AAAP PCSS Mini Grant –

Telehealth Services in OTPs

Mark W. Parrino, MPA
President

Funding for this initiative was made possible (in part) by grant no. 1H79TI081968 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
TABLE OF CONTENTS

➢ Executive Summary……………………………………………………3
➢ The Use of Telehealth Services for Systemic Expansion Through
  OTPs………………………………………………………………………3
➢ Working with Medical Boards and Expanding the Utilization of
  Telehealth Services in OTPs…………………5
➢ Research in Support of Telemedicine-Delivered Opioid Agonist
  Therapy……………………………………………………………………7
➢ Federal Guidance with Regard to the Use of Telehealth Services in
  OTPs…………………. 8
➢ Drug Enforcement Administration……………………… 11
➢ Current Operational Management Issues as Telehealth Expands in
  OTPs………………….. 12
➢ Financing of Telehealth Services………..13
➢ Medicare Coverage of Telehealth Restricted………………..14
➢ Conclusion……………………………………….14
➢ References………………………………………………..15
Executive Summary

At the outset, it is important to recognize that there is very little guidance with regard to the use of telehealth services in the nation’s opioid treatment programs (OTPs). Clearly, there is a national shortage of medical providers in the United States, who are interested in providing services for patients with opioid use disorder. This applies to retaining medical practitioners within the OTPs in addition to developing DATA 2000 practices.

This policy paper will explore several dimensions of how OTPs and their patients could be beneficiaries of using telehealth services. There is a great deal of coordination that goes into providing such care with the OTP serving as the hub site. While telehealth services would appear to be most useful in rural and underserved areas of the United States, where OTPs are located, the case can be made for how urban based environments could also benefit from the use of telehealth services with OTPs.

This paper will provide an overview of the differences of telehealth from telemedicine in addition to some key research findings, current federal oversight perspectives, the future of policy making activity in addition to operational recommendations and the cost born by third-party carriers.

The Use of Telehealth Services for Systemic Expansion Through OTPs

At the present time, there are just over 1,600 SAMHSA certified OTPs in the United States. Wyoming is the only state without any existing OTP. From AATOD’s point of view, the use of telehealth is one of the critical factors in expanding OTP services in rural and other underserved areas of the United States. OTPs could also benefit from the coordination of telehealth/telemedicine services in metropolitan areas.
It is important to reference some basic definitions as indicated in a Report prepared by the National Association of the State Alcohol and Drug Abuse Directors, Inc. (NASADAD), which has support from the Substance Abuse and Mental Health Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), under the NOMS Collaborative Supportive Initiative, Grant Number 5H79T1019551.

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. (June 2009)

The NASADAD Report goes on to explain to definitional differences with regard to telehealth.

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.

The NASADAD Report also discusses the different context of how telehealth is practiced. There are 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 video conferencing, web enabled, web cam assisted and
telephone communication. Store-and-forward telehealth services are used to transfer medical data from one location to another. For example, by sending a digital image via email or submitting an online survey”.

It is important for OTP administrators and managers to understand these key definitional differences in engaging a number of parties or “spoke providers” as a coordinated service delivery system with the OTP acting as a hub site.

**Working with Medical Boards and Expanding the Utilization of Telehealth Services in OTPs**

The American Telemedicine Association published a Telemedicine Toolkit, specifically designed to guide providers in working with medical boards in the states. This was published in 2017 and provides some important reference points.

Telemedicine is used for a diverse range of health applications and circumstances for patients and providers and across the entire continuum of care. Evidence-based research highlights the use of telemedicine as a supplement to quality screening, diagnosis, and treatment of patients. In addition to this telemedicine adds value to the ever-changing health care payment and service delivery system.

In other words, OTPs would benefit from an expanded, spoke driven service delivery system, as have other parts of the general medical community in the United States. It is safe to say that the use of such telemedicine services through OTPs are underutilized.

The American Telemedicine Association’s Toolkit makes an important point.
Telemedicine is a tool used in the delivery of health care. It is not a service or separate clinical specialty and should not require a unique license. Telemedicine is the provision of health care services to a patient from a health care provider who is at a site other than where the patient is located using telecommunications technology. It is simply a means through which health care is delivered.

It can take the form of videoconferencing, remote patient monitoring, or remote image capturing solutions just to name a few. Telemedicine is also supported by digital diagnostic medical device peripherals including an otoscope, pulse oximeter, glucometer, stethoscope, and blood pressure cuff. In fact, physicians are using a variety of popular consumer devices to provide quality care including smartphones and tablets.

