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Telehealth for substance using populations in the age of COVID-19: Recommendations to enhance adoption

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US healthcare systems are rapidly responding to COVID-19 by mobilizing resources to treat infected patients and prevent further transmission. Concurrently, patients with behavioral health conditions continue to need healthcare or they risk becoming silent casualties of the pandemic. Recent national data indicate that 7.8% of adults met past-year criteria for a substance use disorder (SUD).[1] These patients, including those with co-occurring mental health disorders, are vulnerable to serious consequences, including overdose and suicide, if treatments and psychosocial services are disrupted by COVID-19. With COVID-19, it is imperative to minimize transmission, while continuing SUD and mental health care in the context of rapidly evolving healthcare response and policies. This presents an urgent, unprecedented need for telemedicine and mobile health in SUD care and the need to understand how to implement these services now and continue them long-term.

Telehealth increases availability and reach of treatments, but it has been underutilized and understudied in patients with SUDs.[2] Telehealth encompasses a range of telecommunication platforms to support or provide healthcare at a distance. Here, telehealth encompasses 1) telemedicine, or synchronous videoconferencing between providers and patients in separate locations; and 2) mHealth, involving telephone, text, or web-based interventions. In the age of COVID-19, telehealth uniquely supports healthcare delivery while preserving social distancing, reducing disease transmission.

Prior to COVID-19, regulatory hurdles limited wide-scale adoption of telehealth for SUDs. Since COVID-19, five major changes have rapidly reduced barriers across the US:

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1. The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 imposed rules around telemedicine prescribing of controlled medications. With the federal declaration of a public health emergency, the Drug Enforcement Administration (DEA) announced that DEA-registered providers may prescribe schedule II-V medications for patients they have not seen in-person if they are using telemedicine prescribing for legitimate medical reasons under usual practice in concert with relevant state and federal laws.[3] This allows telemedicine, and recently phone visit,[3] starts of buprenorphine treatment for opioid use disorder, without patients first coming to clinic in-person.

2. Health and Human Services announced it will waive HIPAA penalties for "good faith use of telehealth.[4]"

3. SAMHSA issued guidance that restrictions on use and disclosure of patient identifying information under 42 C.F.R. Part 2, specifically applying to behavioral health, would not apply in medical emergencies determined by the clinician.[3]

4. SAMHSA issued new guidance for opioid treatment programs indicating these programs may also prescribe buprenorphine via telehealth and liberalized the number of days of take-home medications, reducing in-person visits.[3]

5. CMS is temporarily waiving restrictions, allowing Medicare to cover additional telehealth services.[5]

These changes remove major regulatory hurdles and enhance the ability to reimburse telemedicine-delivered SUD treatments, including both effective medication and psychotherapy treatments, while reducing the risk for transmitting COVID-19. However, these changes alone are likely insufficient to facilitate widespread adoption of telehealth for SUDs, now or in the future.

Compared to mental health, adoption of telehealth for SUDs has been limited,[6] as SUD treatment often relies on frequent visits, intense monitoring through urine toxicology, and other practices that pose additional barriers.[7] Another major barrier to telehealth adoption is clinician discomfort and concern about loss of therapeutic rapport in remote visits.[8] In addition, wide-scale telehealth adoption requires both training in and access to secure technologies for both patients and clinicians. All of this introduces new costs and logistical complexity for health systems.

While we know challenges occur with new clinical practices, there is currently an unprecedented, unanticipated urgency and need. Below we describe three recommendations to facilitate rapid implementation of telehealth for SUD services. These suggestions also encompass considerations to minimize disruptions in care and enhance SUD treatment access post-COVID-19.

1. Overall guidelines for patient-centered, evidence-based SUD care that incorporate some specific considerations for telemedicine-delivered treatment are needed. Although general practice recommendations exist,[9] additional guidance can identify a range of reasonable practices for telemedicine-delivered treatment

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to ensure similar standards of care. Historically, most SUD treatment has relied on a fairly intensive monitoring and treatment. There is a pressing need to weigh the pros and cons of high-threshold care during COVID-19, but these considerations will also be key post-COVID-19. Issues pertinent to telemedicine include identifying a reasonable frequency and means of obtaining urine toxicology screens and models of telehealth for more complex patients at high-risk for substance use, particularly in the absence or limited availability of higher levels of care. Some of these challenges can be addressed using mobile health technologies to monitor substance use via remote self-report monitoring apps, transdermal devices, and photo verification of mailed biological tests.[10] Incorporating these considerations within current guidelines can help increase clinician comfort as they begin using telehealth.

2. Additional interventions are needed to help facilitate telemedicine-prescribing of controlled medications, particularly buprenorphine for opioid use disorder treatment. Buprenorphine is a life-saving treatment,[9] but there are not enough prescribers. To attract and train clinicians to deliver care via telehealth, toolkits are needed to provide information, in addition to the clinical considerations above, including: technology and infrastructure, billing and reimbursement policies, changing federal and state-level regulations, and strategies to encourage clinic adoption. The limited number of buprenorphine prescribers also makes telemedicine a particularly attractive option for reaching patients in rural and other low treatment access areas. However, further research and expert consensus is needed to inform key questions, such as how do we overcome limited infrastructure and enhance patient acceptability in rural areas. In addition, research is needed comparing the effectiveness of different forms of telehealth including at home delivery, remote clinic delivery, and most recently during COVID-19, phone delivery. There are no trials to date examining or comparing these modalities all of which clinicians are now actively using.

3. Additional resources and tools are needed to help patients with SUDs and with comorbid mental health disorders manage added psychosocial stressors. The stress and uncertainty brought on by COVID-19 emphasize the importance of having resources including psychotherapy treatment, case management, crisis support, and community supports available. Making resources accessible online[3] and adapting evidence-based psychotherapy treatments to telehealth is key and would also support care post-COVID-19. In particular, group therapy is a hallmark of SUD care, which can be delivered via telemedicine, though privacy issues must be considered (e.g., recording conversations, private location, etc).

As we work fervently toward addressing the COVID-19 pandemic, we must also continue delivering ongoing treatment for patients, especially for those whom treatment disruptions may result in equally dire consequences. Telehealth can uniquely address capacity shortages, but much work is needed to support large-scale dissemination and adoption. In the future, it will also be critical to understand the impacts on treatment uptake and on patient outcomes to assess the quality of care delivered. Recent lifting of restrictions is helpful, but many of these guidelines pertain to care only under the current public health emergency. For lasting

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improvements to occur in treatment access, we need to make these changes permanent. Hopefully, years from now, we will look back at this moment not only as a tragedy, but also as a period of rapid improvements in our ability to provide care for patients with SUDs and other mental health disorders.

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