Expanding Treatment & Recovery Services Through Telehealth in the Oklahoma Public Behavioral Health System

The Oklahoma Department of Mental Health and Substance Abuse Services and Grand Lake Mental Health Center Collaborative Program Model

South Southwest (HHS Region 6)
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

NFARtec National Frontier and Rural Telehealth Education Center

ADOPTION AND USE OF VIDEOCONFERENCING TO DELIVER ASSESSMENT, TREATMENT, AND RECOVERY SERVICES IN OKLAHOMA

COLLABORATIVE PROJECT:

South Southwest Addiction Technology Transfer Center (SSW ATTC)

National Frontier and Rural Telehealth Education Center (NFAR*tec*)

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Disclaimer: At the time of this publication, Elinore F. McCance-Katz served as SAMHSA Assistant Secretary. The opinions expressed herein are the views of Nancy Roget, MS, MFT, LADC and Mary Cook, LMSW and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SMHSA for the opinions described in this document is intended or should be inferred.

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EXECUTIVE SUMMARY

A key goal of the South Southwest Addiction Technology Transfer Center (SSW ATTC) is to facilitate use of telehealth technologies to deliver substance use disorder (SUD) assessment, treatment, and recovery services in the HHS Region 6 states it serves (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas). In working toward accomplishing this goal, SSW ATTC identified a successful initiative undertaken by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to increase the uptake of telehealth technologies to deliver assessment, treatment and recovery services by SUD and mental health (MH) providers. Oklahoma's initiative is unique in that both the state department of behavioral health (SUD and MH) services and SUD/MH providers are committed to expanding access to SUD/MH services and working collaboratively to develop state-level policies and initiatives that promote implementation of telehealth technologies.

This report represents the findings from an in-person meeting and individual videoconference interviews with representatives from ODMHSAS (the State) and Grand Lake Mental Health Center (GLMHC; the Provider), which is a model treatment program that has successfully implemented telehealth technologies services. The purpose of these dialogues was to learn about the joint efforts undertaken to implement effective SUD/MH services using telehealth technologies by discussing Oklahoma's telehealth technologies model and implementation processes; implementation strategies; how policies and regulations were changed to support it; successes, challenges, and lessons learned at both the state and provider levels; and future plans/directions.

Summary of Methodology:

To advance understanding of Oklahoma's telehealth technologies initiatives and replicate those successes in other Region 6 states, the SSW ATTC contracted with the National Frontier and Rural Telehealth Education Center (NFAR*tec*), located at the University of Nevada Reno, to conduct interviews with Oklahoma administrators/policy-makers and providers to identify factors that promoted adoption of telehealth technologies to deliver SUD/MH assessment, treatment, and recovery services. Individuals were selected to participate based on their role in the State's policy and regulation, program, and IT services, and experience developing and implementing an innovative telehealth technologies program.

Qualitative measures were developed and used to structure the in-person meeting around the following questions:

- How was the decision made to promote/implement technology-based services?

- How were policies/procedures, regulations, standards, reimbursement strategies, and guidelines established? How were liability/confidentiality issues addressed?
- What types of funding/reimbursement streams are available to cover implementation and service delivery costs?
- How was implementation initiated (pilot, revise, and implement vs. full implementation; timeline)?
- What type of training has been provided to facilitate implementation? Is ongoing technical assistance available/provided?
- What is the scope/specific services provided using telehealth technologies (e.g., assessments; individual sessions; group sessions; family and/or couples sessions; medication prescribing/management; recovery support; clinical supervision)?
- How did providers/clients respond to the idea of using technology-based services?
- What are the advantages to using telehealth technologies?
- What are the challenges/lessons learned?
- What recommendations would you give others interested in replicating your process?

Three weeks after the in-person meeting, individual videoconference follow-up interviews were conducted to engage in more in-depth discussions on how decisions to implement telehealth technologies were made; strategies used to 'sell' the idea that using telehealth technologies is as good or better than face-to-face; reimbursement issues; lessons learned; activities participants wish they had implemented, as well as those that should have been avoided; what processes/activities needed more attention; and specific recommendations for other states considering implementation of telehealth technologies services. The in-person and videoconference interviews were audio-recorded with permission of the participants to ensure accurate reporting of responses.

Summary of Findings

ODMHSAS (the State) and GLMHC (the Provider) agreed that transportation is a significant barrier to receiving services in Oklahoma. Consequently, working together to find a way to facilitate greater access to treatment services was an important issue and using telehealth technologies was appealing to both entities.

1. The State recognized the need to make it easier for providers to change how they delivered services, which included new reimbursement policies.

2. The State acknowledged that training on billing/reimbursement, as well as evidence-based practices (EBPs) was essential.
3. The State recognized that scope of practice issues had to be addressed with credentialing boards.
4. The Provider had to help counseling/recovery staff increase their openness to using telehealth technologies (e.g., talked with them about the fact that effective therapeutic and peer relationships can be established through videoconferencing).
5. The State and the Provider identified the importance of champions that led these efforts for their organizations, as well as turnover in State-level leadership that brought more favorable views of telehealth technologies.

The State's practical approach to making changes at the state-level by adapting regulations that previously served as hindrances to workforce issues and treatment access was key to decreasing barriers, especially in rural areas. The State recognized the importance of starting the conversation with key decision-makers (e.g., the legislature and Medicaid officer) and stakeholders/providers to identify challenges and provide education on how using telehealth technologies can improve treatment access and ultimately client outcomes. In addition, the State built positive and effective relationships with providers across Oklahoma and showed a willingness to sit down with them to learn about their challenges and engage in problem-solving discussions to increase patient access to services and improve outcomes. Engaging in these conversations and making administrative changes were key to the State creating a new service delivery model and the successful implementation of the Provider's iPad 24/7 Program in Northwest Oklahoma.

