# *Using Virtual Visits to Support Behavioral Health Treatment and Medications for Opioid Use Disorder (MOUD) in Jails*


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## What is Telehealth?

"Telehealth" is an umbrella term for modalities of delivering healthcare that effectively connect individuals and their healthcare providers when in-person care is not necessary or not possible. For example, a glucose monitor that is Bluetooth-enabled and automatically uploads an individual's home blood glucose level to the provider's office for review is a form of telehealth. Virtual visits are a form of telehealth where the individual connects to a provider through a real-time, interactive encounter that is most frequently via video (although telephone or live chat are other forms of virtual visits). Virtual visits have been available for over 30 years and have consistently been shown to provide safe and high-quality care.[1]

## Behavioral Health Treatment and Virtual Visits

Prior to the COVID-19 public health emergency (PHE), virtual visits for behavioral health concerns were more widely accepted than visits for physical complaints such as a cough or abdominal pain where the physical exam may require in-person assessment. The lack of access to behavioral health providers was another key driver of the adoption of telehealth for behavioral health services. Consumer satisfaction with virtual visits for behavioral health services is high with many consumers preferring convenient access and broader range of choices in finding a provider that fits their needs. Numerous studies have demonstrated the effectiveness of telehealth for behavioral health across a range of modalities, such as telephone or videoconference, and mental health concerns. Virtual behavioral health services are safe, effective, and comparable in outcomes to in-person services.[2]

The COVID-19 PHE rapidly accelerated the uptake of virtual visits. According to a report from the U.S. Department of Health and Human Services, researchers found that telehealth visits increased over 63-fold from before the PHE.[3] Telehealth visits for non-behavioral health complaints have rapidly diminished since the peak of the pandemic, but telehealth visits for behavioral health needs have remained high. Analysts reviewed data from more than 126 million patients from over 156 healthcare organizations using the Epic electronic health record (EHR) systems. Prior to the pandemic, telehealth represented less than 1% of outpatient care for both mental health and substance use and other concerns. At the pandemic peak in 2020, telehealth represented 40% of mental health and substance use outpatient visits and 11% of other visits. Since then, telehealth visits have decreased to 5% of non-behavioral health outpatient visits but still represent 36% of behavioral health outpatient visits.[4] Virtual visits for behavioral health services are likely to remain the norm moving forward.

## Telehealth and Jails

Telehealth provides safe, convenient access to care when in-person care is less accessible. These qualities make virtual visits an optimal modality for many healthcare services in jails. In-person care is frequently difficult for jails since many are challenged by limited provider workforce, and community-based providers may not want to come into the jail. Jails require external providers to adhere to safety protocols that may be intimidating and counter-cultural to a more traditional healthcare setting. Transporting detainees outside of the jail often requires two

[1] American Telehealth Association. (n.d.). Telehealth: Defining 21st Century Care. Retrieved October 14, 2022, from https://www.americantelemed.org/resource/why-telemedicine/

[2] The Telebehavioral Health Institute. (n.d.). Bibliography. Retrieved October 14, 2022, from https://telehealth.org/bibliography/

[3] Samson, L., Tarazi, W., Turrini, G., & Sheingold, S. (2021). Medicare Beneficiaries' Use of Telehealth Services in 2020 – Trends by Beneficiary Characteristics and Location (Issue Brief No. HP-2021-27). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/reports/medicare-beneficiaries-use-telehealth-2020

[4] Lo, J., Rae, M., Amin, K., Cox, C., Panchal, N., & Miller, B.F. (2022). Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic. Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/

custody officers and is time consuming and expensive to arrange. Detainees have the right to quality healthcare services but not to determine whether the services are in person or virtual as long as the facility can ensure that virtual visits are not substandard. Virtual visits can provide a convenient, cost-effective, high-quality option for many healthcare services during detention in jail, providing needed behavioral health services including treatment for addiction.[5]

***Case Study #1: Mental Health Services***

*A suburban/rural jail in Illinois with a peak average daily population (ADP) of 180 struggled to provide mental health services to detainees. The jail had access to 8 hours of mental healthcare per week through the contracted medical provider. Mental health staffing changed abruptly during the COVID-19 PHE, and the jail found itself without a qualified provider who was able to come into the jail. The jail was able to use the same room where they conduct virtual court to provide virtual visits for mental health services with a qualified practitioner. The room already had a computer with appropriate connectivity and software for virtual court visits. The jail needed to purchase a wireless keyboard, wireless mouse and webcam all costing less than $100.00. There was a phone located in the room for virtual court that had to be relocated to a secure closet for the telehealth visits. Custody officers set up the encounter and then locked the keyboard, mouse and phone in a cabinet to preserve security. Escorting the inmates to the virtual visit is really no different than escorting them to see an in-person mental health provider. Because it is the same provider for all visits, the virtual session stays connected between detainee appointments. The jail experienced some problems with connectivity issues or freezing up in the middle of a session but attributed that to the provider's equipment since the jail is hardwired into the internet. Since the jail is using their contracted healthcare provider, there is no additional cost for the service. Some of the detainees expressed a preference for in-person visits since they were more used to that format, and this change was made abruptly. The jail reverted back to in-person visits once a local provider was available but recognizes the value of having the virtual visits as a back-up option.*

