



Legislative Report

Audio-only Telehealth Services

Patient and Provider Experience

Health Care Administration

March 2026

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is \$354,425.

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I. Executive summary

In 2021, the Minnesota Department of Human Services (DHS) contracted with Wilder Research to conduct a study of telehealth utilization among enrollees in Minnesota Health Care Programs (MHCP). As a follow-up to that study, the Office of Medicaid Medical Director (OMMD) was requested to examine the impact of audio-only telehealth services compared to audio-visual telehealth services. OMMD embarked on a qualitative assessment of audio-only services in 2024, focusing on mental health services. Feedback was collected from community members and providers on their experiences using a variety of feedback methods including formal evaluations with Wilder Research and KA Nichols Consulting, community conversations with Marnita's Table and the DHS Health Services Advisory Committee, and a survey administered online or via interview with the National Alliance on Mental Illness (NAMI) Minnesota. Outcomes and findings from each of these groups are detailed in Section A of this report.

The clear consensus across all groups is that audio-only telehealth services are a valuable tool in addressing the mental health needs of Minnesotans and should continue to be covered as a treatment option.

Overwhelmingly, respondents cited the ease and convenience of audio-only services when trying to access care. This was especially true for people who do not have reliable internet access to broadband for audio-video visits, have transportation difficulties, and for those experiencing anxiety about the need to be on video. Over 90% of respondents to the NAMI survey and participants in the Wilder Research project would recommend audio-only care to others.

Respondents also acknowledged that audio-only visits may not be the best option for all visit types or for all individuals. A good rapport and trusted relationship between patients and providers facilitates a successful telehealth experience. Adequate skills and training on how to effectively use telehealth technology, particularly for those with limited English proficiency or who may not be tech savvy, also can have considerable impact on the telehealth experience.

Recommendations stemming from this report are to:

- Maintain parity coverage for audio-only telehealth services, especially because broadband coverage can be inconsistent
- Consider payment for providers to help patients prepare for telehealth, including efforts to enhance digital literacy
- Fund training opportunities for telehealth providers, particularly on cultural considerations, therapeutic best practices, and administering telehealth services effectively
- Embed Culturally and Linguistically Appropriate Services (CLAS) standards throughout telehealth awareness efforts and service delivery activities to promote health equity
- Monitor risk, impact, and potential opportunities associated with new technology such as artificial intelligence (AI) and machine learning

II. Legislation

Laws of Minnesota 2021, First Special Session, Chapter 7, Article 6, Section 27

STUDIES OF TELEHEALTH EXPANSION AND PAYMENT PARITY.

(a) The commissioner of health, in consultation with the commissioners of human services and commerce, shall study the impact of telehealth expansion and payment parity under this article on the coverage and provision of health care services under private sector health insurance.

(b) The commissioner of human services, in consultation with the commissioners of health and commerce, shall study the impact of telehealth expansion and payment parity under this article on the coverage and provision of health care services under public health care programs.

(c) The studies required under paragraphs (a) and (b) must review and make recommendations relating to:

(1) the impact of telehealth expansion and payment parity on access to health care services, quality of care, health outcomes, patient satisfaction, and value-based payments and innovation in health care delivery;

(2) the impact of telehealth expansion and payment parity on reducing health care disparities and providing equitable access to health care services for underserved communities;

(3) whether audio-only communication as a permitted option for delivering services (i) supports equitable access to health care services, including behavioral health services, for the elderly, rural communities, and communities of color, and (ii) eliminates barriers to care for vulnerable and underserved populations without reducing the quality of care, worsening health outcomes, or decreasing satisfaction with care;

(4) the services and populations, if any, for which increased access to telehealth improves or negatively impacts health outcomes;

(5) the extent to which services provided through telehealth:

(i) substitute for an in-person visit;

(ii) are services that were previously not billed or reimbursed; or

(iii) are in addition to or are duplicative of services that the patient has received or will receive as part of an in-person visit;

(6) the effect of telehealth expansion and payment parity on public and private sector health care costs, including health insurance premiums; and

(7) the impact of telehealth expansion and payment parity, especially in rural areas, on patient access to, and the availability of, in-person care, including specialty care.

(d) In addition, the studies must report:

Audio-only Telehealth Services: Patient and Provider Experience

(1) the criteria payers used during the study period to determine which patients were medically appropriate to be served through telehealth, and which categories of service were medically appropriate to be delivered through telehealth, including but not limited to the use of audio-only communication; and

(2) the methods payers used to ensure that patients were allowed to choose to receive a service through telehealth or in person during the study period.

(e) When conducting the studies, the commissioners shall consult with public program enrollees and other patients, providers, communities impacted by telehealth expansion and payment parity, and other stakeholders. Notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, the commissioners may use data available under that section to conduct the studies and may consult with experts in payment policy and health care delivery. Health plan companies shall submit information requested by the commissioners for purposes of the studies in the form and manner specified by the commissioners.