Summary of Recommendations and Next Steps

The collaborative efforts of the State and the Provider provide an excellent case study regarding how to make a significant system change that involves modifications in regulations, rules, policies, reimbursement, and provider service delivery. Most importantly, the system change addressed is an important tenet of SUD/MH services, expanding access to care especially in rural areas. As a result of this system change, which promoted the use of telehealth technologies to deliver crisis intervention, assessment, treatment, and recovery support services, hospitalization costs decreased; transportation costs for clients, providers, and law enforcement were lowered; rural clients in Northeast Oklahoma were able to access services just as easily as urban clients; and the State was able to eliminate many restrictive oversight functions, which decreased their costs as well.

Helping states implement the use of telehealth technologies to deliver SUD/MH services will require system change activities. As such, training/TA regarding system change may be required and include the following actions.

- Conversations about making a system change need to be initiated by an individual or group that has convening power and a commitment to and investment in the change.
- System change does not occur overnight, which points to the importance of being patient with the process and the amount of time it may take to reach the goal. The link below provides access to an excellent and recent guide (2015) to system change https://www.thinknpc.org/resource-hub/systems-change-a-guide-to-what-it-is-and-how-to-do-it/

Provider and State entities may require training/TA on change activities when considering adopting and implementing telehealth technologies to deliver services (e.g., how to make changes and adjustments).

- Small changes can be made, and adjustments initiated in response to changes using the Plan, Do, Check Act (PDCA) methodology or similar continuous quality improvement actions. The following links provide access to resources for continuous quality improvement and the PDCA cycle: https://asq.org/quality-resources/pdca-cycle ; https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/plan-do-check-act-cycle

Below are four next steps strategies for the SSW ATTC to consider based on the Oklahoma data.

1. ***Start the conversation.*** Assist the State and Providers in forming a workgroup with the goal of expanding access to SUD/MH services for rural populations using telehealth technologies. Meeting with early adopters and individuals with convening influence before the invitations go out may help develop the workgroup. In addition, SSW ATTC can provide administrative and fiscal support to encourage participation.
2. ***Understand existing regulations/rules.*** Before any changes can be made, it is important to determine current regulations/rules and their function/purpose by: examining the current definitions for reimbursable SUD/MH service delivery (e.g., assessment, intervention, treatment, and recovery support services); reviewing Licensing/Certification Boards' regulations/rules regarding remote clinical supervision to be conducted via telehealth technologies; facilitating a discussion with State and Licensing/Certification Board members regarding interest in regulation/rule changes; collecting sample language from Oklahoma and other states that can be used to make changes.

3. ***Be clear about telehealth technologies.*** It is important to develop training materials and activities that include definitions for telehealth technologies (e.g., what it is, what it includes, and the research that supports using it to delivery SUD/MH services) as many professionals have outdated information or use terms interchangeably, which can be confusing and interfere with implementation. Examples include, but not limited to: Fact Sheets; Introductory Webinars; and Curriculum Infusion Package(s) on telehealth technologies for faculty.
4. ***Develop champions.*** Determine who in each state might be interested or is already using telehealth technologies. As a reminder, sometimes early adopters are not always the best promoters or champions of new ideas as they are typically significantly ahead of others and are often seen as different or outliers. However, they often have useful information that can be used to help with actual implementation. Training/TA that helps develop professionals to serve as champions is important. A specific training/TA for telehealth technologies champions or generic training/TA for developing Champions could be conducted.

Introduction

The South Southwest Addiction Technology Transfer Center (SSW ATTC) serves HHS Region 6, which includes the states of Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. One goal of the SSW ATTC is to facilitate the use of telehealth technologies to deliver substance use disorder (SUD) assessment, treatment, and recovery services within the Region. In working toward accomplishing this goal, SSW ATTC identified a successful initiative undertaken by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to increase the uptake by SUD and mental health (MH) providers of telehealth technologies to deliver assessment, treatment and recovery services. Oklahoma is unique as both the state department of behavioral health (SUD and MH) services and SUD/MH providers are committed to expanding access to SUD/MH services by working collaboratively to develop state-level policies and initiatives that facilitate implementation of telehealth technologies.

As part of its grant activities, the SSW ATTC seeks to understand Oklahoma's telehealth technologies initiatives in order to replicate their successes in other Region 6 states. To inform this activity, the SSW ATTC contracted with the National Frontier and Rural Telehealth Education Center (NFAR*tec*), located at the University of Nevada Reno, to conduct interviews with Oklahoma administrators/policy-makers and providers to identify factors that promoted adoption of telehealth technologies to deliver SUD/MH assessment, treatment, and recovery services. These results will help define lessons learned and next steps for other states.

