Telemedicine for opioid use disorder treatment in the age of Covid-19

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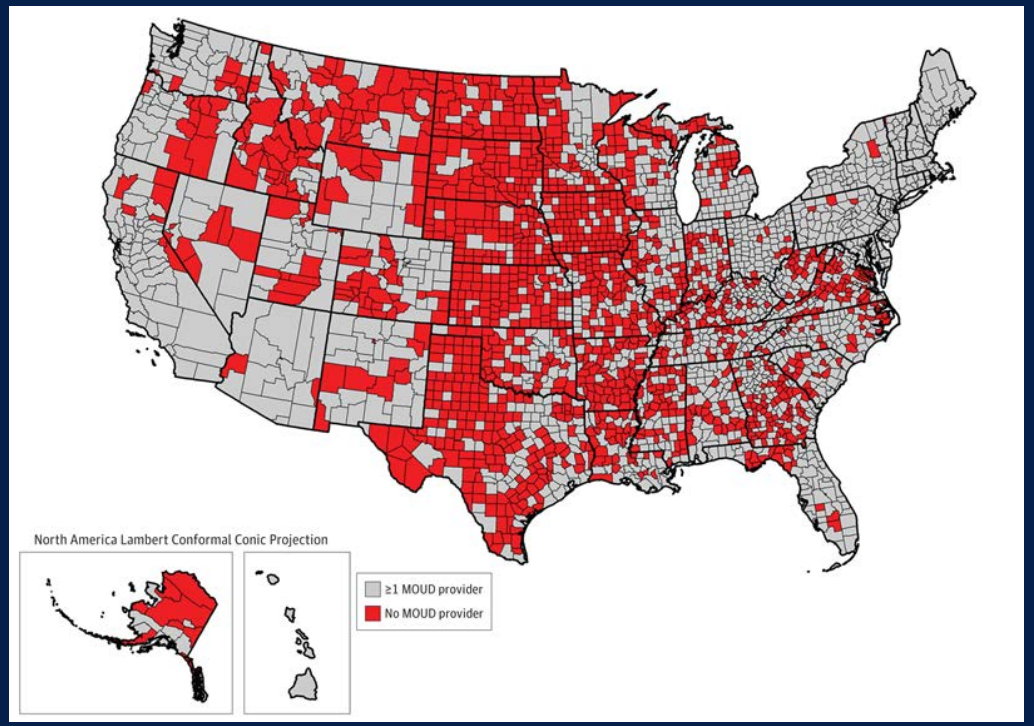
Even before COVID-19, the need for increased accessibility of OUD treatment

- Access
  - Estimates of 20-40% of persons with OUD, perhaps less, receiving effective medication treatment.

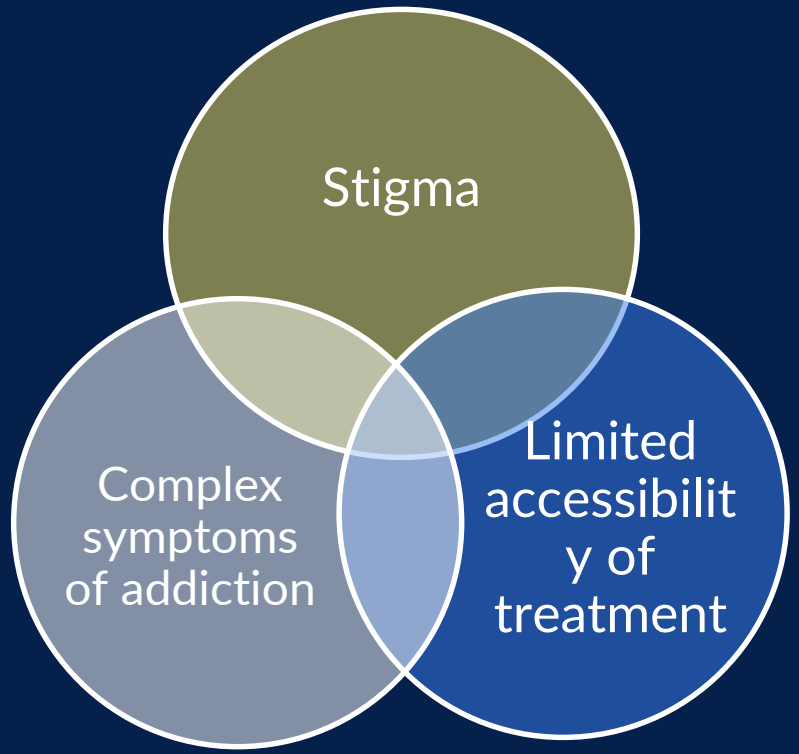
- Sub-optimal Outcomes
  - Even in those who access/start medication treatment, retention is low (< 50% at 3 months of treatment) and there is high risk for overdose and other negative outcomes when patients stop treatment.

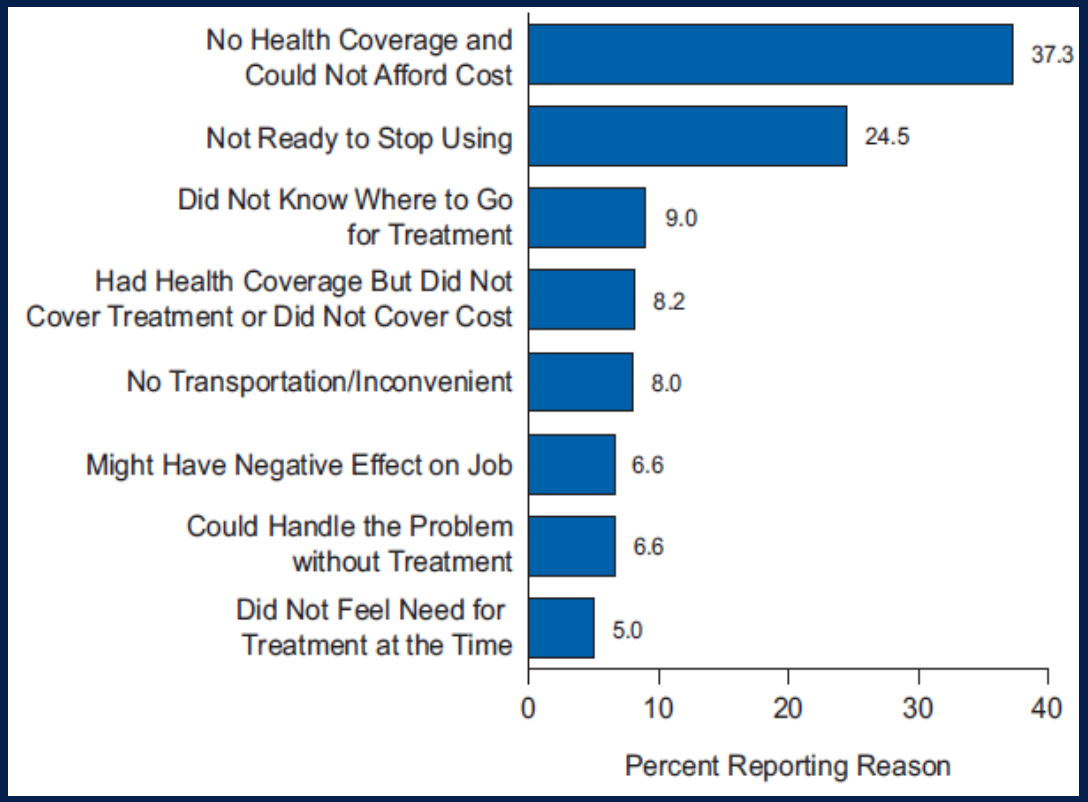


(Haffajee et al., 2019)

Barriers to OUD Treatment

- Despite such extensive negative impacts from OUD, treatment rates have long remained low. The question is why?





(SAMHSA, 2015; Lembke 2016;Morgan 2017;)

Distance a particular barrier for addiction treatment

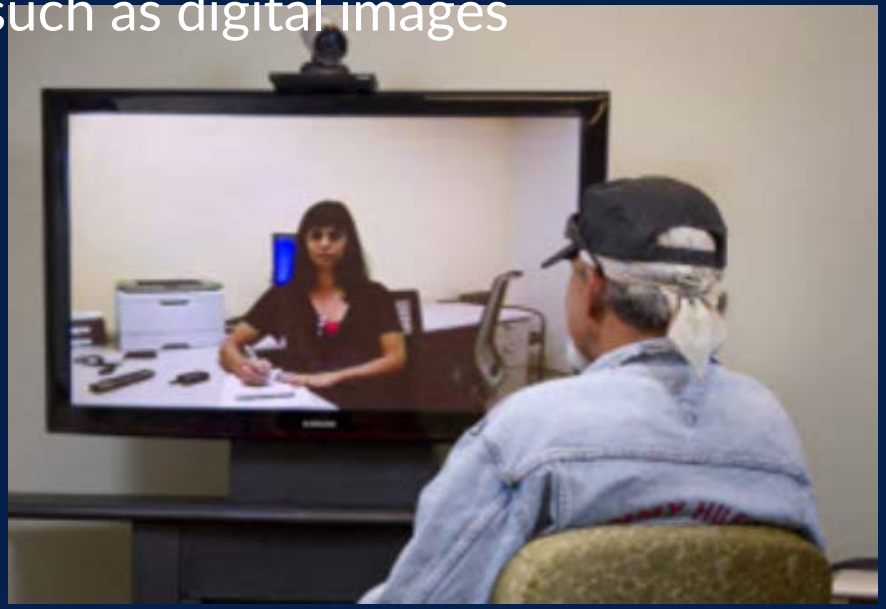
- Distance has been described by patients as a major reason for discontinuing SUD treatment and associated with lower followup for SUD treatment
- Particularly challenging for SUD treatment that often requires frequent (weekly) visits over time and many SUD clinics have practice where they discharge patients if they miss appointments
- Particular barrier for this patient population - “What’s the one thing that could help you engage in treatment?...”

  “That’s easy, a car!”

(Gryczynski et al., 2014; Schmitt et al., 2003)

What is telemedicine?