(f) The commissioners shall present a preliminary report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance and commerce by January 15, 2023. The preliminary report must include qualitative and any available quantitative findings, and recommendations on whether audio-only communication should be allowed as a telehealth option beyond June 30, 2023. The commissioners shall present a final report to the chairs and ranking minority members of these specified legislative committees by January 15, 2024

III. Introduction

Telehealth is “the delivery of health care services or consultations through the use of real time, two-way interactive audio and visual communications. Telehealth provides or supports health care delivery and facilitates the assessment, diagnosis, consultation, treatment education, and care management of a patient’s health care while the patient is at the originating site and the licensed health care provider is at a distant site.”¹

Purpose of report

In 2021, the Minnesota Legislature passed a requirement that the Department of Human Services, Department of Health, and Department of Commerce collectively conduct a study of the impact of telehealth expansion and payment parity (Minnesota Session Laws, 2021). Specifically, the study was required to assess the impact of telehealth on access to health care services, quality of care, self-reported health outcomes and patient satisfaction, with an emphasis on equitable access to care for underserved communities and the effectiveness of audio-only care. DHS took responsibility for collecting information from public program enrollees and the providers who serve them. Clinical outcomes, including symptom reduction or improvements in functioning, were not assessed in the preliminary study.

As a direct expansion of the legislative request, under Laws of Minnesota 2021, First Special Session, Chapter 7, Article 6, Section 27 (the legislation mentioned in the previous section that required telehealth studies), this report aims to further examine the following, specifically in comparison to an audio-visual telehealth mode:

(3) whether audio-only communication as a permitted option for delivering services (i) supports equitable access to health care services, including behavioral health services, for the elderly, rural communities, and communities of color, and (ii) eliminates barriers to care for vulnerable and underserved populations without reducing the quality of care, worsening health outcomes, or decreasing satisfaction with care;

This report was prepared by the Office of Medicaid Medical Director (OMMD) in the Health Care Administration. Information was gleaned from a variety of sources and each subsequent section will provide additional detail.

IV. Findings

This report centers on a qualitative analysis of perceptions and experience of those interacting with audio-only telehealth services, either as a consumer or a provider. The analysis is further narrowed by focusing primarily on audio-only services for behavioral health and/or substance use services.

¹ [Telehealth Services](#), Minnesota Health Care Programs Provider Manual

A. Patient experience

DHS used interviews and surveys to capture feedback from a variety of patients who have used audio-only and audio-video telehealth services. The feedback was gathered through in-person and virtual community conversations, emailed surveys, as well as structured interviews conducted with researchers over Zoom.

Audio-only telehealth research

Wilder Research² conducted virtual interviews with Medical Assistance (MA) and MinnesotaCare enrollees between March and April 2024 to gather detailed, nuanced information about their experiences receiving behavioral health care through audio-only (or “phone-only”) telehealth. To be eligible to participate in an interview, individuals had to be currently or recently enrolled (i.e., in the past 18 months) in Medical Assistance or MinnesotaCare, be at least age 18, and have received care over the phone (without a visual component) about mental health or substance use in the last 18 months. Individuals were still eligible to participate if they had also received audio-visual care, as long as some of their visits had been audio-only. In all, 30 individuals took part in the study. Of these, 70% were between age 40 and 59, and 80% identified as female. Fifty-five percent of respondents identified as White, and 45% identified as either Black (10%), Native American (10%), multiracial (20%), or another racial or ethnic identity (5%). All respondents reported speaking English as their main language at home. Two-thirds of respondents lived in the seven-county Twin Cities metro area, and one-third lived in Greater Minnesota.

Table 1 – Demographics of Interviewees

	Percent of respondents
Age	(N=30)
18-29	0%
30-39	10%
40-49	33%
50-59	37%
60 and over	20%
Gender identity	(N=30)
Female	80%
Male	20%
Another identity	0%
Geography	(N=30)
Seven-county metro area	66%
Greater Minnesota	33%
<i>Rural Minnesota*</i>	<i>17%</i>

² <https://www.wilder.org/wilder-research/services/>

Race and ethnicity	(N=29)
Asian	0%
Black	10%
Hispanic	0%
Multiracial	20%
Native American	10%
White	55%
Another race or ethnicity	5%

Study respondents tended to report regular use of audio-only telehealth, including half who used this form of care eight or more times in the last 18 months, and nearly one-quarter (23%) who used it five to seven times. In addition, while 59% began using audio-only telehealth three to four years ago, during the height of the COVID-19 pandemic, 30% started using this form of care more recently, and 11% used it even prior to the pandemic.

Table 2 – Frequency of audio-only telehealth services

	Percent of respondents
Frequency of audio-only telehealth use in the past 18 months	(N=30)
1-2 times	10%
3-4 times	17%
5-7 times	23%
8 or more times	50%
Years of audio-only telehealth use	(N=27)
2 years or less	30%
3 years	11%
4 years/since pandemic	48%
5 years/since before pandemic	11%
Additional modes of behavioral health care	(N=30)
Phone only	3%
Phone and video telehealth	80%
Phone and in-person care	67%

When asked about the ways in which respondents received behavioral health care, nearly all (97%) used a combination of care by phone as well as by video and/or in-person. Respondents frequently mentioned engaging in video visits (80%) in addition to audio-only care, and about two-thirds of respondents (67%) also utilized in-person visits. Forty-three percent of respondents said that half or more of their care is provided through audio-only visits, with BIPOC respondents and those living in the metro area being slightly more likely to indicate this ratio of care mode.