NFAR*tec* and the SSW ATTC staff worked with ODMHSAS staff to schedule a meeting to examine the steps taken over the past 15 years to successfully implement and expand the use of telehealth technologies services throughout the State. An in-person meeting was held August 23, 2018 at the ODMHSAS offices at 2000 N Classen Blvd, Suite E600, Oklahoma City, OK. Individuals invited to participate in the meeting (listed below) were selected based on their role in the State's policy and regulation, program, and IT services, and experience developing and implementing an innovative telehealth technologies program

Teresa Croom	ODMHSAS Opioid STR and Co-occurring Services
Traylor Rains-Sims	ODMHSAS Policy and Provider Regulation
Kevin Marble	ODMHSAS Information Services
Kristin Brown	ODMHSAS Information Services
Wendy Larsen	ODMHSAS Program Enhancement
Josh Cantwell	Grand Lake Mental Health Center (GLMHC)
Amy Hogan	Grand Lake Mental Health Center (GLMHC)

The purpose of the in-person meeting was to engage in dialogue with ODMHSAS (the State) and GLMHC (the Provider), a model treatment program that has successfully implemented telehealth technologies services, to learn about their joint efforts to implement effective SUD/

MH services using telehealth technologies. Specifically, the SSW ATTC wanted to collect qualitative data regarding Oklahoma's telehealth technologies model and implementation processes; implementation strategies; how policies and regulations were changed to support it; successes, challenges, and lessons learned at both the state and provider levels; and future plans/directions. Having both State and Provider staff present during the initial discussion was purposeful, as it helped guide the discussion and set the stage for follow-up individual meetings. The in-person meeting was structured around the following questions:

- How was the decision made to promote/implement technology-based services?
- How were policies/procedures, regulations, standards, reimbursement strategies, and guidelines established? How were liability/confidentiality issues addressed?
- What types of funding/reimbursement streams are available to cover implementation and service delivery costs?
- How was implementation initiated (pilot, revise, and implement vs. full implementation; timeline)?
- What type of training has been provided to facilitate implementation? Is ongoing technical assistance available/provided?
- What is the scope/specific services provided using telehealth technologies (e.g., assessments; individual sessions; group sessions; family and/or couples sessions; medication prescribing/management; recovery support; clinical supervision)?
- How did providers/clients respond to the idea of using technology-based services?
- What are the advantages to using telehealth technologies?
- What are the challenges/lessons learned?
- What recommendations would you give others interested in replicating your process?

The NFAR*tec* interviewers audio-recorded the meeting with permission of the participants to ensure accurate reporting of responses. The interviewers started the meeting by asking the questions as written. However, after the first couple of questions were asked and answered, the meeting took on a more conversational format, with participants driving the flow of the conversation. Throughout the remainder of the meeting, the NFAR*tec* interviewers tracked the prepared questions to ensure that all content identified by the SSW ATTC was captured, prompting participants' conversation as needed. Participants were engaged and enthusiastic in talking about their efforts from each of their perspectives to expand the uptake of telehealth technologies throughout the meeting.

Individual follow-up interviews were conducted by NFAR*tec* using videoconferencing-based meetings on September 13 – 14, 2018. The goal of these individual interviews was to engage in more in-depth discussions on how decisions to implement telehealth technologies were made; strategies used to 'sell' the idea that using telehealth technologies is as good or better than face-to-face; reimbursement issues; lessons learned; activities participants wish they had implemented, as well as those that should have been avoided; what processes/activities needed more attention; and specific recommendations for other states considering implementation of telehealth technologies services. These interviews were audio-recorded with participant permission. Copies of the interview transcripts are available upon request with permission of the participants.

During the initial joint in-person meeting, participants identified several issues that drove each entity's decision to promote and/or use telehealth technologies in delivering SUD/MH assessment, treatment and recovery services in Oklahoma. State and Provider staff agreed that the driving force for their decision was the need to expand access to services for patients, intervening with patients early, and ensuring they received the 'right dose' of services based on the patient's needs and condition. More specifically, the State's decision to work with providers to make telehealth technologies implementation easier was guided by that fact that:

- most of the state is rural, making transportation and access to services an issue; and
- as is true in many rural states, Oklahoma has a behavioral health (e.g., substance use disorder treatment) workforce shortage, due to clinicians' reluctance to locate in rural areas and salaries being lower in rural compared to urban areas.

For the Provider, the decision-making process to implement telehealth technologies to deliver services started with a realization of the need to:

- develop a 24-hour treatment model to better serve individuals needing help but located a significant distance from providers, especially those in crisis situations during non-office times;
- reduce the burden on law enforcement officers responding to calls and having to spend hours getting the person to the hospital, waiting for lab work and other tests to be done, and for the behavioral health clinician (who may be traveling over an hour to assess the individual) to arrive, etc.;
- improve communication between the hospital, law enforcement, and treatment provider;
- and create a treatment system that more effectively/efficiently provided the correct intensity and type of services and reduced the number of hospitalization days.

During the initial meeting, both State and Provider participants agreed that transportation is a significant barrier to receiving services in Oklahoma. Individuals living long distances from towns or small cities (market centers) that are large enough to support a treatment provider may be unable to attend sessions on a regular basis due to a lack of reliable transportation or needing to take time off from work to travel and attend the session, which in many cases is not financially feasible. Consequently, finding a way to facilitate greater access to treatment services was an important issue and appealing to both the State and the Provider.

At the end of the August 23rd meeting, five important take away points were identified: 1) the State recognized the need to make it easier for providers to change how they delivered services, which included new reimbursement policies; 2) the State acknowledged that training on billing/reimbursement, as well as evidence-based practices (EBPs) was essential; 3) the State recognized that scope of practice issues had to be addressed with credentialing boards; 4) the Provider had to help counseling/recovery staff increase their openness to using telehealth technologies (e.g., effective therapeutic and peer relationships can be established through videoconferencing); and 5) the State and Provider staff identified the importance of champions that led these efforts for their organizations, as well as turnover in State-level leadership that brought more favorable views of telehealth technologies. These five take away points were discussed in greater depth during the individual interviews. The next section of this report includes information gathered during both the initial meeting and the individual interviews and highlights how the State worked with providers to facilitate and promote the use of telehealth technologies to deliver SUD/MH assessment, treatment, and recovery services and the Provider’s experiences and lessons learned through the iPad 24/7 Program implementation.

