Emerging Practices of Telehealth to Advance Health Equity of Substance Use Disorder (SUD) Treatment in Medicare and Medicaid Programs

Overview of Health Equity and SUD Treatment

Telehealth is the delivery of remote care through various audio and video telecommunication tools.[1] This alternative care method is a viable treatment option for individuals with SUD and addresses a critical access barrier that many in rural communities encounter.[2] The use of telehealth services has remained high for mental health and substance use treatment, even as the use of telehealth for other health services declined over the course of the pandemic, signaling strong consumer demand for telehealth.[3]

One study examining the adoption of telehealth in outpatient treatment facilities found that 32% of mental health treatment facilities and 43% of SUD treatment facilities did not offer telehealth as of January 2021.[4] Expanded telehealth capacities in Medicaid and Medicare programs have the potential to improve access to care, support continuity of care, and support retention in treatment of SUD among enrollees who may experience barriers in accessing these services, such as provider shortages, lack of transportation, and stigma associated with being seen going to a particular clinic.[5–7] Key barriers to effectively and equitably leverage telehealth include access to devices and internet, digital literacy and comfort using technology, confidentiality and privacy considerations, and telecommunications infrastructure.[8,9]

The Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH) conducted an environmental scan to collect promising practices from states and health systems around telehealth for SUD-related services with a focus on improving equity among individuals served by CMS programs.

Gaps in Telehealth Options

32%
Of Mental Health Treatment Facilities Do Not Offer Telehealth

43%
Of SUD Treatment Facilities Do Not Offer Telehealth

Scalability of Telehealth Programs

Scalability of telehealth programs require rigorous design and testing methodologies, with primary consideration given to the population served, their health conditions, and barriers to treatment and access. Organizations that have prior telehealth capabilities are well positioned to test scalability of digital health care and advance telemedicine science.[14] Organizations that wish to replicate telehealth promising practices can consider the following questions as they determine feasibility, applicability, and organizational readiness to scale their telehealth program(s).

1. What population does the organization serve?
2. What conditions are most prevalent within this population?
3. What are the barriers to receiving and sustaining treatment? How will telehealth reduce these barriers?
4. What is the organization's goal for the patient experience?
5. How can the organization customize telehealth to address the needs of their population?
6. What infrastructure is needed to support a new telehealth program and is it feasible for the organization?
7. How does the emerging practice and the setting/conditions it was implemented under compare against the organizations setting/conditions?

Telehealth Impact on Priority Populations

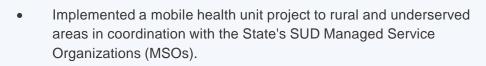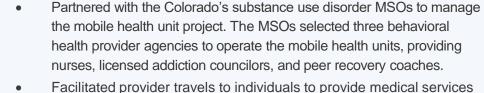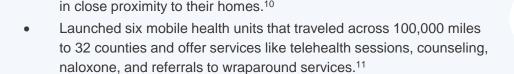| Priority Population	Potential Impact of Telehealth
Members of racial and ethnic communities	Enhanced patient engagement and improved access to care of telehealth could facilitate enrollee access to a providers and SUD treatment who is of the same racial or ethnic background and/or provides culturally competent care.
People with disabilities	Improved access to care and patient engagement for individuals experiencing mobility or transportation issues, physical and sensory disabilities (i.e., hearing and visual impairments).
Members of the LGBTQI+ community	Enhanced patient engagement due to improved access to SUD treatment programs familiar with LGBTQI+ issues and comfort with providers.
Individuals with limited English proficiency	Improved access to care through telehealth could facilitate enrollee access to providers and SUD treatment programs that deliver care in the individuals' primary language, and may offer other characteristics that are important to the individual.
Members of rural communities and geographically isolated areas	Improved access to care and SUD treatment for residents in rural areas with shortages of providers and physical SUD treatment facilitates by connecting individuals virtually to providers in other geographic locations with capacity for new patients.
Tribal Nations	Improved access to care and SUD treatment for American Indian and Alaska Native (AIAN) by connecting individuals to providers that provide culturally competent care.
Individuals affected by persistent poverty or inequality	Improved access to care for individuals with limited transportation, inflexible work schedules or limited paid time off, and other social risks factors that pose barriers to entry and utilization of SUD treatment services.