- Synchronous/live videoconferencing: connects providers and patients in real time for direct care delivery (most common modality reimbursed)
- Asynchronous/store and forward: not ”real time,” allow for electronic transmission of medical information, such as digital images
- Other modalities such as telephone, text or web-based interventions not included

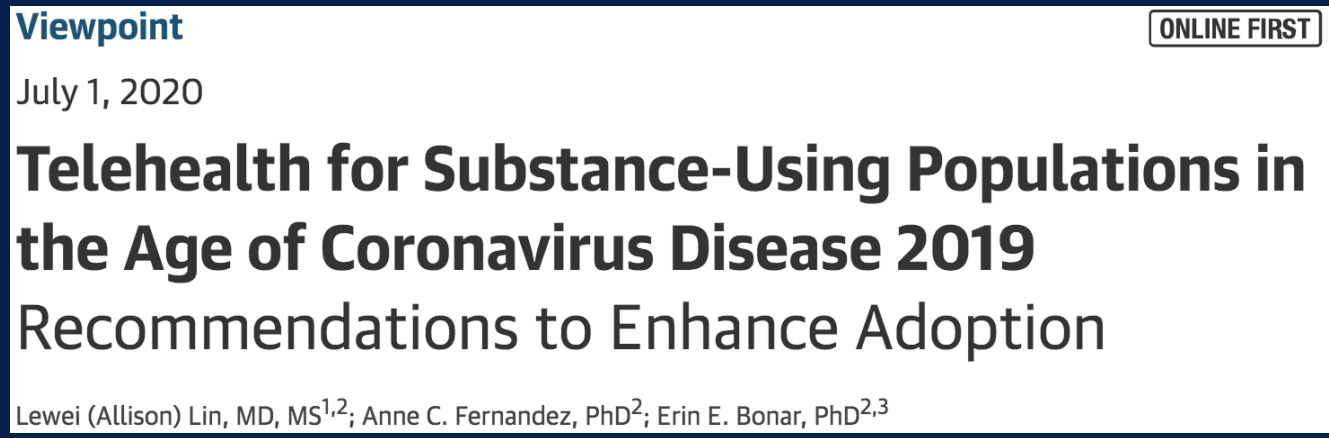


Ryan Haight Online Pharmacy Act of 2008

- Concerns prescribing of controlled medications when provider and patient are not in the same location
- Must conduct an initial face-to-face evaluation unless:
  - The facility where the patient is physically present has its own DEA license
  - Covering provider or emergencies
  - And other exceptions (*including current federally declared public health emergency*)

And then came COVID-19

- Ryan Haight Online Pharmacy Act Exemption during Public Health Emergency
- New guidance and changes from SAMHSA, DEA, payers and others decreasing barriers in :
  - Use of phone visits
  - Take home methadone
  - CFR42 part 2
  - HIPAA
  - Reimbursement
  - Prescribing across states


Viewpoint

ONLINE FIRST

July 1, 2020

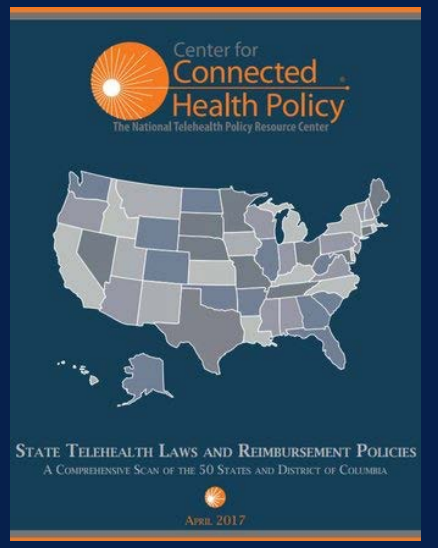
Telehealth for Substance-Using Populations in the Age of Coronavirus Disease 2019

Recommendations to Enhance Adoption

Lewei (Allison) Lin, MD, MS[1,2]; Anne C. Fernandez, PhD[2]; Erin E. Bonar, PhD[2,3]

But barriers still exist and will likely persist after COVID-19

- Urine toxicology testing
- Clinical guidelines on high quality treatment practices
- Adhering to state laws on prescribing controlled medications
- Uncertainty about whether new regulations will persist
- How to treat more complex patients who may at times need higher level of care and you may want to assess in person?
- Interest/comfort level in using telemedicine by clinic staff



https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies

Patient views on OUD telemedicine

- **Patients who have received tele-buprenorphine:**
- “I mean it’s just more convenient… It’s less time that I have to spend to take out what I need to do in life. Like going to (the clinic), it’s kind of rough to have a day off once a week to go to (the clinic) to see a doc and do all of this.”
- “I don’t feel like there’s any more risk or anything like that. I think right now maybe because of the corona situation maybe so”, (getting prescription w/o drug test) , “me personally no it’s not a problem whatsoever”
- The least helpful part is…medication getting lost in the mail, the VA not getting your UDS, you not being home and your medication goes someplace else…that’s real real crazy stuff to happen, you don’t want to wind up with no medication… medication getting shipped out to the right place, someone’s gotta be home to sign”

Questions

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1,2

Implementation of Hub and Spoke Tele-Buprenorphine During the Coronavirus Pandemic

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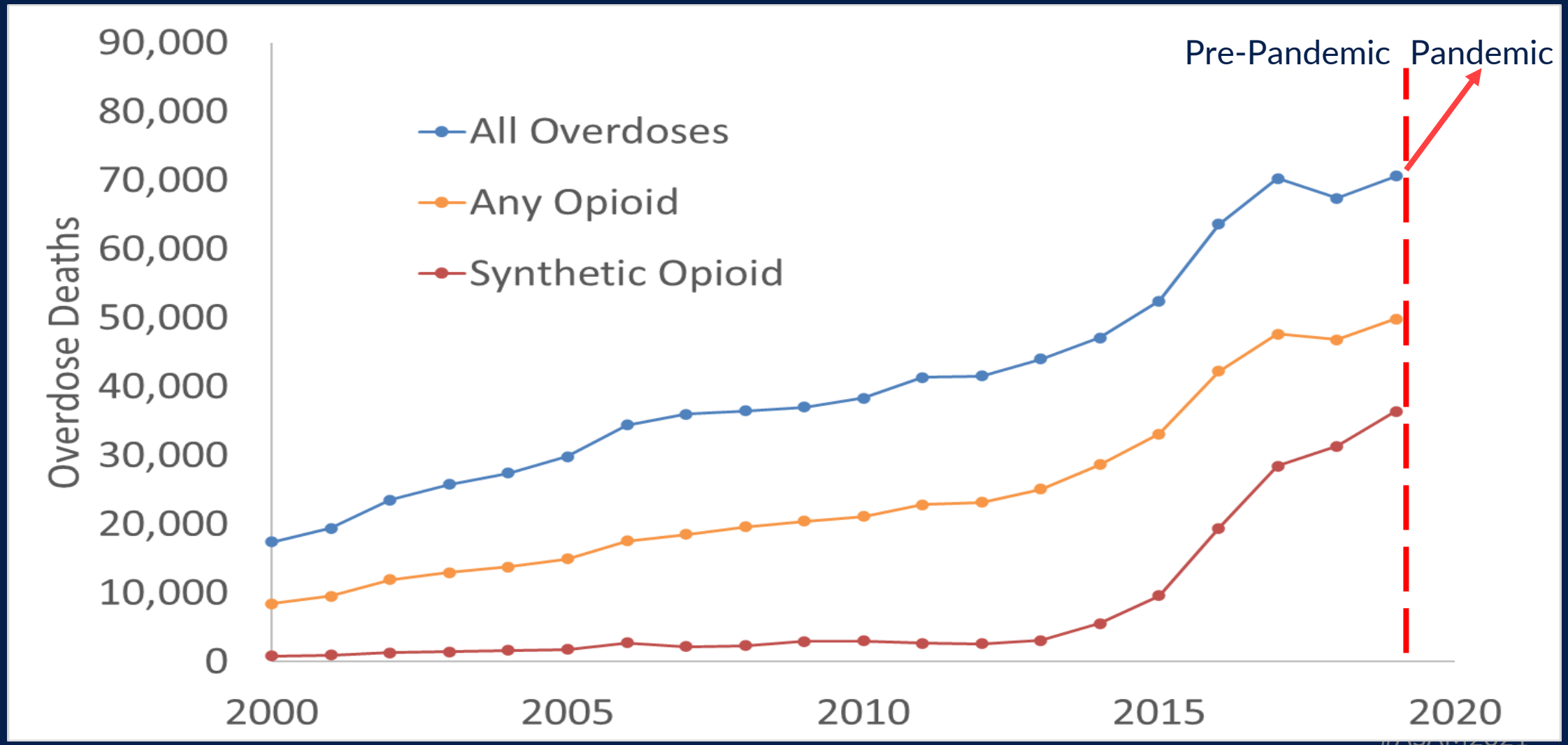
Disclosure Information (Required)

- Presenter 1: David T. Moore, MD PhD
  - Presenter 1 Commercial Interests: Alkermes, payment for consulting

Key Points

- During the pandemic, overdose rates have dramatically increased
- Many communities with increased overdose rates, also have low access to buprenorphine prescribers
- Hub & Spoke Telemedicine can:
  - Accelerate implementation of buprenorphine
  - Increase the resilience of existing buprenorphine services
- Hub & Spoke tele-buprenorphine prescribers need to join larger interprofessional team

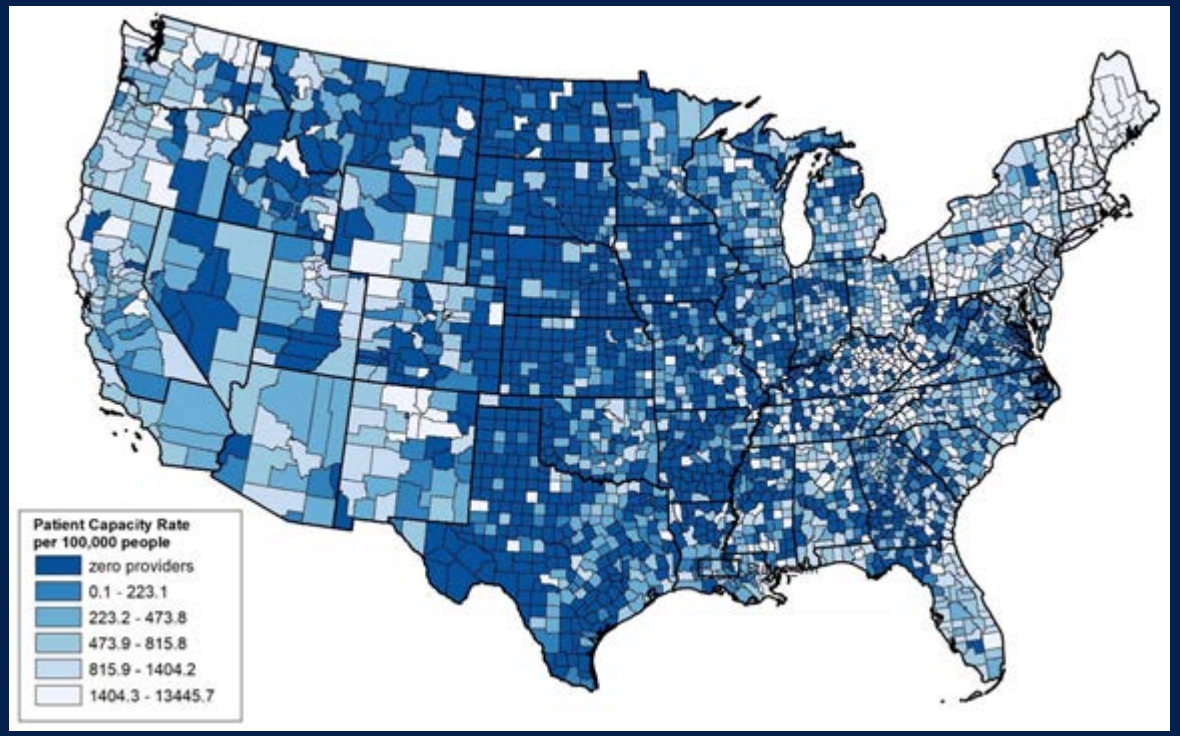
Fatal Drug Overdoses Accelerated During the Pandemic



