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Policies to Improve Substance Use Disorder Treatment with Telehealth During the COVID-19 Pandemic and Beyond

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Abstract

The COVID-19 pandemic has created an urgent need to expand access to substance use disorder (SUD) treatment through telehealth. A more permanent adoption of tele-SUD treatment options could positively alter the future of SUD treatment. We identify four steps that will help to ensure a broader transition to telehealth will be successful in improving the health outcomes of patients with SUDs. These steps are: (1) investing in telehealth infrastructure to enable health care providers and patients to use telehealth; (2) training and equipping providers to provide SUD treatment through telehealth; (3) providing patients with the financial and social support, hardware, and training necessary to use telehealth; (4) making temporary changes to telehealth law and regulation permanent. We believe these four steps will be critical to initiating SUD treatment for many persons that have yet to receive it, and for preserving SUD treatment continuity for millions of other patients both during and after the pandemic.

Keywords

Telehealth; telemedicine; tele-SUD; substance use disorder; COVID-19

Over 100,000 people in the United States have already died from the COVID-19 virus. In addition to these and future COVID-19 deaths, 150,000 more “deaths of despair”—deaths from suicide and drug or alcohol overdoses—could occur over the next decade as a result of

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the socioeconomic costs of the pandemic.¹ This projection highlights the urgent need for novel approaches to expand access to care for conditions other than COVID-19. Today's pandemic and economic downturn present unparalleled challenges, but also opportunities to save lives by improving treatment for patients with substance use disorders (SUDs).

Treatment for SUD was predominantly administered face-to-face before the pandemic. Regulatory barriers often restricted *tele-SUD*, the remote delivery of SUD-related health care services, which was primarily a complement to in-person care and growing slowly.² Key regulatory barriers included the Ryan Haight Act, which requires controlled substance prescriptions be initiated in person, and state licensing requirements that prohibit physicians, nurses, and behavioral health providers from treating patients in other states via telehealth.³ Reimbursement for telehealth has also been limited. As of 2019, nine states lacked laws requiring insurers negotiate telehealth reimbursement with providers, and only six states have laws requiring telehealth be reimbursed at parity with in-person care.³ There is also large cross-state variation in the types of telehealth reimbursed by Medicaid. Many states limited Medicaid telehealth reimbursement to live video; only 19 allowed patients to receive virtual care at home.³

The COVID-19 pandemic caused sweeping changes to tele-SUD policy and dramatic shifts in SUD treatment practices ensued. Federal agencies have allowed providers to initiate buprenorphine treatment without an in-person evaluation, by telephone if necessary. Restrictions on tele-SUD reimbursement, types of providers that can deliver tele-SUD, and locations where patients may receive tele-SUD have been relaxed.⁴ States have followed the federal government's lead in state Medicaid programs.⁵ Tele-SUD visits have grown exponentially.⁶ Group therapy sessions are hosted on Zoom, non-contact medication pickup is commonplace, and patient-provider communication occurs over telephone calls and text messages.^{6,7}

Although tele-SUD has many potential benefits—including greater access to care, increased convenience, and decreased COVID-19 exposure risk—the literature on the effectiveness of tele-SUD is limited. Recent observational analyses found patients using tele-SUD for opioid agonist therapy had retention rates that were higher or no different than patients treated in-person; a small randomized trial had similar findings for patients with alcohol use disorder.⁸ However, there have been no randomized trials that have studied the clinical effectiveness of tele-SUD compared to in-person care.⁸ Research on the impact of the COVID-19 pandemic on SUD treatment outcomes is in its very early phases. In addition, little is known about the clinical effectiveness of different forms of telemedicine in relation to one another, or how decreased use of urine toxicology screenings are affecting patients' care during the pandemic.

A more permanent transition to tele-SUD treatment options has the potential to positively alter the future of SUD treatment, particularly for opioid use disorders. Below, we outline four critical steps that, with the proximal goal of pandemic response and the distal goal of providing outstanding post-pandemic care, can ensure this transformation to tele-SUD is successful in improving patient health. Although we discuss the four steps in the context of SUD treatment, they have important implications for other medical conditions.

