

Telehealth in State Substance Use Disorder (SUD) Services

Prepared by:

The National Association of State Alcohol and Drug Abuse Directors, Inc.
(NASADAD)

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Telehealth in State Substance Use Disorder (SUD) Services

Executive Summary

Preliminary evidence suggests telehealth/telemedicine is a promising tool for substance abuse treatment and support. Several studies have found that telehealth therapy across the continuum of care is as effective as face-to-face intervention. States lacking an adequate number of substance abuse (SA) and mental health (MH) workforce specialists and facilities, such as is the case in rural communities, can pursue telehealth technologies as a means to expand access to care. Conflicting State legislation, specifically regarding regulations to incorporate telehealth into SUD/MHD services and reimbursement policies around these services, complicates the expansion of telehealth within State SA and MH. Despite its regulatory hurdles, research suggests telehealth is a viable option for SUD and MHD education, support, and treatment. To learn more, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) distributed an inquiry to the National Treatment Network (NTN) membership regarding the use of telehealth in their States' SA and MH systems. NASADAD staff collected data from 37 States on the types of telehealth technology they use, the purposes these technologies are serving, and the regulations surrounding them.

Introduction

Telehealth is a promising tool for providing substance abuse prevention, treatment and recovery support services across the continuum of care and is especially effective in expanding access to SA services, despite reimbursement issues and regulatory hurdles.

As defined by Nancy Brown (2005), telehealth is used as an umbrella term for all possible variation of healthcare services that utilize telecommunications such as medical treatment, education, administration, and research. A subset of telehealth, telemedicine “describes the direct provision of clinical care via telecommunications.” Additionally, the term “telemental health” refers to the use of telehealth to provide mental health services to individuals; “telepsychiatry” refers to the inclusion of telehealth in the psychiatry realm.

Telehealth and all of its subsets utilize telephones, computers, the internet, and interactive video to provide mediated healthcare services for clients. Telehealth is practiced in two different contexts: real time (synchronous) and store-and-forward (asynchronous). Real time telehealth services require a communications link that allows an immediate interaction to occur between the parties, such as in videoconferencing, web-enabled, webcam assisted, and telephone communication. Store-and-forward telehealth services are used for transferring medical data from one location to another, for example by sending a digital image via email or submitting an online survey.

The literature shows that this modern treatment methodology is able to overcome the barriers of distance, physical disabilities, and social stigmas that prevent many Americans from receiving healthcare (Curie, 2005). Telehealth technology has been especially useful to rural communities that lack the medical specialists often found easily in urban and suburban centers (Brown, 2005). However, telehealth can not solve the workforce dilemma of having the specialized providers/resources in rural areas (Telemedicine Information Exchange [TIE], 2008). In an interview

with the Fresno Bee newspaper, Tom Nesbitt, director of the Center for Health and Technology at UC Davis said "Telemedicine doesn't create more specialists...What it can do is redistribute the knowledge of specialists over a larger geographic area" (TIE, 2008).

Telehealth in Mental Health and Substance Use

There are many telehealth resources available to people in need of SUD and/or MH support. Common search engines, such as Google, provide various links directing consumers to preventative/educational interventions, websites of providers who offer real time telehealth services (i.e. web-cam assisted counseling), and information regarding web-enabled administrative/management tools. The Rural Assistance Center (http://www.raonline.org/info_guides/telehealth/) identifies various telehealth resources such as the Telemedicine Information Exchange and AHRQ National Resource Center for Health Information Technology. The internet offers SUD support in the form of counseling programs, preventative/education interventions, and support groups. Preventative/educational web-based interventions are self-paced learning programs that typically include educational information, assessments that provide personal feedback, an online forum, therapeutic strategies for change, a journal for self-monitoring, and links to other resources (Branigan, 2003; Copeland & Martin 2004). AA online (www.aaonline.net) and individual organizations like www.TheSecondRoad.org offer online meetings to promote self help support through the internet. Additionally, internet-based systems designed to facilitate drug and alcohol screening, such as the Drug and Alcohol Problem Assessment for Primary Care (DAPA-PC), seem useful in administrative settings (Copeland & Martin, 2004).

