

## Medicaid Innovation Accelerator Program Webinar

### Exploring Telehealth Delivery Methods for Substance Use Disorder Treatment

September 10, 2019

[logistics]

ROXANNE DUPERT-FRANK, CMS: (Slides 1-4) I want to welcome the facilitator, Dr. Lisa Patton. Dr. Patton is a clinical psychologist and a behavioral health and disparities development lead at IBM Watson Health. Dr. Patton has more than 20 years of experience in behavioral health services, research and evaluation. Prior to joining IBM Watson Health, Dr. Patton worked for two agencies within the Department of Health and Human Services. In her last role in the federal government, Dr. Patton served as the Division Director for Evaluation, Analysis and Quality within the structure for behavioral health care statistics and quality at SAMHSA. She currently coaches states related to the enhanced understanding of opioid data and works across IBM Watson Health to identify innovative solutions to the opioid epidemic.

DR. LISA PATTON: (Slide 5) I'd like to share about our purpose and learning objectives, introduce key speakers, then lay the groundwork for where we are with telehealth now and how it's being used in behavioral health. The purpose and learning objectives this afternoon are to really talk about the reasons why the use of telehealth delivery methods are increasing, how we're seeing that change, and how they can be used in particular for substance use disorder (SUD) treatment. We'd also like to look at barriers and facilitators of telehealth delivery methods.

Our speakers will talk about some of the ways telehealth has been implemented and some of their forward thinking on that. Speakers from New York this afternoon will share information around the telehealth delivery methods in their state under Medicaid and how telehealth has been implemented in the state's SUD treatment delivery system.

(Slide 6) Our first speaker is Jonathan Lang. Jonathan is a Project Coordinator with the Office of Health Insurance Programs within the New York State Department of Health. With a wide-ranging portfolio, his responsibilities include interfacing with external stakeholders to strengthen collaborative relationships with Medicaid's many partners and leading the implementation of new benefits, such as Medicaid's dual pilot and the expansion of telehealth.

(Slide 7) Our second speaker is Mary Zelazny, the CEO of Finger Lakes Community Health, a federally qualified health center (FQHC) in the Finger Lakes region of upstate New York. Her organization has received PCMH level 3 2014 recognition. Mary has focused a lot of the agency's work on the integration of health information technology, health IT, within the organization, including the development and operation of the Finger Lakes Telehealth Network. The Finger Lakes organization is now a nationally recognized leader in the implementation and use of telehealth, connecting a wide variety of healthcare providers through technology to provide greater access to care for patients. Mary has worked diligently to promote the incorporation of a high level of cultural competency of staff, as well as integrating care coordination and technology into primary care. So it's really worked to create new collaborative relationships, and this effort has resulted in expanded access and better health outcomes, which is what we're all driving toward with these efforts for patients, by addressing the many barriers to care that are

inherent, particularly in rural communities of New York state and I'm sure in many of the more rural communities in your states as well.

(Slide 8) Before our speakers, just a background on today's conversation. I'm sure you all have examples you can share as well. We will have a Q&A at the end of talks today. So telehealth delivery methods are becoming increasingly used to deliver care across the healthcare spectrum and that includes behavioral health and SUD. Part of what we know from the literature is that we are beginning to develop a strong evidence base of the effectiveness of telehealth in comparison to in-person care. Roxanne mentioned I had been with the federal government in that capacity. Probably five or six years ago, we were looking at telehealth in particular around behavioral health issues and really trying to look at what a range of federal grantees were doing in that capacity, and get a better handle on it. I can certainly say within the past five years there has been a tremendous push to look at the landscape of telehealth, who does that work for, in what capacity, and what are the best methods of implementation for telehealth to make it accessible to a wide variety of patients? That literature is now available to us.

Telehealth also offers a tremendous potential to lower healthcare costs in a variety of ways. We looked at the economic benefit of the impact of telehealth in a variety of ways and how that reduces costs, not only in terms of access but in terms of transportation, how the patients get to care, and how do we deliver care more effectively and efficiently. So telehealth really allows us to expand access to care for a variety of patients. It has also achieved increasing accessibility among providers, patients, payers and policymakers. If any of you has worked in this field for a while you've seen the changing impetus and drive to access telehealth but also increasing comfort level with it, and a sense that it really is a modality that works for a variety of patients and providers.

