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Using telehealth to improve buprenorphine access during and after COVID-19: A rapid response initiative in Rhode Island

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ABSTRACT

Despite its proven efficacy, buprenorphine remains dramatically underutilized for management of opioid use disorder largely due to onerous barriers to treatment initiation. During the COVID-19 pandemic, many substance use disorder treatment facilities have reduced their hours and services, exacerbating existing barriers. To this end, the U.S. Drug Enforcement Administration and Substance Abuse Mental Health Services Administration adjusted their guidelines to allow for new buprenorphine prescriptions following audio-only telehealth encounters, no longer requiring an in-person evaluation prior to treatment initiation. Under this new guidance, we established a 24/7 telephone hotline to function as a "tele-bridge" clinic where people with opioid use disorder can be linked with a buprenorphine prescriber in real-time for OUD assessment and unobserved buprenorphine initiation with connection to follow-up if appropriate. Additionally, we developed an ED callback protocol to reach patients recently seen for opioid overdose and facilitate their entry into care if interested. In this commentary we describe our hotline and ED callback protocols, discuss theoretical and anecdotal benefits to this approach, and advocate for continuation of current regulatory changes post-COVID-19 to maintain expanded access to novel treatment approaches.

There are more than 2 million people in the United States living with opioid use disorder (OUD) and overdose is a leading cause of death nationwide (Substance Abuse and Mental Health Services Administration, 2019). Treatment with buprenorphine decreases mortality in people with OUD by approximately 50% (Sordo et al., 2017) and confers numerous other personal health and social benefits including reduced illicit drug use and maintenance of employment (National Academies of Sciences, 2019). Despite its proven efficacy, less than 35% of people with OUD receive any form of addiction treatment, and only a fraction of those receive treatment with medications (Jones & McCance-Katz, 2019).

To initiate buprenorphine, traditional models of care require patients to overcome multiple obstacles during a vulnerable time including stigma, lack of available providers, transportation, and being under- or uninsured. This can delay treatment enrollment, potentially resulting in prolonged opioid withdrawal, continued use of nonprescribed opioids, and deferral of treatment. Currently, the federal Ryan Haight Act ("Ryan Haight Online Pharmacy Consumer Protection Act of 2008", 2008) makes it illegal in most cases for a person with OUD to begin buprenorphine treatment without having an in-person visit with the prescriber. Designed to prohibit illicit online pharmacies, the Act has the unintended consequence of limiting access to treatment of OUD, particularly among people living in rural areas, those without reliable transportation, and those with significant family care or work obligations.

Given the clear mortality benefit and safety profile of buprenorphine, the harms of limiting access far outweigh any potential benefits. Low-threshold models of buprenorphine treatment prioritize a harm reduction, patient-centered approach that includes same-day treatment availability and minimizing administrative barriers (Jakubowski & Fox, 2020). Examples of low-threshold buprenorphine care include: unobserved buprenorphine initiation, as recommended in the latest American Society of Addiction Medicine guidelines (Kampman & Jarvis, 2015); "bridge clinics," which initiate buprenorphine treatment and link patients to community providers for maintenance treatment (Snow et al., 2019); and telehealth for treatment maintenance, which has demonstrated comparable treatment retention, substance use, therapeutic alliance, and medication adherence compared to in-person care (Eibl et al., 2017; Uscher-Pines et al., 2020; Zheng et al., 2017). A frequently cited concern about low-threshold buprenorphine access is diversion. However, primary uses of diverted buprenorphine are therapeutic, including treating withdrawal symptoms and abstaining from illicit opioid use (Cicero et al., 2018).

Currently, there are inequities in access to buprenorphine due to race, income, and geography. People with OUD who are Black (Goedel et al., 2020; Lagisetty et al., 2019), Medicaid-insured (Lagisetty et al., 2019), or living in rural areas (Amiri et al., 2018; Andrilla et al., 2019; Goedel et al., 2020; Jones et al., 2015) are less likely to have access to or be maintained on buprenorphine compared to people who are white (Goedel et al., 2020; Lagisetty et al., 2019), privately insured (Lagisetty et al., 2019), or living in urban areas. (Amiri et al., 2018; Andrilla et al., 2019; Goedel et al., 2020; Jones et al., 2015) During the COVID-19 pandemic, barriers to treatment and the consequences of untreated OUD are magnified, with an already marginalized population facing heightened barriers to care (Alexander et al., 2020; Becker & Fiellin, 2020; Volkow, 2020). Compounding the crisis, many facilities have decreased their hours and services. Patients may also be reluctant to attend in-person treatment due to governmental stay-at-home orders and fear of contracting COVID-19. Combined, these threaten to worsen treatment access and increase overdose mortality. Without rethinking

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how we can meet the needs of our patients, we will see the ramifications of this for years to come.