The majority of respondents indicated individual therapy (80%) and medication management (80%) as the types of care they received through audio-only visits. Far fewer respondents said that their phone visits included diagnostic assessments (17%) and just one respondent said that they engaged in family therapy through audio-only care.

Respondents were asked to share the top three symptoms that they wanted to work on when they first started using audio-only telehealth. Respondents most commonly identified anxiety, including panic attacks (77%), and depression (50%), among the symptoms they wanted to address. Some respondents also mentioned PTSD (27%) and ADHD (13%) as a focus of their mental health care. Just one respondent specifically mentioned substance use, though this topic was touched on in other interviews. A few also said that they used audio-only care for medication management (13%). In addition to these diagnosis-focused targets of care, nearly one-quarter of respondents (23%) expressed wanting to receive support for their mental health more broadly, including developing coping and emotional regulation skills or learning tools to improve their overall well-being.

Ninety percent of respondents indicated that they feel comfortable with describing, and asking questions about, their mental health and/or substance use symptoms during audio-only visits. Of the 27 participants who reported that they were comfortable describing and asking questions about their symptoms, six (22%) indicated that they actually preferred discussing their symptoms over the phone rather than through a video or in-person visit. Three of these participants specifically preferred discussing symptoms via audio-only because of their anxiety, self-consciousness, or fear of judgement.

“I feel it’s very easy to do. There is no difference whether we’re on a phone call or in person. We’re able to give the same information and sometimes it’s easier because you can prepare for the call and have notes ready to go and a script of what you want to talk about in the session and it helps you make an agenda and get all of the topics you want to talk about out and on the table. That allows you to cover everything during the session.”

Ten percent of respondents reported feeling unsure or not good about describing and asking questions about their behavioral health symptoms during audio-only visits. Of the two who felt unsure, both indicated that their confidence or comfort would depend on the circumstances around the visit. One noted that their established history with the provider would affect their comfort level, as would the time allotted for the visit. The other participant who was unsure noted that their comfort level conversing about symptoms would depend on the situation driving the visit, with more chaos in the patient’s life (e.g., initiating or returning to substance use) making communication potentially more difficult. The participant who reported feeling not good about describing and inquiring about symptoms reported difficulty explaining their symptoms without being able to rely on non-verbal gestures: “Sometimes, with mental health, some things that are not said are understood anyway, but it doesn’t get caught when you’re over the phone.”

Study participants were asked to assess whether they received the information they needed to manage their behavioral health symptoms or condition through their audio-only care. Nearly all participants (93%) indicated that their informational needs were met through audio-only care. Participants noted that, in some cases, they were able to get referrals to adjunct services, or their providers would follow up with resources via email. In other cases, participants reported having an easier time managing the information being shared, for example by taking notes on their computer during or after the call: “I can just hop on the computer and take notes and not think about a long trip back home.”

Researchers also asked participants whether audio-only care is sufficient to meet their care needs around mental health and substance use. More than three-fourths (79%) of the 29 respondents who answered the question reported that audio-only care is sufficient. Respondents emphasized the particular value of audio-only care as a

way to provide therapy (vs. physical health care), to increase access to care from a logistical perspective, and to increase patient comfort when face-to-face interaction might be uncomfortable. The remaining respondents reported that audio-only care is not sufficient to meet their behavioral health needs. A few of these respondents emphasized the value of having a visual component, especially during therapy.

In all, 83% of respondents reported that audio-only care had the hoped-for outcome. Respondents who provided detail about these outcomes described: quicker engagement in care among their children, a decrease in time away from work (which would reduce their pay), the benefit of feeling a human connection in the home, reduced substance use, and quicker response times from providers.

Study participants were asked to indicate, based on their experiences receiving behavioral health care services via audio-only telehealth, the extent to which they were satisfied with these services. Of the 29 participants who responded to this question, all indicated that they were satisfied.

“Telehealth services have been great. I see no downside to it.”

“I’m 110% satisfied. I almost panicked when a couple of providers said that insurance wasn’t going to continue to pay for phone-only telehealth. It’s been such a positive thing and made such a difference, why would we go backwards?”

“If everyone in the state had it, it would be best practice.”

A few respondents gave caveats to their satisfaction. Three respondents noted that while they were satisfied with audio-only care, they still prefer to have multiple care modes available. One explained, “Phone-only is not sufficient enough to meet the mental health care needs, but it works in a pinch.”

Overall, 90% of respondents reported that they would recommend audio-only behavioral health care to their family and friends. Most responses were enthusiastic (“Absolutely!”), and three participants reported that they had already recommended audio-only care. A theme among a few respondents (20%) was that whether they would recommend audio-only care would depend on the friend or family member’s needs or diagnosis.

“For people who have a complex about going in person to see a provider or people who are afraid to see someone, a phone call would be excellent for them because you can do it in the privacy of your own home and still be able to get help.”

