June 29, 2022

NAM Action Collaborative on Countering the U.S. Opioid Epidemic Telehealth and Virtual Care Meeting Series

Throughout the course of the COVID-19 public health emergency (PHE), telehealth and virtual care have emerged as potentially paradigm-shifting tools for both pain management and substance use disorder (SUD) care, impacting patient access, care delivery, and quality of care for the millions of Americans affected by these related, but disparate, health conditions. Yet, several challenges remain to fully integrate these services into the continuum of care for these patient populations—related to policy, regulations, payment and reimbursement, training, technology, digital literacy, and equity.

To better understand these challenges and identify potential solutions, the Pain Management Guidelines and Evidence Standards (PM) and Prevention, Treatment, and Recovery Services (PTR) Working Groups of the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic—a public-private partnership working to advance multisector, interprofessional solutions to reduce opioid misuse and improve outcomes for individuals, families, and communities affected by the opioid crisis—convened a four-part meeting series on telehealth and virtual care in the

care, patient and professional health-related education public health, and health administration." However, as CDR Dimeris noted, the field of telehealth has been rapidly evolving, and there has been considerable variation in the use and meaning of different telehealth-related terminologies. Recognizing the need for "common definition[s] we're all working from," OAT is currently working with the University of Arkansas's Center for Telehealth to develop a standardized list of telehealth terminology and definitions (available as of May 6, 2022) (Eswaran and Dawson, 2022).

Beyond terminology-related issues, CDR Dimeris noted that with the increased interest in, and uptake of, telehealth since 2020 (see *Figure 1*)—driven in part by regulatory flexibilities enacted during the COVID-19 PHE—several important benefits for providers, patients, and payers alike have emerged, including:

- For patients, increased access to care and a reduction in travel and wait times;
- For providers, the opportunity to improve workforce development and care delivery, serve more patients, and reduce no-show rates; and
- For payers, a reduction in the cost for transport as well as enhanced outcomes and lower costs due to receipt of more timely care.

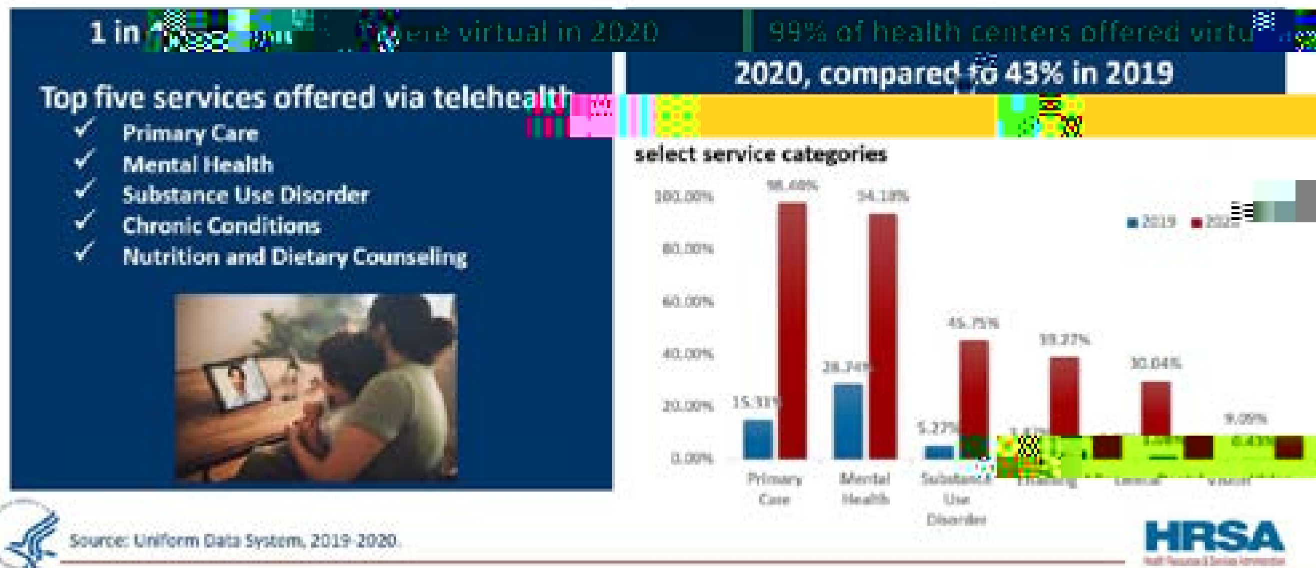
However, beyond the COVID-19 PHE and associated flexibilities, CDR Dimeris shared that the future advancement of telehealth faces several barriers, including:

- A lack of adequate broadband access for both patients and clinics,
- Variation in billing and reimbursement rates,
- Inconsistent and limited interstate licensure of health care providers,
- Difficulties encountered by providers when prescribing controlled substances under the Ryan Haight Act, and
- Access to credentials for telehealth practitioners from distant site hospitals.

CDR Dimeris highlighted that as policy makers consider extending some of the current telehealth flexibilities, it will be important to weigh both the aforementioned benefits and barriers, as well as to better understand "where telehealth can be the right fit, at the right time" and "where we need . . . more information to understand the [impact on] health outcomes."