https://wonder.cdc.gov/mcd.html

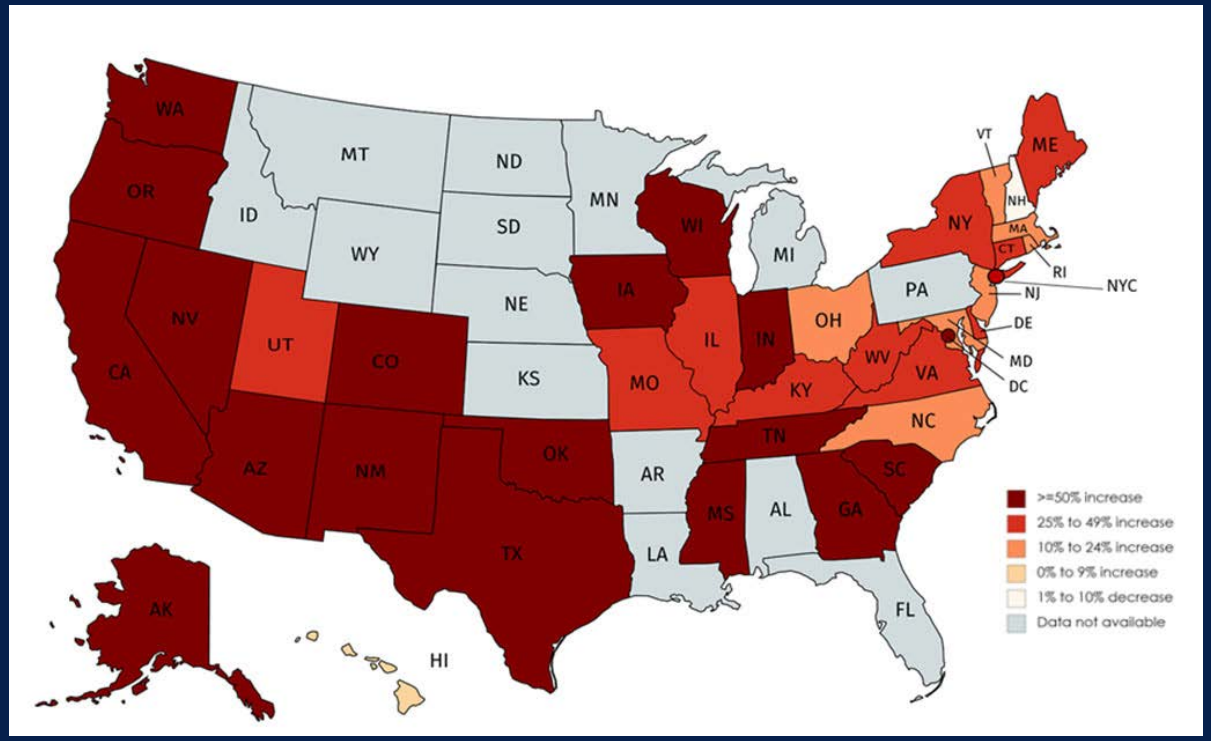
Buprenorphine Access and Overdose Rates Depend on Location

Per-Capita Buprenorphine Prescribers



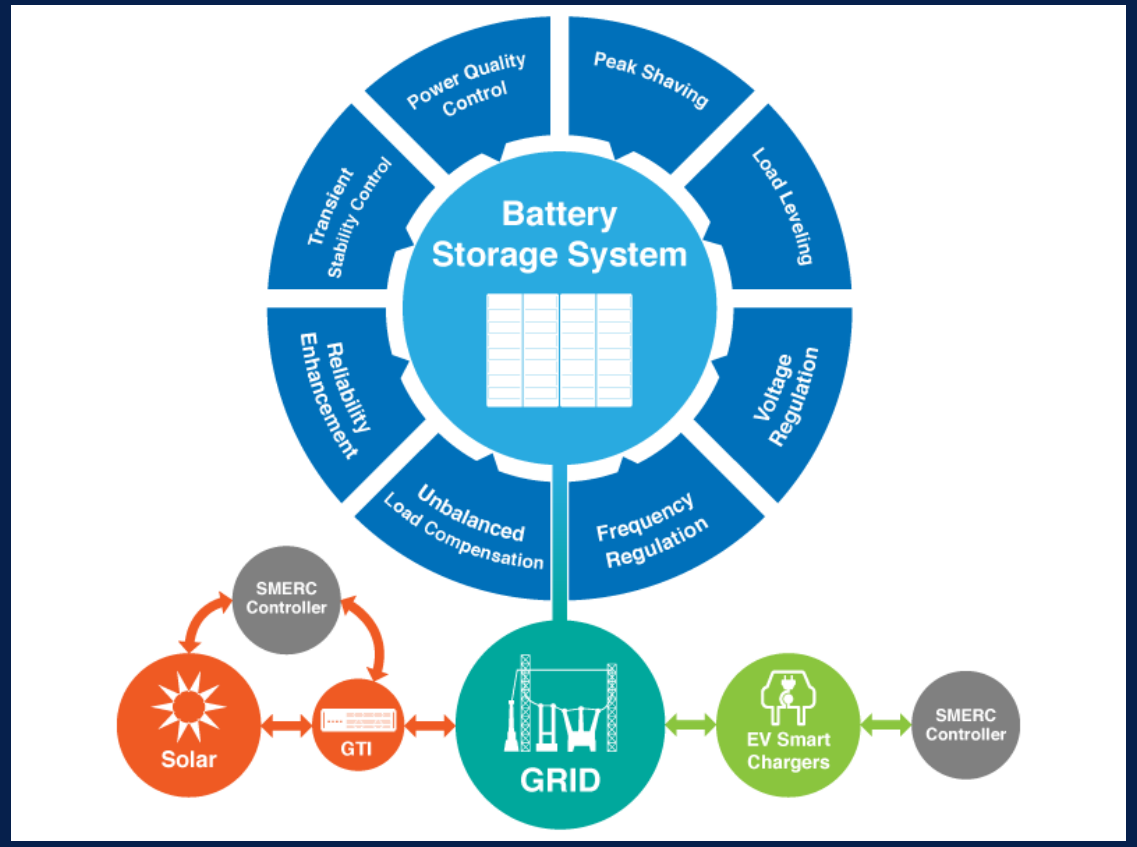
HHS Office of Inspector General. *Geographic Disparities Affect Access to Buprenorphine Services for OUD.* January 2020.

Synthetic Opioid Mortality Increased >98% in Western States (May 2020 vs June 2019)

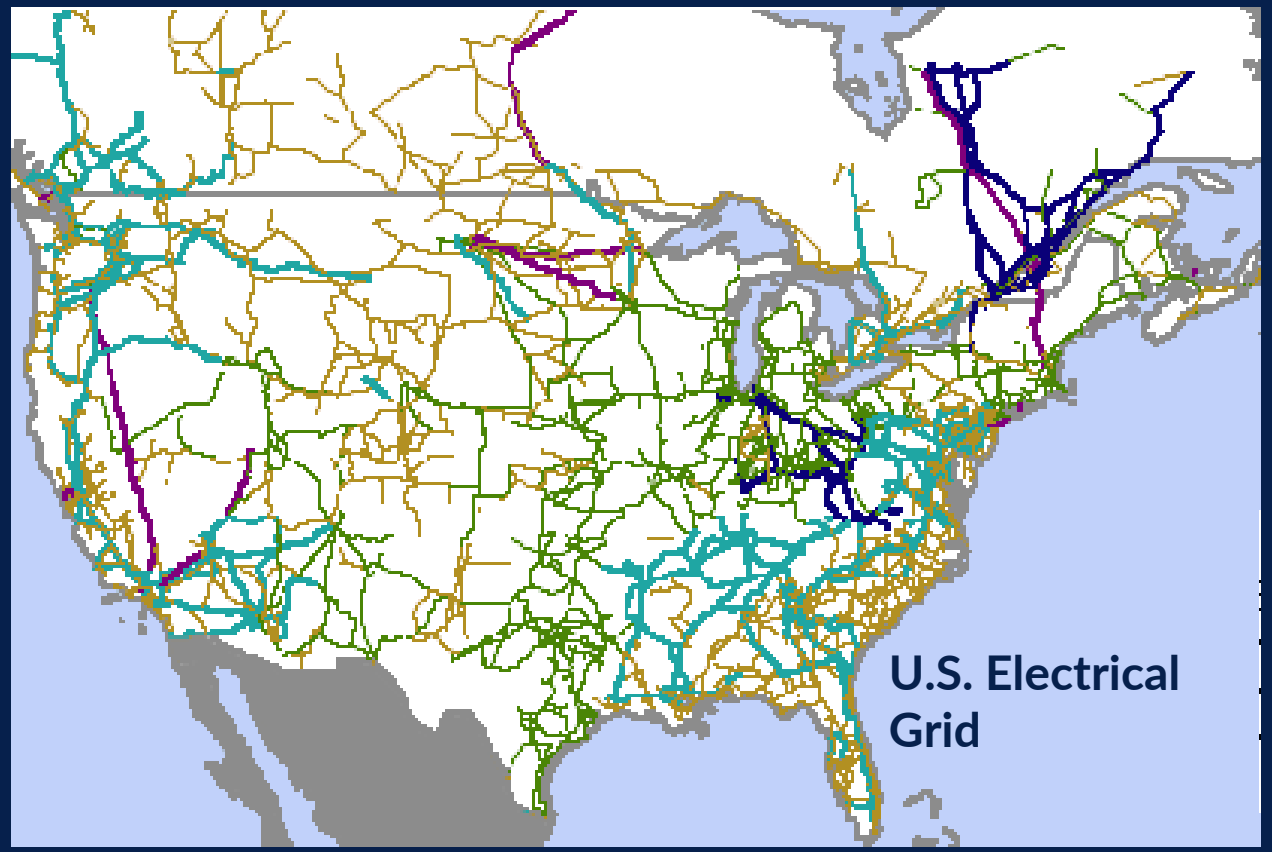


CDC Health Alert Network. *Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic.* 2020.