Three individuals also expressed some misgivings about recommending audio-only care. One noted that they themselves would still prefer in-person care but “if phone only telehealth is the only option then yes, I would recommend it.” Another observed, “I would recommend doing [phone-only care] just in case you have no other option for care – so until you can get access to go in person or [by] video.” The third cautioned, “I would say if this [mental health care] is a new thing for you, I think you need to do it in person until you have it figured out, because it’s scary at first.”

Eighty percent of respondents indicated that audio-only care was as effective as or more effective than other types of care. Of these 24 individuals, more than half (58%) judged audio-only care as about the same as other modes of care delivery, while 42% judged audio-only care to be more effective than other modes.

Among the 14 respondents who said that audio-only care was as effective as other care delivery modes, several described the logistical advantages of audio-only service delivery that made it as effective as other methods for them, primarily the convenience of scheduling and attending the appointment. Some respondents again noted caveats of effectiveness, namely the trusted relationship that must be built with the provider. Additionally, respondents advised that situations where visual cues are important, such as particular types of treatment like Eye Movement Desensitization and Reprocessing (EMDR) or taking certain types of psychiatric medications that require careful monitoring, might make phone-only care a less suitable option.

“For certain situations, it was more effective since sometimes I don’t feel as comfortable being on camera so there would be no other care to get. There’s times when the video is too overwhelming, so, growing up with talking on the phone, it’s more comfortable and gets through the hardship to speak about problems.”

“I felt more comfortable talking. I just come into my bedroom, shut the door, and receive the treatment that I’m going to receive to be able to talk about it.... I’m not worried about, you know, what, I look like. That’s nice thing about the phone as opposed to even video is like, I can see myself in video and so it’s like, you know, guess I should have looked a little better for this, but with the with the phone, you don’t worry about any of that kind of stuff. You just, you know, here’s the call and I pick up and do the appointment and then go back to doing the things that I was doing. So I don’t have any time where I’m sitting in traffic or sitting in a lobby, so that’s comfortable and I also am in my own home in my own environment where generally, I do feel safe, comfortable, and at peace.”

Over half (57%) reported that they would be comfortable continuing with audio-only care (“I wouldn’t mind doing phone full-service”), with 17% specifying that they prefer audio-only care. In contrast, 13% of respondents indicated that they are not comfortable continuing with audio-only care and would prefer video or in-person services. Just under half (47%) of respondents reported that they would like to have a mix of care modes available to them, whether that be audio-only, video, or in-person.

While statistical analysis by demographic variables is not feasible given the sample sizes and qualitative nature of these data, there were some patterns by geography and race/ethnicity in participants’ preferences about continuing with audio-only care. A slightly higher proportion of metro area respondents and White respondents said they were comfortable continuing with audio-only care when compared to respondents from Greater Minnesota and BIPOC respondents, respectively. Specifically, 60% of respondents from the seven-county Twin Cities metro area reported that they were comfortable continuing with audio-only care, compared to 50% of respondents from Greater Minnesota. Additionally, 69% of White respondents reported that they were comfortable continuing with audio-only care, compared to 54% of BIPOC respondents.

Another geographic and racial/ethnic pattern was that a higher proportion of White respondents and respondents from Greater Minnesota prefer having a mix of care modes available to them compared to BIPOC residents and metro area respondents, respectively. Specifically, 60% of respondents from Greater Minnesota reported that they would like access to a mix of care modes, compared to 35% of respondents from the metro area. And 50% of White respondents reported that they would like access to multiple care modes, compared to 38% of BIPOC respondents.

Overall, 87% of respondents identified improvements in their behavioral health symptoms as a result of receiving audio-only care. Many respondents described improvements in their anxiety and/or depression symptoms and more effective coping skills to manage their symptoms. Some respondents described better medication management, which helped to improve their symptoms. A couple also shared that they have been able to maintain sobriety because of the care they received. Specific benefits of audio-only care that led to symptom improvements include convenience, consistency, and more rapid responses from providers. However, others specified that these improvements were due to the overall quality of care and relationship with their providers, regardless of the mode of care.

“I’m better able to recognize when I’m having symptoms and catch them early. And I am more accepting of things when they come. And having trust [that] it will be ok. So, it’s a huge difference.”

“I haven’t had an episode of depression in quite some time because there’s people to reach out now that weren’t there beforehand. I never had people before to just call so it’s been a positive experience.”

“Anxiety was bad but having phone sessions with the therapy over time was helpful—for example using the therapy work in public to calm down at that moment.”

“I was able to keep up with the appointments a lot easier, and then we were able to figure out which medication wasn’t working and the side effects. We ended up changing a couple different times, but it was a lot easier to have her call me. I knew when to expect the phone call and I could watch for it. That really helps with all my phobias.”

Despite half of respondents stating that the nature of their mental health condition fluctuated from time to time, 81% of those who reported an improvement in symptoms said that these improvements sustained over time. Some respondents described experiencing changes that have sustained over months, while others over years. In many cases, individuals described being better equipped to manage difficult periods and recover more quickly because of the care they have received. Four respondents discussed increased feelings of isolation and less accountability due to not having in-person sessions with their provider.