Building on many of the themes introduced by CDR Dimeris, David J. Tauben, founder and past director of the University of Washington's (UW's) TelePain program, spoke to the specific applications of and considerations for using telehealth in the context of pain management. By understanding that effective pain care necessitates a coordinated, collaborative, and interdisciplinary approach, Tauben noted that "telehealth offers [the] potential to transform clinical pain management . . . by removing barriers to multidisciplinary pain management," including inadequate education and training on chronic pain for clinicians, too few multidisciplinary pain care providers, and logistical challenges for patients associated with attending appointments in person.

Drawing from his experience as a clinician-educator and holding up programs such as Project ECHO (https://hsc.unm.edu/echo/what-we-do/about-the-echo-model.html) and UW TelePain (https://depts.washington.edu/anesth/care/pain/telepain/mini-site/index.shtml) as helpful examples, Tauben reflected that telehealth is also "a powerful pre-licensure and continuing edu-



F[illegible]E 1. The Rise of Virtual Visits in Health Centers in 2020
SOURCE: Presentation by CDR Heather Dimeris, December 17, 2021.

However, when asked to reflect on some of the challenges associated with telehealth-enabled pain care, panelists shared concerns regarding exacerbating existing disparities, including the digital divide. Nicholson noted that lack of broadband access has ramifications for policy, including coverage of audio-only telehealth. Further, due to interstate variations in licensure and coverage of providers, Burns noted that, in some cases, patients have had to drive across state lines to take their telehealth appointments in their parked car. Additionally, the panelists mentioned that given the multidisciplinary nature of pain care, it can be difficult for patients and caregivers to navigate the different systems and processes used across providers. Other challenges raised were instances of missed diagnoses and misdiagnoses, which panelists suggested may have stemmed from the inability for a proper physical examination, as well as privacy concerns, including the security around non-FDA-regulated devices, HIPAA security standards, and the need for patients to have access to a private, secure place to conduct their telehealth visits.

With both the benefits and challenges of telehealth in mind, panelists emphasized that the future of telehealth for pain management requires an integrated, hybrid approach—blending both in-person and virtual care—that can be adapted for the individual needs of a diverse patient population. Panelists noted that providers will need to work with their patients to determine how a hybrid model can best meet their needs, while payers and policy makers will need to ensure that patients experiencing pain can continue to access whatever type of care produces the best possible outcomes for them.

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Turning the discussion to the use of telehealth-enabled SUD care, Daniel P. Alford, director of the Clinical Addiction Research and Education (CARE) Unit at Boston University School of Medicine, remarked that many of the benefits and challenges experienced by those treating patients experiencing pain overlap with those treating patients with SUD. Yet, given the highly regulated environment for in-person opioid use disorder (OUD) treatment, there needs to be a large emphasis on policy and guideline changes when considering telehealth-enabled care for SUD and OUD. In response to the COVID-19 PHE, regulators enacted several temporary changes to ensure continuity of care, including allowing buprenorphine initiation without an initial in-person evaluation, dispensing larger supplies of medications for OUD (MOUD), requiring little to no counseling to access MOUD, and waiving urine drug testing requirements.

These changes, and other aspects of telehealth-enabled OUD/SUD care, have had a range of both positive and negative impacts. Referring to results from a recent series of qualitative studies of providers in both office-based OUD treatment settings and opioid treatment programs (OTPs)[1], Alford described several positive impacts, including increased access to and convenience of care, reduced anxiety for patients, and an improved understanding of patients' home environments, which can improve the therapeutic

1 Office-based opioid treatment (OBOT) refers to outpatient treatment offered by primary care or general health providers with a DATA-2000 waiver to prescribe MOUD, including buprenorphine and naloxone. Similarly, OTPs offer medication-based treatment for OUD; however, unlike OBOT programs, OTPs—which must be certified by SAMHSA's Center for Substance Abuse Treatment—are the only treatment setting in the United States that can prescribe methadone for OUD.

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relationship between clinician and patient. However, these surveys also found that the pivot to telehealth-enabled OUD care has resulted in less structure and accountability for the patient, less information to inform clinicians' clinical decision making, difficulty in establishing a personal connection with patients, and technology-related challenges and limitations. Particularly in OTP settings, there has been a growing concern about patient risk and liability related to medication diversion and overdose and potential quality implications. To overcome these challenges and realize the full potential of telehealth-enabled OUD/SUD care, Alford urged policy makers, clinicians, and others to think critically about "what we had previously accepted as norms and 'established' practice patterns" for OUD/SUD care.

Br. Bill Bradley—a person in long-term recovery supported by MOUD, a veteran, and a Shatterproof ambassador[2]—and Zachary C. Talbott—a person in long-term, medication-assisted recovery; a licensed drug and alcohol abuse counselor; and the president of the National Alliance for Medication Assisted Recovery—highlighted perspectives of those with lived experience and reflected on stechnug wocl (of th)10.1 (e challenges that th)10.2 (ye hve iencounver)24.2 ted pseonasly and turird pery andestkhthoderynbetorkns. T7.2 the
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