## Virtual Visits and Medications for Opioid Use Disorder (MOUD)

Both the President's Commission on Combating Drug Addiction and the Opioid Crisis[6] and the American Society of Addiction Medicine (ASAM)[7] endorse the use of virtual visits to expand access to substance use disorder (SUD) treatment including medications for opioid use disorder (MOUD) which is also known as medication assisted treatment (MAT) or medication assisted recovery (MAR). There are three FDA-approved drugs for MOUD—buprenorphine, methadone, and naltrexone—all of which have been shown to decrease overdose deaths and improve retention in care. Studies have demonstrated that telehealth services for individuals with SUD reduce illicit drug use,[8] improve patients' ability to stay in recovery, and may increase access to MOUD, especially in underserved urban, rural, and remote areas.[9]

[5] Tian, E. J., Venugopalan, S., Kumar, S., & Beard, M. (2021). The impacts of and outcomes from telehealth delivered in prisons: A systematic review. PloS one, 16(5), e0251840. https://doi.org/10.1371/journal.pone.0251840

[6] President's Commission on Combating Drug Addiction and the Opioid Crisis. (2017). Final Report. Washington (DC): White House. https://trumpwhitehouse.archives.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf

[7] American Society of Addiction Medicine (2020, September 8). Supporting Access to Telehealth for Addiction Services. https://www.asam.org/quality-care/clinical-recommendations/covid/supporting-access-to-telehealth-for-addiction-services

[8] Eibl, J. K., Gauthier, G., Pellegrini, D., Daiter, J., Varenbut, M., Hogenbirk, J. C., & Marsh, D. C. (2017). The effectiveness of telemedicine-delivered opioid agonist therapy in a supervised clinical setting. Drug and alcohol dependence, 176, 133–138. https://doi.org/10.1016/j.drugalcdep.2017.01.048

[9] Lin, L. A., Casteel, D., Shigekawa, E., Weyrich, M. S., Roby, D. H., & McMenamin, S. B. (2019). Telemedicine-delivered treatment interventions for substance use disorders: A systematic review. Journal of substance abuse treatment, 101, 38–49. https://doi.org/10.1016/j.jsat.2019.03.007

## Regulatory Issues

Historically, regulatory concerns were a key barrier to using virtual visits for MOUD. When the Ryan Haight Act was passed in 2008 to prevent rogue internet pharmacies from selling controlled substances online, [10] its telemedicine exceptions were not clearly defined. When the U.S. government declared a PHE on January 31, 2020, in response to the COVID-19 pandemic, federal lawmakers invoked an exception to the rule set forth in the 2008 Ryan Haight Act requiring in-person evaluation to prescribe a controlled substance, including buprenorphine for the treatment of opioid use disorder (OUD). Clinicians can now prescribe buprenorphine after conducting an initial virtual visit, using either audio-visual or telephonic communication. This exception is only effective for the duration of the PHE. There are efforts at the federal level to make this change permanent; however, tracking the ongoing regulations regarding telehealth and MOUD will be important for jails as they develop a telehealth program for MOUD.

***Case Study #2: Accessing Prescriber for MOUD in Rural Jail***

*A jail in rural California with an ADP of 100 has provided virtual visits for mental health for over five years. This rural community lacks access to many healthcare services, and telehealth has become an accepted way of accessing care, both in the community and in the jail. The virtual visits are conducted in the same exam room as in-person visits. The custody staff escort the detainee to the clinic area. The nurse remains with the detainee during the virtual visit and manages the connectivity and also provides additional clinical observations. The psychiatrist providing telehealth services is employed by the same healthcare vendor as the regular jail healthcare provider and both document care and orders in the same vendor-based EHR. The jail Health Services Administrator (HSA) reported that strong collaboration between the onsite, in-person healthcare team and the virtual provider is essential. The in-person clinical staff may have observations about the detainee that may not be appreciated during the virtual visit. The program has been highly successful for managing mental health issues, and the facility required no safety cell placements in over one year. When the jail recently initiated an MOUD program with buprenorphine, they used the same telehealth protocols to connect with the MOUD prescriber.*

## Methadone and Virtual Visits

Methadone is another FDA-approved medication used to treat OUD as well as for pain management. Methadone is a long-acting full opioid agonist and a schedule II-controlled medication.[11] When taken as prescribed, methadone is safe and effective. Methadone helps individuals achieve and sustain recovery and reclaim active and meaningful lives. By law, only a treatment program certified by Substance Abuse and Mental Health Services Administration (SAMHSA), called an Opioid Treatment Program (OTP), can dispense methadone for the treatment of OUD. The OTP provides a whole-person approach with a comprehensive treatment plan, methadone prescribing, and counseling and other behavioral health therapies. While federal guidance for OTPs currently stipulates a requirement for delivery of behavioral health counseling, the 2020 ASAM national practice guidelines for the treatment of OUD stipulate that a "patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay treatment with methadone, with appropriate

[10] Ryan Haight Online Pharmacy Consumer Protection Act of 2008, 122 STAT. 4820 (2008). https://www.congress.gov/110/plaws/publ425/PLAW-110publ425.pdf

[11] Substance Abuse and Mental Health Services Administration. (2022, September 27). Methadone. U.S. Department of Health and Human Services. https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/methadone

medication management." [12,13] As with all forms of MOUD, treatment planning with each individual should prioritize medical stabilization of any withdrawal symptoms or other health conditions followed by determination of the medication best for the patient based on the prescriber's clinical judgement, the patient's choice and access to the medication, and the ability of the patient to benefit from psychosocial interventions.

