

Expanding Telemedicine to Enhance Equity for Persons with Opioid Use Disorder: Position Statement of the Association for Multidisciplinary Education, Research in Substance use and Addiction (AMERSA)

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Executive Summary

The COVID-19 pandemic and its economic, social, and emotional consequences have exacerbated the opioid crisis. Rising overdose rates and decreasing access to treatment have highlighted the inequities in access to evidence-based treatment of opioid use disorder (OUD). Buprenorphine saves lives, but rural, Black, and lower socioeconomic status patients have historically had limited access to in-person buprenorphine. Technological barriers such as lack of broadband and smartphones have prevented many patients from accessing audio-visual telemedicine buprenorphine services. With the changes in telemedicine regulations during the COVID-19 public health emergency, audio-only telemedicine (i.e. telephone based) has made buprenorphine accessible to those who need it most. Extending this practice beyond the COVID-19 public health emergency would be an important step towards mitigating the opioid public health crisis.

Background

Opioid agonist medications for opioid use disorder (OUD), buprenorphine and methadone are associated with a more than 50% reduction in all-cause mortality, and are among the most effective treatments for OUD¹. However, pharmacotherapy with buprenorphine, methadone, and naltrexone remains underutilized as only 18% of Americans with OUD received an evidence-based medication last year². Increasing access to these medications is an essential strategy for reducing overdose deaths, yet access is particularly limited for certain populations due to systemic racism, income inequality, limited transportation, and rural health care disparities. Currently, over 40% of US counties do not have a buprenorphine³ prescriber and Black communities with high levels of segregation have decreased buprenorphine access⁴.

Inequities and barriers to buprenorphine access have increased during COVID-19. With the onset of the pandemic, drug overdose deaths have surged⁵. In addition to risk factors such as social isolation and fentanyl contamination of the drug supply, decreased access to in-person

substance use treatment due to COVID-19 infection control measures is likely a significant contributor. Many treatment providers were unable to accept new patients or see patients at all since the start of the pandemic. In a recent survey of buprenorphine prescribers⁶, 78% stated that they had to reduce or terminate in-person visits. Telemedicine is one option for increasing access to care for patients facing these barriers. Use of telemedicine was enabled during the COVID-19 public health emergency through federal guidance issued by the Drug Enforcement Administration and SAMHSA released March 31st, 2020. The Ryan Haight Act had previously required in-person evaluation prior to two-way audio-visual service provision⁷. Current guidance permits buprenorphine initiation by telephone alone without in person visits or video technology.

Telemedicine delivered buprenorphine treatment has demonstrated similar treatment retention and rates of opioid abstinence compared to in person programs^{8,9}. However, audiovisual telemedicine is not available to all Americans due to barriers including racial and economic inequities, inadequate broadband infrastructure, low digital literacy, and health system barriers. Nearly thirty percent of adults with an annual household income less than \$30,000 do not have a smartphone and 44% do not have home broadband services.¹⁰ Similarly, over a third (37%) of rural Americans do not have home broadband access.¹¹ For people experiencing homelessness, access to broadband and smartphones are limited. In all, it is clear that expanding access to audio-only telemedicine without requiring an audiovisual component is necessary to provide more equitable addiction care.

The DEA and SAMHSA's bold and rapid response allowing for telemedicine delivered buprenorphine during the COVID-19 pandemic opened up the possibility of telemedicine to many Americans who would otherwise be unable to access these services. During COVID-19, nearly half (48%)⁶ of surveyed buprenorphine providers reported initiating buprenorphine by phone, which would not have previously been possible. However, without further action this step towards equitable care will lapse at the end of the COVID-19 public health emergency and telemedicine services will once again exclude the most vulnerable patients, leading to ongoing disparities in treatment access.

Responses and Policy Options

The pandemic has heightened disparities in accessing and receiving treatment for persons with OUD in general, and persons with social inequities in particular. Regulations around buprenorphine have been lifted at the federal- and state-levels as a result of the pandemic. Lasting changes can be made to ensure ongoing access.

The DEA has administrative discretion to permit the initial evaluation to be conducted via audio only in addition to audiovisual, real-time, two-way interactive communication systems. The DEA used this discretion to permit telephonic consultation during the COVID-19 emergency and could extend the use of that discretion for the extent of the opioid emergency as well.

Per the SUPPORT Act of 2018, the Attorney General is required to create regulations governing in-person exemptions to the Ryan Haight Act within one year. This one-year period has passed

without regulations. Future regulation could address the ability to prescribe buprenorphine via telemedicine (audio-only or audiovisual) without an initial in-person evaluation.