Emerging Practices

Emerging Practices Key

Offers Telephone-Based Recovery Support

Offers Video-Based Support

Offers Telephone-Based Support

Mobile Health Unites for OUD Treatment

Colorado Department of Human Services, Office of Behavioral Health (OBH)
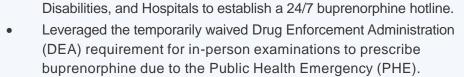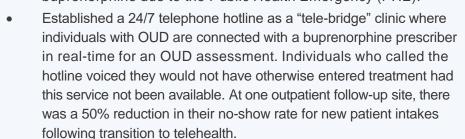
- Implemented a mobile health unit project to rural and underserved areas in coordination with the State's SUD Managed Service Organizations (MSOs).
- Partnered with the Colorado's substance use disorder MSOs to manage the mobile health unit project. The MSOs selected three behavioral health provider agencies to operate the mobile health units, providing nurses, licensed addiction councilors, and peer recovery coaches.
- Facilitated provider travels to individuals to provide medical services in close proximity to their homes.[10]
- Launched six mobile health units that traveled across 100,000 miles to 32 counties and offer telehealth sessions, counseling, naloxone, and referrals to wraparound services.[11]
- Delivered Medication Assisted Treatment (MAT) services to over 500 individuals.[12]
- Coordinated with Colorado's Medicaid Program to provide transportation assistance to medical appointments and pharmacies.[12]
- Mobile health clinics see a 12-to-1 return on investment on average.[10]

Tele-bridge 24/7 Buprenorphine Hotline

The Rhode Island Department of Health

- Partnered with the Department of Behavioral Health, Developmental Disabilities, and Hospitals to establish a 24/7 buprenorphine hotline.
- Leveraged the temporarily waived Drug Enforcement Administration (DEA) requirement for in-person examinations to prescribe buprenorphine due to the Public Health Emergency (PHE).
- Established a 24/7 telephone hotline as a "tele-bridge" clinic where individuals with OUD are connected with a buprenorphine prescriber in real-time for an OUD assessment. Individuals who called the hotline voiced they would not have otherwise entered treatment had this service not been available. At one outpatient follow-up site, there was a 50% reduction in their no-show rate for new patient intakes following transition to telehealth.
- Fielded 93 calls, resulting in 74 new buprenorphine prescriptions from mid-April 2020 to mid-November 2020.
- Developed an emergency department (ED) callback protocol to outreach to individuals recently seen for opioid overdose and discuss options for follow-up treatment.[13]

Telehealth Treatment of SUD

The Citywide Case Management Program (Citywide)

- Provides SUD treatment, MAT, substance use treatment groups, and socialization groups as part of the University of California San Francisco's (UCSF) Department of Psychiatry.
- Supports 1,500 adults with serious mental illness (SMI) who are experiencing unstable housing or homelessness, with 90% of clients on social security or county general assistance.
- Implemented a "Para-Telehealth" appointments a hybrid approach using video-based technology with patients and providers connecting while in separate interview rooms.
- Utilized synchronous forms of telehealth, including phone and video calls between patients and providers.
- Provided telehealth training to providers and staff by developing "Para-Telehealth" video tutorials, protocols, and online walk-throughs.
- Purchased and distributed 250 flip-phones to their patients. Use of phones increased patient access by 40% and led to 66% of patients using these phones to contact their support systems. Case Managers were also able to use these phones to contact their patients the day after a fentanyl overdose, provide Narcan coaching, and discuss enrollment in the Substance Treatment Outpatient Program (STOP) group at Citywide.[5]

Mobile Clinics for MAT

Eastern Shore Mobile Care Collaborative (ESMCC)