(Slide 9) There have in fact been more than 160 telehealth bills introduced in 44 states in 2018 alone. So, as you see, there's a real push in terms of regulatory work, policy work, how do we bring all these levers to bear on delivering better telehealth. CMS released a proposal in 2018 providing guidance on and expanding access to telehealth for Medicare beneficiaries. (Slide 10) Some of the barriers that we know from conversations with states from providers and from the literature, some of the barriers to solid implementation of telehealth delivery include costs associated with implementation, how does this get reimbursed, how do we make this work across the provider spectrum, lack of knowledge about reimbursement for telehealth delivery methods—how does that occur and how do we build that into our current payment systems.

There are also issues of providers' unfamiliarity with technology and how to make the best use of that. We've done some work to look at different provider characteristics that lead to more ease of use with technology and a lot of the literature shows that providers of all sorts like access to technology and believe it offers them greater possibility to reach their patients in meaningful ways. So there are a lot of characteristics that actually serve as facilitators for technology use.

There is also a lack of an implementation model. What does telehealth implementation look like in the field and for a variety of providers? How do you make that work in practice? And particularly for behavioral health and SUD, confidentiality regulations often come up as a barrier. How do we ensure we're protecting patient privacy and confidentiality when dealing with such sensitive information? With the real push to maintain patient confidentiality around these issues how do we do that in a way that feels secure and meets the highest standards?

(Slide 11) Some of the facilitators of telehealth we also know quite a bit about are the new funding possibilities. There are reimbursement mechanisms in place and providers are beginning to make use of

them and to sort out how to make that work in a changing technology environment and with different methods of collaboration across different types of providers.

We're also hearing a lot about local examples of success, some of what you'll hear today in terms of local examples of success. We've heard about a lot of those where there have been different opportunities to collaborate across provider spaces or using different types of technology and figuring out how to make that work in a particular setting.

There are also key champions, influential champions at the payer and treatment agencies who have been critical to achieving better access through telehealth and really moving into the telehealth arena in a meaningful way that works for patients and providers. So those champions have given voice to some of the needs for better access and some of the issues that are being addressed through telehealth. And it really meets a pressing need, particularly for any of you working in rural areas you understand the issues around transportation and other issues—the cost of getting somewhere, how do individuals pay for their transportation to get to treatment, especially if they have multiple providers and multiple health conditions. That is often the case for individuals battling an SUD. They may have several co-morbid conditions they're trying to address. How do you make sure you have all of those needs met? Telehealth is one way to begin to achieve that.

(Slide 12) If we think about some of the provider and patient interactions via the telehealth delivery methods the real goal looking at this is to understand how to increase the availability, quantity of access, to behavioral healthcare. One thing we know is that even with MHPAEA, with the parity act, one of the big barriers to that once that was implemented in 2011 was workforce shortages. That continues to be a huge barrier to care. So telehealth offers one innovative way to really address workplace shortages and increase access to behavioral healthcare. We all hear quite a bit about lack of psychiatric care, other behavioral health providers, and SUD treatment is one of those areas where we know there's often a shortage in care providers. Telehealth is one way to really get at that. It allows providers to make services available in areas where in-person services may not be readily available or accessible.

And there are a lot of innovative approaches to addressing substance use treatment in this way. We've heard about even in-home recovery treatment, for example. So there's a lot of innovation happening in this space and particularly using telehealth as a bridge to some of these activities.

Telehealth provides a bridge to traditional behavioral health services. As I mentioned, it addresses factors such as transportation barriers, inability to pay for transportation, geographic issues. It also gets at stigma. Again, especially for individuals working in rural areas, you may know that when you pull up in front of the mental health treatment center everybody knows your car. So it often is a way to really lessen stigma and help individuals who may feel very uncomfortable seeking treatment in their own communities, reduce some of that stigma and get care for these pressing issues when they're really willing to receive it, ready to receive that care.

(Slide 13) Some of the different types of telehealth delivery methods we've heard about and talked with states and providers about seen in the literature are live video conferencing, so two-way real time video conferences between the patient and healthcare provider, so that real time, almost face-to-face interaction. Store and forward, where a patient's healthcare documents are stored and shared electronically for use and analysis by a healthcare provider so that healthcare provider can then, separate from the time the patient has put the information in, take a look at that, get back with questions. So we've seen that work in a variety of ways.

(Slide 14) A couple other approaches we're hearing about from the field are remote patient monitoring where a patient's healthcare data is collected at one site and shared with a healthcare provider at another

site for monitoring and review. So looking for risk of relapse, for a variety of healthcare issues or potential risk factors that can be monitored real time or in collaboration with another provider.