The Role of the State in Facilitating the Use of Telehealth Technologies Services

The decision to promote the use of telehealth technologies was driven by two key factors. First, Oklahoma has a shortage of SUD/MH workers, particularly in rural areas. In addition to barriers to recruiting professionals to work in rural and remote areas of the state, there is a salary disparity as it is difficult to pay providers working in not-for-profit agencies as much as those clinicians working in for-profit or tribal agencies. Changes in Medicaid funding has helped address some salary disparities as reimbursement for services can lead to higher salaries in some cases, but workforce recruitment and retention problems still exist. For example, clinicians/interns may work for a rural provider while they accrue their hours for licensure/certification. However, once licensed/certified they often move to a more populated area in the state and enter private practice. Thus, many rural providers end up with a revolving door of less seasoned (trained) staff as individuals stay just long enough to earn their hours for licensure/certification and then leave. As such, many providers are unable to build a stable of well-trained staff. In addition, for those individuals that want to stay/work in rural areas access to supervision as part of licensure/certification requirements can be difficult as supervisors tend to live/practice in more urban areas.

> "… if you never start a conversation, you can't ever get things changed."
>
> Teresa Croom
> Sept. 14, 2018

In large part, the practicality of the State's approach to adapting regulations that previously served as hindrances to workforce issues and treatment access was key to decreasing barriers, especially in rural areas. First, the State recognized that "if you never start a conversation, you can't ever get things changed". Likewise, they acknowledged that working with key decision-makers (e.g., legislature and Medicaid officer) and stakeholders/providers to identify challenges and provide education on how using telehealth technologies can improve treatment access and client outcomes. Next, the State built positive and effective relationships with providers across Oklahoma and showed a willingness to sit down with them to learn about their challenges and engage in problem-solving discussions to increase patient access to services and improve outcomes. For example, a key factor to the successful implementation of the Provider's services has been the willingness of the State to create a state-level workgroup that included Medicaid representatives to work through some of the barriers to delivering behavioral health services for the iPad 24/7 Program in the Northwest part of Oklahoma. The work of this committee as well as input from the provider community was instrumental in driving changes at the administrative level to take on a new service delivery model. In addition, the University of Oklahoma Health System served as a role model for the State with its successful implementation of their

hospital-based telestroke services roughly 15 years ago. Over the past 11 years, the State has streamlined its policies to facilitate expansion of the use of telehealth technologies. The following narrative discusses three specific areas the State has addressed to promote the implementation of telehealth technologies which include: changes in policies; licensing/certification; and IT infrastructure and support.

Changes in Policies

Approximately two years ago, the State began decreasing the overly administrative burden related to providing telemedicine services. Policies were revised and/or rewritten to be less restrictive, making it possible to take full advantage of and promote efficient use of telemedicine. Essentially, the State decided that rather than making the policies more restrictive, "at some point you have to stop making rules for the exceptions" and facilitate ways to provide better and easier access to services. The following are examples of changes made by the State for delivering SUD and MH services using telehealth technologies.

- The initial restriction on the type of SUD/MH services (e.g., assessment, individual counseling, recovery support services, crisis intervention) changed so these services could be offered using telehealth technologies. However, group counseling must still be done in-person to facilitate interaction among participants.
- The requirement that the first visit for any treatment service had to be face-to-face was dropped early in the telehealth technologies adoption process. State law now says that videoconferencing is considered face-to-face. The exception to this law is a federal requirement that mandates the initial session for medication assisted treatment (MAT) for opioid use disorder be done in person to take vitals, history, etc., with subsequent support visits done via telehealth technologies. Likewise, clients have to come in daily for their methadone dose.
- The policy initially stated that telehealth technologies had to be delivered using a secure network, but there were only 5-10 networks available. The policy has since been changed and now requires that services need to be provided over a secure connection and it is up to the individual provider to determine if their connection meets those requirements.

"At some point you have to stop making rules for the exceptions"

Traylor Rains-Sims
Aug. 23, 2018

Previously, coverage was limited to HRSA provider shortage areas with a 20-mile radius rule, where the provider had to be farther than 20 miles from the client. The policy was changed to eliminate the urban – rural mileage restrictions so services delivered by telehealth technologies could be used by anyone having difficulty accessing services (e.g., transportation).

- The State sent certification staff to ensure that the room, lighting, sound, and video met certain specifications. Guidelines are now broader, and it is up to the provider to ensure the established policies/requirements (e.g., secure connection; appropriate setting) are met.

According to the State, there has been little to no resistance from the public regarding these changes to services provided using telehealth technologies. However, there has been some resistance from previous Medicare/Medicaid officers and other clinicians and counseling professionals who believe that face-to-face services are better than services delivered through telehealth technologies. This belief is not substantiated by the strong scientific literature showing that delivering SUD/MH services using telehealth technologies is efficacious and results in good outcomes, especially for treating MH conditions.