Patients generally start methadone by attending the OTP daily to participate in counseling and receive their methadone in a supervised setting. After a period of stability based on progress in substance use recovery and proven/consistent compliance with the medication, patients are allowed to take home doses of methadone between program visits.

In order for jails to provide methadone as part of their OUD regimen, they must either become licensed as an OTP or medication unit, transport detainees to an OTP, develop a relationship with an OTP to provide services in the jail or via a mobile unit, or provide methadone for OUD within a licensed hospital inside the jail. OTPs can provide continuity of care for other OTPs through guest dosing, including for patients while they are incarcerated, where the dispensing OTP communicates with the home-base OTP and then continues to provide methadone until the patient can get back into their home-base OTP.

In the past, because of the regulatory requirements, the use of virtual visits for management of OUD with methadone was limited. Like other healthcare services, the regulations related to methadone were loosened during the PHE. SAMHSA issued guidance allowing providers to provide methadone to existing patients of the OTP via telehealth, assuming applicable standards of care are met. For new OTP patients that are treated with methadone, the requirements of an in-person medical evaluation remain in force.[14] At least one study demonstrated that despite a near-doubling of take-home methadone doses during the PHE, the increase in take-home doses was not associated with negative treatment outcomes in methadone-adherent clients.[15] More permanent changes allowing greater flexibility for methadone administration have been considered by the federal government which will likely continue to expand the use of virtual visits for individuals receiving methadone.

***Case Study #3 Prison and Methadone***

*In 2019, a State Department of Corrections (DOC) in the Mid-Atlantic region wanted to expand their MOUD program to be able to provide methadone as clinically appropriate. The DOC asked their comprehensive healthcare vendor to collaborate with a community-based OTP to provide the methadone treatment.*

*The vendor and OTP signed a memorandum of understanding (MOU) spelling out expectations for each party, payment of medication and services, and terms for termination of MOU. The MOU also included terms regarding the process for confirming patient enrollment and dosage with OTP (exchange of information); the method of medication transportation/delivery to the facility (including Chain of Custody documentation); and expectations/requirements for staff accessing the EHR including background checks and security protocols. Despite the MOU, the OTP providers struggled with virtual visit technology and remote access to the EHR.*

[12] Substance Abuse and Mental Health Services Administration. (2015). Federal Guidelines for Opioid Treatment Programs. U.S. Department of Health and Human Services. https://store.samhsa.gov/sites/default/files/d7/priv/pep15-fedguideotp.pdf

[13] American Society of Addiction Medicine. (2019). National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline

[14] Substance Abuse and Mental Health Services Administration. (2020, April 21). FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency. U.S. Department of Health and Human Services. https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf

[15] Amram, O., Amiri, S., Panwala, V., Lutz, R., Joudrey, P. J., & Socias, E. (2021). The impact of relaxation of methadone take-home protocols on treatment outcomes in the COVID-19 era. The American journal of drug and alcohol abuse, 47(6), 722–729. https://doi.org/10.1080/00952990.2021.1979991

*The regulatory nature of methadone prescribing requires a high degree of communication and trust between the OTP and jails or prisons. Subsequently, this DOC sought a partnership with a different OTP. Again, the healthcare vendor developed a MOU with the new OTP, and again included specific information regarding expectations for each party. Based on lessons learned from the original pilot, the DOC and OTP spent additional planning time designating roles and responsibilities and developing a workflow. Through frequent communication and setting clear expectations, the OTP and prison were able to collaborate and use virtual visits as the primary method of providing methadone to incarcerated individuals, as well as developing smooth pathways for required in-person assessments, urine drug screening, and guest dosing.*

## Building Blocks for Developing Virtual Visits to Support Implementation of MOUD in Jails

The United States is one of the only countries in which opioid agonist/partial agonist medications (buprenorphine and methadone) are not consistently offered in correctional settings despite evidence of their effectiveness and classification by the World Health Organization as essential medications.[16] In a recent survey of Illinois jails, only 22% of jails responding to the survey indicated that they offer MOUD to detainees, and most commonly they offered only naltrexone-based MOUD. Only 8% offered buprenorphine or methadone.[17] In 2022, the Department of Justice released a statement specifically stating that failure to continue MOUD during incarceration was a violation of the Americans with Disabilities Act.[18]