First, *health care systems and state policymakers should invest in telehealth infrastructure to enable health care providers and patients to use telehealth.* Over 40% of the most rural counties in the United States lack broadband infrastructure necessary for video-based telehealth visits.⁹ Historically, the government and telecommunications firms have expanded internet access by laying broadband cable. This approach can be prohibitively costly in sparsely populated areas. New 5G cellular networks will increase the range and quality of wireless connections, eliminating the need to physically connect patients' homes to the internet.¹⁰ This new technology can expand high-speed internet access to rural America. In rural and urban settings, 5G networks can help quarantined patients with SUDs to continue engaging in controlled medication management, behavioral health counseling, and participate in support groups.¹⁰ Investments in 5G cellular communications networks thus will benefit persons with SUDs, irrespective of geography, and will support patients with other chronic conditions during and after the COVID-19 pandemic. State governments should consider these health benefits, as well as the numerous other social and economic benefits of internet access, when allocating CARES Act funding to improve telecommunications infrastructure.

Internet access is necessary but insufficient for effective telehealth delivery. *Funding is also needed to train and equip providers to administer SUD treatment through telehealth.* Providers new to telehealth could be integrated into hub-and-spoke models of telecare. Trained spoke provider could provide SUD treatment to a patient in one state with support from a specialized hub in another state. Spoke providers do not need to be SUD specialists. Indeed, this telehealth-centric hub-and-spoke approach could address many of the mental health and substance use crises that occur alongside epidemics by connecting specialists to generalists and generalists to patients without geographic boundaries.¹¹ Access points could be infinite if designed correctly. In conjunction with the DEA's recent order to allow buprenorphine treatment initiation over telehealth,¹² such a strategy would help to ensure that persons with opioid use disorder start and continue treatment during the pandemic and beyond. More broadly, a hub-and-spoke approach could enable the health care workforce to address geographic disparities in SUD treatment through telehealth.

The success of these efforts will also depend on *providing patients with the financial and social support, hardware, and the training necessary to use telehealth.* An April 2020 survey of opioid treatment programs in western Pennsylvania found that difficulties accessing and using communications devices for telehealth were a major, if not the primary, barrier to telehealth utilization.¹³ These difficulties included an inability to pay for internet and cellular data plans, limited digital literacy, and lacking access to computers, tablets, and cellular phones. These barriers are particularly acute for patients with SUDs, who often experience financial hardships and housing instability.¹⁴ Health care systems can use funding from the CARES Act to provide patients with devices such as tablets, and the financial support and training necessary to use them.¹⁵ Given severe short-term resource constraints, however, health care systems should consider whether telephone-based services are sufficient in lieu of two-way audiovisual communication. Although there is a gap in evidence regarding the effectiveness of telephone-based care, patients may require far less training on devices with which they are already familiar. Telephone-based care also may be the only option to treat patients with SUDs facing housing instability or barriers to internet

access. Experience preparing patients to use telehealth during the pandemic will ready providers for a future in which they can more effectively engage persons with SUDs who were previously unable to access treatment.

Lastly, *state policymakers should make existing changes to telehealth law permanent*. In response to the pandemic, many states have eliminated restrictions on the types of providers that can deliver tele-SUD, suspended in-state licensing requirements for telehealth delivery, and mandated Medicaid reimbursement for telehealth services.⁵ These changes should be made permanent to create stronger financial incentives to provide tele-SUD services during the pandemic, and to encourage the long-term growth of telehealth provider capacity. Without permanent changes, tele-SUD providers will return to a world in which reimbursement for tele-SUD services is uncertain, virtual prescribing of controlled substances is restricted or banned, and licensing requirements prohibit cross-state networks of providers from joining together to treat patients with SUDs. Such reversions would be especially problematic if they disrupt continuity of care for patients that have grown accustomed to tele-SUD treatment.

Our experiences treating patients during the pandemic suggests that tele-SUD has a much larger role to play in efficacious SUD treatment. By eliminating travel costs required to receive in-person care, tele-SUD can bring more persons with SUDs into treatment and make it easier for existing patients to maintain continuity of pharmacotherapy. And, by allowing providers to treat patients irrespective of location, tele-SUD can address disparities in access to treatment experienced by populations with disabilities, limited transportation, or that live in areas with few providers waived to prescribe buprenorphine. Likewise, tele-SUD provides the potential for waived providers to efficiently reach a greater number of patients with OUD, regardless of urban or rural residence. As tele-SUD and hybrid models of care increase, it will be essential for researchers to identify best practices.

The four steps discussed above will be critical to initiating and maintaining SUD treatment during and after the pandemic. The four steps are also key components of a broader strategy to expand access to care for other chronic health conditions via telehealth. While the health and economic consequences of COVID-19 are staggering, the pandemic has opened the door to potential improvements in the treatment of SUDs and other chronic conditions with telehealth. If the medical profession succeeds in using this trying time to learn and invest in telehealth, it could lead to a transformed, flexible SUD treatment system that is a vast improvement over that which existed prior to the pandemic.

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