Licensing and Certification

Workforce shortages in Oklahoma have driven changes to licensure/certification requirements for professionals regarding the use of telehealth technologies to deliver services. Specifically, scope of practice issues and clinical supervision delivery models have been impacted. The State successfully worked with all licensing boards to revise their scope of practice and supervision regulations regarding the use of telehealth technologies. The State credits this, in part, to the original workgroup and having overarching state legislation that says face-to-face services includes services delivered through videoconferencing. This definition seems to be the key linchpin for expanding the uptake of telehealth technologies. In addition, the State and licensing/certification boards allow clinical supervision to be done via videoconferencing. However, some of the boards still try to regulate the amount of clinical supervision hours that can be done through videoconferencing. Continuing to have regulations that only half of clinical supervision hours annually may be conducted via interactive live audio/video conferencing is detrimental to developing the workforce and so additional work needs to be conducted to change these regulations. The same is true for acquiring continuing education units (i.e., not all continuing education units can be earned through online learning). Additional information on Oklahoma's licensing and certification laws can be found at

- http://www.okdrugcounselors.org/laws.php
- https://ok.gov/odmhsas/Additional_Information/Provider_Certification/

Funding/Reimbursement

Currently, the State uses a behavioral health code that includes different modifiers to indicate if the service is for SUD or MH conditions. The reimbursement rates are the same and determined by the service no matter if they are delivered face-to-face or through telehealth technologies

(refer to the original definition that face-to-face includes videoconferencing). An exception occurs when there are different levels of reimbursement for providers. For example, there are three different levels of reimbursement for case management based on the provider's experience and background. In addition, the State reimburses for recovery support services, which can be delivered using telehealth technologies.

> "How do we make this more economically sound for the provider?"
>
> "What can we do to help them ease administrative burden since we are reducing their payments?"
>
> Traylor Rains-Sims
> Sept. 13, 2018

Historically, Oklahoma has made changes to telehealth technologies in stages. For example, up until about three years ago, clients had to go to an approved originating site (e.g., a designated mental health center or emergency room), have someone be present with them as part of the service delivery, which included taking vitals. This is how the site could collect a fee. That requirement was eliminated, so clients can now receive services in their home and the provider can be reimbursed for the actual service (no originating site is required). The decisions to not require specific equipment and specific sites was largely made because of the budget climate in Oklahoma at the time. In the past, the State took pride on having 100% Medicare reimbursement. But in 2010, the State budget started to decline, and budget cuts occurred. After the second and third rounds of cuts, the State started asking questions like, "How do we make this more economically sound for the provider?" "What can we do to help them ease administrative burden since we are reducing their payments?" Thus, many of the decisions were geared towards increasing client access, decreasing costs, and increasing efficiency since reimbursement was lower, which helped set the stage for the adoption of telehealth technologies to deliver services.

> "… efficiency and what's best for the clients was the driving force behind eliminating the 20-mile radius rule"
>
> Traylor Rains-Sims
> Sept. 13, 2018

The State provided an excellent example during their interview of how changes were made to the administrative rules to improve access and efficiency. Oklahoma had a 20-mile radius rule that services could not be provided using telehealth technologies if the client was within 20 miles of the provider, meaning that videoconferencing could not be used if the client was in another clinic or at home within 20 miles of the provider. The impetus for this change came from the Oklahoma University Health campus (which spans over 1 mile) where administrators discovered that a physician using videoconferencing to deliver health care services could see three patients in the same amount of time it took to see one patient if the physician was walking from one part of the health campus to the other. In addition, client wait times were decreased, costs lowered, and service delivery more efficient. At that same time, the larger Oklahoma health systems were also

experimenting with conducting virtual primary care visits and finding that the 20-mile radius rule for using videoconferencing seemed inefficient and costly. Thus, the ability to show increased "efficiency and what's best for the clients was the driving force behind eliminating the 20-mile radius rule".

IT Infrastructure

The State houses a full dual data center that can be used for meetings and telehealth (e.g., videoconferencing) services. The communications technology has been switched from the old frame relay system to Multiprotocol Label Switching (MPLS) routing technique, which is a more robust way to connect. The Central office has a main data center with a set of servers that route services to 48 active sites, with roughly 400 active user accounts across those sites. The State IT program is offered as a service that includes an active help desk. The State charges a fee for its IT system and there is no requirement for providers to use it to provide SUD/MH telehealth technologies services.

Although the State's technology systems work well, there are challenges to providing telehealth technologies services throughout the State and many of these issues exist at the provider location in rural areas. First is the challenge of having enough bandwidth. Telehealth and electronic medical records (EMR) require the use of different products. An organization needs a minimum of 10mgb, which was cost prohibitive at one time for small agencies. However, lower prices on data plans has greatly reduced that barrier. Also helping with bandwidth access is that data lines are covered by the federal or state corporation commission telephone fees. The State got a grant to put fiber systems around the state and another grant that required 99.9% coverage (5g) for first responder cell phone programs, which also helped with coverage and accessibility. Finally, the State's move to using MPLS has improved some of the bandwidth issues.

Another challenge came with moving to mobile device use (e.g., how does an Apple device communicate with an Android device). The State found the best solution was to load software (i.e., an app) on the various devices to improve communication between brands. They are currently upgrading the system to continue improving communication between Apple and Android devices. Working in border towns where phone/communications providers differ across state lines is also an issue that needs to be addressed.

Model Program: Agency-level Implementation of Telehealth Technologies Services

Grand Lake Mental Health Center (the Provider) implemented their telehealth technologies program to:

- provide 24-hour/7days per week assessment, intervention, treatment, and recovery support services to better serve individuals needing help but located a long distance from providers;
- reduce the burden on law enforcement officers responding to calls and having to spend hours getting the person to the hospital, blood work done, waiting for the behavioral health clinician (who may be traveling over an hour to assess the client) to arrive, etc.; improve communication between the hospital, law enforcement, and treatment provider;
- minimize the number of times clinicians have to travel long distances to provide services late at night; and
- create a treatment system that more effectively/efficiently provides services at the correct level of care.