In addition to attitudinal barriers to providing MOUD, jails face significant operational barriers. A key barrier is a lack of qualified providers. There is a national shortage of providers who have been trained to prescribe buprenorphine for OUD. Jails frequently contract with a healthcare vendor who may not have employed staff with clinical experience managing buprenorphine and methadone. Most jails do not have or pursue an OTP license given the regulatory requirements related to methadone necessitating a collaborative relationship with a community-based OTP. The ability to use virtual visits with an experienced prescriber or an OTP increases options for jails to effectively deploy MOUD and the behavioral health counseling services to support it. While federal guidance for OTPs currently stipulates a requirement for delivery of behavioral health counseling,[19] the ASAM national practice guidelines for the treatment of OUD (2020)[20] stipulate that a "patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay treatment with methadone, with appropriate medication management." As with all medications for OUD, treatment planning with each individual should prioritize medical stabilization of any withdrawal symptoms or other health conditions followed by determination of the medication best for the patient based on the prescriber's clinical judgement, the patient's choice and access to the medication, and the ability of the patient to benefit from psychosocial interventions.[21]

[16] World Health Organization. (2021). World Health Organization Model List of Essential Medicines – 22nd List, 2021 (WHO/MHP/HPS/EML/2021.02). https://www.who.int/publications/i/item/WHO-MHP-HPS-EML-2021.02

[17] Reichert, J., Weisner, L., Marcheschi, T., Gleicher, L., and Adams, S. (2018). Addressing Opioid Use Disorders in Corrections: A Survey of Illinois Jails. Illinois Criminal Justice Information Authority. https://icjia.illinois.gov/researchhub/articles/addressing-opioid-use-disorders-in-corrections-a-survey-of-illinois-jails

[18] Civil Rights Division. (2022). The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery. United States Department of Justice. https://www.ada.gov/opioid_guidance.pdf

[19] Federal law 42.CFR.8.12; https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8#8.12

[20] American Society of Addiction Medicine. (2019). National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline

[21] Health Management Associates. (2022). Position Statement on Medications for Addiction Treatment (MAT) and Behavioral Health Interventions. https://addiction-free-ca-prod.s3.amazonaws.com/public/Position-Statement-on-Medications-for-Addiction-Treatment-(MAT)-and-Behavioral-Health-Interventions-6-30-2022.pdf

A published literature review of telehealth services in jails and prisons concluded that virtual care had potential for positive impact, but the authors cautioned that careful planning was required noting, "For telehealth to fulfill its potential and achieve sustainability, critical factors encompassing seamless integration into routine practice, financial sustainability, interdisciplinary collaboration, and regular evaluation need to be addressed throughout the process."[22] Jails need to develop a planning team and carefully consider each of the factors discussed below as the "building blocks" for implementing virtual visits for MOUD. Each building block is discussed in detail and a worksheet for jails to evaluate and develop their own building blocks is included in Appendix A.

## Building Blocks for Virtual Visits in Jails



**Leadership and Planning Support**: Moving to a new system of healthcare delivery requires commitment from leadership and staff as well as an investment in planning. Each jail will need to develop a team. The jail administrator does not need to serve on the team but needs to be supportive of the change. Planning for virtual visits requires a project **sponsor** – a person who introduces and supports a proposal and has the leadership authority and responsibility to ensure change is implemented. The project **champion** is the key leader of the planning process who is empowered by the sponsor and has the skill set to lead the implementation of the change. When considering virtual services for MOUD, both healthcare and custody staff need to be engaged in the planning process. Because telehealth requires some technological changes, the team may need input related to technology for virtual services, whether this is internal or supplied through a vendor, contractor, or consultant. The planning team drives communication with other internal and external stakeholders. The jail should consider the rationale for the change and consider the "success factors" for virtual care such as cost effectiveness, improved patient outcomes, and improved staff safety. The planning team needs to define process metrics for the project (e.g., number of individuals treated, cost per individual) and outcome metrics (e.g., number of individuals released and connected to MOUD in the community, cost effectiveness of the program).



**Clinical Model and Staffing:** The jail needs to determine how virtual services are going to be arranged. This may involve using a known healthcare provider such as a contracted jail healthcare services vendor who is providing on-site services and can augment MOUD care through virtual services. Other arrangements may involve a separate healthcare provider for MOUD services, whether this is a company that specializes in virtual services[23] or another community-based provider. A consideration for MOUD services is whether the provider can continue to care for the detainee upon release and maintain continuity of care. Access to MOUD in the community may be scarce as well. Some vendors specialize in virtual MOUD care in the community and work with individuals in probation or parole but may lack experience working directly with jails and prisons.[24] If the virtual services are provided by a separate provider, the jail must ensure coordination among the various healthcare providers and obtain the appropriate release of information forms. Jails are accustomed to having multiple healthcare providers such as separate physical health, dental health, and mental health providers and can draw from these

> *"Coordination of services between the onsite care and virtual care is essential. Virtual providers need 'eyes and ears' at the facility.'"*
>
> —Jail HSA with long-term telehealth experience

[22] Tian, E. J., Venugopalan, S., Kumar, S., & Beard, M. (2021). The impacts of and outcomes from telehealth delivered in prisons: A systematic review. PloS one, 16(5), e0251840. https://doi.org/10.1371/journal.pone.0251840
[23] For example: OrbitHealth: https://www.orbithealth.com/telepsychiatry-services/correctional-care/
[24] For example: BrightHeart Health: https://www.brightheartheath.com/

examples of MOUs that describe how the various providers will work together as needed to share data and ensure optimal patient outcomes. The jail HSA plays a key role in coordinating care. Providers who are unaccustomed to providing either care to incarcerated individuals or virtual care may require additional training in either or both aspects of care. Providers who are new to the jail setting may not understand issues related to delay in the encounter when the jail is on lock-down or other security-related delays. Providers may also struggle with setting boundaries that are appropriate for detainees. Vendors who are specialized in the provision of virtual care should provide training oversight on conducting a virtual visit, and jails should consider this when contracting. Ideally, the providers of virtual visits can visit the jail and test the equipment at the originating site, so they can understand the limitations during the virtual encounter.