Audio-only telehealth resulted in considerably positive impacts on quality of life:

- 93% of respondents identified increased independence and confidence in taking care of their daily needs, both because of decreased behavioral symptoms and because of the convenience of audio-only telehealth services.
- 86% of respondents reported that audio-only telehealth helped improve their ability to handle stressful situations, primarily due to the improved coping skills they learned from their behavioral health care.
- Two-thirds of respondents felt that their audio-only telehealth care improved their ability to participate in the community. Many respondents identified greater comfort in social situations due to decreased anxiety symptoms and improved boundaries. 30% did not see a change – typically because it wasn’t an area of focus in the care – and one participant experienced a decline.
- Sixty percent of respondents reported that their ability to get along with others improved because of their audio-only telehealth care. Some respondents felt that their improved symptoms, including emotional

regulation, led to improved relationships, particularly with family. A couple of respondents received care along with their family members, which helped to improve relationships.

Forty percent of respondents mentioned convenience as the greatest advantage of audio-only care. The convenience was multi-faceted but often related to not needing transportation or internet connection. There was the additional benefit of not needing to arrange for childcare. One in four respondents believe audio-only care increases access to behavioral health services overall. While some people have in-home internet access, those who depend on public internet sources like libraries, for example, lack the necessary privacy to be able to do telehealth services over video. Of those who noted issues with internet connections, location was not a significant co-occurrence and respondents from the Twin Cities experienced this barrier as well as those from Greater Minnesota. Some of these respondents added that they appreciate being able to utilize audio-only care when they are away from home, or when the video connection during a telehealth visit cuts out.

Audio-only visits also provided significant opportunity for patients to participate in the session with lower anxiety for multiple reasons. Respondents reported just feeling more relaxed in their own home or had reduced anxiety because there is no need to stress over transportation arrangements, for example. Multiple respondents noted that audio visits allowed them to prepare for the visit differently, and they were more likely to be ready with questions and organize their thoughts in advance of the call. The flexibility of not needing to be on video also allowed some respondents to be able to not be self-conscious or worried about their appearance. Just under one in five respondents (17%) noted that they felt able to be more vulnerable and share more openly without video. Another respondent appreciated the ability to be able to walk during the appointment, as this was a coping mechanism for panic attacks.

“It saved me a lot of time because the appointments with a psychiatrist are 10 to 20 minutes, and I do not have access to a car, so I have to take medical cab rides, and I have to schedule that, and all the time related to trying to get there. And then the medical cab ride sometimes gets you there an hour before your appointment and you're waiting, and then it sometimes takes an hour to pick you back up sometimes to go home.”

“That's my major thing—that it is more accessible for people. And when you're disabled and low-income, lack of accessibility can be quite a barrier to receiving the treatment that you need. Who wants to be surviving; we all want to be able to thrive, right?”

In terms of disadvantages to audio-only care, the sentiment that other modes of care better supported relationship building was most commonly cited (23% of respondents). One respondent noted that language or cultural barriers may be exacerbated if the provider is unable to also use visual cues. Nearly half (43%) felt there were no significant downsides to audio-only care.

Interview respondents were generally in favor of audio-only care and many recommended efforts to increase availability and promote its use. Respondents also supported continued insurance coverage as well as training for providers to ensure quality of care. Several respondents expressed concern over the discontinuation of federal cell phone assistance programs, which would have far-reaching implications beyond the availability of telehealth services. Poor cell phone reception in rural areas was also noted. Patients also suggested changes to licensing rules so that they could receive care with their established and trusted provider while temporarily being out of state.

Community Conversations

Pathways to Racial Equity in Medicaid

As part of its broader work to centering its population health priorities in communities impacted by structural racism, DHS contracted with Marnita’s Table to facilitate community conversations as part of creating the Pathways to Racial Equity in Medicaid: Improving the Health and Opportunity of American Indians in Minnesota report. Participants in the conversations held virtually and in-person in Duluth, Bemidji, and Minneapolis were asked specifically about their experiences with audio-only telehealth. Virtual participants in particular noted the impact of cell phone reception “dead spots” and considerable gaps in Wi-Fi/broadband service when trying to access telehealth services.

Participants generally were supportive of audio-only services in terms of quality and convenience and advocating for Medicaid prioritizing telehealth accessibility and culturally competent care. However, several mentioned that their telehealth experience lacked the same kind of connection with the provider, and they preferred in-person visits when possible, especially when more comprehensive care is needed.

One conversation group discussed the impact of the availability of audio-only services on elders and those who may be hearing- or vision-impaired. It was also noted that many people in this situation, especially elders, will simply nod in agreement when in actuality they may simply be avoiding the shame of acknowledging they don’t understand. They expressed concern that perhaps these individuals do not have adequate awareness of the benefits of audio-only telehealth, and may need additional training on how to use the technology appropriately.

Health Services Advisory Committee (HSAC)

Staff from the Office of Medicaid Medical Director (OMMD) presented at the May 8, 2024 meeting of the Health Services Advisory Council (HSAC).³ The presentation primarily addressed previous and ongoing work related to audio-only telehealth and provided preliminary draft recommendations for consideration and feedback.

Committee members shared that, especially in rural areas, many patients are older and have difficulties with technology needed for telehealth. Despite those challenges, telehealth will be an integral part of care delivery going forward, particularly as providers continue to retire and can be difficult to replace.