The Telemedicine Toolkit also indicates that telemedicine is used in many forms in every state and practically every hospital or healthcare system in the United States. It delineates the type of services and providers that compose this system.

- Teleradiology – Including radiology departments, outsourced (nighthawk) specialty companies and individual radiologists that occasionally work from home.

- Urban to rural telemedicine networks – These may involve large tertiary care hospitals and smaller rural clinics.

- Correctional care – Prison systems and contracted health providers

- Veterans Administration Services – Many facilities use telemedicine and remote monitoring which are provided to veterans throughout the nation.
• Emergency departments and critical care centers – Many hospitals use telestroke and other specialty services such as tele-ICU. About 125,000 patients will be seen this year by a neurologist using telemedicine and almost 500,000 patients in the ICU will be remotely monitored by a specialist.

• Remote cardiac monitoring – Cardiologists and implantable device companies provide remote monitoring for patients with an arrhythmia and with pacemakers.

• Remote intraoperative neurophysiological monitoring - Approximately 750,000 surgical procedures use such monitoring nationally, of which the majority are performed via telemedicine.

• Direct to consumer services – This year there will be 800,000 consultations provided over the Internet through an increasing array of providers. These include stand-alone private services, health systems and insurers and local group practices.

The American Telehealth Association clearly provides an important understanding for the different kinds of services delivered under the general umbrella of telehealth, which should be considered by OTP Administrators/Managers.

**Research in Support of Telemedicine-Delivered Opioid Agonist Therapy**

The study compared treatment outcomes for in person versus telemedicine delivered opioid agonist therapy in Canadian based treatment centers. Over 3,700 patients were identified. One of the conclusions is critical to understand the importance of how these services can be utilized in OTPs. “Patients treated via telemedicine were more likely to be retained in therapy than patients treated in person.”

This study included 58 addiction treatment programs in the province of Ontario, between January 1, 2011 through June 17, 2012. “Of these patients, approximately 47% (N = 1745) received over 75% of their physician encounters via telemedicine. Approximately 42% (N = 1570) received less than 25% of their physician encounters via telemedicine; and the group of their physician encounters via telemedicine and the group of patients that received a mix of in person and telemedicine treatment accounted for 11% of the patients (N=418).”

The study provides an important conclusion, especially as one of the important points of developing this policy paper.

The current findings suggest that in addition to supporting specialists’ consults, the use of telemedicine can be expanded to facilitate the interaction of physicians and patients in a removed supervised clinical setting. With the prevalence of opioid use disorder and the burden of associated overdose mortality (Park and Bloch, 2016), early access to maintenance therapy is a priority for the treatment of opioid dependence (Golmes et al. 2014; Volkow et al. 2014)

The study provides an important reference point because it concluded that telemedicine services had a similar effectiveness to in person developed opioid agonist treatment. The key here is having the structure of an opioid treatment
program as the hub site with the telemedicine services serving as spokes, as indicated in the earlier section of this paper.

Federal Guidance with Regard to the Use of Telehealth Services in OTPs

The singular reference for telemedicine use in OTPs is contained in the SAMHSA Federal Guidelines for Opioid Treatment Programs, as published during March 2015.

Compliance with various aspects of the regulations contained in 42 CFR § 8.12 is impacted in a general way by larger trends in healthcare delivery. One of these is the use of technology. Digital communications, including telemedicine, telehealth, and e-therapy, both enriches and complicates providing treatment that is in compliance with federal regulations. The terms telemedicine, telehealth, and e-therapy often are used interchangeably. The Institute of Medicine defines telemedicine as the “use of medical information exchanged from one site to another via electronic communications to improve patient health status.” As a result of telemedicine, individuals unable to avail or who lack access to medication-assisted treatment may receive appropriate services.

The SAMHSA Guidelines also reference the Center for Medicare and Medicaid Services (CMS) guidance with regard to telemedicine.

- Medicaid guidelines require all providers to practice within the scope of their state practice. Some states have enacted legislation that requires providers using telemedicine technology across state lines to have a valid state license in the state where the patient is located. Any such requirements or restrictions placed by the state are binding under current Medicaid rules.
- For the purposes of Medicare and Medicaid, telemedicine services must be conducted via an interactive audio and video telecommunications.
system that permits real-time communication between the healthcare provider at the distant site and the patient at the originating site. An originating site is the location of the patient at the time the service being furnished via a telecommunications system occurs.

The SAMHSA Guidelines also provide consideration with regard to telemedicine service in the provision of buprenorphine under DATA 2000.

When buprenorphine is administered or dispensed for a patient enrolled in the OTP, the provision of care via telemedicine is not impacted by the Controlled Substances Act (CSA) (28 USC § 802).