**Policies, Procedures, and Workflows:** Once the provider has been selected and equipment is in place, the jail needs to establish workflows for the virtual visits. These will largely mimic the processes for onsite, in-person visits where the detainee either requests a visit or is scheduled for a visit. Instead of transporting the detainee to the onsite medical examination room, the custody staff will escort the detainee to the space arranged for the virtual visit. In some cases, a jail healthcare staff member (typically a nurse, medical assistant or social worker) may accompany the detainee during the virtual visit and serve as a "telepresenter" and facilitate interaction with the remote provider. In many smaller jails, this type of telepresenter is unavailable, and custody officers may serve to gather vital signs and initiate the virtual encounter. Processes need to be in place for emergency clinical protocols (e.g., detainee demonstrates suicidal ideation or is agitated), connectivity or equipment failure (e.g., the virtual visit cannot be satisfactorily completed due to unstable signal connection), or other possible disruptions (e.g., the jail is on lock-down). It is highly recommended that jails have several trial runs of mock virtual visits with jail staff to assess each potential disruption or emergency scenario prior to initiation for actual virtual visits. Simple workflows and swim lane charts may serve as useful tools to document these processes.



**Documentation of the clinical encounter:** All healthcare encounters, whether virtual or in-person, must be satisfactorily documented. The jail and healthcare provider will need to determine how the encounters are documented and where records are stored. If the jail has an EHR, then virtual care providers may access the record remotely and document directly in the EHR. If other paper record systems are used, the process for exchanging records between the provider and jail must be established including the process for exchanging lab results, vitals, and other clinical data to the remote provider. Clear expectations for the timeliness of documentation should also be determined. The jail HSA provides oversight to ensure that the documentation meets clinical standards. Jails need to consider security of the transmission of the clinical documents if they are electronically transferred from the provider to the jail.



**Purchasing and Financial Model**: As stewards of public funds, jails seek to provide the best possible care in the most cost-effective way. There is a significant body of literature that demonstrates that providing MOUD in jails reduces costs to society, reduces overdoses deaths, improves recidivism, and improves multiple other health and justice outcomes.[25] While jails and other community leaders may need to persuade other stakeholders on the value of MOUD, the specific issue for the telehealth planning group is considering the costs of delivering MOUD

[25] Moore, K. E., Roberts, W., Reid, H. H., Smith, K., Oberleitner, L., & McKee, S. A. (2019). Effectiveness of medication assisted treatment for opioid use in prison and jail settings: A meta-analysis and systematic review. Journal of substance abuse treatment, 99, 32–43. https://doi.org/10.1016/j.jsat.2018.12.003

services onsite versus virtually. Because many facilities are currently not offering any onsite MOUD services, it may be difficult to make a head-to-head comparison. In some cases, there may not be any option for onsite MOUD services rendering the cost comparison moot. In calculating the cost of providing virtual visits, the team needs to consider costs for any changes to the physical facility; hardware equipment; software; upgrading connectivity, if necessary; custody labor costs for transporting detainees to the virtual care originating site and monitoring the visit; and the cost for the provider. Jails may contract with virtual care providers "per session"—meaning virtual visits are completed in a scheduled block time and the number of visits does not affect the cost or contract per detainee visit.



**Regulatory and Compliance Issues**: The regulatory environment for telehealth is evolving rapidly. All participants in telehealth need to stay abreast of the evolving regulatory landscape for each state. As a purchaser of telehealth, for the most part, jails ~~are able~~can ~~to~~ avoid the regulations related to commercial insurance, Medicare, and Medicaid reimbursements. However, jails still need to comply with the regulations regarding consent for treatment, online prescribing, licensure, and professional standards. These may vary from state to state. For example, several states suspended the requirement that telehealth providers needed to be licensed within the same state as the originating location as the patient during the PHE. Most experienced telehealth providers are aware of the regulatory requirements and can assist jails in maintaining compliance. As noted above, prescribing controlled substances such as buprenorphine or methadone have additional regulations that telehealth providers need to be aware of. While the providers are primarily responsible for compliance with professional regulations, jails should be cognizant of the requirements and ensure that their provider contracts require provider compliance.

A useful resource is the Center for Connected Health Policy (CCHP) which serves as the federally designated National Telehealth Policy Resource Center. The CCHP actively researches and analyzes important telehealth policy issues and provides key telehealth policy resources nationwide. https://www.cchpca.org/how-we-work/



**Physical Space**: In many jails, physical space is at a premium. The security considerations in building jails means that the space is hard configured, and it is difficult to re-purpose space within the jail. Jails need to consider balancing detainees' privacy while meeting with their providers' and the jail's primary charge of safety and security. Jails may have some spaces already configured for video visitation or video court which may be appropriate for virtual healthcare visits. Other jails may need to locate space within the jail for video visits. The space must be able to accommodate the video screen and other necessary equipment and adequate lighting is necessary, so the provider can observe the patient during the virtual visit.