One of the consumer representatives on the committee articulated their personal experience with both audio-only and audio-visual telehealth services. In more than one case, the member had a very strong rapport with the provider during in-person visits prior to the pandemic that was not positively impacted by telehealth. The provider's ability to focus on the visit changed, especially if the provider was working from home and had other distractions (kids, doorbell, etc.). They also shared an example of being told by one provider that a particular visit type was now currently only offered through audio-only, even if it wasn't going to be beneficial for the patient to

³ <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/health-services-council/>

be able to take in the information most effectively. The member felt strongly that the patient should have the choice of which modality to use, particularly when “hidden” issues like the patient’s ability to lip-read or rely on other visual cues may be affected.

While not part of the initial scope of this report, the HSAC also had a robust discussion on the use of artificial intelligence (AI) and machine learning. Members relayed experience and knowledge of previous and ongoing AI and machine learning work related to psychiatry, as well as dictation and chart entry. Issues of consent were also raised, such as ensuring the patient knows that AI is being used and whether acknowledgement of accuracy does or should take place. A consumer member indicated that patients may be willing to use AI if it means similar outcomes and shorter wait times, rather than booking a visit with an in-person human provider.

Survey

As part of this report, NAMI Minnesota created a survey to gather information about experiences with audio-only care. Invitations were posted on NAMI’s social media pages and sent via a targeted email. 176 individuals responded to the survey. As there was no interest in participating in a focus group, some interviews were conducted over the phone and their responses were entered into the survey tool.

All survey respondents had used audio-only services, and 84% had also met with a mental health professional over video call. When asked to rate their experience on a scale of 0 to 10 with 10 being the high score, similar percentages of respondents gave a score of 6 or above for audio-only compared to video calls (82.4% and 86.2%, respectively).

Reasons respondents liked audio-only care included convenience, ease of use, the ability to avoid traveling (especially in winter), flexibility in scheduling (including when appointments may have been forgotten), anonymity, and being able to take a call from the comfort of their home. Additional reasons cited were not having to worry about their body language or their personal appearance or appearance of their home, as well as the option to be able to connect quickly in a crisis. Audio-only was also very helpful when the patient’s video or internet was not working.

The biggest downsides to audio-only care frequently centered on feeling a lack of a personal connection and not being able to visually see the provider. Concerns about interruptions and multi-tasking were also cited.

A striking 93% of respondents would recommend accessing audio-only mental health to others. Ease and convenience were the primary drivers for that recommendation. Several respondents also noted that audio-only care allowed for better continuity of care, provided anonymity by not having to be seen going into a therapist’s office, and offered the opportunity to utilize a provider when no one local is in-network with insurance companies. Another respondent shared that audio-only care was “instant access” and there wasn’t the opportunity to turn your car around and go home when the prospect of in-person care was too overwhelming, which would prevent the patient from receiving the services they need in the moment.

Overall patient experience themes

In addition to the oft-noted advantages of convenience and ease of use, the following themes emerged across all patient experience feedback gathered for this report:

- Need for additional training for patients and providers
- Importance of a trusted relationship with a provider
- Determination of types of visits and topics that are most appropriate for audio-only visits
- People report a similar perceived efficacy between audio-only and audio-video services
- Audio-only should be an option until internet access is more consistently available and reliable

B. Provider experience

DHS engaged with KA Nicholas Consulting to conduct interviews with four organizations who received additional telehealth funding as part of their grants to promote and implement Culturally and Linguistically Appropriate Services (CLAS) standards. Telehealth plays a vital role in realizing the National CLAS Standards, a set of 15 standards intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.⁴

Systematically marginalized communities often experience the health disparities that CLAS standards seek to alleviate. Systemic oppression creates barriers to receiving health care, like increased time burdens, lack of or inconsistent health insurance, and lack of safety in public spaces, as well as barriers to accessing education and employment pathways to work as licensed mental health providers. CLAS telehealth helps alleviate these barriers.

Providers at these organizations recognized the positive impact telehealth services had on reducing geographic, transportation, and time barriers when accessing care. In particular, telehealth reduced barriers for those who lack access to a flexible work schedule, paid time off, or transportation; or do not feel safe in public spaces due to the risk of deportation or abuse based on race, ethnicity, gender expression, sexual orientation, etc.

Providers discussed the benefits of telehealth for clients with post-traumatic stress disorder (PTSD), mobility barriers, or those prone to canceling appointments due to anxiety and depression. For these clients, activities associated with leaving the house, traveling to appointments, and feeling exposed to the public eye or being in unfamiliar spaces are significant barriers to accessing care.

The safety, privacy, and cultural responsiveness of CLAS telehealth services are particularly beneficial for survivors of domestic or sexual violence and clients with severe anxiety. These clients can receive support without the fear of being seen or followed to a physical location, thereby reducing stress and making it easier to engage in therapy.

⁴ [CLAS Standards - Think Cultural Health](#)

“I have clients who have crazy schedules, or they have such intense mental illness that it’s hard to leave the home. That’s when they need it most. It shouldn’t be a barrier to not get services when you can’t leave the home because of their mental health.”

