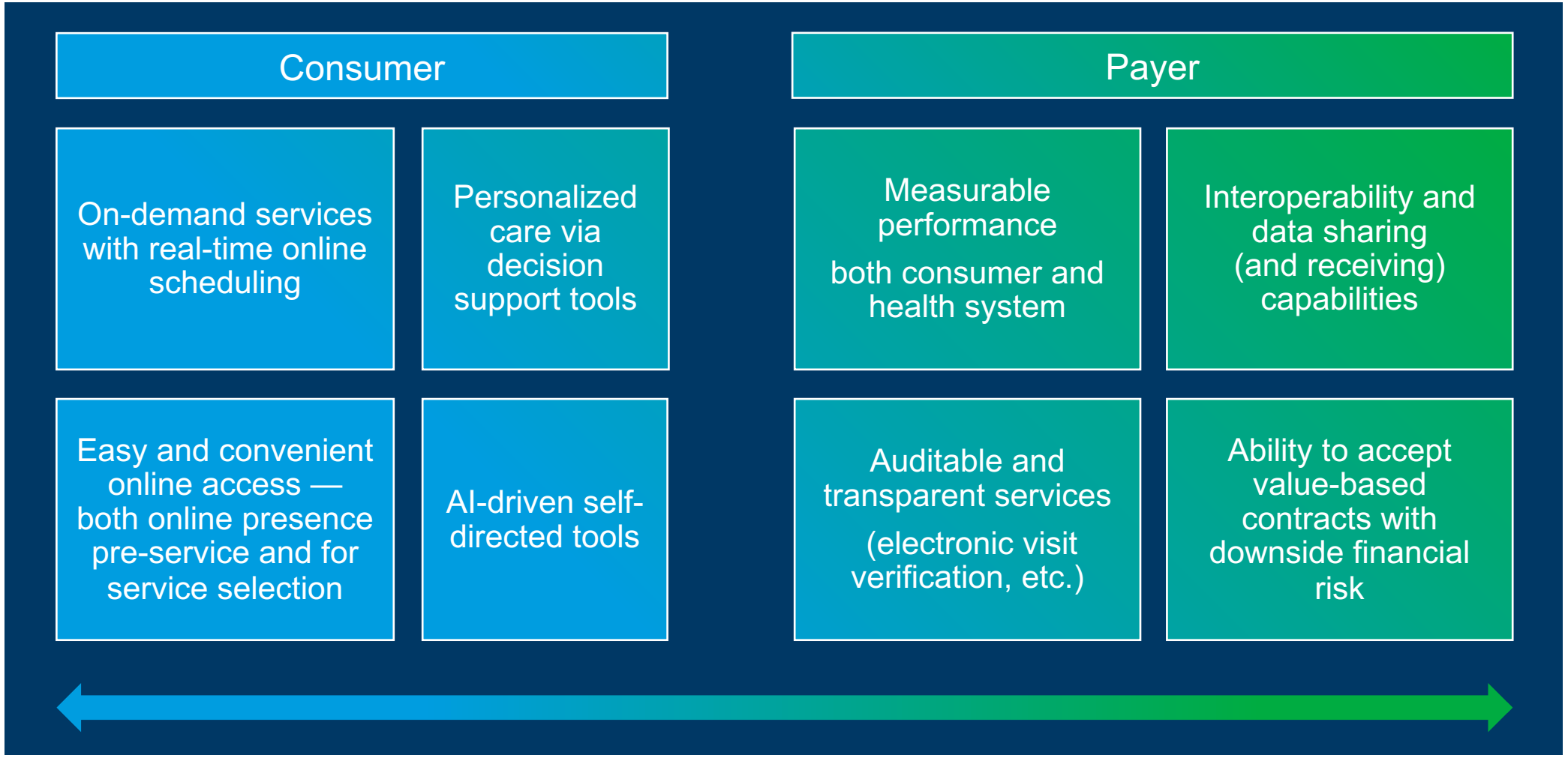
Consider whether you want to use existing telehealth software or hire someone to create a new behavioral health platform just for your practice

Factors in deciding on a hybrid model

Other possible expenses	Staff training time	Exploring telehealth technology	Get connected
• Hiring a project manager or telehealth coordinator to set up telehealth technology for patients • Hiring an IT specialist to keep your software and internet running smoothly	• Spend time to ensure your staff has the skills to do their job well • Help staff support your patients with training on the basics of telehealth as well as addiction and mental health disorders • Include cultural sensitivity and accessibility requirements as part of your regular skills training		• Your top priority = ensure patients can get online for telehealth • Research = ensure broadband internet is available, affordable, and easily accessible in your community • Some cities also offer “tele-hubs” — rooms with a computer and free internet access, often located in community centers or libraries

Marketplace expectations

Expectations



Importance of a digital storefront

Increase in consumer online searching for virtual behavioral health

Building a provider **digital storefront improves** search rankings and visibility

For consumers who find **your** virtual services, consider providing **"walk in"** ability for immediate telehealth sessions

When telehealth is **immediately** available, it is likely the consumer will continue with that provider long-term

Chances are that a consumer searching for telehealth is in need **"right now"**. So how do you make the "right now" possible?