The Provider makes a clear delineation of terms associated with providing SUD/MH services using technology-based services based on delivery method: telemedicine is conducted using installed physical equipment in their offices, whereas the iPad 24/7 Consultation/Treatment Model uses mobile technologies. Since the Provider delivers services using both modes, this differentiation is important for reimbursement requirements.

Background

The Provider's move towards implementing the iPad 24/7 Program began with an awareness that people needing intervention were going into in-patient (hospital-based) care because there was no level of care between in-patient and out-patient treatment services especially during/after a crisis situation. In response to this perceived need, the Provider opened an intensive out-patient care unit, which gave their Center the ability to provide another level of crisis service to ensure clients receive the correct level of care and avoid hospitalization. Although helpful, it quickly became apparent that offering an additional level of care only addressed part of the treatment access issue – people still had to get to the facility. Given that their service delivery area is 5,000 square miles, the Provider was essentially offering 24-hour services that were inaccessible to many individuals due to geographic limitations.

Lack of transportation was a huge barrier, whether people found their own transportation or were transported by law enforcement. In response to this problem, the Provider's Chief Operating

Officer (COO) identified a solution and recommended that crisis services be provided using telehealth technologies. The Provider refers to the telehealth technologies they use to deliver SUD/MH services as 'mobile technology', which emphasizes the mobility aspect of a device that clients and staff can carry with them and receive/provide services at any time.

The idea of using mobile technology to deliver services was initially met with skepticism by the Provider staff, in part due to the size of the change being suggested. Although accustomed to making small changes in operations, implementing a new service delivery model required looking at delivering services in a different way represented a big risk and required staff to work outside their comfort zone. Staff had to be willing to implement the new model and engage in an ongoing process of evaluating, adapting, and re-evaluating the program to make it as effective as possible. Over an 18- to 24-month period, the COO shared his conceptualization for the mobile technology program and periodically revisited it to normalize the idea. When the staff started taking ownership of the idea, he engaged them in its development and implementation. To gain buy-in from all staff prior to initiation, a 'what is best for the client' approach was used to emphasize the benefits and desire to create a model program that would 'provide services when and where people need them'. Taking this approach was critical to successful implementation of the mobile technology program.

> … use technology to "create a model program to provide services when and where people need them"
>
> Josh Cantwell
> Sept. 14, 2018

Expanding the idea of using mobile technology to provide 24/7 services from concept to actual service delivery was a lengthy, complex, multi-step process. For example, there are several devices that could be used to deliver the mobile technology services for this project. However, it was critical to determine which mobile technology device would provide optimal security, functionality, and durability, while also being user-friendly. In addition, the Provider wanted to ensure the device would support app development so their service delivery was always improving. The amount of time it took to research and choose the device best suited for service delivery was time consuming. However, taking this step during the early development process has proven to be worthwhile, as the device (i.e., iPad) has enabled the Provider to evaluate and adapt the program as needed.

With the movement towards value-based treatment and outcomes-based funding, the Provider realized the importance of measuring program outcomes to ensure services were being administered as reported. For example, the Provider tracked the number of hospitalizations that occurred before and after implementation of the iPad 24/7 Program. Days of hospitalization have dropped dramatically every year since the implementation of the iPad program. In doing this, the Provider showed that this new approach to service delivery is not just different – it is better based on a quantifiable impact.

Implementation of the iPad 24/7 Program

Gaining staff buy-in for using mobile technology was a step-by-step process, with younger staff helping convince older staff of the benefits for expanding services. When the idea of using mobile technology was first presented, staff were skeptical about people actually using it to access services, concerned that the connection associated with seeing clients face-to-face would be lost. However, many staff concerns were addressed and decreased when service delivery was designed to include both the use of telehealth technologies (iPad) and onsite services. Another benefit realized by staff included the flexibility of the technology that afforded the clinician the opportunity to contact a client that was scheduled later in the day to move their session up should another client miss an appointment. This increases the efficiency of the clinic by essentially eliminating the cost of no-shows and making better use of clinicians' time. The Provider looked at a variety of mobile devices for their 24/7 Program but decided to use the iPad because 1) Apple does the work to ensure security and the type of data collected; 2) the screen size; and 3) the FaceTime app is HIPAA-compliant as it does not save video like other videoconferencing apps do (e.g., Skype).

The decision to use the iPad was also driven by the fact that the State approved the use of iPads, which means the State and the Provider's reimbursement sources (i.e., reimbursement comes from 3rd Party insurance; state contract; Medicare/Medicaid; grants for iPads; Certified Community Behavioral Health Clinics (CCBHC), cost-reimbursement model) have determined delivering services using an iPad is the same as doing face-to-face sessions. The Provider used webinars, podcasts, and other available resources to train staff on how to conduct counseling sessions online. There has been some resistance to the training as it is not just teaching them how to conduct online counseling sessions but also includes helping clinicians change their paradigm and learn to teach patients how to use the iPad and apps.

How Does It Work

Any individual that comes to the crisis center receives an iPad when they leave (if appropriate). Clients are given training packets on how to maintain, clean, and update the iPad. One of the challenges to offering mobile technology service delivery is ensuring that clients have mobile/WiFi service access at all times because providing a mobile device without wireless service is useless. The Provider identified four primary issues surrounding mobile access. First, the cost of having wireless service might be prohibitive for some clients. Second, if clients are responsible for paying for a wireless provider and have problems, there is the possibility of service gaps if the bill is not paid. Likewise, the Provider could spend a lot of time troubleshooting technical connectivity issues rather than providing treatment services. Finally, there was not one mobile service provider that had adequate wireless service throughout the state, so the Provider had

to determine how to work with several service providers. Since the goal was to ensure clients always had connectivity, the Provider decided the best way to address this problem was to provide clients with a data plan when they receive the iPad. The Provider now has a huge data plan of over one terabyte of pooled data, which is adequate to handle the roughly 1200 iPads currently in use. The number of iPads currently in the field is the result of slowly building their inventory through buying a few iPads and then using the money saved on client in-patient treatment admissions and incarceration to buy a few more, etc. To date, few iPads have been lost, in part because they are labeled with the Provider's contact information and easily returned if found. In addition, the Provider is developing a tracking app that will document when and by whom the iPads were checked out and returned. The ultimate goal and "next step is getting an iPad to every adult consumer and every family so we create that ability for them to reach us anytime".