And then mobile health. I'm sure many of you have seen, heard, used many of the mobile health applications that support continued monitoring of a patient's health. I know there are often concerns about confidentiality and privacy in that regard, and so a lot of the mobile health applications are doing a great job of working through consent and what that looks like, and how to help patients better stay in recovery or reach out for help real time if they find themselves in crisis or in need as they're in recovery or even to get treatment and to seek medication-assisted treatment (MAT) and other types of support for SUD. So the mobile health application market is growing and increasingly bringing people into treatment and supporting recovery in ways we have not had the opportunity to do previously.

(Slide 15) I've talked about many things on this slide, but again telehealth can enable us to remove barriers of time and distance, as well as stigma. It can address workforce barriers and help expand the capacity to care for people in need of substance use treatment and able to receive it where they are at that point in time. It has great potential to enhance treatment and recovery for people with SUD as I've described and I'm sure you all have many other examples of how it can be helpful for individuals who often need real time access to care. It also offers clinicians ways to increase access to their SUD clients during and after treatment. That's one of the areas where we've heard great support from clinicians is it offers an almost noninvasive way to reach out, check in on recovery, check in on treatment progress, and offer support in ways that are meaningful to the patient or client.

Recent legislative and regulatory changes could increase the use of telehealth delivery methods to furnish services for SUD and expand access to SUD care, so we're really pleased to see that. I see the chat box lighting up, keep those questions coming. (Slide 16) Now a poll: Is your state using telehealth delivery methods as a way to increase SUD treatment services in your Medicaid program? Your choices are: Yes, you're already engaged in this work; no, but you're planning to do so; or no, but at this point you don't have any plans. Looks like over 50% are engaged in telehealth delivery methods so I'm sure we'll have a rich discussion after our speakers, and lots of plans on the horizon.

(Slide 17) Now Jonathan from New York.

JONATHAN LANG: (Slide 18) I'm with the New York State Medicaid program. It's a privilege and pleasure to represent the New York Medicaid program and give you some insight on how we're implementing telehealth here in the Empire State. I'm joined by my colleague, Megan Prokorym, who is worth her weight in gold in terms of overseeing our agency processes.

(Slide 19) This is just a basic slide that talks about the definitions of how we're defining telehealth to the originating site. It's where the member is located at the time of the health services being delivered and the distance site is where that telehealth provider is.

(Slide 20) We have just done an expansion of our Medicaid policy in February 2019. We issued a Medicaid update, which is our version of a policy document. For folks interested in getting into the granular details about what we're doing here in New York State I certainly recommend you look at that Medicaid update available on our website. So we just moved forward in terms of expanding the Medicaid health benefit.

MEGAN PROKORYM: (Slide 21) With the latest legislative expansion to telehealth in 2018 part of that included a mandate to develop an interagency guidance document to explain and help facilitate one of the barriers that we have learned of the different regulatory policies between our various state agencies with regard to telehealth. So we have convened an interagency workgroup that is developing this guidance document so it explains the differences in the legal and regulatory requirements for telehealth.

(Slide 22) This is a little snapshot of what the document will look like. The document will be geared towards many different types of stakeholders—the consumer level, the practitioner level, our various regulatory facilities, as well as insurers. Practitioners really need to know their licensing settings in order to be able to conform with utilizing telehealth as a way or a modality to deliver a service. For instance, this slide indicates whether or not there are regulations specific to telehealth. As you can see for our DOH license providers, which would be hospitals, nursing homes, diagnostic treatment centers, etc., we don't have regulations specific to telehealth. However, through our New York State Office of Alcoholism and Substance Abuse Services, those licensed providers do have to conform to regulations that are specific to tele-practice. So this document will help explain to all those various stakeholders what those different requirements are.

JONATHAN LANG: (Slide 23) Here's a comparison of where we started off in 2015 and where we are today. In 2015, we had a fairly limited definition of telehealth. We only had telemedicine, which we talked about earlier is the live, interactive audiovisual communication. We also only allowed telemedicine to occur at specific sites. In 2018, we've expanded our modalities to include storing forward now. We're also doing remote patient monitoring. We've also opened up where providers can provide services and where Medicaid recipients can receive them. I'm not going to go through the entire list but the biggest changes were that now patients can receive care in their home via telehealth and also providers can provide telehealth applications as long as it's in a secure location anywhere in the continental U.S.

(Slide 24-25) Here is also a very expansive list of providers that are allowed to provide from a house in New York state. These are all listed in New York state law and so for us in order to amend this list would actually require legislative action.