Smart Electrical Grids can "Load Balance" to Keep the System Healthy



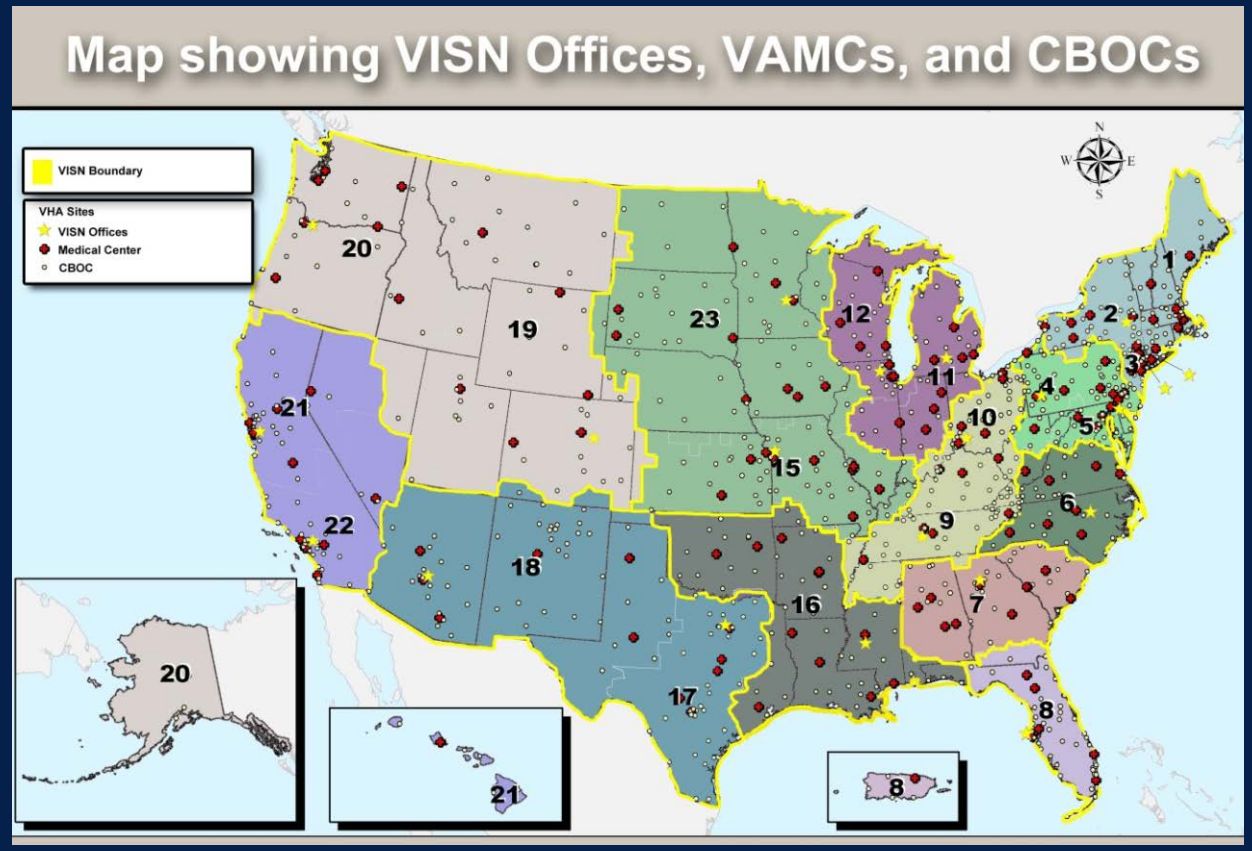
https://smartgrid.ucla.edu



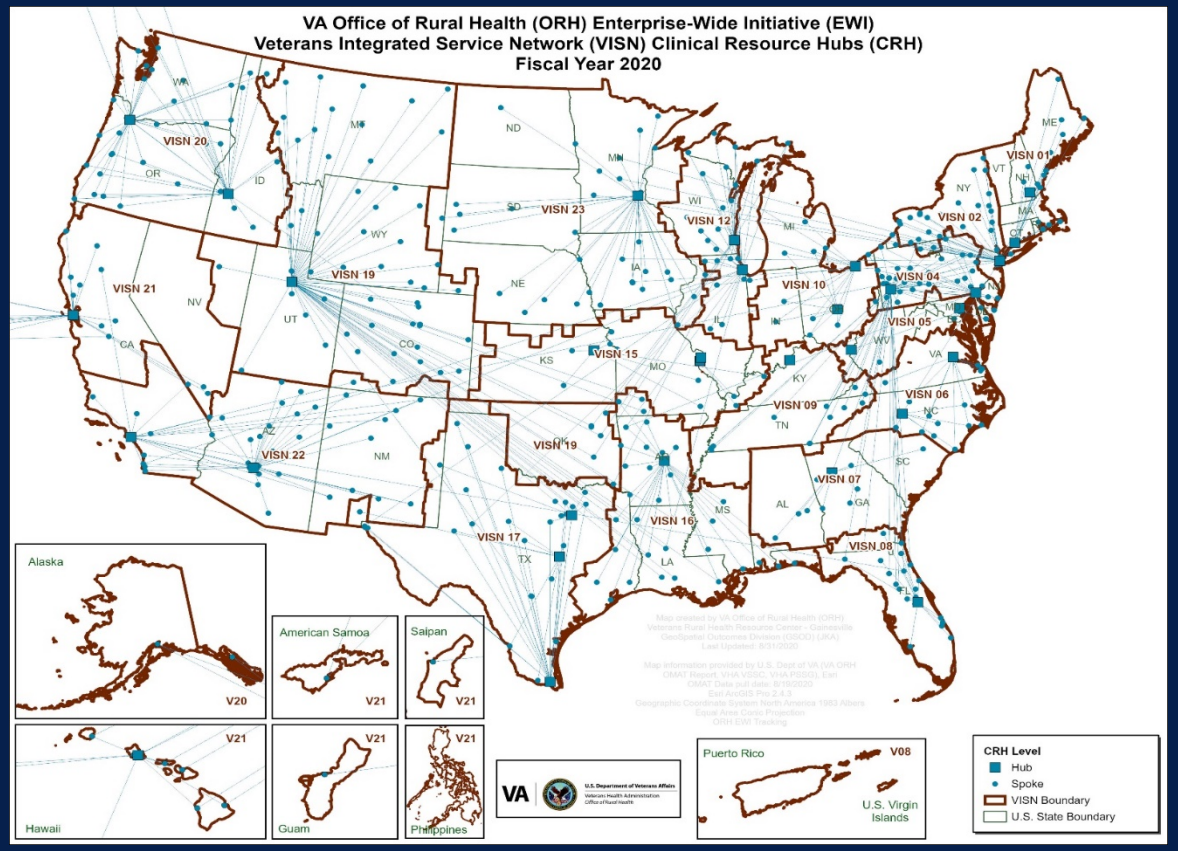
https://www.eia.gov/todayinenergy/detail.php?id=8930

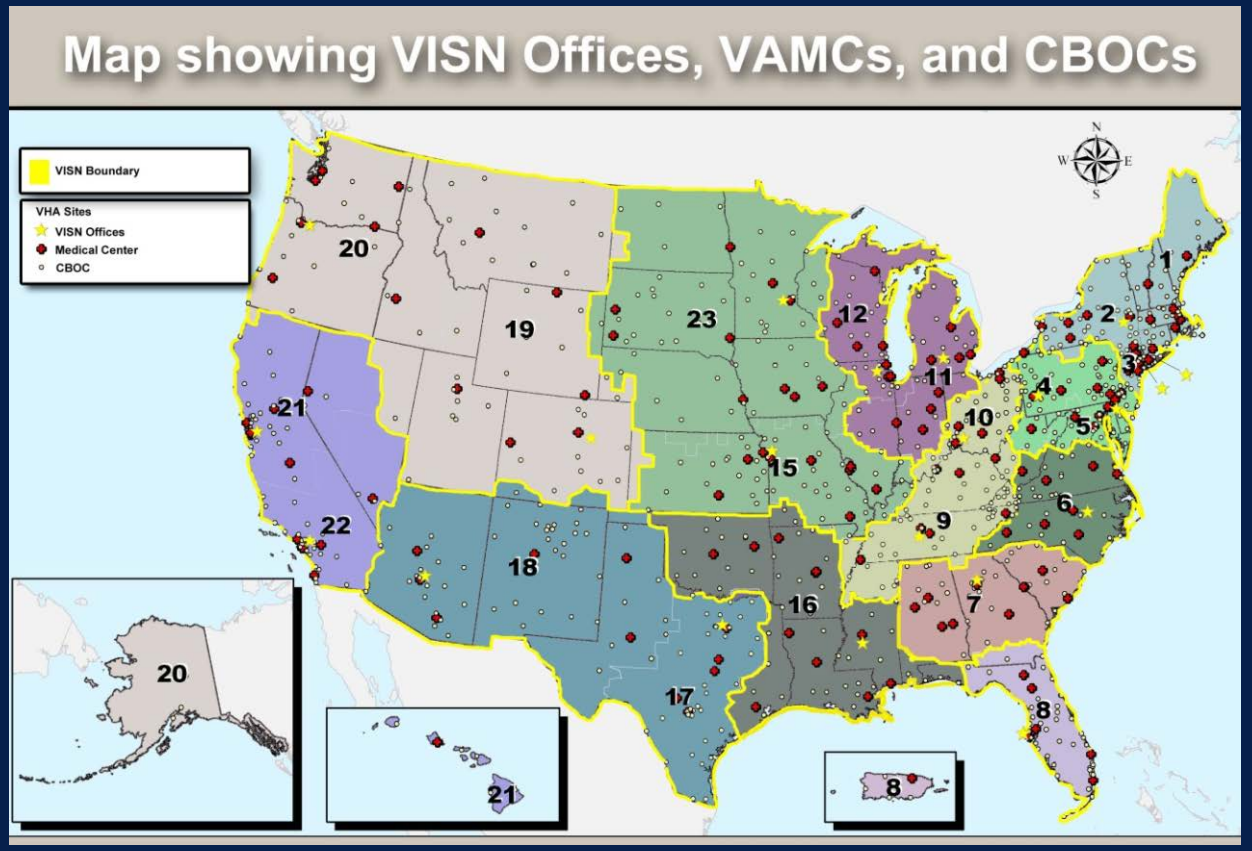
Can Resilient Services be Provided Across a Complex Healthcare System?