Preliminary evidence suggests telehealth/telemedicine is a promising tool for substance abuse treatment and support (Frueh, et al., 2005; Health Canada, 2009; King et al., 2009; Rohde, et al., 1997). CRC Health Corp. ran a study involving 602 subjects that found an 80% completion rate for their eGetgoing internet-based outpatient alcohol and SA treatment program. This is double the completion rate of 41% for traditional outpatient treatment indicated in SAMHSA's 2002 Drug and Alcohol Services Information System Report. According to Gen. Barry R. McCaffrey, former Director of the White House Office of National Drug Control Policy (ONDCP), "studies nationwide report the importance of program completion to more favorable outcomes as compared to those who begin, but who do not complete, treatment" (Alcoholism and Drug Abuse Weekly [ADAW], 2003). In a few small studies, telehealth has been shown to be equally as effective as face-to-face SA and MH interventions (Copeland & Martin, 2004; Frueh, et al., 2005; Health Canada, 2009; King, et al., 2009). Some of the studies have even found that people prefer telehealth because of the convenience and increased confidentiality (Copeland & Martin, 2004; King, et al., 2009; ADAW, 2003). However, Rohde, et al. (1997) found that though communication via the telephone is as effective as the traditional face-to-face medical interaction, and diagnoses were found reliable across assessment methods, results for mental disorders were found to be more reliable than were results for alcohol and substance use disorders; the telephone interviews tended to identify fewer symptoms than the in-person assessments of alcohol and substance use disorders.

Though the current literature generally shows positive results, more research is needed. There is not extensive literature on the efficacy of telehealth methods for SUDs and MHDs, and in the existing studies, sample sizes have been small and the control group (face-to-face) interventions were not necessarily effective or evidence-based. Within these studies, counseling via telemedicine has only been studied in the context of group sessions (Frueh & Myri, 2005; King, et al., 2009).

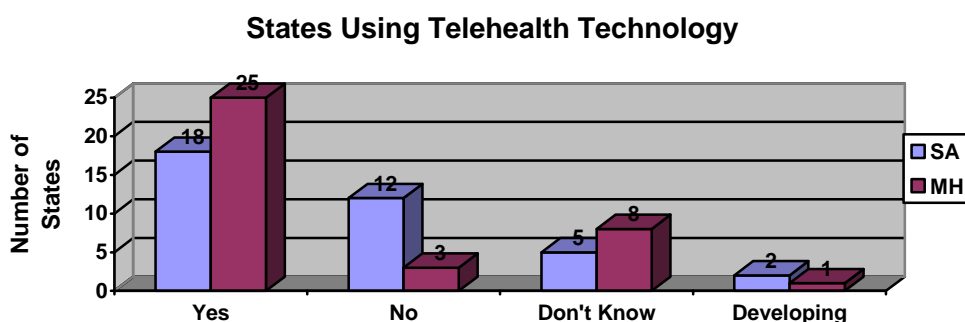
Studies that were conducted on individual subjects only explore the effectiveness of telehealth in doing SUD and MHD assessments and web-based intervention programs (Copeland & Martin, 2004; Health Canada, 2005).

Methodology

NASADAD staff distributed an inquiry via email to the National Treatment Network membership to identify which States are incorporating telehealth/telemedicine into their SA and/or MH programs in December 2008. Members were asked if any SUD and/or MH treatment providers in their States provide treatment or related services electronically; what, if any, these services are; and if there are licensing standards or other documents regarding these services. Responses from the States utilizing electronic treatment methods were then categorized by types of services and regulations.

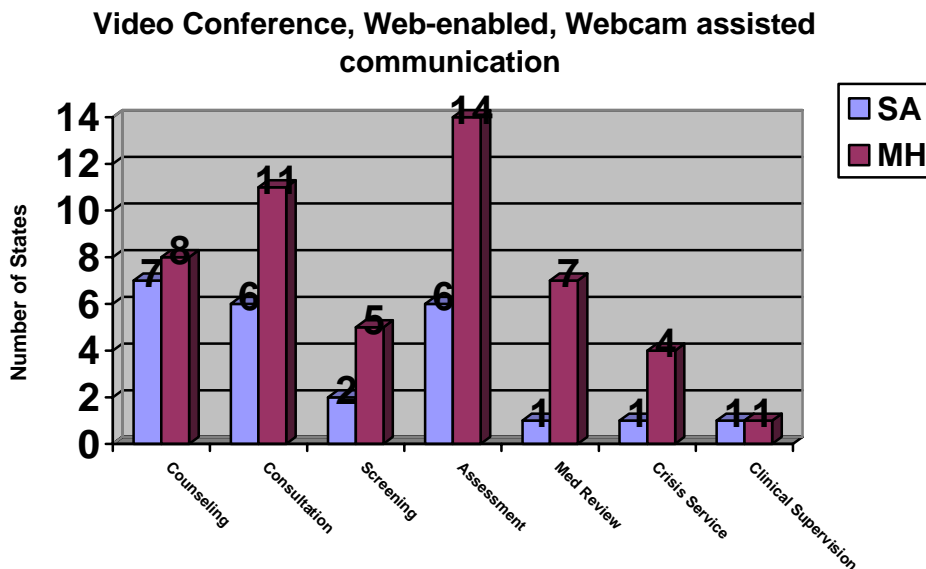
State-specific Mental Health and Substance Use Disorder Telehealth Initiatives