(Slide 26) In order to provide telehealth in New York state, there are a couple things the telehealth practitioner has to do. They have to be licensed to provide care in New York state. They have to be enrolled in the Medicaid program, and they have to be operating within their scope of services. So there's no reason for a provider who is operating outside of what they would normally do to be able to provide it in telehealth. So if a nurse is trying to do something that's probably outside her scope of practice, they couldn't provide that service in telehealth. We try to make sure that as much as possible we're protecting the safety and privacy of our patients.

(Slide 27) Credentialing, privileging is a little tricky. We realize that individuals who are at the originating site where the patient is, they may not have the expertise or the capacity to verify if somebody is an appropriate provider of services at the distant site. Here in New York state we have a law that allows for the originating site to rely on the credentialing and privileging a distant site practitioner. There is a process in which that distant site practitioner will submit their credentials and privileges and there is a process for which it is verified over about six months to two years on a regular basis.

(Slide 28) This is a little bit more about the credentialing and privileging. This is a way in which we're trying to reduce the administrative burden for providers, too. We recognize that particularly for originating sites in rural areas, the geographically isolated areas, they may not have the capacity to verify that neuroscientist or physician is appropriate for their client. This is a way we're able to provide them a little bit of relief in that area. There is more work to be done in this space but it's a solid start.

(Slide 29) Confidentiality, so we always are making sure that our clients are protected through HIPAA. They have to have a written business associate agreement or contract with the provider for the privacy and security of the PHI, protected health information. One of the things we always tell folks is that having a practitioner do a telehealth consult while they're waiting in line in midtown Manhattan for their

Starbucks latte is not a secure location. We want to make sure that as we're talking about very sensitive information that that's protected at all times.

(Slide 30) Consent is also something we want to make sure is documented and we want to make sure it's documented in the medical record. In our Medicaid update there are about six questions or so that have to be consented to and it's basically telling the patient they have the right to refuse telehealth if needed so you can't force somebody to have their medical intervention through telehealth, making sure that they're aware of all the other options available to them, and that basically they have the right to say no if it's not something that they want to do.

(Slide 31) Always with transmission, we love technology but sometimes things go very wrong and just making sure that there's a policy in place for when that does happen.

(Slide 32) These are the different modifiers that we're asking folks to use for telehealth, so we use the 95 and the GT modifiers for telemedicine, that's the live audiovisual. Also for the GQ it's for storing forward, and then 25 is used for agencies using separate and distinct services.

(Slide 33) We also use the 02 for the place of service code. We just want to make sure that at all times we're using that place of service code to indicate it's a telehealth provision of service.

(Slide 34) For Medicare/Medicaid dual-eligible beneficiaries, we are following the lead of Medicare. So, when Medicare is allowing for services to be done through telehealth, Medicaid is able to pay for that. We know there's some guidance that's going to be coming out soon hopefully that will expand what Medicare can do, and once that happens we'll also be aligning our policy with Medicare.

(Slide 35) Then with managed care considerations, basically we're providing some foundations for Medicare/Medicaid managed care plans to consider and then we're asking them to work directly with providers on negotiating their rates, etc., for reimbursement.

(Slide 36) Any questions you can reach us at the numbers below. Also directly at [jonathan.lang@health.NY.gov](mailto:jonathan.lang@health.NY.gov). The slides will be made available.

MARY ZELAZNY: (Slide 37) I'm happy to be here to talk about our journey with telehealth for a FQHC program in upstate New York. We're very rural. As with most FQHCs around the country, we try to provide one-stop shopping for our patients because of the stigma to provide access to all levels of services, and now the push because of the opioid epidemic. We've been really engaged in beefing up what we can with SUD treatment internally but also with a lot of our behavioral health partners, because we can't do it all ourselves. We really need them to help us get through.

(Slide 38) Why would we use telehealth? There are a lot of reasons anybody would use telehealth to provide services in their setting. For us, it was a big lack of access to care. We couldn't get people in with transportation barriers, geographic barriers that Dr. Patton mentioned earlier, workforce shortages. We have nine sites across our area that we cover, nine FQHC sites, and it's really challenging for us to get medical providers, behavioral health providers to fill every slot in all of our health centers, so it's always been a real struggle for us.

We serve a lot of patients that don't speak English in our very rural area, which is unusual for us because most of the population's Caucasian. But for Finger Lakes 53% of our patients have identified they want to be served in a language other than English, so that provided us with one more reason to try this technology to solve these problems.