- >170 Medical Centers
- >1,0000 Community Clinics
- From Maine to Miami to Guam



Telemedicine Hubs Match Services to Communities Where Demand is Highest





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Hub & Spoke Video Telemedicine

Hub & Spoke Telemedicine can Support All Parts of Stepped Care

Level 0

Self-management

- Mutual help groups
- Skills application

Step 1

Addiction-focused medical management

- Primary Care
- Mental Health

Step 2

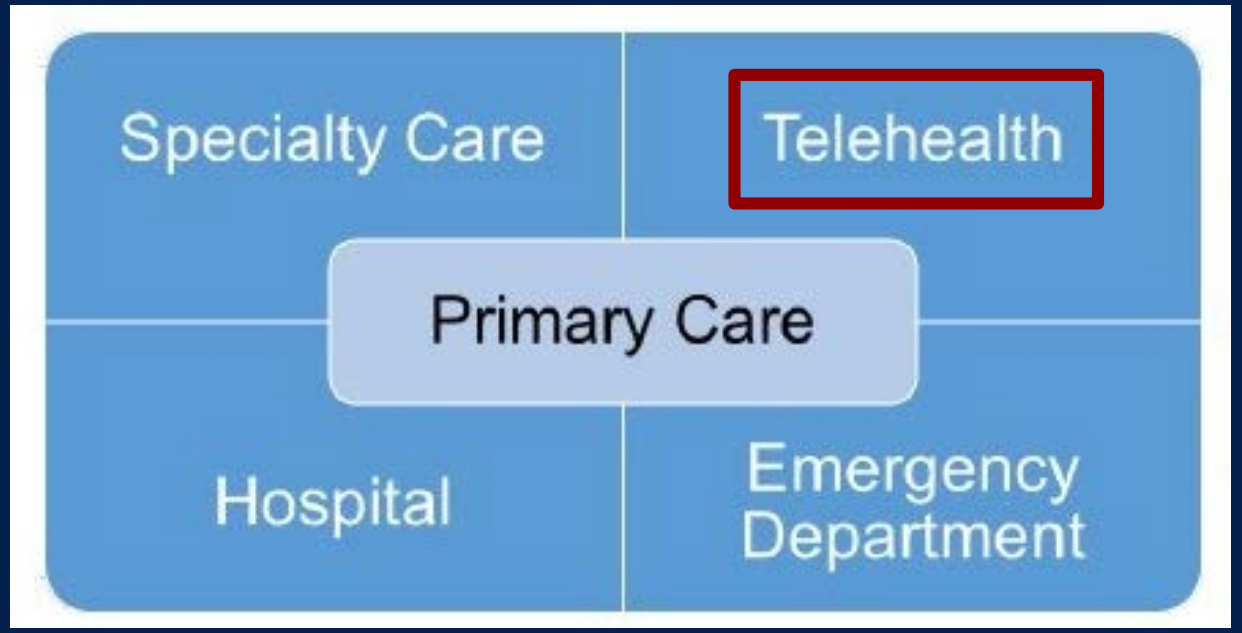
SUD Specialty Care

- Addiction specialty care
- CBT-SUD
- SUD groups
- IOP
- Residential

Gordon, A.J., et al. *Substance Abuse*. Volume 41, 2020 - Issue 3

CONsortium to Disseminate and Understand Implementation of Treatment of Opioid Use Disorder (CONDUIT)

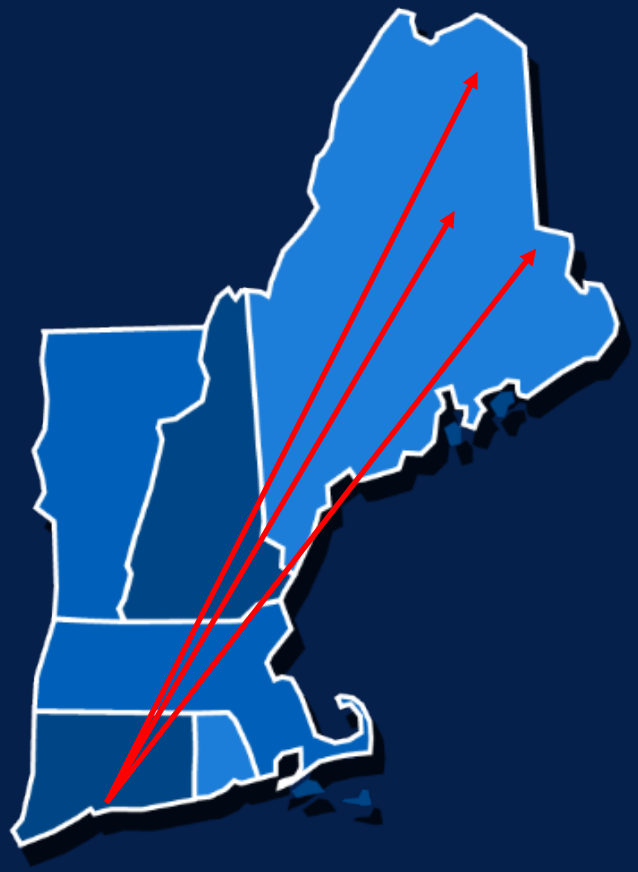
Five Implementation Facilitation teams collaborating to increase access to Medications for OUD at nearly 60 sites



Brunet, Nicole, et al. *Substance abuse* (2020): 1-8.

CONDUIT: Implementation of Tele-buprenorphine in Rural Clinics

- Implementation-Facilitation Tools:
  - Local Champions: nursing staff, telehealth presenters
  - Internal Facilitators: Clinical Pharmacists
  - Audit and feedback
- Facilitators:
  - Local staff want buprenorphine in their communities
  - Comfort with telemedicine
- Barriers:
  - Uncertain regulations
  - Local vs remote practices
  - Mailing medications



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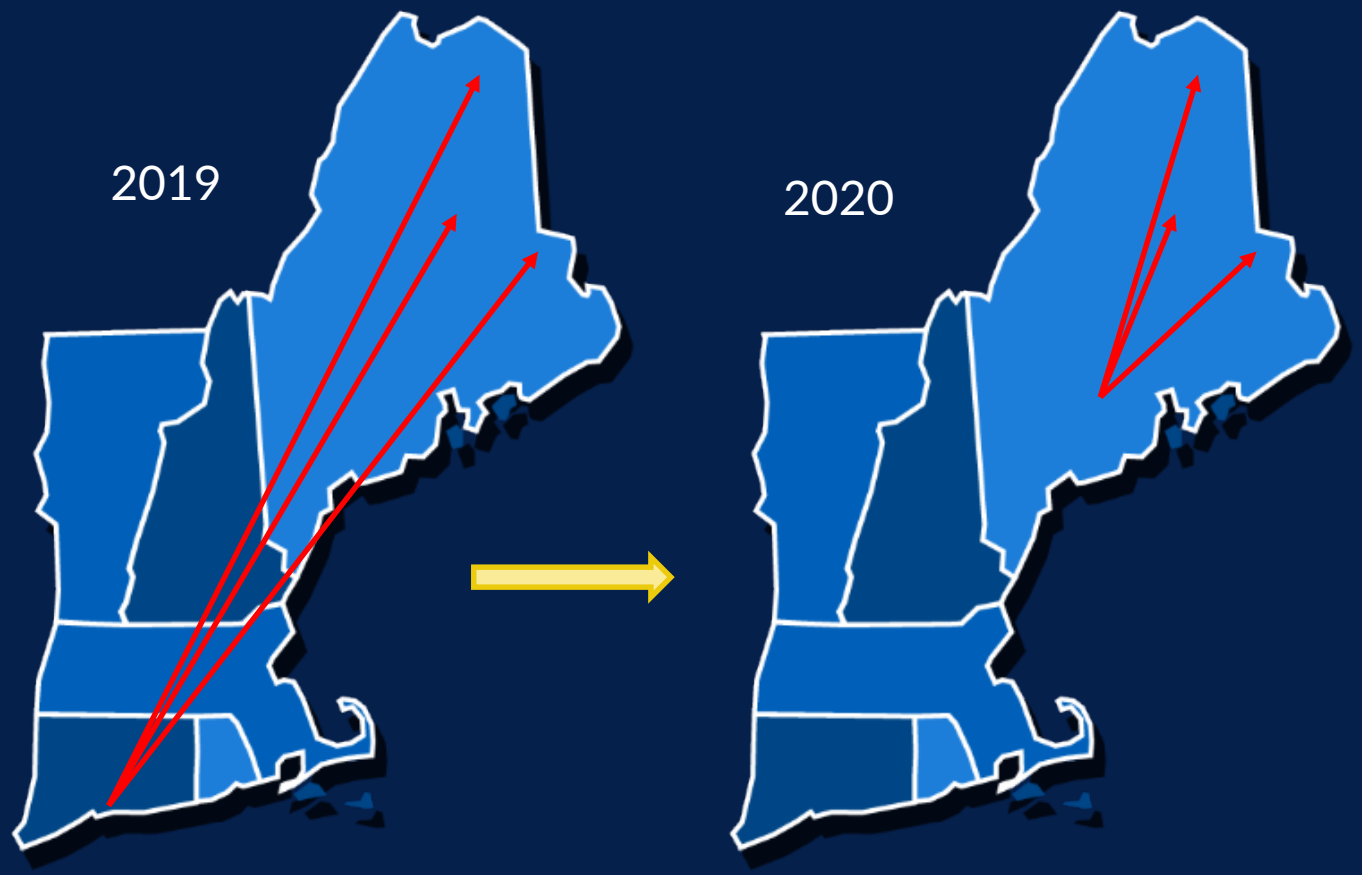
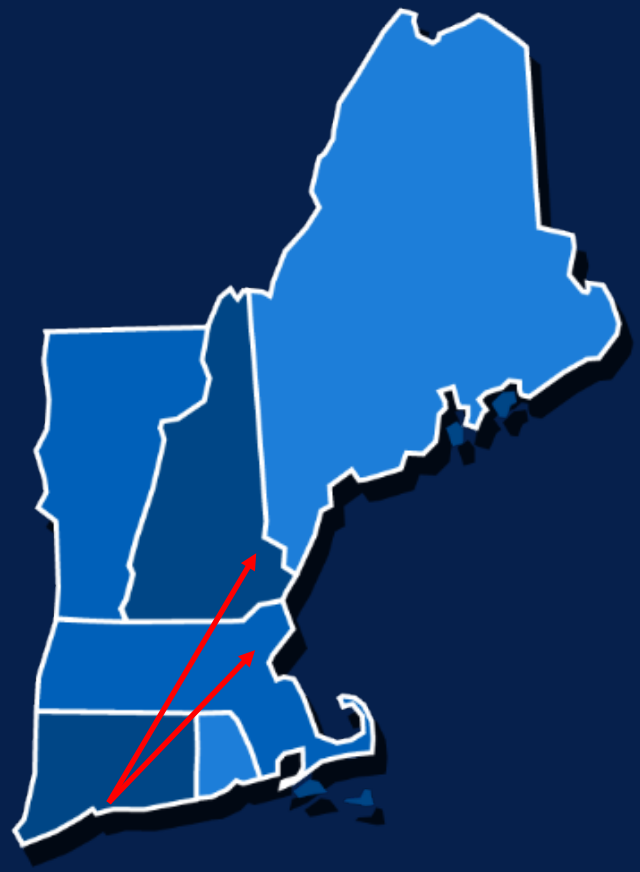
Remote Prescribing can Pave the Way for Local Adoption