**Technology/Hardware**: For virtual visits, the site where the patient is located is referred to as the "originating site," and the site where the provider is located is known as the "distant site." In order to accomplish virtual video visits, jails (originating site) will need a computer with an integrated camera and microphone or the ability to add a webcam and microphone plug-in. The distant site will require the same equipment. Technology has accelerated so rapidly over the past decade that almost any computer, tablet, or even a smart phone now has the hardware capabilities to perform an adequate virtual visit. There are specialized carts for telehealth that offer plug-ins for various diagnostic instruments such as a blood pressure cuff and heart monitor. The plug-ins are rarely necessary in a jail environment. If needed, jail healthcare staff, or even custody staff, can augment the virtual visit by assessing the

pulse, blood pressure, and temperature of the patient. An additional factor for jail to consider is the responsibility for maintenance of the telehealth equipment. Since this is not typical healthcare, communication, or security equipment, the responsibility for equipment maintenance may not be easily accounted for in traditional jail hierarchies, and this role must be established.

> *"Virtual visits need to be easy and user friendly, or people get frustrated. Tech support and training are necessary, so things run smoothly."*
>
> –Jail HSA with long-term experience with virtual visits



**Technology Platforms or Software**: Outside of the jail environment, many EHRs now offer an integrated platform for virtual visits. This allows for easy documentation of the virtual visit in the provider's medical record. If the jail is planning on using virtual visits extensively, then assessing whether a telehealth platform is an option in the jail's existing EHR may be appropriate. Jails can also purchase a subscription to a stand-alone telehealth platform. These tailored platforms streamline the virtual visit by offering options like a "virtual waiting room" or the ability to "push" or send documents through the application to the patient. However, any platform that allows a virtual video meeting can serve as a platform for a virtual healthcare encounter. The only additional consideration is whether the platform is compliant with the privacy and security standards outlined in the Health Insurance Portability and Accountability Act (HIPAA). For example, FaceTime is not HIPAA compliant whereas Webex is.[26]



**Connectivity and bandwidth**: Due to security considerations, access to computers and the internet is strictly regulated within the jail. The physical facility with limited windows and secure building construction impacts the wireless transmissions. Additionally, the same geographic regions that experience a lack of providers are also likely to experience lack of broadband connectivity to support the audio-visual capacity necessary for a virtual visit. Jails will need to ensure adequate connectivity to conduct virtual visits without interruption.



**Continuous Quality Improvement**: After purchasing and installing equipment, selecting a provider, and starting virtual visits, jails may feel like the project is over; however, jails have an ongoing responsibility to continue to monitor the quality of the healthcare they provide—whether virtual or onsite. Jails are likely tracking various healthcare metrics already such as the number of provider visits, transfers to emergency rooms, and unexpected health events. Jails should continue to monitor these after virtual visits are implemented. Additionally, jails should monitor factors such as timeliness of virtual visits and number of visits interrupted by equipment or connectivity issues. All MOUD programs whether in-person or virtual should track metrics such as number of individuals in withdrawal from various substances, number of individuals with valid community-based MOUD prescriptions who are either continued or withdrawn during detention, and number of individuals initiated on MOUD. Reentry metrics such as the number of individuals on MOUD who are discharged with naloxone kits, the number of individuals with an appointment within 7 days of release, and the number of individuals who attend the appointment should also be considered. A simple registry of individuals on MOUD may be a useful tool to track this information. If both in-person and virtual visits are utilized, the registry can record that as well, offering a useful comparison in the future. Oversight for the virtual visit program needs to be delegated to one individual or team who will troubleshoot any issues, track metrics, periodically review contracts and MOUs, review virtual visit documentation, and ensure integration with other healthcare services.

[26] U.S. Department of Health & Human Services. (2021, January 20). Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

# Appendices

## Appendix A: Checklist of Building Blocks for Virtual Visits

1. **Leadership and Planning Support**
    a. Sponsor
    b. Champion
    c. Custody representation on planning team
    d. Healthcare representation on planning team
    e. IT/technology resources on team
    f. Definition of success metrics
2. **Clinical Model and Staffing**
    a. Selection of virtual visit provider
        i. Training and experience of provider with carceral environment and virtual visits
    b. Integration with existing healthcare services
3. **Policies, Procedures, and Workflows**
    a. Workflow for virtual visits established and documented
    b. Define telepresenter role
    c. Emergency processes established
        i. Clinical/psych emergency
        ii. Technology interruptions
4. **Documentation**
    a. Access to jail EMR
    b. Transfer of records from virtual provider to jail
    c. Transfer of vital signs, observations from jail to provider
5. **Purchasing and Financial Model**
    a. Implementation costs
        i. Hardware and A/V equipment
        ii. Physical facility upgrades
        iii. Software
        iv. Connectivity
    b. Cost comparison between in-person and virtual model
    c. Contracting arrangements (block session vs per visit)
6. **Regulatory and Compliance**
    a. Licensure
    b. Prescribing of controlled substances
7. **Physical Space**
    a. Adequate for virtual visit, lighting, privacy, etc.
8. **Technology/Hardware**
    a. Computer
    b. A/V equipment
    c. Maintenance responsibility
9. **Technology Platform/Software**
    a. HIPAA-secure platform