A lot of chronic disease in the population we serve as with most FQHCs, so not only do they have maybe multiple—diabetes, hypertension, they also have depression, potentially SUD, something going on. So we have these really rough patients that need a lot of services. So telehealth has allowed us to address some of those. Provider burnout. Most importantly stigma, to try to reduce the problem with stigma for our patients because as Dr. Patton talked about, going into your local mental health clinic in your very small town, everybody knows who you are. You might be related to somebody that works there so people just don't go.

(Slide 39) As discussed, telehealth does help me in so many things across our healthcare system for our patients. We have found in our system that the use of telehealth has really helped to improve the outcomes that our patients experience because they have access to so many different providers. They're not having to go to different places to get their care. We can really bring everything to them so that they don't have to worry about traveling. Because a lot of times patients can't get there. They don't have money, a car, any way to bring them. They have children they can't leave. So this has been a really great help for us with the technology.

(Slide 40) Our providers love it. We are cutting edge at all of our FQHCs because we have to be. We have to provide that level of service and the only way we can do it is by using telehealth technology. We've attracted young providers who have said we really like having these pieces of equipment available to us and be able to use this mode of provided care for our patients.

It's also helped us with our costs. Everybody talks about reimbursement and we've worked really hard with Megan and Jonathan and the team at New York state's DOH to try to figure out the reimbursement for telehealth. But frankly for me, we have been doing this a long time without reimbursement because we believe that there is a return on investment that always isn't seen when you bill a visit and I know that's hard for a lot of people to accept, but we use it extensively throughout our healthcare system in my organization. It has really helped us to reimburse travel for staff. We've been able to use it for educational purposes, administrative purposes, clinical purposes, which is fantastic.

Then for our workforce, we're able to have one MD be at one health system and see a patient at another health center. So if I don't have a provider in one of my health centers for some reason I can still get that patient seen or if I have several walk-ins in one of my health centers I can call another one where maybe there's a provider available and say hey, can you help us out with these patients. We don't want to turn patients away, because oftentimes as we all know patients really struggle just to get to us, so we want to make sure we get them seen by someone.

(Slide 41) For SUD services, we use telehealth for MAT, counseling services that go along with our MAT services. We do a lot of case conferencing. We do crisis intervention. We do workforce coverage. We're also starting to work with one of our behavioral health partners using HS, which is a cellphone technology to help people in recovery trying to stay in recovery, which is a great asset, but it's all technology.

(Slide 42) As they talked about, there are a couple different ways that telehealth visits happen, real time video or storing forward, which is synchronous.

(Slide 43) When you talk about telehealth in your organization for a lot of people it's new, and as we all know everything you want to do to change a process in your health center or organization, it can be a big deal. That's no different with telehealth, because telehealth is really about changing management because what you want to do is bring in new technology to help provide better services for your patients and better communications for your staff and your team. But there are a lot of steps you're going to have to take in order to do that including getting a real commitment from leadership; it has to come from the

top. If you just have a few people that really want to be doing telehealth and you don't have your leadership involved you're going to struggle and it's going to be really challenging.

You have to get your providers on board, at least a few, who can be your champions because they're going to have to lead the fight. You're going to have to get buy-in from your whole staff really and we've struggled with this at times. It's been challenging. You get certain nurses or staff members that just aren't interested in telehealth, and we've really had to say you know what, this is good for our patients. This has to happen. So if this isn't something that you're really interested in, maybe this isn't the kind of organization you want to work at. It really does involve a commitment from your leadership.

We have had workgroups formed within our organization and also with our partners that we're doing telehealth with to make sure that everybody's on board as we build our telehealth programming, because remember you have two sides to the equation. You have where the patient is and you have where the provider is. And if the patient's at your site and the provider's maybe at some other hospital or something, everybody has to work together as you're developing your clinical process to make sure that you're dotting all your I's, crossing all your T's, and that patients are not left out in the cold because it can happen.

You also have to have IT support. You really need to make sure that as you do your visits if something goes wrong what are you going to do? How are you going to address those problems? What happens if all of a sudden the camera stops working or the connection is lost? What is the plan? And everybody needs to be aware of that plan. You have to have a safety plan, particularly when you're dealing with behavioral health services in any shape or form. You really have to have safety plans. What happens if the patient potentially becomes very agitated and exhibits some suicidal tendencies? You have to have planned for all that before you ever see your first patient.

(Slide 44) The first thing we always ask people when they're starting to talk about telehealth is have you done an assessment to see if you're ready to take on this kind of a commitment, because there is a commitment there because there's a lot of work initially. Do you have that buy-in? Are you able to get equipment? Do you have the right broadband? Do you understand the regulations based on your licensure? What does your state allow for telehealth? Is there any reimbursement? Who is really going to lead the change? Who is your team leader? Who are your champions?