Of the 37 States that responded, 29 are currently utilizing some form of telehealth. The following chart presents the States' responses to the inquiry:



The inquiry differentiated between States' SA and MH systems and found that 18 States use telehealth for SA and 25 for MH. Real time telehealth technology in the forms of video conferencing, web-enabled, and webcam assisted communication is the most widely used form of telehealth among these States—16 out of 18 States use it for SA and all 25 States use it for MH. This equipment is most often used for counseling and consultations and less often for screenings, assessments, medication reviews, crisis services, and clinical supervision. See chart below for a breakdown of the services for which States are using video conferencing, web-enabled, and

webcam assisted telehealth communication.



States infrequently use other types of telehealth services (i.e. telephone counseling) in their SA and MH programs. Of all 37 States that responded to the inquiry, three conduct telephone counseling (SA-2, MH-2), four utilize preventative/educational web-based interventions (SA-3, MH-2), and three employ web-enabled administrative/management tools (SA-2, MH-2).

Regulating Telehealth

Expanding access via telecommunications to healthcare services across State borders and even internationally poses problems for State-based healthcare systems (Goldberg, 2007). For example, “because laws and regulations governing nursing practice differ from State to State, it is often not clear which laws apply to [providers of] telehealth services across State boundaries” (ANA, 2008). Despite these tribulations, there have been various proposals made to amend the current State-based system to adapt to the increasing demands of telehealth” (ANA, 2008).

Legislators, regulators and practitioners are hesitant about expanding telemedicine practices for reasons including, but not limited to, the following:

- Privacy/HIPAA issues;
- Selective/limited reimbursements for services from public and private payers
- Fraud and billing abuses could arise from services rendered remotely; and
- Differences in credentialing and licensure across States (Goldberg, 2007).

The Telecommunications Act of 1996 removed major economic and legal barriers to the development and deployment of these innovative healthcare services. Today, the U.S. government now spends \$400 million a year to deliver telecommunication healthcare services in rural communities (CTeL, 2009b). Additionally, “under the Rural Health Care Program of the Universal Service Fund, the public and non-profit health care providers can receive telecommunications services necessary for the provision of health care services at rates comparable to those paid in urban areas”(CTeL, 2009b).

In 2007, laws related to telemedicine/telehealth were passed in California, Colorado, Kansas, Massachusetts, New Mexico, New York, Oregon, Texas, and Utah. Five of those States (KS, MA, OR, TX, UT) allowed or required reimbursement for telehealth services from Medicaid and/or private insurance providers. The legislatures in three States (CA, MA, NY) provided specific appropriations to fund programs and projects to expand the use of telehealth services. Legislation in two States (CA, NY) created regulatory bodies and working group specifically for telemedicine (Bloch, 2007). See Appendix A for more detailed descriptions of the new legislation by State.

The NASADAD inquiry also explored the regulations implemented by State-specific SA and MH telehealth programs. The results show that less than half of the responding States have established standards for telehealth within their SA/MH systems. Only 14 of the 29 States allowing SA/MH telehealth provide some sort of regulation (SA only-6, MH only-7, SA & MH- 1). States have taken the following actions to regulate telehealth in their jurisdictions:

- Five States require those practicing telehealth services to act in accordance with the standards used for face-to-face services (SA only- 2 [IN, FL], MH only- 3 [NY, MI, MN])
- Three States require those who practice telehealth to formalize protocol (SA only-2 [SD, MT], MH only-1 [KY])
- Two States meet telehealth certification requirements (SA only-1 [ME], MH only-1 [WI])
- Wyoming has an MOU to fund telehealth equipment for publicly funded SA and MH treatment centers
- New Mexico's SA system has standards specifying how SBIRT should be done using telehealth
- Two States' MH departments created provisions that amended requirements for face-to-face services to apply to telehealth services (NJ, OH).

Of the remaining States, 21 States do not have regulations around telehealth in their SA systems and 8 States do not know the regulations, if any, which might apply to their SA systems. Only 1 State's SA department (North Carolina) is in the process of developing telehealth standards. In North Carolina, there is proposed legislation to conduct involuntary commitment evaluations via telehealth technology (current statute requires that the clinician conduct the evaluations in person).