(http://www.deadiversion.usdoj.gov/21cfr/21usc/802.htm), which defines the limits on the use of telemedicine in the context of providing a valid prescription for a controlled substance. When patients are receiving buprenorphine for an opioid use disorder from a physician who has a waiver under the DATA 2000, policies must be in place to assure compliance with the CSA. The restrictions may be reviewed by accessing 21 USC § 802. There are no restrictions or limitations on the use or administration of extended release injectable naltrexone (ERIN). For more information, please refer to An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People with Opioid Dependence.

It is important for SAMHSA/CSAT to provide more specific guidance concerning the use of telehealth services in OTPs. In our judgement, the development and release of such specific guidelines will provide further direction to the OTPs in addition to encouraging its expanded use. In this particular case, the expanded use of telehealth services in OTPs becomes one of three critical points of increasing the reach of OTPs in rural and underserved areas of the country, in addition to cities and states that do not provide access to experienced providers due to workforce limitations. In this case, telehealth
becomes one of three critical components to such expanded reach, which will also include the use of mobile vans and the expanded use of medication sites, utilizing the OTPs has hub sites. This will be discussed in the conclusion of this paper.

There are some current complicating factors in how the SAMHSA/CSAT guidance, as discussed above, are interpreted. In this particular case, it is important to reference a communication, dated October 17, 2016, from CARF International. CARF International is one of the official SAMHSA approved accrediting entities that provide services to OTPs to determine compliance with the existing SAMHSA regulations governing OTPs. The correspondence indicates that there has been an increase in the number of OTPs, who are using telemedicine services as a method of admitting patients in the lieu of “face to face, hands on, physical examinations”. Please keep in mind that this is a very specific reference to the use of telemedicine services as it specifically relates to patient admissions. The communication concludes that “CARF has received clarification from CSAT on this matter and a telemedicine evaluation cannot be substituted for the actual physical examination.”

This policy consideration may be reevaluated as an interpretation of how telemedicine services can be provided through an OTP and what services can be provided. This is the value of SAMHSA producing a separate policy guidance statement on how telemedicine services can be used through OTPs, including the full range of services as earlier specified.

The CARF communication also references an important guidance to the OTP.

OTPs are advised to proceed thoughtfully and with full understanding of requirements established by the state or health professional licensing boards. Exceptional attention needs to be paid to data security and privacy in this evolving field. Telemedicine services should, under no circumstances, expand the scope of practice of a healthcare professional
or permit practice in a jurisdiction (the location of the patient) where the provider is not licensed. Also, telemedicine may not substitute for a physical examination when one is needed, although it may be used to support the decision making of a physician when a provider qualified to conduct physical examinations and make diagnoses is physically located with the patient.

**Drug Enforcement Administration**

It appears that the Drug Enforcement Administration (DEA) has one specific requirement when an OTP is working with other parities with regard to telehealth services. In this particular case, the entity providing the telehealth services must have a DEA registration in the same state as does the OTP. While the telehealth practitioner might have other locations outside of the OTP resident state, the practitioner must also have a DEA registration in the same state as the OTP.

Other entities have requested that the DEA provide an expanded guidance document on how telehealth services can be used in treating substance use disorder. This will also be a second critical federal guidance document, which will certainly encourage the understanding of how telehealth services can be used by OTPs in addition to the SAMHSA guidance document.

**Current Operational Management Issues as Telehealth Expands in OTPs**

It is important to provide some practical guidance in how OTPs should plan for the utilization of telehealth services. While these issues may be basic in nature, it provides a beginning blueprint on how OTPs can actually proceed to develop relationships with telehealth providers as spokes with the OTP as the essential hub site.
Some of these recommendations where discussed during the National RX Drug Abuse and Heroin Summit of 2018, with Dr. Laura Dunlap, Dr. Peter Yellowlees, Dr. Patrick Marshalek and Dr. Judy Bartlett, presenting information on “Expanding Access to OUD Treatment: The Role of Telehealth”. This is a recent and important presentation, which would guide how OTPs would expand access to telehealth services.

Some of the basic issues include having the OTP engage in planning to prior to implementation, in creating strong communication between patients, distance sites and the originating sites (OTPs). The guidance and best practices go on to discuss ensuring that there are protocols in place for privacy and that the programs are tailoring needs specific to the patient.

OTPs should also consider retaining a dedicated telehealth coordinator, which will help with scheduling, training and other parts of the technology assistance.

Their needs to be appropriate cross training and implementation for all participating parties in this version of the hub and spoke system.

The roles for all participating staff need to be clearly documented and there needs to be a clearly defined technology infrastructure, including proper bandwidth to support each element of the telehealth hub system.