And it doesn't happen overnight. It takes a long time to really get some of this stuff ingrained in the organization so there has to be a commitment that's going to be pretty longstanding. It's not going to happen in a couple weeks or even a couple months when you first start taking on this work. It does force change so you really have to be aware of it.

(Slide 45) So where do you start? I want to do telehealth. With this needs assessment, look and see where you will use that telehealth technology to address either services or maybe your administrative team's going to use it for department meetings or case conferencing between you and the substance use treatment provider you're working with. What are you going to use it for? What about using it for employees when we do interviews so that first interview you can say this person's not going to work out and you haven't had to bring that person in or tie up the staff a long time. There are a lot of ways you can use this technology but you have to sit down and figure out what you want to use it for.

(Slide 46) What we feel is really important is to really make sure you build your clinical team and your operations team that are going to be involved in your telehealth work. What are you going to be looking at? It's fine to put the patient in front of a camera and have them be seen but you want to put some metrics around that. What are you going to measure, are there certain things? For instance, for our diabetic patients we have a registry we create when we do our telehealth work, for every modality we use telehealth with. But for diabetics, for instance, we want to be able to track certain things so we can



see if telehealth provides more access to care, reduces barriers, produces better outcomes for our patients.

So what are those metrics we're going to track to see if we are making progress? With our telehealth work we always track a lot of data and we, as I said, we do the registry and then we have a baseline—where are we at right now? And how can we work together to improve all these programs we're trying to address? How are we going to collectively work together?

We also want to be able to do PDSAs because you're going to find that as you do your telehealth work you can't just assume that Plan A is going to work because it usually doesn't. Sometimes you end up going with Plan B and don't be surprised if you end up with Plan C. But it's all in the building of your program, and if you can be a little bit flexible, it will be a lot easier for everybody to succeed as you build your telehealth program.

We do a lot of program evaluations, constantly evaluating the program to ask providers. We do a lot of patient surveys, satisfaction surveys for patients when they're seen by telehealth. We ask the providers to do some kind of a survey so that we can really understand what works, what doesn't work, where we should tweak so we can really create a good experience for not just the patient, but for the provider as well. That's really important.

Then of course you want to make sure you build the policies and procedures so that other people as they come in they can have a guideline in terms of how the program runs. You really want to take your telehealth work, you don't want to invest building all these new systems. You really want to take how you run your clinical programs and try to add in telehealth services rather than building all new clinical practices. You don't want to change everything because then your staff will freak out, they're not going to do well in that situation. You want to keep as much as you can the same so that as they start using the technology there's not too much they have to be dealing with at once.

(Slide 47) For us, a big focus of course is the clinical workflow. You do have to address broadband. You have to address your equipment. Those are given. But the clinical workflow is a really big part of building your telehealth program. You have to figure out why are you doing this? What do we want to get out of this program after we get it all implemented and we're starting to see patients? Where are those really key factors we want to address? How do we do referrals? Who's going to do the referrals? Who's going to room the patient? Who's going to be on the other end in the event there's a problem where the provider is? Who's going to be where the patient is in the event there's a problem? What is the emergency phone number that has to be in place in case the provider feels that the patient is getting agitated? All those things have to be set up.

What about prior authorizations, all those billing considerations that we all have to deal with on a daily basis? How does it fit into your telehealth program? How are you going to make sure that you're still addressing that stuff?

But also keep in mind that the telehealth program, since you have the patient potentially with you in your organization and the provider could be at the hospital somewhere, you have to figure out both sides of that equation. So what we highly recommend is when you're building your telehealth program that you bring people together from both where the patient's going to be and where the provider is going to be so that you can work through your plans as you build and say okay, what forms do we have to fill out? Who's going to fill them out? Who's going to room the patient? Are there tests that have to be done? Bloodwork that has to be drawn or urine taken before the patient is seen? Who's going to do that work and how is it going to flow? How am I going to get the test results? If I need something from another provider, some

evaluation that was done on the patient, who's going to get me that now that I don't have the patient in front of me anymore?

So there's a lot of that detail that has to be addressed. But once you address it you're in good shape. You have to look at scheduling, reserving your rooms, how does that look on your scheduling system, if you use an EMR how does that work? Because you're really scheduling for a provider that's not even in your organization potentially, so how are you going to put that into your daily flow?