— Change, Inc. interviewee

Warm lines, such as those offered by Wellness in the Woods (WitW), provide care and support outside traditional business hours and separate from hospital emergency departments. WitW staff noted frequent night calls, especially from individuals with PTSD, and that these calls are even more common among new Americans who experienced traumatic events during their migration journey.

Many of the CLAS grantees have bilingual providers on staff, which strengthens the therapeutic relationship and facilitates more effective communication for patients and their families. Access to these bilingual providers in a home setting via telehealth often mitigates the reliance on family members serving as interpreters. Additionally, when clients and providers don’t have to rely on interpreters there is more privacy, less frustration, and fewer misunderstandings. Being able to communicate without a third party also saves time for both the client and provider. Less reliance on interpreters also benefits the provider’s organization, because it addresses frustrations associated with Minnesota’s Language Line such as limited availability of interpreters, frequent interpreter cancellations, and the cost of having to reimburse the language line for services when a client cancels or no-shows.

In addition, the Language Line may not be able to accommodate regional dialects or provide interpretation support for multilingual families. For example, many people from Central and South America speak unique Spanish dialects or speak Spanish as their second language. An interpreter who is unfamiliar with the client’s dialect may misinterpret regional sayings or metaphors, affecting the quality of care and potentially leading to misdiagnosis. Providers who are skilled in CLAS standards familiarize themselves with different dialects and regional expressions, ensuring they can communicate effectively and empathetically with clients from various backgrounds.

One in four mental health and substance abuse counseling jobs in Minnesota is unfilled, according to a 2022 study by the Minnesota Department of Health.⁵ To address this shortage, organizations have used CLAS telehealth funding to hire or contract with providers from other states and U.S. entities (e.g., Puerto Rico) who are licensed in Minnesota or are willing to become licensed. This expands the pool of providers to be representative of the diverse communities within Minnesota and increases capacity to meet demand for services. Telehealth also helps organizations retain staff when providers need to relocate or have life changes that make virtual work more attractive.

Telehealth that meets CLAS standards gives clients access to a larger provider pool which makes it easier to schedule appointments at times that work for the client’s schedule. The option to conduct initial assessments and ongoing therapy sessions through telehealth reduces the wait time that clients might otherwise face for in-person appointments, thus decreasing the likelihood a client will cancel or miss an appointment. The shorter wait times also make it easier for people to seek care before their symptoms become severe.

⁵ [PANDEMIC-PROVOKED WORKFORCE EXITS, BURNOUT, AND SHORTAGES](#)

Providers noted a decrease in no-shows and cancellations as a result of being able to have a virtual session when the provider or client needs to stay home due to minor illness, transportation barriers, caregiving responsibilities, or when travel is difficult because of weather conditions. This allows for greater continuity of care, increased access to care during times of instability, and supports the therapeutic relationship.

Telehealth that meets CLAS standards removes barriers, in particular by supporting technology literacy. This allows families, especially elders and recent immigrants, to use telehealth to address other health care needs, use virtual platforms to better advocate for their students and support their children's education, and find work using their increased technology literacy.

CLAS telehealth grants have allowed organizations to invest in the tools and administrative time to provide high quality care. Organizations have used these grants to provide desktop and mobile friendly platforms for virtual sessions, develop instructional guides for providers and clients in multiple languages, and purchase tablets or computers clients can use to access care.

Despite the perceived benefits of increased technology literacy, many clients are still unfamiliar with using telehealth platforms, which can lead to difficulties in logging in or staying connected during sessions. This means providers spend additional time walking clients through the steps to access telehealth services, sometimes in-person before transitioning to virtual sessions. Providers noted they bore the cost of a gap created by a decrease in billable time for service delivery when they engage in training and onboarding. Providers identified the ability to bill for the time gaining CLAS telehealth competency as essential to making this modality of telehealth sustainable.

“Telehealth has the opportunity to completely enhance someone's experience if they have some education and orientation about how to operate telehealth, what to do if one of our internet connections disconnects, and how to get a hold of each other. If you have support from a provider, that's how we incorporate justice into our services. But in the absence of education, I think it becomes disempowering or isolating. A client participating in services could feel confused, disoriented, or frustrated if things aren't working on their computer, their device is glitchy, or they don't own a personal computer and the application on their phone isn't the same quality. This could really damage your relationship with the client, or it could enhance the efficacy of the service. It's kind of a make-or-break situation.” - CLUES interviewee

Additionally, offering telehealth means investing in robust telehealth platforms and ongoing technical support to clients to ensure smooth access to services. Organizations are carrying the costs of enterprise level subscriptions to tools like Zoom, Doxy.me, and DocuSign that are essential for providing telehealth.

Providers said they would benefit from ongoing training and professional development to help translate therapeutic best practices into a virtual environment, including relationship and rapport building, and integrating arts-based and play therapy into video calls. Providers who started offering telehealth during the COVID-19 pandemic said they learned these tools on the fly and would benefit from more formal CLAS telehealth-specific training.