In light of the compounded barriers to accessing care during the COVID-19 pandemic, the Drug Enforcement Administration (DEA) has temporarily waived the requirement for an in-person examination to prescribe buprenorphine, allowing providers who are otherwise permitted to prescribe buprenorphine for OUD to initiate buprenorphine treatment via telehealth (video or audio-only) encounters (Drug Enforcement Administration, 2020, Mar 31). Following these changes, in partnership with the Rhode Island Department of Health and the Department of Behavioral Health, Developmental Disabilities, and Hospitals, we established a 24/7 buprenorphine hotline. This hotline functions as a 24-hour "tele-bridge" clinic where people with OUD can be linked with a waivered provider in real-time for an initial assessment and, if appropriate, can initiate buprenorphine through unobserved induction with linkage to longitudinal outpatient care. Patients are co-prescribed naloxone and emailed unobserved buprenorphine induction instructions, local harm-reduction information, community recovery support resources, and behavioral health services. From mid-April 2020 to mid-November 2020, the hotline has fielded 93 calls, resulting in 74 new buprenorphine prescriptions.

Concurrently, we also began an emergency department (ED) callback initiative to reach patients recently treated in the ED for an opioid overdose. This initiative identifies patients who recently presented to the ED following opioid overdose but who are not prescribed medication for opioid use disorder (MOUD). If the patient is interested in initiating buprenorphine treatment, they are connected in real-time to a waivered prescriber and undergo evaluation, treatment initiation, and linkage to care as outlined above.

Telephone assessments bypass many socioeconomic and geographic treatment barriers that currently limit buprenorphine access (Goedel et al., 2020; Grimm, 2020). Patients are able to connect to treatment the moment they feel ready and do not have to accommodate clinic hours or location, Internet availability, or transportation limitations. While this initiative has just begun and research needs to rigorously evaluate it, patients calling the hotline have voiced that they would not have otherwise entered treatment had this service not been available. Likewise, outpatient providers report improved engagement with telehealth. Our primary outpatient follow-up site, for example, has reported a 50% reduction in their no-show rate for new patient intakes (largely referred from the hotline) following transition to telehealth. Future research should determine whether telehealth can effectively address access barriers and increase the number of patients engaging in treatment, and if the privacy inherent in bypassing waiting rooms will decrease patients' experiences of stigma.

There are several regulatory and legal changes that would permit telehealth-delivered buprenorphine to continue. First, Congress could amend the Ryan Haight Act to permit waivered providers to initiate buprenorphine without an initial in-person visit where clinically indicated, as is currently proposed in the recently introduced Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act ("Telehealth Response for E-prescribing Addiction Therapy Services Act or the TREATS Act," 2020). Although the TREATS Act currently requires an audiovisual interface, it could be amended to allow for audio-only telehealth encounters. Congressional action is not necessary, however. The Ryan Haight Act's restrictions can be waived for providers practicing telemedicine during any public health emergency. While the current waiver was predicated on the COVID-19 pandemic, the DEA can and should extend the current waiver to initiate buprenorphine via telemedicine, including use of the telephone only encounters where necessary, for the duration of the opioid public health emergency that has existed since late 2017 (Davis & Samuels 2020).

Gaps and inequities in buprenorphine treatment access did not start with COVID-19 and without structural changes in policy and practice, they will persist long after the pandemic ends. Federal law should help to expand access to buprenorphine, not inadvertently obstruct treatment access. COVID-19 has given us an opportunity to develop innovative strategies to improve access to care and address access inequities and we should not abandon them when the COVID-19 public health emergency is resolved. Congress and federal agencies can and should act now to support the continuation and evaluation of buprenorphine telehealth initiatives to expand treatment access and address treatment gaps and inequities.

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