The use of such services will certainly increase access to specialty providers in OTPs. In this case, if the hub OTP site does not provide testing or treatment for Hepatitis B or C or HIV infection, telehealth services will then be coordinated through the OTP. If the patient has specific needs with regard to behavioral care, specifically related to the treatment of anxiety or depressive disorders, then similar treatment providers can be contracted with in order to provide such services to the patient.
Once again, the organization of such telehealth services would not be restricted to rural and underserved areas, although it is understood that they would be seen as primary beneficiaries. In this particular case, the OTP actively coordinates services wherever they are needed, due to the lack of workforce availability, even in large metropolitan areas.

**Financing of Telehealth Services**

The American Telemedicine Association developed another state policy toolkit in 2019 “Improving Access to Covered Services for Telemedicine”. The Report discusses that 49 states\(^1\) have some coverage for telemental services, 40 states\(^2\) have some coverage for home telehealth, while 22 states\(^3\) are authorized to cover remote patient monitoring and 16 states\(^4\) are authorized to cover store-and-forward based services. The reference point for each of these states are noted in the footnote.

With regard to private insurance coverage, the report also indicates that 31 states and the District of Columbia, have enacted laws mandating coverage of telehealth provided services under private insurance plans. This is also referenced in the footnote.

**Medicare Coverage of Telehealth Restricted**

Medicare coverage of telehealth is restricted at the present time. As OTPs get access to a specific Medicare reimbursement rate in treating Medicare eligible patients, the opportunity to utilize Medicare coverage with coordinated telehealth services becomes a future consideration.

**Conclusion**

Ultimately, telemedicine services are currently underutilized in OTPs. It is argued that when SAMHSA and the DEA provide additional guidance to OTPs, with regard to the use of such telehealth services, there would be expanded utilization. As has been noted in references throughout this paper, the use of such telehealth services will expand the reach of OTPs throughout rural and underserved areas of the United States. Such telehealth services will also expand the opportunity for patients with comorbid conditions throughout the United States, including metropolitan areas, to receive care for undertreated conditions. The OTP serves as the essential hub site in coordinating the role of such services.

Obviously, for all of this to work, there needs to be a dedicated staff member at the OTP working to organize the use of such telehealth services to be sure that patients are receiving coordinated care.

As indicated earlier in the paper, the expanded use of telehealth services is one of three important components in expanding the current reach of OTPs. A second approach would be the increased use of medication units, which are currently allowed under SAMHSA regulations so that a bricks and mortar facility would be able to provide medication to patients with minimal services but be connected to the OTP hub site. It is our understanding that under current DEA regulations, such medication units would need their own separate DEA registration. Once again, the OTP acts as the hub site, maintaining operational work/authority with the medication unit.
The use of mobile vans, which are connected to OTPs, is dependent on the release of new DEA regulations, governing how mobile vans can be used by OTPs. Such mobile vans are in existence at the present time, but they are few in number. The mobile vans are directly connected to the OTPs. The OTPs provide authority in the use of such vans under their operating aegis and provide key staff and medications as the vans disembark from the OTPs bricks and mortar site through a designated series of stops.

In an expanded utilization of such mobile van units as connected to OTPs, it is anticipated that the DEA, in conjunction with SAMHSA through separate licensing authority, would have these vans serve in other capacities. Illustratively, such vans could be dispatched near correctional facilities to serve inmates, who have opioid use disorder. This would require the cooperation of SAMHSA, the DEA and the State Opioid Treatment Authority in addition to the OTP. Once again, this is for future consideration, depending on the guidance that will be contained in the DEA regulations.

The point of this whitepaper and this policy development is to engage in a creative and highly coordinated system of care with the OTP as the central hub site. The use of such services, especially the telehealth services as contained in this paper, is expected to increase their reach of the OTPs and improve access to care for the patients in the OTPs.

This paper has covered a number of complex areas including how telehealth services can be used by the OTP, the necessary governing regulations for the OTPs in using such services and future policy development and financing.

As our nation continues to struggle with the opioid use epidemic, the OTPs, which are able to use all federally approved medications to treat this disorder, are a critical point of contact in connecting the patients with so many other parts of the system.
References

1. National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), with support from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Substance Abuse Treatment (CSAT), under the NOMS Collaborative Support Initiative Grant # 5H79TI019551. NASADAD is solely responsible for the content and recommendations herein. Telehealth in State Substance Use Disorder (SUD) Services. 24 Mar. 2015, nasadad.org/2015/03/telehealth-in-state-substance-use-disorder-sud-services/.

2.