This comprehensive care model — both the virtual consumer experience platform and the service delivery management platform should serve as the foundation of data for business intelligence and population health management

Funding Options

Telehealth Resource Center grant program

Telehealth Resource Centers (TRCs) assist health care organizations, health care networks, and health care providers in the **implementation** of cost-effective telehealth programs to serve rural and medically underserved areas and populations

Health Resources & Services Administration (HRSA)

The purpose of this program is to connect specialists at academic medical centers with primary care providers in rural, frontier, and underserved populations providing **evidence-based training and support** to help them treat patients with complex conditions in their communities

Coordination with other states

Build on work of Eastern States Multi-state Council to share best practices; modeling Western States Pact. Both regional groups manage **connected health issues** as a result of COVID-19. The Western States Pact includes goals on broadband as well

Public/private partnership

Many states and counties are at various stages of implementing **"middle mile"** and other public/private partnerships

Broadband infrastructure program

https://broadbandusa.ntia.doc.gov/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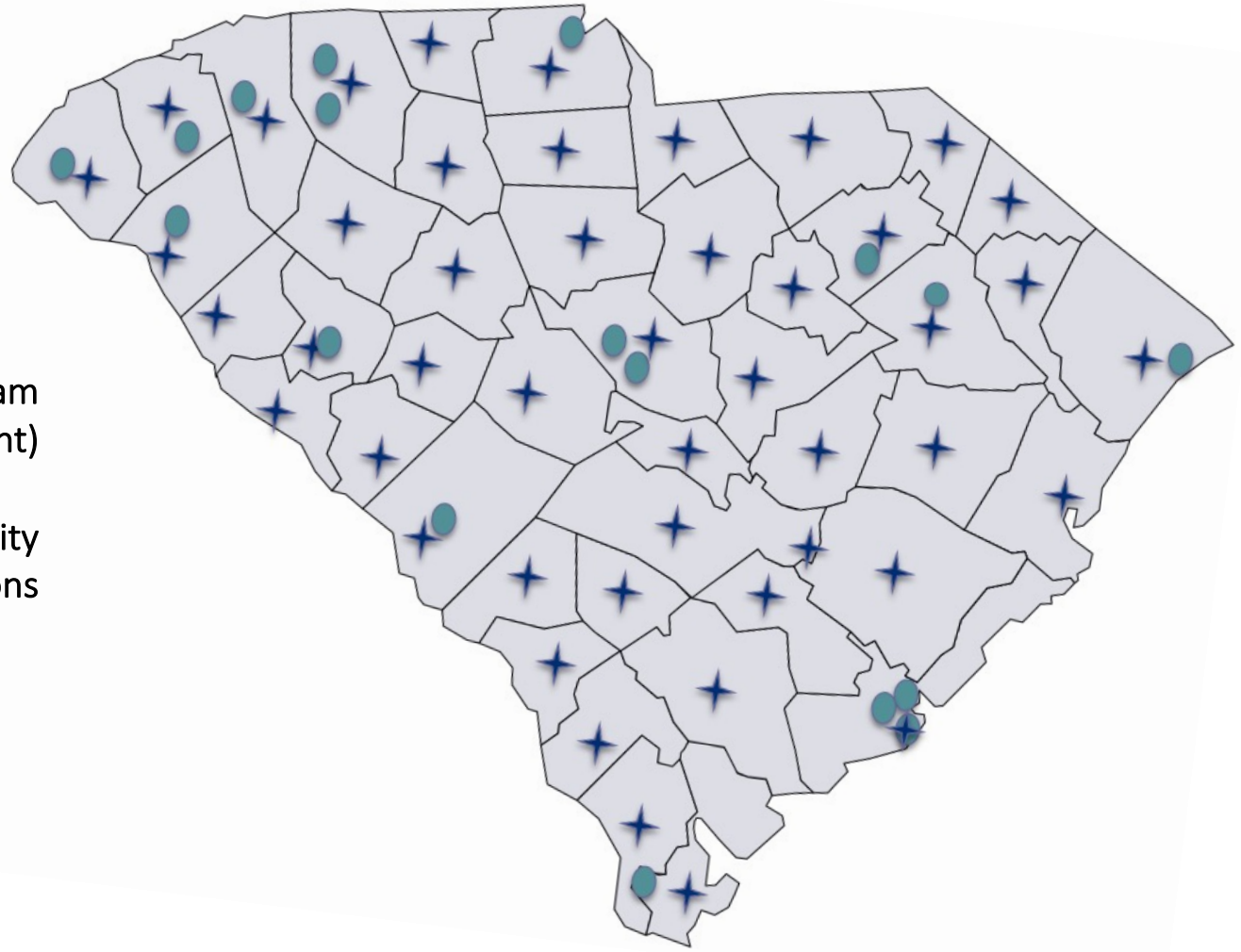
South Carolina DAODAS
Department of Alcohol and Other Drug Abuse Services