In addition to legislation, JCAHO and other bodies have provided certification for telehealth providers, including those who offer MH and SUD services since 2001. The American Psychological Association (APA) applies the same guidelines from in person therapy to therapy that uses internet or phone (2003). The National Association of Social Workers (NASW) and the California Association of Marriage and Family Therapists (CAMFT) require providers to explain the potential risks, consequences, and benefits of electronic therapy to their clients. The American Counseling Association (ACA), American Mental Health Counselors Association (AMHCA) and National Board for Certified Counselors (NBCC), in contrast, devote entire sections in their code of ethics to telehealth providers regarding limitations, access, informed consent, use of the Web and more. Most importantly these bodies require counselors to adhere to specific guidelines to ensure privacy, confidentiality, informed consent and safety for the clients. They also require counselors to review "local, State, provincial, and national statutes as well as codes of professional membership

organizations, professional certifying bodies, and State or provincial licensing boards” (NBCC, 2005) in the counselor's home jurisdiction as well as the client's.

Reimbursement for Telemedicine

States establish the laws and regulations for private insurers within their State. Five States—California, Louisiana, Texas, Oklahoma, and Kentucky, have enacted such laws that “prohibit payers from excluding services solely because they are delivered telemedically” (Hoffman, 2008).

Inter-State politics can make reimbursements for telehealth services more difficult. Often, conflicting State, Medicaid and/or private insurers’ policies mean that providers must pay close attention to legislation in order to assure they will be reimbursed for their services. For example, some States require the practitioner to have a valid State license in the State where the patient is located (Brown, 2005). Over 50% of States have enacted regulations or created programs to help overcome the barriers (CTeL, 2009a; Hoffman, 2008; ATA, 2006), but consistent, comprehensive reimbursement policies are necessary for the successful integration of telemedicine into healthcare.

As the use of telemedicine is becoming more commonplace in healthcare, many Federal, State, and private insurance plans are revamping their policies to include coverage for telemedicine (Centers for Medicare and Medicaid Services [CMS], 2008; CMS 2005; Hoffman, 2008). Medicare reimburses telemedicine services at rates equivalent to face-to-face services (CMS, 2005). The Center for Telehealth and E-Health Law found that 27 States’ Medicaid Programs are providing at least some reimbursement for telehealth services—the most rapid reimbursement expansion happening in the area of behavioral health (2009a). In 2005, the American Telemedicine Association and AMD conducted a phone survey of 72 private insurance programs offering potentially billable telehealth services that found payers reimbursing in at least 25 States. Over 100 private payers currently reimburse for telemedicine services. Still many payers do not reimburse at all (Hoffman, 2008).

The American Telemedicine Association estimated that the total amount of federal funds appropriated to grants and contracts for telemedicine demonstrations and research in 2003 was \$270 million. One third of this was funded through research contracts with the U.S. Department of Defense for equipment and service delivery (ATA, 2009). Grants and contracts are available through federal programs such as the Rural Development Distance Learning and Telemedicine Loan and Grant Program of the U.S. Department of Agriculture and the Office for Advancement of Telemedicine’s Telehealth Network Grant Program (Health Resources and Services Administration [HRSA], 2005). The Veterans Health Administration is the largest provider of telehealth services, and it was “projected to deliver approximately 350,000 patient services remotely in 2003” (ATA, 2009). Unfortunately, spending on telehealth services provided by the Federal government is not tracked, and thus the total amount is unknown. Medicare spending for telemedicine is unknown, as well, because it is only partially tracked (ATA, 2009).

The Medicare Payments for Telehealth Services, listed under Section 15516, addresses needs in rural shortage areas by providing “coverage and payment for Medicare telehealth [including] consultation, office visits, individual psychotherapy, [psychiatric diagnostic interviews] and pharmacologic managements delivered via a telecommunications system” (CMS, 2003). Additionally the law provides that telehealth services that produce “similar diagnostic findings or therapeutic interventions as compared with a face-to-face ‘hands on’ delivery of the same service”

(CMS, 2005) are to be covered under Medicare. Reimbursement is also dependent upon the type of practitioner providing the service and the location where the Medicare beneficiary is receiving the telehealth service. Physician assistants, nurse practitioners, nurse midwives, clinical nurse specialists, clinical psychologists, and clinical social workers are able to bill Medicare for covered telehealth services. Clinical psychologists and clinical social workers, though, are not permitted to “bill for [telehealth] psychotherapy services that include medical evaluation and management services under Medicare” (CMS, 2003). Providers eligible for providing these services include offices of physicians or other eligible practitioners, hospitals, critical access hospitals, rural health clinics, and federally qualified health centers (CMS, 2003). Medicare will also reimburse providers for providing telehealth services that are part of Medicare-reimbursable services (CMS, 2008).