(Slide 48) Again there's a lot of work that has to be done in terms of making sure your patients are comfortable with telehealth, which in our experience we have had very, very few patients say I'm not interested in telehealth. Actually particularly with like counseling services, we actually have patients that request having their visits using telehealth rather than being in person. So it's been pretty interesting to see what people choose.

You have to worry about registration and all the consents, all that documentation that has to be done. Remember you're doing it for another provider so how can you streamline that process? You have to understand what forms your specialist or distant provider would want to have filled out. Someone's got to do all that.

How do you do pre-visit planning? Testing equipment? You always have to remember with telehealth is you have an audience in front of you, a patient potentially and maybe a distant provider. So you really have to make sure that everybody's comfortable with the equipment and that there is also a plan if something goes wrong. How are you going to continue to get this patient the care they need even if something goes wrong?

(Slide 49) For us it's all about data. When you do any kind of telehealth work you really want to track what you're doing. You don't want to put all this work into play to use technology to address your patients and then find out that you're not helping anybody. Your patients aren't getting better, you're not saving any money, it's costing you too much money, your staff's cranky. You really need to use data to drive the decisions in your program and make sure that they help you as you work through this.

(Slide 50) You also have to think about pharmacy. If you're doing MAT, if the distant provider is five hours away how are you going to get the pharmacy needs to the patient. You've just got to have that stuff in place. It's all little things, but it all adds up, so you want to make sure you pay attention to the details as you're building your program.

(Slide 51) Here's some more suggestions you really have to think about. (Slide 52) There's a lot of legal and regulatory the state was talking about. In New York state we have four different agencies and for seeing patients we really have to understand where we fall in terms of licensure. How does that look in your state? What are you able to do, what aren't you able to do? You don't want to get in trouble.

(Slide 53) Also the big thing for us is that patients like telehealth a lot, particularly the millennials and now the Z generation. They love it, they want to see it. They don't want to have to go into a traditional facility and sit in a waiting room and wait and wait and then go in and see the nurse and wait and then go see the provider and wait. They want to have their healthcare like they have their banking. So how can we use telehealth technology to really provide that service because the problem we all have providing healthcare services is that if we don't start to integrate telehealth technologies into our health system, our competitors are. So we're going to lose out. Our patients are going to go somewhere else if we really can't figure this out. So it's really important to start looking at how you can build your own telehealth technologies and find people that have been doing this and really work with them, because there's a lot of help out there.

(Slides 54-55) Some secrets to success if you will. You don't know what you don't know so find out, talk to others. Don't try to reinvent the wheel. We've all invented it and we've gone through every mistake so find people that can help you build your telehealth program so that you don't have to go through all that. Be very careful. There are a lot of vendors out there now and they'll sell you as much as you have in your checking account, so be very careful and know exactly what you need before you start talking to vendors. Then of course let your clinical people test your equipment because if they don't like it, if you buy it and they just say I don't like this otoscope, I don't want to use it, then you've just bought maybe an expensive piece of equipment that nobody's going to use. What we do is we say to the providers here's some otoscopes, you pick what you like, so they can get buy-in for that. It's really important. And involve them in every step of the way.

For us, we have used telehealth technologies for a lot of primary care services, interpretation services, visits with our regular providers. We have a lot of specialists, pediatric neurology, psychiatry, counseling, and now SUD services. And every time we start a new program we find that telehealth really just enhances the level of service we're able to provide our patients so that they have better outcomes.

DR. LISA PATTON: (Slide 56) Thank you. Great information to have. We have a number of questions. One was around what SUD services are being covered with telehealth? Mary, you mentioned MAT, counseling services and crisis services. Could you provide an example of how you are using telehealth to provide MAT? Before that, Jonathan and Megan, did you want to add any SUD services you're covering with telehealth?

JONATHAN LANG: Nothing to add on that front.

DR. LISA PATTON: Mary, could you talk about how MAT gets delivered through telehealth?

MARY ZELAZNY: In my system we have five of our providers that have their waiver. So what happens is a patient comes in. We do the first visit of course face to face and establish the relationship and talk about a contract and all those details. But then after that, the provider, because our providers sometimes move around can get seen by their provider for their MAT visit from where they're at and our provider may be in one health center or another health center. So what it allows us to do is my providers who are waived can see patients at different health centers so that I can cover all nine of my sites for MAT services. Right now I have five waived providers. So the technology has really allowed us to expand how many patients we can get seen.

Additionally, because when we have our patients come in for their MAT visit we like to have them see one of the behavioral health counselors just to check in—how's everything going? Sometimes we don't have a counselor right there so we can use telehealth, maybe one of the counselors is in another health center. So we just tap in and call the other health center and say can you spend a few minutes with this patient and they can get their services done?