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To ensure the data plan is used only for treatment and recovery-related services, the Provider locks down the iPads so clients only have access to recovery resources and programs and a few specific apps that serve as learning extenders (e.g., CBT-based homework and worksheets.) The Provider is able to track the usage data, which is tied to the Provider's electronic health record system. The Provider can then review how often clients access resources and consider if there is a correlation between the use of resources, improvement of symptoms, and length of treatment. Tracking iPad usage and client outcomes lends credibility to the services provided. The Provider is currently in the process of adding an application that allows clients to journal.

Advantages of the iPad 24/7 Program

The Provider, greater community, and individuals receiving services have all seen substantive benefits from implementation of the iPad 24/7 Program, including:

- ***Cost savings.*** The Provider's data shows that prior to implementing the iPad 24/7 Program, 1,115 people were admitted for in-patient services at a cost of roughly $500/day per patient. After the first year of the iPad 24/7 Program (2016), that number dropped to 677 in-patient admissions. In 2017, the number of admissions dropped to 402, and the admission rate between January and August 2018 was two people who could not be stabilized or provided services using the iPad. A similar downward trend has been seen in the number of incarcerations. This substantive decrease in admission and incarceration rates is realized in a decrease in treatment costs (e.g., less transportation required and

fewer in-patient services) and has saved the State over $6.5 million over the past 2 years. These outcomes have resulted in other Oklahoma organizations contacting the Provider to learn how to adopt technology-based services.

- ***Law Enforcement.*** In many rural areas, law enforcement is often called to transport individuals to an in-patient facility a long distance away and may result in the officers staying with the person until a crisis interventionist arrives to do an assessment. Giving law enforcement officers an iPad allows them to more quickly connect the individual in crisis with a variety of specialists trained to address the situation, thereby decreasing the amount of time officers are unavailable to respond to other calls. The iPad 24/7 has proven to be time and resource efficient and local law enforcement is in the process of putting iPads in every vehicle in the service area.
- ***ER Services.*** Providing iPads to emergency departments can decrease the amount of time it takes to provide assessment and crisis intervention. For example, many ER physicians feel they do not have the mental health expertise to deal with the crisis situation and the closest crisis interventionist may have to travel one to two hours/long distances to assess the patient. The iPad 24/7 Program allows the physician to give the iPad directly to the client so the crisis interventionist can assess the situation and consult with the doctor about what needs to be done, thereby expediting patient treatment.
- ***Client Care.*** The iPad 24/7 Program has enhanced and expanded access to client services by improving communication between law enforcement, hospitals, and treatment providers. Using iPads facilitates a quick connection to a crisis interventionist and referral to various treatment systems, rather than waiting for the crisis interventionist to arrive to assess the situation. In addition, the iPad can help ensure patient safety by providing a visual of the situation. For example, a client with an iPad who was cutting her/himself had contacted the clinician, who was then able to make police responding to the situation aware of the presence of the knife and what the client was doing with it. This advance information guided the officers' approach to the client, which decreased the possibility of police perceiving the situation as personally threatening and any harm occurring as a result.

Other Considerations

There are several benefits to using the iPad 24/7 Program model, including providing better care in a less restrictive environment. One question that has been posed is if iPad 24/7 helped change attitudes related to SUD/MH. The Provider believes with a high level of certainty that it was useful in reducing stigma by assisting and essentially teaching law enforcement and hospital ER personnel how to deal with SUD/MH crises; decreasing incarcerations; and moving

from the old ‘crisis hotline’ call model to the person being able to see a crisis interventionist when needed. This model also gains credibility with clients; they are guiding their own treatment.

Innovative technology is about using what is available, focusing on no wasted effort, demonstrating best practice and practice change, and being outcome-based. The Provider believes that if the program cannot show that something is working, it needs to be changed. The Provider also believes the success of the iPad 24/7 Program is due to the forward-thinking nature of their agency combined with the State’s willingness to work together to come up with a plan to make it work. As a result of this joint effort, policies and regulations were changed to enable better treatment access for people when they need it. In recognizing the benefit of this approach to one small agency (the Provider), the State realized what the impact could be if more programs adopted it, thereby giving it credibility and promoting it as a model for the rest of the State.

Summary

Staff from the Oklahoma Department of Mental Health and Substance Abuse Services (the State) and Grand Lake Mental Health Center (the Provider), a model treatment program that has successfully implemented telehealth technologies services, were invited to participate in an in-person meeting and individual follow-up interviews via videoconferencing. The purpose of these conversations was to learn about their joint efforts to implement effective SUD/MH assessment, treatment, and recovery services using telehealth technologies. Specifically, the SSW ATTC wanted to collect qualitative data regarding Oklahoma's telehealth technologies model and implementation processes; implementation strategies; how policies and regulations were changed to support it; successes, challenges, and lessons learned at both the state and provider levels; and plans/directions for the future.