Instead of relying on temporary regulatory waivers and special registrations, Congress could modify the Ryan Haight Act to enact a permanent legislative solution permitting X-waivered providers to conduct a remote evaluation for buprenorphine OUD treatment initiation and follow-up via telemedicine, including audio-only technology where necessary, without an in-person visit.

The currently proposed TREATS act allows initial audio-visual telemedicine visits and subsequent audio-only telemedicine for buprenorphine prescription. Congress could amend the TREATS Act to allow for audio-only telemedicine for buprenorphine initiation.

AMERSA Position

Expanding access to evidence-based and life-saving medications such as buprenorphine, methadone, and naltrexone is essential to reducing overdose deaths. To improve treatment access for our most vulnerable patients, we must ensure that buprenorphine can be equitably initiated through telemedicine. This demands that we take anti-racist actions to counter systemic racism, socioeconomic barriers, and geographic access inequities that impact our current addiction treatment landscape. Audio-only telemedicine initiation of buprenorphine treatment is a critical step toward this goal. Additional steps can and should be taken to preserve and expand access to telemedicine buprenorphine for these vulnerable populations. In parallel, steps should be taken to increase access to other evidence-based medications including methadone and naltrexone.

Recommendations

Leverage the position of AMERSA as interdisciplinary leaders in substance use education, research, care, and policy to:

- Advocate for audio-only telemedicine initiation of buprenorphine treatment at the federal level. AMERSA may direct this paper to the DEA and Congressional representatives, with a goal of extending easement of regulations to allow all buprenorphine prescribers to offer audio-only telemedicine services, including for patients who are being newly initiated on buprenorphine.
- Utilize AMERSA mentoring program to support clinicians who are currently providing buprenorphine, or considering doing so to focus on strategies for increasing access to care, reliable transportation, and use of telemedicine.
- Keep AMERSA members apprised of related legislative actions via email blasts, social media, and postings on amersa.org
- Recruit AMERSA members to the organization's Diversity Committee with an agenda focusing on the removal of barriers to buprenorphine treatment such as systemic racism, income inequality, limited transportation, and other care disparities.

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References

1. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017;357:j1550.
2. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. National Survey on Drug Use and Health 2019. <https://www.datafiles.samhsa.gov/>. Accessed November 6, 2020.
3. U.S. Department of Health and Human Services, Office of Inspector General. Geographic Disparities Affect Access to Buprenorphine Services for Opioid Use Disorder. <https://oig.hhs.gov/oei/reports/oei-12-17-00240.asp>. Accessed November 6, 2020.
4. Goedel WC, Shapiro A, Cerda M, Tsai JW, Hadland SE, Marshall BDL. Association of Racial/Ethnic Segregation With Treatment Capacity for Opioid Use Disorder in Counties in the United States. *JAMA Netw Open*. 2020;3(4):e203711.
5. American Medical Association: Advocacy Research Center. Issue brief: Reports of increases in opioid- and other drug-related overdose and other concerns during COVID pandemic. <https://www.ama-assn.org/system/files/2020-11/issue-brief-increases-in-opioid-related-overdose.pdf>. Published 2020. Accessed November 6, 2020.
6. American Academy of Addiction Psychiatry. First glance: COVID-19 Buprenorphine Provider Survey Report. <https://www.aaap.org/first-glance-covid-19-buprenorphine-provider-survey-report/>. Published 2020. Accessed November 6, 2020.
7. Ryan Haight Act. In. HR 63532008.
8. Eibl JK, Gauthier G, Pellegrini D, et al. The effectiveness of telemedicine-delivered opioid agonist therapy in a supervised clinical setting. *Drug Alcohol Depend*. 2017;176:133-138.
9. Zheng W, Nickasch M, Lander L, et al. Treatment Outcome Comparison Between Telepsychiatry and Face-to-face Buprenorphine Medication-assisted Treatment for Opioid Use Disorder: A 2-Year Retrospective Data Analysis. *J Addict Med*. 2017;11(2):138-144.
10. Anderson M, Kumar, M. . Digital divide persists even as lower-income Americans make gains in tech adoption. <https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/>. Published 2019. Accessed November 6, 2020.
11. Perrin A. Digital gap between rural and nonrural America persists. <https://www.pewresearch.org/fact-tank/2019/05/31/digital-gap-between-rural-and-nonrural-america-persists/>. Published 2019. Accessed November 6, 2020.