Strategies to Support Telehealth Infrastructure for Substance Use Disorder Services

South Carolina Publicly Funded Treatment Locations



Opioid Treatment Program (Methadone Treatment)

County Alcohol & Drug Abuse Authority Service Locations

SAMHSA BEHAVIORAL HEALTH TREATMENT LOCATOR

Telehealth Capacity Before COVID-19

- South Carolina Telehealth Alliance
- All County Authority Treatment Sites Had a Telehealth Cart
- DAODAS Subsidized Providers' Broadband Costs with State Funds
- No Medicaid Reimbursement for Clinical Services
- Approval for Buprenorphine Initiation Limited by State's Board of Medical Examiners

SOUTH CAROLINA Telehealth ALLIANCE

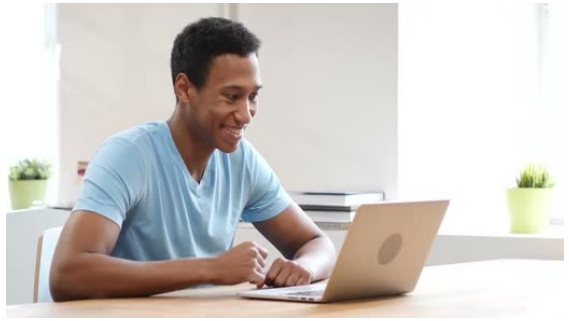
USDA

Tele-Services During COVID-19

- Medicaid/Block Grant/SOR Reimbursement for clinical services approved for:

  Crisis Management, Individual Psychotherapy, Peer Support, Case Management, and other behavioral health services provided via telehealth *or telephone*

- Each County Authority allocated $5,000 to purchase cellular phones and minutes for use by patients in need of access (State Funds)
- State's Board of Medical Examiners approved more prescribers to initiate buprenorphine via telehealth
- Counselors worked from home and office using doxy.me and Vidyo for clinical services by laptop



Vidyo

doxy.me

Positive Results

- Patient retention and increased engagement – fewer “no-shows”
- Deeper clinical work with a glimpse of home life and engagement of family
- Patients reporting high satisfaction and a desire to continue services due to enhanced accessibility, flexibility, and privacy