- 2019: Three sites in Maine received buprenorphine services from a prescribers in CT
- 25 Veterans in highly rural primary care clinics
- VA Maine Healthcare System increased number of buprenorphine providers from 2019 to 2020
- In 2020, VA Maine HCS took over tele-buprenorphine services



Coverage of "Step-2" Specialty Addiction Services During the Pandemic

- Buprenorphine prescriber shortages occurred after intense COVID-19 outbreaks
- 30 bed addiction residential program
  - On-site nursing, therapy, case management, and social work
- 300 patient dual diagnosis clinic with 100 patients on buprenorphine
  - On-site nursing, therapy, case management, and social work



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Coverage of Specialty Clinics Means Joining Interprofessional Teams

Frequent Virtual Huddles

Complex Scheduling

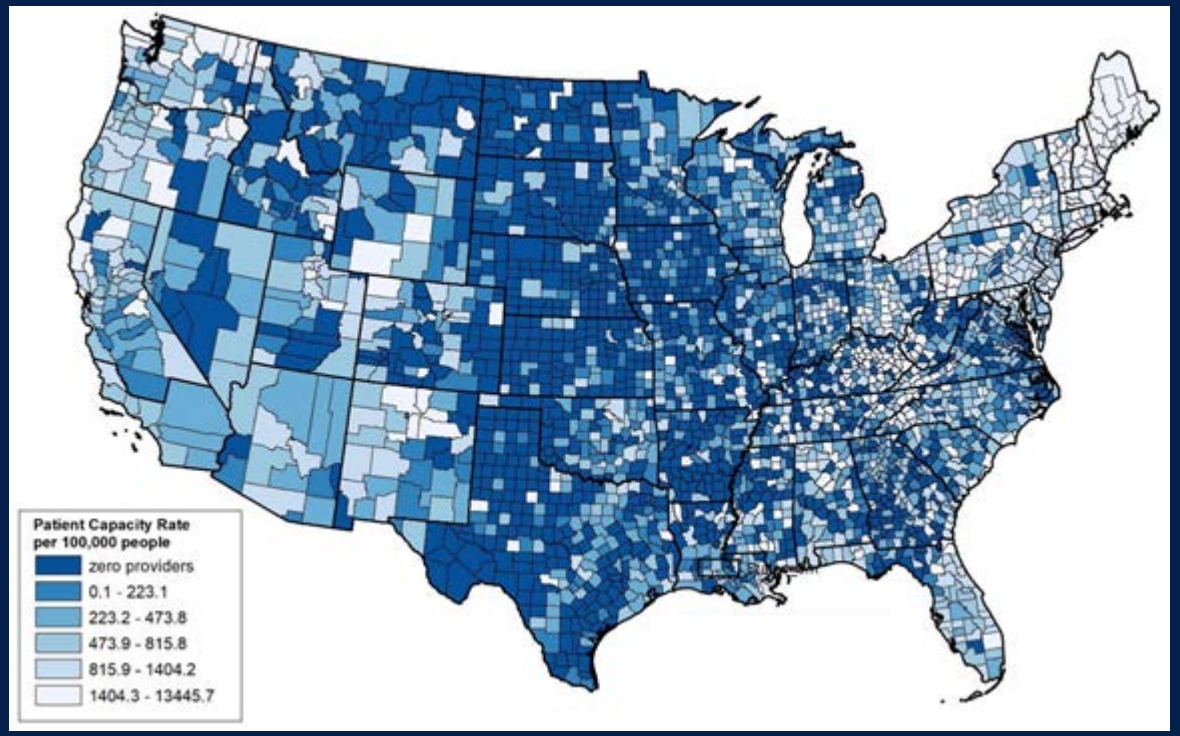
On-site Staff

On-site COVID Precautions

Urine Toxicology

Buprenorphine Access and Overdose Rates Depend on Location

Per-Capita Buprenorphine Prescribers



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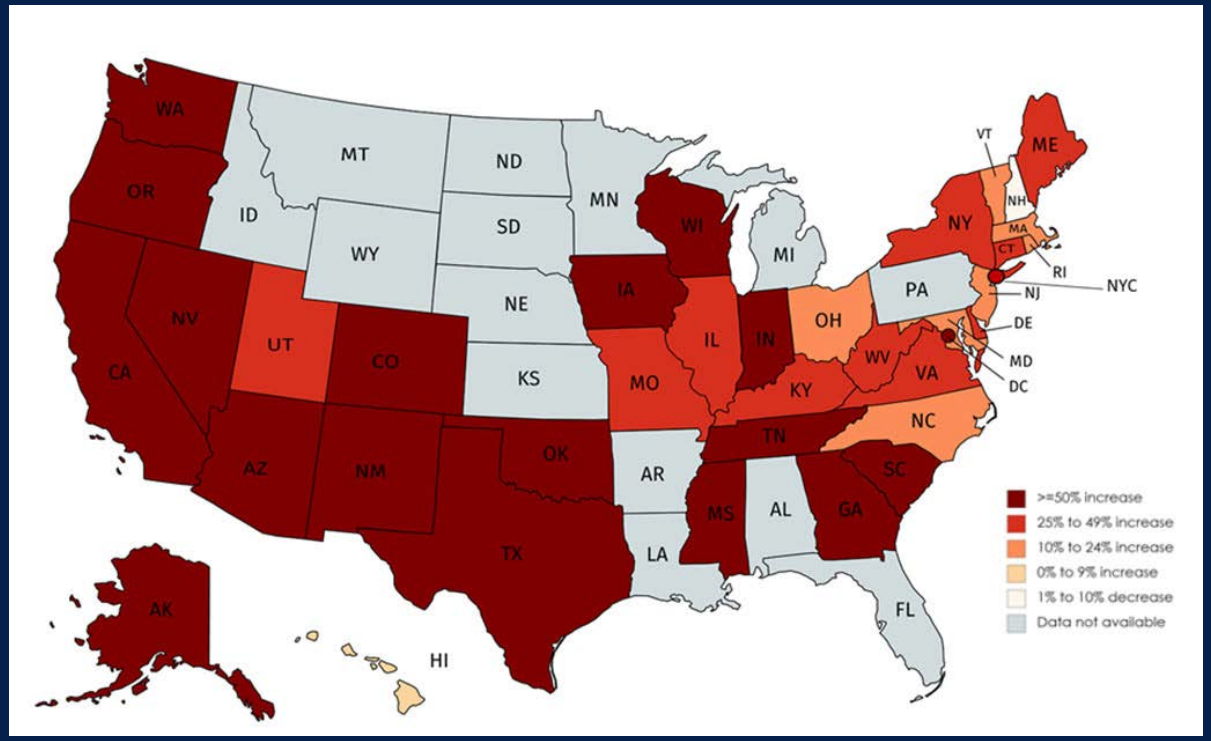

CDC Health Alert Network. *Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic.* 2020.

Final Takeaways

- Hub & Spoke Tele-buprenorphine supports dissemination and sustainment of buprenorphine services
- The COVID-19 pandemic has shown that our OUD treatment network is fragile
- Tele-buprenorphine services are needed to reach communities without buprenorphine prescribers during the pandemic

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4. CDC Health Alert Network. *Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic. December* 2020.

Telemedicine for Opioid Use Disorder Treatment in Rural Settings

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Disclosure Information

- Larissa Mooney, MD
  - No Disclosures
  - Rural Expansion of Medication Treatment for Opioid Use Disorder (MOUD), NIDA Clinical Trials Network (CTN), CTN-0102
    - Grant Number: 1UG1DA049435

Learning Objectives

- Discuss OUD treatment needs in rural settings
- Discuss three perceived provider-level barriers to TM
- Identify three social/structural disparities in digital access

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  - Todd Korthius, MD (Co-LI)
- Weil Cornell Medical College
- Participating rural clinics

Telemedicine to Expand Access to OUD Treatment in Rural Communities

- Rural areas experience opioid overdose and death rates among the highest in the country.
- Despite national efforts to increase office-based opioid treatment (OBOT), uptake has been slow in rural communities, with relatively few X-waivered providers.
- Relative lack of rural substance use disorder (SUD) specialty care
- Integrating TM for delivery of medication treatment for opioid use disorder (OUD) into rural primary care may increase treatment access and retention.[1,2]

CTN-0102 Rural MOUD Expansion

- **Primary goal:**
  - Study the effectiveness and impact of a program delivering MOUD that includes both TM and OBOT in rural settings
    - MOUD initiation/retention

- **Secondary goals:**
  - Patient level outcomes (e.g., opioid use)
  - Barriers and facilitators of implementing TM+OBOT in rural settings
  - Uptake of extended-release injectable formulations
  - Economic evaluation

Phase 1: Feasibility Study

Objectives	• Identify ways to integrate TM with OBOT in rural primary care settings • Pilot test the integration of TM and OBOT
Design	• 6 rural sites with varying levels of OBOT capacity: • 0, 1-3, more than 3 waivered providers
Outcomes	• Appropriateness, Acceptability, Feasibility • Clinic and patient level outcomes • (number of patients and days on MOUD)

Rural Primary Care Clinics: Initial concerns and motivation for TM participation[2,3]

Initial concerns re: TM

- Compatibility in treatment philosophies
- Uncertain about remote therapeutic relationships
- Lack of trust
- Potential competition for patients

Reasons for interest:

- Limited number of waivered prescribers
- Lack of or limited behavioral health
- Non-adherent or more complex pts
- Providers are seeking better care for their patients
- To expand MOUD access in surrounding communities in need

TM Service Delivery Arrangement[2-3]

- Type of services desired from TM
- Referral procedures
- Communication on patient progress
- Plan to address no-shows/dropout from services
- Billing for services