“With talking to kids, I have a few middle schoolers on my caseload, and kids know the internet pretty well. They can share things with you, we can watch clips of favorite shows together, relate it to life and therapy in different

ways. Sharing screen, draw, share a whiteboard. They can draw for me what they're talking about." - Change, Inc interviewee

Training topics should include the technical elements of telehealth including using the tools and technology, supporting clients with low technology literacy, creating safety plans that work in a virtual environment, and training to address emerging and evolving challenges such as Zoom-bombing. Additionally, further guidance and promising practices gathered around the best infrastructure for desktop and mobile viewing would greatly support the organizations doing CLAS telehealth work.

Children with ADHD, Autism Spectrum or other behavioral issues can find it hard to stay engaged during virtual sessions, and some clients lack intrinsic motivation to participate actively in telehealth services. Providers have adapted by incorporating interactive elements and activities into sessions, using digital games or art activities to keep them engaged. They also set clear expectations with clients and parents about the structure and participation required in telehealth sessions, and follow up with parents separately to discuss progress and address any concerns. This level of expertise requires training resources and the investment of training time for providers to gain the unique telehealth skillset required to create a strong continuum of care and increase health equity.

VI. Report recommendations

Recommendations stemming from this report are in keen alignment with existing recommendations across previous DHS work^{6,7} and with the Study of Telehealth Expansion and Payment Parity from the Minnesota Department of Health released in September 2024.⁸

1. Extend audio-only telehealth in statute and maintain parity coverage for audio-only telehealth services

Maintaining parity coverage for audio-only telehealth services is a strong theme across the qualitative research conducted as part of this study, and it also would be consistent with the Centers for Medicaid and Medicare Services (CMS) Proposed Fee Schedule for Medicare for Calendar Year 2025.⁹ Recommended in the initial telehealth report as well, extension of audio-only telehealth as a type of telehealth service permanently in statute is necessary in providing essential health care for members, and can address access issues.

2. Consider funding for providers to help patients prepare for telehealth

Patients seek providers with whom they already have a trusting relationship. Providers would be well positioned to offer a “digital coaching” approach to ensure patients have an appropriate understanding of how to correctly use digital technology tools like laptops, videoconferencing platforms such as Zoom, and mobile apps. This can only realistically be done, however, if providers are adequately compensated to provide meaningful education tailored to their organization’s specific telehealth service delivery method(s), policies, and procedures.

3. Fund training opportunities for telehealth providers

Not only do patients need assistance adapting to a telehealth visit, but as noted in MDH’s report, healthcare providers also need additional training to effectively utilize a new and evolving technology and service delivery methods. Patients were very vocal about the need for providers to be both adequately equipped and prepared to provide services via telehealth. Potential training topics include:

- Best practices on telehealth implementation and operations (ex. Data collection and policy compliance)

⁶ [Minnesota Department of Human Services Telehealth Study | Wilder Foundation](#)

⁷ [Assessing Telehealth Utilization and Experiences Among Adult Medical Assistance \(MA\) Enrollees in Minnesota](#)

⁸ [Study of Telehealth Expansion and Payment Parity – Final Report to the Minnesota Legislature 2024, September 2024](#)

⁹ <https://www.cms.gov/files/document/telehealth-faq-calendar-year-2025.pdf>

- Effective use of audio-only telehealth (e.g., visit types best suited for audio-only care)
- New technologies and strategies for audio-only telehealth delivery (e.g., use of video clips, apps)
- Cultural sensitivity
- Health and digital literacy

4. Embed Culturally and Linguistically Appropriate Services (CLAS) standards throughout telehealth awareness efforts and service delivery activities

The importance of incorporating of CLAS standards was a common thread highlighted through the research studies and community conversations. Communicating about the availability of services in people’s first language and highlighting the availability of culturally competent providers is essential. A comprehensive marketing toolkit can help raise awareness of telehealth services while also reducing the cultural stigma found in many communities. In addition to the more traditional connotations of race, ethnicity, and language, CLAS should also be broadened to include geographic diversity as rural and low-income populations struggling with broadband and cell phone coverage face their own unique barriers when accessing care. Using interpreters in a virtual setting or via 3-way call also can present challenges when visual cues are especially important. Despite those challenges, the use of telehealth is also a significant contributor to culturally appropriate care by increasing the availability of culturally specific providers and interpreters in areas where they might not otherwise be permanently located for in-person visits.

5. Monitor risk, impact, and potential opportunities associated with new technology

As technology continues to evolve, the nature of telehealth interactions is also bound to change in response. While AI and machine learning may offer tremendous opportunity, there also may be tremendous risk in adopting those or similar technologies, as identified by the HSAC committee earlier in this report.

This report focused almost exclusively on audio-only behavioral health services. There is a wide range of other clinical and non-clinical services that can also be provided virtually. Other states like Arizona, California, and Colorado have implemented payment methodologies that incorporate telehealth in areas beyond traditional medical and behavioral health services. In the spirit of whole-person care, further analysis of service delivery methods and payment options should be conducted for services such as:

- Dentistry
- Specialty care
- Pediatric primary care
- Emergency/urgent care
- Physical and occupational therapy
- Non-clinical services, such as application assistance for housing and other health-related social needs

VIII. Appendices

Audio-only Telehealth Report



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Pathways to Racial Equity Report



DHS 2024 Pathways
to Racial Equity in Me

CLAS Telehealth Evaluation Report



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