DR. LISA PATTON: There's a lot of conversation in the chat box about DEA rules and their requirements for the provider to be physically present with the police system, but we'll talk a bit more about that in a sec. I did want to ask Jonathan if you might be able to talk about some of the remote patient monitoring work and how you have implemented that.

JONATHAN LANG: Sure. The remote patient monitoring is a really interesting and fascinating part of telehealth. Basically what happens is that an individual is able to send their vitals of metrics to a provider remotely and then that provider is able to observe their blood pressure, their heart rhythm, etc. and then use that as part of their plan of care. It's really fascinating to see how the technology has advanced fairly rapidly. We had a provider come in and it really looked like something out of Star Trek in terms of you can

take all these measurements on somebody without even probing them or anything like that. So for folks who may be bed-bound or uncomfortable around intrusive traditional methods for getting this information or house-bound, it's a really wonderful way for the information to be sent off to the healthcare provider. And the healthcare provider can bill the Medicaid program once a month for the provision of the remote patient monitoring.

DR. LISA PATTON: A great use of telehealth. There are also some questions around OTPs, which we can get into if we have time. But it's also critical, one of our participants noted recent research that supports the practice of the first patient visit being in person. I want to note I don't think we're presenting telehealth as universal substitute for that kind of in-person care. It's really intended to be an expansion of care and a way to increase access with the issues we've described earlier—transportation, workforce, stigma reduction. What telehealth does is it offers a different way of accessing care and addressing some of those needs so we can get at some of those more vulnerable populations that might not receive care if we didn't have that telehealth access. I think it was Mary who talked about there are some individuals who really prefer that kind of telehealth approach. So being really responsive to where the patients are when they come in and particularly with opioid use disorder or SUD, being responsive to their preference of how they receive their care, it can really move us greatly toward improved recovery outcomes and better health outcomes overall.

One of our participants also noted that there is a provider, and this is what I was going to mention with regard to OTPs as well, that there are models which I mentioned early in the presentation, one-off or local models where people are really championing ways to—and this example was shared that this particular clinic has been certified through the state so that the first MAT visit does not have to be face to face. So there are models happening, perhaps not at scale at this point but there are a lot of different approaches being worked on.

Back to our speakers, if you could speak on DEA-waivered physicians and how you're working with DEA waivers and so forth to deliver care through telehealth.

JONATHAN LANG: There's actually a great and timely topic of discussion that we're having right now between our various agencies. We see the need clearly for increasing the access to buprenorphine and realizing that having a limited number of DEA-waivered providers is a challenge and so we're having conversations right now to think about ways in which we can overcome some of those obstacles. Hopefully there will be more to report from New York state later on.

MARY ZELAZNY: It's really challenging to get the providers to go through the process although it's not very long. Some providers really struggle with wanting to deal with patients we might have. But what we've done at our organization is we've made it mandatory and then everybody's got to go through the waiver process. It just becomes a commitment that the health center system needs to make or the organization needs to make because this is a huge need and it's really a great service for our patients, and we have to be able to provide that where the patient's at so that we can get the patient seen.

DR. LISA PATTON: One more question and then complete the evaluation at the end on your screen. You can reach out to us or the presenters via the contact information on the slides we'll be sharing shortly. You'll be able to reach out with additional questions. One last question for our presenters: Who or which organization was the biggest driver to increase access to telehealth? What's really been the impetus for your growth in telehealth? Legislation, Medicaid, provider organizations, consumers who wanted telehealth support?

JONATHAN LANG: We have prioritized this within our state budget process as an opportunity to increase access and even potentially get some savings. That was a big impetus for us to implement telehealth. Also

I have to give a lot of credit to Mary and her colleagues in the FQHC community for continuing to press the Medicaid program and the agencies to really consider taking a more aggressive stance on telehealth.

MARY ZELAZNY: I would say the biggest driver for us at Finger Lakes was our patients. That's how we can provide services for our patients and get them the care that they need. It's the best way, it's our sweet spot.

DR. LISA PATTON: (Slides 57-58) Thank you again. The last couple of takeaways are that telehealth is being widely used and it is being delivered through the efforts of clinical and leadership champions. As Mary said, it takes a lot of effort and a lot of planning and a lot of collaboration. Sort of choosing where to work with people on that and where it's going to be most effective. Know your legal and regulatory issues and help to educate your consumers and their families. How can they get better access to care and what meets their needs to you can support them in their treatment and recovery from opioid use disorder or SUD.

[end of recording]