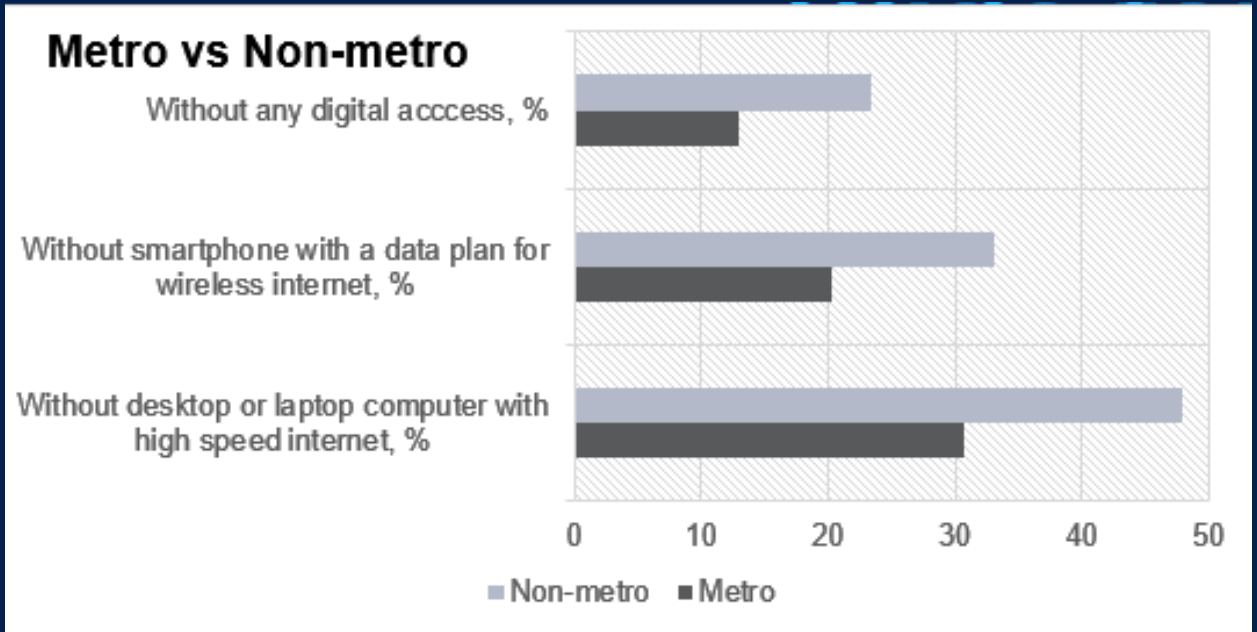
Which patients to refer to TM[2-3]

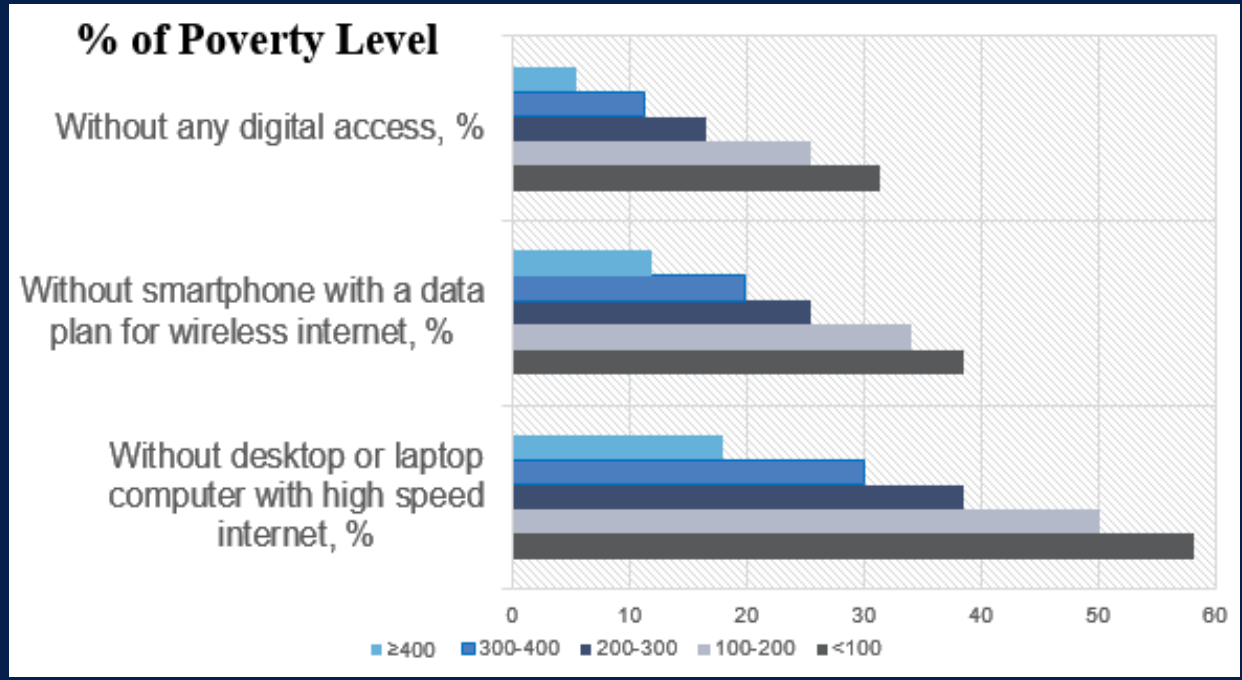
- Refer all OUD pts, if no or limited X-waivered providers/behavioral health care on site
- Patients with logistical barriers (distance, transportation)
- Patients with high clinical complexity (or low?)
- Patients with stated preferences for TM

Early Lessons from Feasibility Study (Implemented July/Aug 2020)[3]

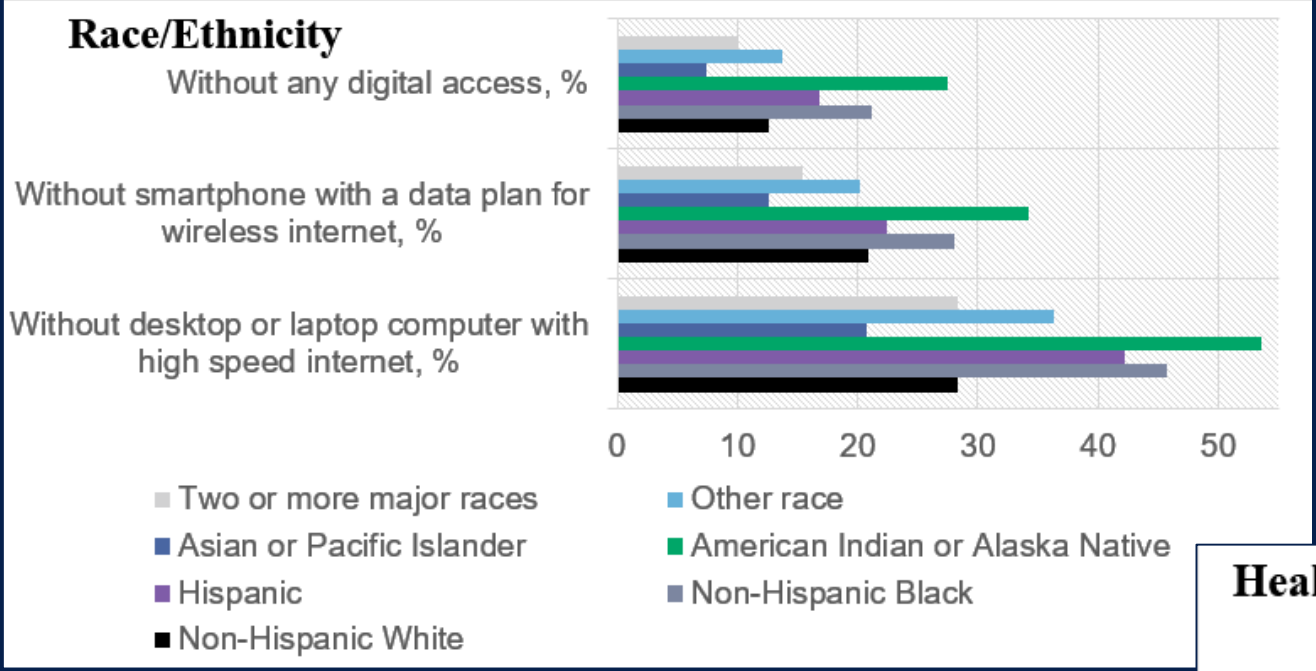
- COVID impact: Clinics' adjustments in procedures, staffing, visits
- TM referrals initially slow
  - Initially more clinically complex patients
  - Some patients resistant to being referred out
    - Preference for in-person visits
  - Drug court preferences for in-person visits
- Digital access challenges (devices, broadband)
  - Particularly during COVID when public Wi-Fi access is not available
  - Disparity
- OUD Screening & diagnosis
  - Low yield from screening
  - Both patients and providers not comfortable with SUD diagnosis
  - Other substance use problems and/or mental health problems

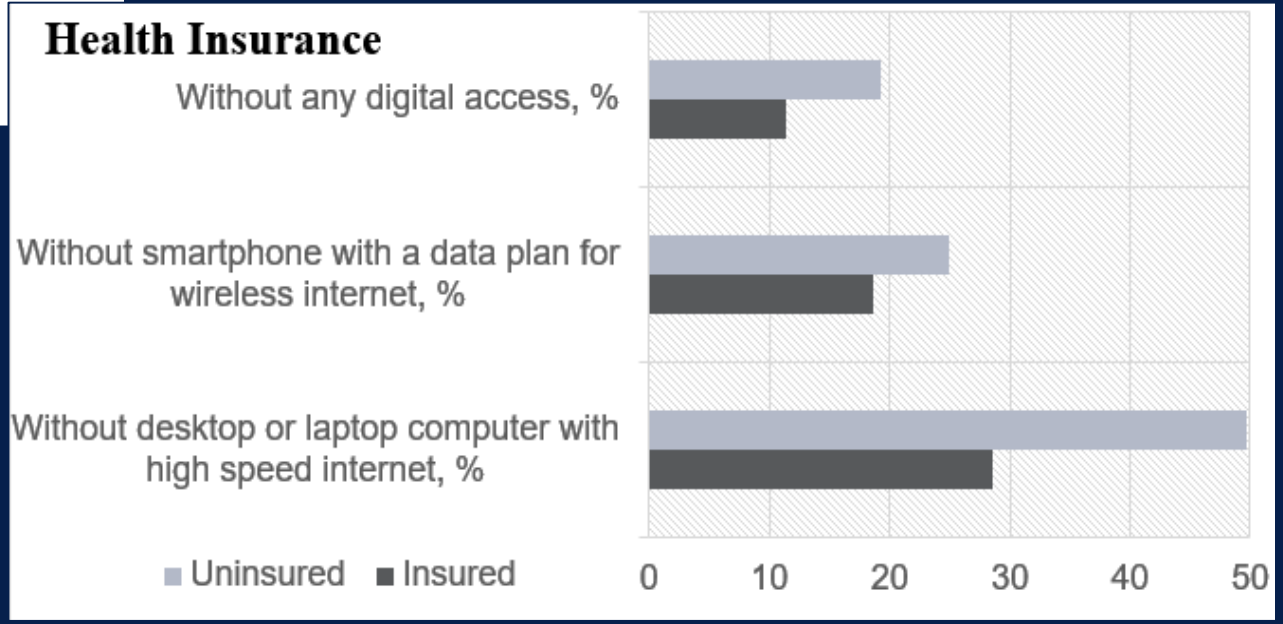
Disparities in Digital Access –2019 ACS[5]





Disparities in Digital Access –2019 ACS[5]





Focus Groups: Clinic TM during COVID[6,7]

- Factors influencing decisions about on-site TM vs. in-person care:
  - Internet connectivity
  - Concerns about pt monitoring & care (e.g. drug screens)
  - Pt engagement/accountability (e.g. missed visits)
- Perceptions about partnering with TM vendor
    - More privacy/less stigma
    - Access to resources not available locally (e.g. chronic pain, behavioral health)
  - Perceived barriers:
    - Connectivity/technology
    - Trust/communication
    - Cost/insurance
    - Concerns about quality of TM vs. in-person care

Summary

- TM may be used to expand MOUD service delivery in rural areas
- Use of external TM company/providers is one model to facilitate rapid scale-up
- Disparities in digital access (e.g. devices, broadband) create barriers to TM access in rural communities
- Addressing concerns about trust, communication, and clinical care may facilitate TM implementation and service planning

Thank You!