10. **Connectivity**
    a. Bandwidth capacity exists within the jail to support virtual visits
11. **Continuous Quality Improvement**
    a. Implementation metrics are established
    b. Process metrics established
    c. Outcomes metrics established
    d. Oversight function exists
        i. Periodic review of contracts
        ii. Periodic review of MOUs
        iii. Review documentation of virtual visits
        iv. Ensure integration with other healthcare services

# Appendix B: Useful Resources

## Web Resources

- A useful resource is the Center for Connected Health Policy which serves as the federally designated National Telehealth Policy Resource Center. CCHP actively researches and analyzes important telehealth policy issues and provides key telehealth policy resources nationwide.
    - https://www.cchpca.org/how-we-work/
- The Bureau of Justice Assistance has resources available for helping jails and the criminal justice system implement telehealth:
    - https://www.cossapresources.org/Content/Documents/BriefingSheets/Using_Telehealth_for_Behaviorial_Health.pdf - Infographic - Behavioral Health Specific (Bureau of Justice Assistance)
    - https://www.cossapresources.org/Content/Documents/Events/COSSAP_Webinar_Telehealth_in_Jails.pdf - Webinar Slides (Bureau of Justice Assistance)
- Information and links from the Rural Health Information Hub:
    - https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/01/21/state-prisons-turn-to-telemedicine-to-improve - Examples of locations that have successfully implemented telehealth in their state prisons
    - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5332924/ - Article over current state of U.S. prison system and healthcare systems, identifying gaps that telehealth may fill

## Annotated Bibliography

1. Donelan, C. J., Hayes, E., Potee, R. A., Schwartz, L., & Evans, E. A. (2020). COVID-19 and treating incarcerated populations for opioid use disorder. *J Subst Abuse Treat, 124*, 108216. doi:10.1016/j.jsat.2020.108216

The Franklin County Sheriff's Office (FCSO) in Greenfield, Massachusetts, is among the first jails nationwide to provide correctional populations with access to all three medications to treat opioid use disorder. FCSO implemented and adapted a hub-and-spoke MOUD model, developed telehealth capacity, and experimented with take-home MOUD at release to facilitate continuity-of-care as individuals reentered the community.

2. Krsak, M., Jeffers, A., Shah, J., Johnson, S. C., & Montague, B. T. (2020). Access to Specialty Services: Opportunities for Expansion of Telemedicine to Support Correctional Health Care in Colorado. *Telemed J E Health, 26*(6), 776-783. doi:10.1089/tmj.2019.0130

A survey-based pilot study using mixed methods research techniques to evaluate current services, as well as any potential need for expansion of telemedicine, within correctional settings in Colorado.

3. Molfenter, T., Roget, N., Chaple, M., Behlman, S., Cody, O., Hartzler, B., Johnson, E., Nichols, M., Stilen, P., & Becker, S. (2021). Use of Telehealth in Substance Use Disorder Services During and After COVID-19: Online Survey Study. JMIR mental health, 8(2), e25835. https://doi.org/10.2196/25835

COVID-19 social distancing guidelines caused a rapid transition to telephone and video technologies for the delivery of substance use disorder (SUD) treatment. The study examined adoption of these technologies across the SUD service continuum; acceptance of these technologies by service providers; and intention of providers to use these technologies following the pandemic. An additional analysis used the validated Technology Acceptance Model (TAM) to test the rigor of the intent to use the technology post-pandemic.

4. Staton, M., Webster, J. M., Leukefeld, C., Tillson, M., Marks, K., Oser, C., Bush, H. M., Fanucchi, L., Fallin-Bennett, A., Garner, B. R., McCollister, K., Johnson, S., & Winston, E. (2021). Kentucky Women's Justice Community Opioid Innovation Network (JCOIN): A type 1 effectiveness-implementation hybrid trial to increase utilization of medications for opioid use disorder among justice-involved women. Journal of substance abuse treatment, 128, 108284. https://doi.org/10.1016/j.jsat.2021.108284

The Kentucky Justice Community Opioid Innovation Network (JCOIN) will implement a type 1 hybrid effectiveness and implementation trial to examine an innovative MOUD pretreatment model using telehealth (alone and in combination with peer navigators) for justice-involved women in transition from jail to the community. The overall goal of the project is to increase initiation and maintenance of MOUD among high-risk justice-involved women during community reentry to reduce opioid relapse and overdose.

5. Bureau of Justice Assistance. (2020). Using Telehealth for Behavioral Health in the Criminal Justice System. U.S. Department of Justice. https://bja.ojp.gov/library/publications/using-telehealth-behavioral-health-criminal-justice-system

The article notes that when implemented successfully, telehealth can improve access to care under recent social distancing requirements due to the COVID-19 pandemic. It also describes the types of telehealth services that can address impediments that prevent in-person interaction with treatment providers. The types of telehealth modes described are live video; the electronic transmission of photos and x-rays; the transmission of data from monitoring devices; and the use of cell phone apps that provide health-related information. Descriptions of key steps to telehealth readiness address the selection of one or more types of telehealth services to be offered; the identification of which policies and procedures must be changed; preparation of the staff involved in the program; the preparation of patients; and the analysis of costs and benefits.