- Implemented ESMCC through the Caroline County Health Department in Maryland used mobile clinics to provide MAT to individuals with Opioid Use Disorders (OUD) in underserved rural communities.
- Launched mobile treatment unit equipped with medical supplies and telecommunication devices and staffed by a nurse and peer recovery specialist.
- Established relationships with local organizations such as churches, emergency medical services (EMS), and other community partners to reach more individuals.[12]
- Linked mobile treatment units via encrypted, Health Insurance Portability and Accountability Act (HIPAA) compliant videoconferencing technology to an addictions medicine specialist at the University of Maryland, School of Medicine in Baltimore. Nurses conducted an initial interview, nursing assessment (vital signs, test for other drug use, medical history, etc.), and administer assessments.
- Provided mobile assessments, tele-video assessments, and telepsychiatry consultation services including medication management and monitoring and crisis intervention.[12]
- Provided transportation services to the mobile unit and pharmacies for individuals receiving MAT.[12]
- Serves 200 patients and holds 30 MAT appointments weekly.[12]

Telehealth Treatment of SUD

The REACH (Respectful, Equitable Access to Compassionate Healthcare) Project, Inc.

- Provided SUD, MAT treatment, and primary care services via in-person and telehealth in Ithaca, NY to individuals with SUD, co-occurring mental disorders, and other complex needs.
- Supports 32 counties in rural and urban areas with a patient population of 80% Medicaid enrollees.
- Leveraged regulatory changes post COVID-19, such as the ability to initiate buprenorphine without an in-person visit, to provide MAT to clients.
- Offered treatment initiation services, medication monitoring, treatment stabilization, case management, recovery coaching, and support groups through telehealth.
- Utilized synchronous forms of telehealth, including phone (cellphone or landline) and video calls, all through tablets, computers, and smartphones.
- Leveraged asynchronous secure text messaging through their HIPAA-compliant platform, and messaging through the electronic medical record (EMR). Their telehealth platform does not require patients to have an email address and can obtain access through their phone number as well.
- Provided telehealth training to providers and staff, as well as real-time trouble shooting support. Technical assistance made available to providers, staff, and clients.
- Initiated 407 new clients on MAT by shifting to telehealth while maintaining high client satisfaction.[6]

Future Implications

- Though the federal and state governments introduced numerous policy changes and investments to support the expansion of telehealth during the pandemic, many of these policy changes are temporary or require further large-scale investments in telehealth infrastructure to ensure equitable access to telehealth during and beyond the pandemic.[15]
- To advance equity in SUD treatment through telehealth, programs can support inclusion of telehealth interventions in state and federal policies beyond flexibilities offered by the PHE.[1]
- Programs can also support telehealth regulations that help standardize treatment across method of MOUD and setting to promote health equity and address disparities.[16]
- Specifically for individuals with disabilities who face infrastructure barriers, programs should consider implementing comprehensive telehealth regulations that adhere to web accessibility standards, monitor patient-centered outcomes by disability type, and sensitivities to distancing patients with disabilities who prefer in-person care.[17]
- Better understanding of current telehealth infrastructure and capacity among behavioral health providers would enable federal policymakers to target resources more efficiently and equitably to providers who experience the largest obstacles to widespread use of telehealth technologies.

About CMS OMH

The CMS Office of Minority Health (CMS OMH) offers a variety of resources to help increase awareness about health disparities and improve health of people with disabilities; members of the lesbian, gay, bisexual, and transgender community; individuals with limited English proficiency; and rural communities. CMS OMH is dedicated to working on behalf of all CMS enrollees, while strategically focusing on CMS's priority populations (i.e., historically underserved populations including, racial and ethnic minorities, individuals with disabilities, sexual and gender minorities, individuals with limited English proficiency, and individuals who live in rural areas). This work was performed under CMS OMH's Health Equity Accelerator (contract number 47QRAA18D001P-75FCMC21F0086). The Health Equity Accelerator performs both quantitative and qualitative research to generate insights that can inform action to support CMS OMH's vision that all individuals who are served by CMS's programs – Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplaces – have achieved their highest level of health and well-being possible, and that all disparities in health, health care access, and health care quality have been eliminated.

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