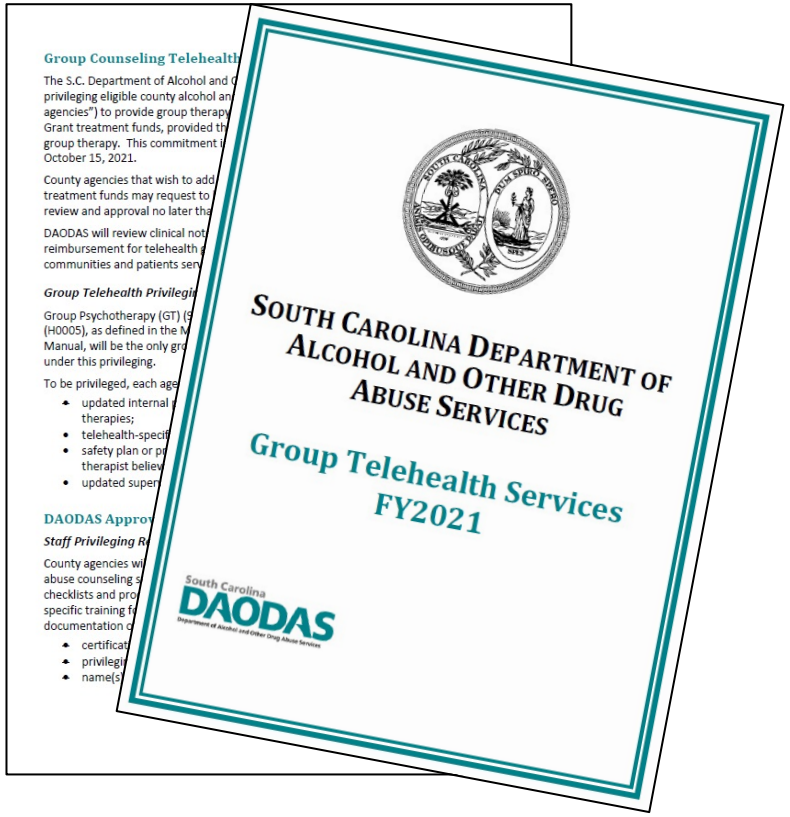
Challenges

- Uncertain future
- Walk-ins for new admissions dropped dramatically
- Group therapies

Group Psychotherapy & Group Counseling (90853 & H0005)

Training, Privileging, Approval

- Training on ethics and legal guidelines, clinical delivery
- Updated policies/procedures, consent forms specific to telehealth for individual and group therapies
- Safety plan or protocol specific to telehealth service provision
- Updated supervision policies, to include telehealth service provision
- Tips for success
- Billing codes and reimbursement
- Observation questionnaires



The Present and Future

- Greater need for services for South Carolinians who are and will be hurting
- Workforce – private sector and remote jobs are competitive
- Licensing boards could approve providers for telehealth service long-term
- Addressing barriers preventing vulnerable populations from accessing telehealth services (internet connectivity in rural or low-income communities)

South Carolina
DAODAS
Department of Alcohol and Other Drug Abuse Services

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Steve Sisolak
Governor

Richard Whitley
Director

State of Nevada

Department of Health and Human Services

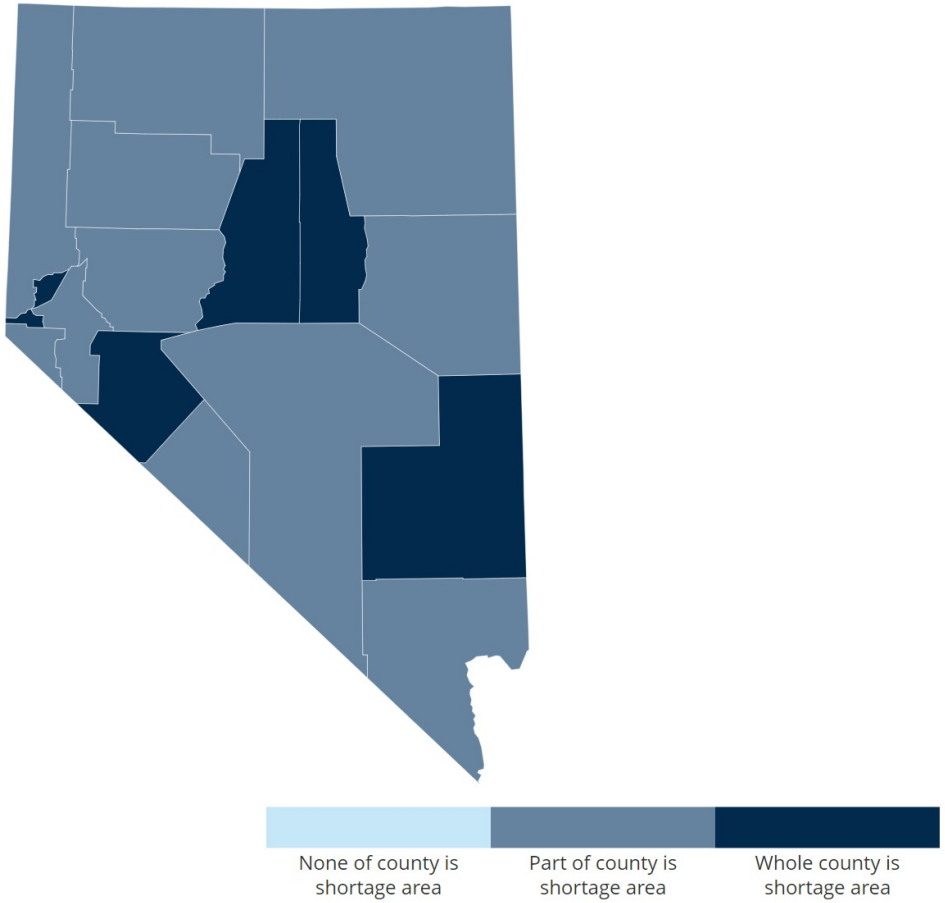
State Strategies to Support Telehealth Infrastructure

April 7th, 2022

Sarah Dearborn, Nevada Medicaid Behavioral Health Unit Chief
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

Helping people. It's who we are and what we do.