The Federal Medicaid statute, Title XIX of the Social Security Act, also does not recognize telemedicine as a distinct service. Similar to Medicare, “reimbursement for Medicaid covered services, including those with telemedicine applications, must satisfy federal requirements of efficiency, economy and quality of care” (CMS, 2008). States have the option to allow reimbursement for telehealth services that model the traditional face-to-face services between doctor and patient or to fund telehealth applications that are simply apart of Medicaid-covered services [i.e. ECG interpretation] (CMS, 2008). All States’ Medicaid programs cover “telehealth store-and-forward for teleradiology, telepathology, ECG interpretation, ultrasound and echocardiography, [but as of 2003 only] 23 States have some form of reimbursement for services delivered via telemedicine technologies for interactive consultations to Medicaid recipients” (ATA, 2006). According to the Telehealth Alliance of Oregon, 35 States now reimburse Medicaid recipients for telemedicine services (Hoffman, 2008). The majority of States’ Medicaid programs that reimburse for telehealth services are doing this in an effort to improve specialists’ access to rural communities and reduce transportation costs (CTeL, 2009a).

Conclusions

The following lessons have been learned from NASADAD’s inquiry and literature review on telehealth:

- Telehealth resources are easily accessible through the internet ;
- There are high patient satisfaction ratings and equivalent results between traditional face-to-face and telehealth methods for treatment services;
- Regulation is complicated, but legislators, regulators, and practitioners are making attempts to expand the use of telehealth;
- Medicare as well as several private payers and Medicaid programs reimburse for telehealth services that are equivalent to face-to-face methods and;
- Many States have enacted legislation around telehealth for SUDs and MHDs.

States have begun to adopt telehealth services in a variety of ways. States are progressively using telephones, video conferencing, web-enabled, and webcam assisted communication technologies to educate, treat, and support people struggling with SUDs and MHDs. States are using these technologies in place of face-to-face communication to perform the following services: counseling, consultations, screenings, assessments, medication reviews, crisis services, clinical supervision, preventative/educational interventions, and administrative/management processes.

States continue to wrestle with how they should regulate telehealth services. The main concerns include privacy issues, fears of fraud, and a lack of provisions for reimbursement of providers (Goldberg, 2007). Despite these concerns, States are rapidly beginning to implement telehealth programs as a means to cutting costs and gaining convenience. Overall, the technological advances of the information age have a major impact on substance use disorder treatment and its direction for the future (Brown, 2005; CTel, 2009a; Curie, 2005; Goldberg, 2007).

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Appendix: State Laws Passed Regarding Telemedicine in 2007

- **California** - AB 329 would enable the Medical Board to regulate telemedicine and establish a pilot program to expand telemedicine and to form a working group.
- **Colorado** - HB 6838 would promote the use of telecommunications technology for medical diagnosis and patient care.
- **Kansas** - HB 2065 would require any individual or group health insurance policy, medical service plan contract, hospital service corporation contract, hospital and medical service corporation contracts or any health maintenance organization covering accident and health services to provide coverage for telemedicine.
- **Massachusetts** - S 680 to establish healthcare services delivered by a certified home health agency using telemedicine to be reimbursed when the clients are eligible under Medicaid.
- **New Mexico** - HB 871 to enable the Department of Health to receive \$5000,000 to spend in FY 2008 to use to coordinate and assist in implementing telemedicine programs and projects throughout the State.
- **New York** AB 422 to establish a Statewide telemedicine/telehealth task force to make recommendations to the governor and legislature on the development of telemedicine and telehealth systems and to study standards, changes in licensure and certification, and establish a telehealth and telemedicine demonstration program under a Statewide not-for-profit association representing healthcare providers. SB 4669 to improve the management of acute or chronic health conditions along with developing and implementing patient care models using telemedicine and telehealth for special populations. SB 4677 would authorize healthcare delivery, but require an informed consent from the patient prior to delivering care. The Act would require insurers to provide coverage for telemedicine and also authorizes the education department in the State to license the practice of telemedicine by physicians licensed in other States.
- **Oregon** - SB 519 would require health insurers and the Department of Human Services through State medical assistance programs to reimburse for services performed using telemedicine.
- **Texas** - SB 760 and SB24 would reimburse for telemedicine medical service providers under Medicaid.
- **Utah** - HB 444 would require the State Medicaid Program to allow telemedicine to be used for certified services to be reimbursed under Medicaid (Bloch, 2007).