6. Molfenter, T., Boyle, M., Holloway, D., & Zwick, J. (2015). Trends in telemedicine use in addiction treatment. *Addiction science & clinical practice*, 10, 14. https://doi.org/10.1186/s13722-015-0035-4

A project conducted from February 2013 to June 2014 investigated the adoption of telemedicine services among purchasers of addiction treatment in five states and one county. The project assessed purchasers' interest in and perceived facilitators and barriers to implementing one or more of the following telemedicine modalities: telephone-based care, web-based screening, web-based treatment, videoconferencing, smartphone mobile applications (apps), and virtual worlds.

7. Bashshur, R. L., Shannon, G. W., Bashshur, N., & Yellowlees, P. M. (2016). The Empirical Evidence for Telemedicine Interventions in Mental Disorders. *Telemedicine journal and e-health: the official journal of the American Telemedicine Association, 22*(2), 87–113. https://doi.org/10.1089/tmj.2015.0206

The authors reviewed relevant studies that met rigorous methodological criteria. The concluded that the published scientific literature on telemedicine modalities for mental health reveals strong and consistent evidence of the feasibility of this modality of care and its acceptance by its intended users.

8. Huskamp, H. A., Busch, A. B., Souza, J., Uscher-Pines, L., Rose, S., Wilcock, A., Landon, B. E., & Mehrotra, A. (2018). How Is Telemedicine Being Used in Opioid and Other Substance Use Disorder Treatment? *Health affairs (Project Hope), 37*(12), 1940–1947. https://doi.org/10.1377/hlthaff.2018.05134

This article describes how tele-SUD is currently being used. By using 2010–2017 claims data from a large commercial insurer, the article identifies characteristics of tele-SUD users and examines how tele-SUD is being used in conjunction with in-person SUD care.

9. Molfenter, T., Brown, R., O'Neill, A., Kopetsky, E., Toy, A. (2018). Use of Telemedicine in Addiction Treatment: Current Practices and Organizational Implementation Characteristics, International Journal of Telemedicine and Applications, vol. 2018, Article OD 3932643. https://doi.org/10.1155/2018/3932643

This analysis assessed the interest in and use of 11 telemedicine applications in a sample of 363 SUD organizations in the United States.

10. Belcher, A. M., Coble, K., Cole, T. O., Welsh, C. J., Whitney, A., & Weintraub, E. (2021). Buprenorphine Induction in a Rural Maryland Detention Center During COVID-19: Implementation and Preliminary Outcomes of a Novel Telemedicine Treatment Program for Incarcerated Individuals with Opioid Use Disorder. Frontiers in psychiatry, 12, 703685. https://doi.org/10.3389/fpsyt.2021.703685

The article describes a new program of telemedicine-based clinical provision of new/continuing buprenorphine treatment for individuals detained in a rural jail.

11. Senanayake, B., Wickramasinghe, S. I., Eriksson, L., Smith, A. C., & Edirippulige, S. (2018). Telemedicine in the correctional setting: A scoping review. *Journal of Telemedicine and Telecare, 24*(10), 669–675. https://doi.org/10.1177/1357633X18800858

This study aimed to collate the current evidence related to the use of telemedicine to deliver health services within correctional settings.

12. Young, J. D., & Badowski, M. E. (2017). Telehealth: Increasing Access to High Quality Care by Expanding the Role of Technology in Correctional Medicine. *Journal of clinical medicine, 6*(2), 20. https://doi.org/10.3390/jcm6020020

This is a review article summarizing the benefits of telehealth for incarcerated persons who may lack access to evidence-based, up-to-date medical care, particularly by subspecialty providers, due to limitations of geography, travel, cost, and other resources. The use of telehealth technologies can remove these barriers, increasing access to high quality, multidisciplinary care. Studies have shown that, with telemedicine, timely triage and medical management can be provided across many disciplines, which may lead to improved clinical outcomes and significant cost savings.

13. Rappaport, E. S., Reynolds, H. N., Baucom, S., & Lehman, T. M. (2018). Telehealth Support of Managed Care for a Correctional System: The Open Architecture Telehealth Model. *Telemedicine journal and e-health: the official journal of the American Telemedicine Association*, *24*(1), 54–60. https://doi.org/10.1089/tmj.2016.0275

This study evaluated time to match initial investment of a new statewide correctional system telehealth program based upon cumulative savings by avoidance of transportation and custody-related costs. It demonstrated significant cost savings through telehealth by avoiding detainee transfers.

14. Tian, E. J., Venugopalan, S., Kumar, S., & Beard, M. (2021). The impacts of and outcomes from telehealth delivered in prisons: A systematic review. *PloS one, 16*(5), e0251840. https://doi.org/10.1371/journal.pone.0251840

A systematic review was conducted to synthesize the evidence base to date for the impacts of and outcomes from telehealth delivered in prisons.