Nevada's Geography and Health Professional Shortage Areas (HPSA; 2022)



Source: data.HRSA.gov, January 2022.

- Nevada is comprised of 17 counties with two urban counties and 15 rural/frontier counties
- At least some of every county in Nevada is a Health Professional Shortage Area
- The geographic challenges for access to all types of health care has encouraged the use of telehealth

Nevada's Telehealth Policy Prior to the COVID-19 Pandemic

Since 2015, Nevada State law described telehealth as public policy to encourage and facilitate the use of telehealth to improve public health and quality of care while lowering health care costs (NRS 629.515(3)(c))

- Allows for boards to issue special-purpose licenses to out-of-state providers who want to practice telemedicine only (NRS 630.261)
- Providers must provide services in accordance with their scope of practice and meet standards of care
- Requires Nevada Medicaid and other health insurers to cover telehealth to the same extent as in-person care
- Can not require an established provider relationship, prior authorization if not required for in-person services, or make telehealth a condition of paying for services

Nevada's Telehealth Policy Prior to the COVID-19 Pandemic

In 2018, Nevada Medicaid established policy for telehealth to align with legislation.

Policy provides for:

- Payment parity
- Prior authorizations must be applied equally to telehealth and in-person services
- Use of HIPAA compliant audio-visual technology
- Synchronous and asynchronous services
- Providers must use telehealth within their scope of practice

Payment parity for grant funded substance use disorder treatment providers for telehealth-alignment with Nevada Medicaid Policy

Immediate Actions following the Emergency Declaration for COVID-19 and Substance Use Disorder Treatment

- Directive 11-allowed licensed providers in good standing to register with occupational licensing boards in Nevada which enabled broad telehealth access for behavioral health services
- Federal grant sub-awardees allowed the flexibility to purchase telehealth equipment to allow for rapid uptake of telehealth services
- Utilization of telehealth services for residential treatment
- Information dissemination through provider portals and web announcements for telehealth health policy from DHCFP (3.18.20)
- Expansion of allowances of telehealth for some services
- Telehealth prescribing for MAT
- Inclusion of audio-only services

Behavioral Health Utilization and the Impact of COVID-19

Patients by Visit Method	Patients Provided Services within this Time Period Mar 1, 2019- Dec 31, 2019		Patients Provided Services within this Time Period Mar 1, 2020 - Dec 31, 2020		Patients Provided Services within this Time Period Mar 1, 2021 - Dec 31, 2021	
	OFFICE/OTHER	TELEHEALTH	OFFICE/OTHER	TELEHEALTH	OFFICE/OTHER	TELEHEALTH
Number of Patients	198,779	5,818	184,139	59,997	204,146	53,056
% Telehealth		3%		25%		21%

Senate Bill 5 (81st Legislative Session; 2021)

In 2021, Senate Bill 5 was passed allowing for audio-only telehealth while allowing Nevada Medicaid flexibility in policy and payment.

- State Plan Amendment
- Medicaid Service Manual Policy Update
- Payment Parity

Medical Necessity and Telehealth

Nevada Medicaid 103.1 defines medical necessity as

A health care service or product that is provided for under the Medicaid State Plan and is *necessary* and *consistent* with generally accepted professional standards to:

diagnose, treat or prevent illness or disease;

regain functional capacity;

or reduce or ameliorate effects of an illness, injury or disability.

Medical Necessity and Clinical Appropriateness

The determination of medical necessity is made on the basis of the individual case and takes into account:

a. *Type, frequency, extent, and duration of treatment* with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.

b. *Level of service that can be safely and effectively furnished*, and for which no equally effective and more conservative or less costly treatment is available.

c. *Services are delivered in the setting that is clinically appropriate* to the specific physical and mental/behavioral health care needs of the recipient.

d. *Services are provided for medical or mental/behavioral reasons* rather than for the convenience of the recipient, the recipient's caregiver, or the health care provider.

Medical Necessity shall take into account the ability of the service to allow recipients to remain in a community-based setting, when such a setting is safe, and there is no less costly, more conservative or more effective setting.

Key Topics under Consideration for Telehealth and the Treatment of Substance Use Disorders

Equity issues and access to broadband and Wi-Fi

Digital literacy

Informed consent

The patient-provider relationship

Offering patient choice

Lessing the impact of barriers to care (transportation, childcare, leave time).

Managing high risk patients

In-home MAT induction

Levels of Care appropriate for telehealth and implications for programming

Incentivizing continuity of care

Emerging technologies for asynchronous telehealth and remote patient monitoring

Questions?

Facilitated Q&A

Thank you!

Please be sure to complete the post-webinar evaluation.