Representatives from the State and the Provider participating in these discussions agreed that transportation is a significant barrier to receiving services in Oklahoma. Consequently, working together to find a way to facilitate greater access to treatment services was an important issue and using telehealth technologies was appealing to both the State and the Provider. Key findings from these discussions are as follows.

1. The State recognized the need to make it easier for providers to change how they delivered services, which included new reimbursement policies.
2. The State acknowledged that training on billing/reimbursement, as well as evidence-based practices (EBPs) was essential.
3. The State recognized that scope of practice issues had to be addressed with credentialing boards.
4. The Provider had to help counseling/recovery staff increase their openness to using telehealth technologies (e.g., talked with them about the fact that effective therapeutic and peer relationships can be established through videoconferencing).
5. The State and the Provider identified the importance of champions that led these efforts for their organizations, as well as turnover in State-level leadership that brought more favorable views of telehealth technologies.

The State's practical approach to making changes at the state-level by adapting regulations that previously served as hindrances to workforce issues and treatment access was key to decreasing barriers, especially in rural areas. The State recognized the importance of

> "… start by getting people's perspective on what they see as the strengths and struggles of using telehealth technologies; then you can have genuine conversations and help them answer their questions and dispel myths".
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starting the conversation with key decision-makers (e.g., the legislature and Medicaid officer) and stakeholders/providers to identify challenges and provide education on how using telehealth technologies can improve treatment access and ultimately client outcomes. In addition, the State built positive and effective relationships with providers across Oklahoma and showed a willingness to sit down with them to learn about their challenges and engage in problem-solving discussions to increase patient access to services and improve outcomes. Engaging in these conversations and making administrative changes were key to the State creating a new service delivery model and the successful implementation of the Provider's iPad 24/7 Program in Northwest Oklahoma.

Recommendations and Next Steps

The collaborative efforts of the State and the Provider provide an excellent case study regarding how to make a significant system change that involves modifications in regulations, rules, policies, reimbursement, and provider service delivery. Most importantly, the system change addressed is an important tenet of SUD/MH services, expanding access to care especially in rural areas. As a result of this system change, which promoted the use of telehealth technologies to deliver crisis intervention, assessment, treatment, and recovery support services, hospitalization costs decreased; transportation costs for clients, providers, and law enforcement were lowered; rural clients in Northwest Oklahoma were able to access services just as easily as urban clients; and the State was able to eliminate many restrictive oversight functions, which decreased their costs as well.

Helping states implement the use of telehealth technologies to deliver SUD/MH services will require system change activities. As such, training/TA regarding system change may be required and include the following actions.

- Conversations about making a system change need to be initiated by an individual or group that has convening power and a commitment to and investment in the change.
- System change does not occur overnight, which points to the importance of being patient with the process and the amount of time it may take to reach the goal.
- The link below provides access to an excellent and recent guide (2015) to system change https://www.thinknpc.org/resource-hub/systems-change-a-guide-to-what-it-is-and-how-to-do-it/

Provider and State entities may require training/TA on change activities when considering adopting and implementing telehealth technologies to deliver services (e.g., how to make changes and adjustments).

- Small changes can be made, and adjustments initiated in response to changes using the Plan, Do, Check Act (PDCA) methodology or similar continuous quality improvement actions. The following links provide access to resources for continuous quality improvement and the PDCA cycle: https://asq.org/quality-resources/pdca-cycle ; https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/plan-do-check-act-cycle

Below are four next steps strategies for the SSW ATTC to consider based on the Oklahoma data.

1. ***Start the conversation.*** Assist the State and Providers in forming a workgroup with the goal of expanding access to SUD/MH services for populations using telehealth

technologies. Meeting with early adopters and individuals with convening influence before the invitations go out may help develop the workgroup. In addition, SSW ATTC can provide administrative and fiscal support to encourage participation.

2. ***Understand existing regulations/rules.*** Before any changes can be made, it is important to determine current regulations/rules and their function/purpose.
    - Examine the current definitions for reimbursable SUD/MH service delivery (e.g., assessment, intervention, treatment, and recovery support services)
    - Review Licensing/Certification Boards' regulations/rules regarding remote clinical supervision to be conducted via telehealth technologies
    - Facilitate a discussion with State and Licensing/Certification Board members regarding interest in regulation/rule changes
    - Collect sample language from Oklahoma and other states that can be used to make changes
3. ***Be clear about telehealth technologies.*** It is important to develop training materials and activities that include definitions for telehealth technologies (e.g., what it is, what it includes, and the research that supports using it to delivery SUD/MH services) as many professionals have outdated information or use terms interchangeably, which can be confusing and interfere with implementation. Examples include:
    - Fact Sheets
    - Introductory Webinars
    - Curriculum Infusion Package on telehealth technologies for faculty
4. ***Develop champions.*** Determine who in each state might be interested or is already using telehealth technologies. As a reminder, sometimes early adopters are not always the best promoters or champions of new ideas as they are typically significantly ahead of others and are often seen as different or outliers. However, they often have useful information that can be used to help with actual implementation. Training/TA that helps develop professionals to serve as champions is important. A specific training/TA for telehealth technologies champions or generic training/TA for developing champions could be conducted. The Pacific Southwest ATTC is piloting a new champion training/TA series which may be useful.
    - Identify providers that are currently using telehealth technologies
    - Interview these providers to collect information on how they implemented telehealth technologies

- Solicit providers who are interested in telehealth technologies and ask them to nominate a potential champion
- Create or hire the Pacific Southwest ATTC to conduct a Champion training/TA series

South Southwest (HHS Region 6)

ATTC Addiction Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

NFARtec National Frontier and Rural Telehealth Education Center