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AMERICAN SOCIETY OF ADDICTION MEDICINE
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Telemedicine: Outcomes and Approaches

BRIGHT HEART HEALTH

David Kan, MD

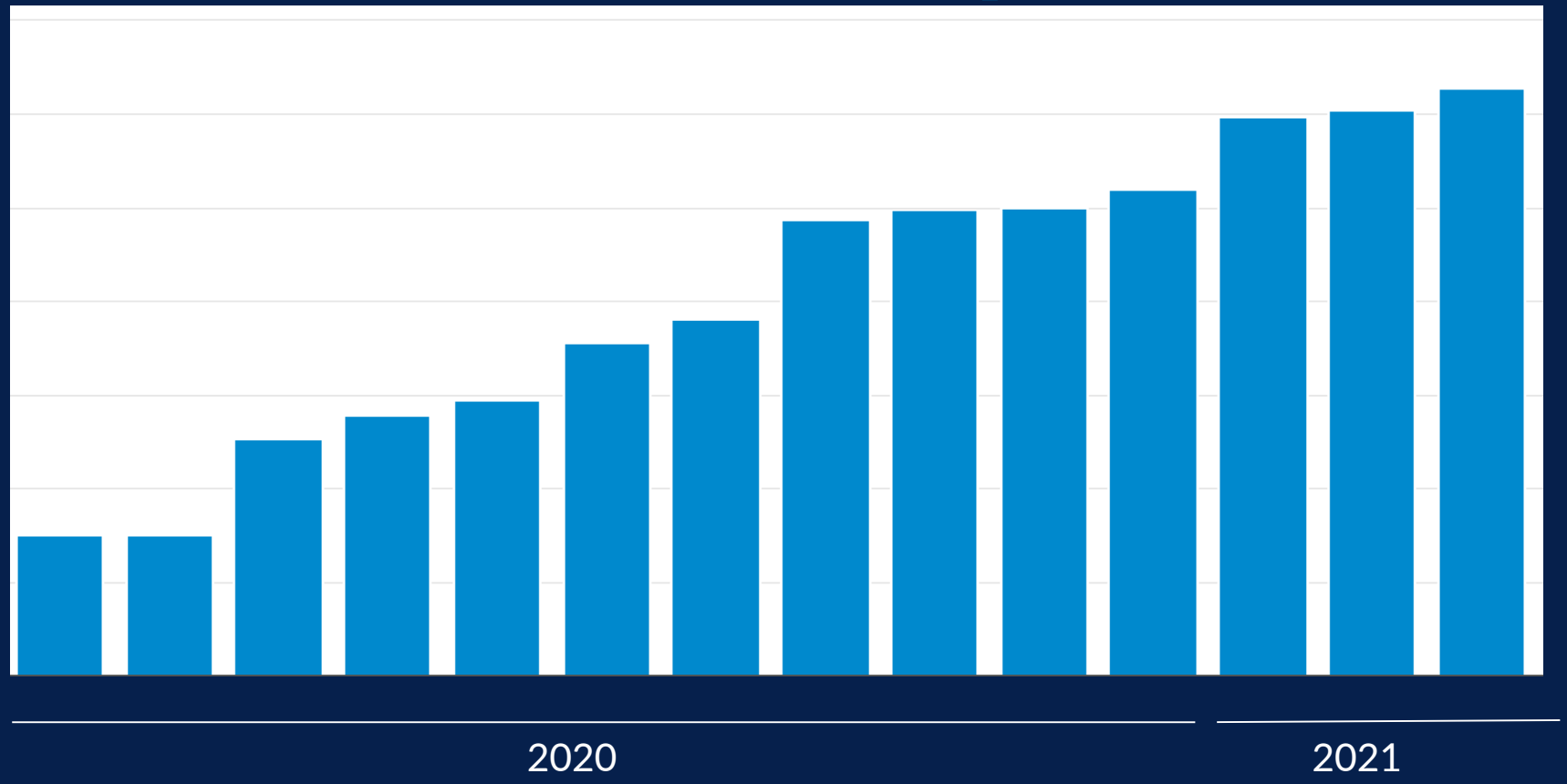
PSYCHIATRIST, ADDICTION MEDICINE

- Volunteer Clinical Faculty UCSF
- Chief Medical Officer of Bright Heart Health
- Private Practice
- CMO of Bright Heart Health
- Equity holder in Bright Heart Health

Company Overview

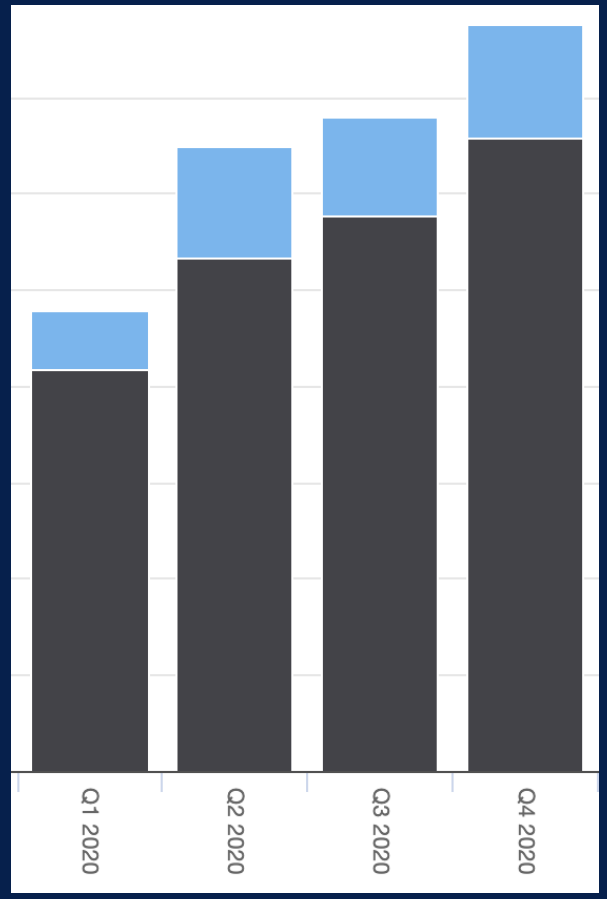
- Active in 40+ states
- Multidisciplinary team
  - Physicians
  - Nursing
  - Therapists
  - Care Managers
- Digitally Native
- Payor mix
  - 65% MediCaid
  - Commercial and Medicare
- Addiction, Behavioral Health, Chronic Care Management
- Harm reduction

COVID Impact

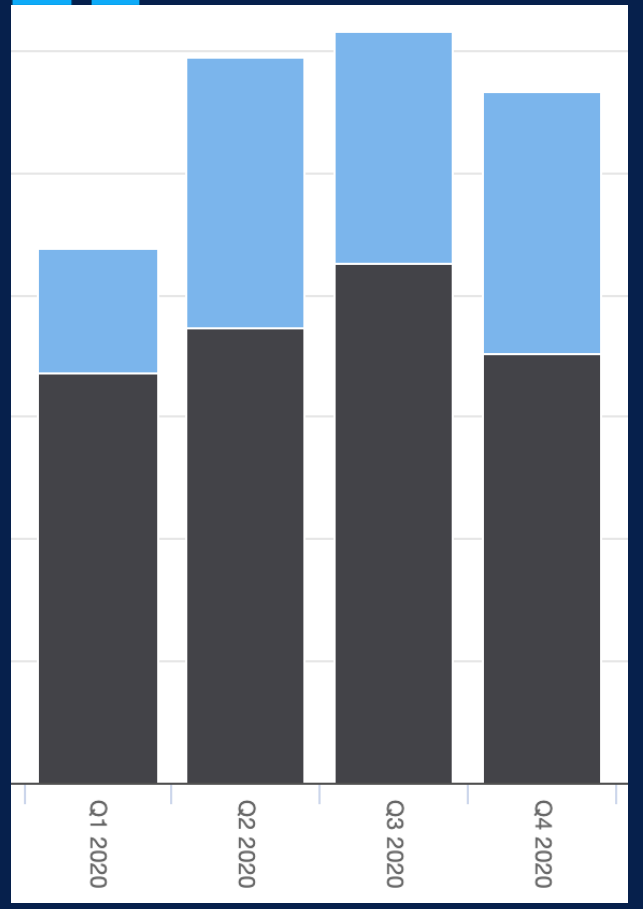


Retention Data – MOUD Program – 2/25/2021

30-Day Retention



90-Day Retention



Agenda

- Telemedicine 1.0
  - Enablement
- Telemedicine 2.0
  - Patient Centered Care
- Telemedicine 3.0
  - Advancement and Innovation

Telemedicine 1.0

Enablement

Determine Approach – Levels of Delivery

- Adjunct to in-person care
  - Provide sessions on a case-by-case basis
    - Example: “sent telemedicine link in email”
- Hybrid Model – Some Services thru Telemedicine
  - Provide sessions on a service line – Therapy, Specialists, etc.
    - Example: “All counselor appointments are telemedicine”
- Telemedicine Clinic – All Services via Telemedicine
  - Provide full clinic services in virtual space
    - Example: “Waiting room, exam rooms, group rooms. etc.)

Pro/Con

- Easy setup
- Challenging to coordinate

- Consistent model, reduces confusion
- Need Telemedicine support team to coordinate care

- Single model
- Requires complete patient pathways

Security & Risk Management

SECURITY

- BAA
- Use Waiting Rooms or other security measures to prevent unwanted guests
- Headphones
- Scan room to ensure privacy

- Check-in more frequently
- Easy to supervise care and ensure adherence
- Pill/Wrapper Counts on-demand
- Virtual Drug Screens
- Easy to move patients to other ODS providers who need care through joint session (super warm handoff)

Telemedicine 2.0

Patient-Centered Care

No Limits to Specialty (-ization)

- Specialists can be located anywhere, as long as licensed in state of practice
- Ability to provide patient-centered services
  - EMDR
  - Psychiatry
  - Etc.
- Specialty Tracks
  - Pregnant Females
  - LBGTQ
  - Male
  - Stimulant Usage
- Non-Provider Encounters
  - Yoga
  - Exercise & Movement

Telemedicine 3.0

Advancements in Care

Easy Engagement

- 24 x 7 Walk-in Clinic
- Digital Access Points
- Engagement Models
  - SMS
  - Website
  - Encounters

Contact Information

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