

Telehealth for Opioid Use Disorder Toolkit: Guidance to Support High-Quality Care





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Introduction

The U.S. continues to face an addiction epidemic with over 90,000 people dying of opioid and other overdoses in 2020,¹ 20,000 more than in the year before the COVID-19 pandemic began.^{2,3} Buprenorphine and methadone are both effective treatments for opioid use disorder (OUD), which reduce opioid use and are associated with reduced mortality.⁴ Extended-release naltrexone (XR-naltrexone) also can reduce substance use and is a third medication option.⁵ In spite of their effectiveness, estimates show only 20-40% of patients with an OUD receive these medication treatments,^{6,7} and rates are even lower in many communities.^{8,9} Although numerous factors contribute to low treatment rates, the limited accessibility of trained providers is widely recognized as a major contributor.¹⁰ Telehealth is a promising approach to increase availability and reach of treatment services, and use and interest has grown for telehealth-delivered treatment of OUD since the COVID-19 pandemic.^{11,12}



Telehealth modalities and scope of toolkit

Telehealth encompasses a range of telecommunication modalities to provide healthcare at a distance. This toolkit focuses on real-time (synchronous) videoconferencing, and to a lesser extent, patient visits conducted by telephone. Use of other technology-based modalities (e.g., text messaging, store-and-forward) are outside the scope. This toolkit focuses on buprenorphine (typically formulated as buprenorphine/naloxone, hereafter termed buprenorphine) and adjunctive psychotherapy treatment options for OUD and does not cover methadone treatment or XR-naltrexone. The primary goal of this toolkit is to provide clinically relevant information to support high-quality delivery of outpatient OUD care via telehealth, while reducing barriers to starting and maintaining both medication and psychosocial treatments. This toolkit is intended for clinicians, administrators and policymakers who are involved in delivering, managing and considering telehealth for OUD care. Specific tools (e.g. flowchart, checklist, sample note) are included for clinicians; these tools should be used in combination with existing tools and guidance on general OUD treatment (e.g. induction and maintenance, dosing, etc.).¹³⁻¹⁵ The goal is to help clinicians deliver high-quality tele-OUD care beyond the COVID-19 pandemic.



Background

Evidence for telehealth delivery of OUD treatment

The research on telehealth for mental health and other chronic conditions is extensive and has shown that overall, telehealth-delivered care, including medication visits and psychotherapy, is no less effective than traditional in-person care in many situations.¹⁶ Fewer studies of telehealth for OUD or other substance use disorders (SUD) have been conducted.¹⁷ Among two studies comparing videoconference-delivered psychotherapy to in-person psychotherapy for patients who were receiving methadone treatment in person, both found no difference in number of sessions attended or percent of drug positive urine tests during follow-up, and good rapport with providers.^{18,19}

Among studies examining video-delivered medication treatment for OUD pre-COVID-19, most focused on telehealth delivered by providers in one clinic location to patients at a rural clinic.¹⁷ It is noteworthy that none of these studies were randomized trials. Results generally showed similar or improved retention in treatment compared to similar care provided in person.²⁰ One study examined OUD treatment in the initial months after the start of COVID-19 and found major increases in telehealth use and decreased urine toxicology testing in the setting of social distancing during COVID-19.¹²

Finally, a few studies have examined clinician and clinic experiences of telehealth use. This body of research found major increases in both video and phone delivery of OUD and other substance-related treatment during the COVID-19 pandemic, with high interest in sustaining telehealth services post-COVID-19.^{17,21} Clinicians also describe a range of experiences, including positive impacts due to increased access for patients and issues, such as technology challenges, feeling they had less information available to inform clinical decision-making and challenges in connecting with patients.²²

In summary, research on tele-OUD care is limited compared to other forms of telehealth-delivered care and no large randomized trials have been conducted to inform effectiveness. However, studies that have examined real-world care delivered via telehealth and randomized trials for other conditions suggest that similar outcomes are possible to in-person treatment. What is unknown is the impact of other practice changes, including less frequent urine drug screens, and how those changes may impact outcomes including access to treatment and retention in OUD care.





Federal regulations and policies

Federal and state regulations govern telehealth in general and treatment involving use of controlled medications. At the federal level, the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 imposes specific rules around telehealth prescribing of controlled medications.²³ In addition to acting in the usual course of professional practice and prescribing for a legitimate medical purpose, typically a provider must conduct an in-person evaluation prior to prescribing a controlled medication. Several exceptions were built into this legislation, including exemptions for the Veterans Health Administration, the Indian Health Service, and during public health emergencies. In addition, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 included provisions to support telehealth, including waiving the requirement that patients reside in a rural area for Medicare to cover OUD care delivered remotely.²⁴



The public health emergency declared due to COVID-19 temporarily removed the requirement of an initial in-person visit that would typically be required under the Ryan Haight Act to prescribe buprenorphine for OUD. Initially, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the federal Drug Enforcement Agency (DEA) announced that practitioners could prescribe buprenorphine and other schedule II-V controlled substances to patients using telemedicine (real-time, two-way, audio-visual communication) without first conducting an in-person evaluation. This was followed by further loosening of restrictions that permitted buprenorphine prescribing after telephone evaluations for both new and existing patients.²⁵ Notably, “This may only be done, however, if the evaluating practitioner determines that an adequate evaluation of the patient can be accomplished via the use of a telephone.”²⁶ These policies will likely continue to evolve.²⁶ Access to HIPAA-compliant telehealth technology has been a barrier to telehealth adoption for some practices and treatment programs. Prior to the COVID-19 pandemic, choices of video communication products that were HIPAA compliant and available to clinical practices were limited.²⁷ During the pandemic, the Department of Health and Human Services (HHS) issued a notification of enforcement discretion that allowed healthcare providers to use any non-public facing audio or video technology (Skype, Zoom, WhatsApp, etc.) to provide telehealth care to patients.²⁸ Public-facing platforms like TikTok and Twitch were never allowed. While this notice will likely expire, the recent experience of both clinics and HIPAA-compliant vendors may create more technology choices for medical care delivered by telehealth.

The Confidentiality of Substance Use Disorder Patient Records regulations (42 CFR Part 2) are in place to protect patient privacy by limiting the way records from federally assisted SUD treatment programs can be shared.²⁹ Recent revisions to these regulations already loosened some restrictions on sharing SUD treatment records in general medical settings like primary care practices and emergency departments. Until this regulation is updated, obtaining explicit consent to share records and coordinate care remains important for OUD care delivered both in person and via telehealth.



State regulations and policies

States also regulate OUD treatment via telehealth. Regulations vary widely across states and have changed over time. Clinicians need to be aware of general telehealth regulations pertaining to healthcare delivery and additional regulations that pertain to OUD care. Providers and health systems in each state must become familiar with both their own laws and the laws of the state where patients are located if they are delivering care across state lines. The expansion in states adopting cross-state licensing has helped facilitate this practice, though these rules are constantly evolving. Regulations are in place that apply across different aspects of tele- OUD treatment, including telehealth for specialty SUD care (e.g., regulations that may be specific to telehealth for SUD treatment programs), telehealth for controlled medications (e.g., buprenorphine), drug screening requirements, credentialing of providers delivering telehealth, and other state-level regulations. In the setting of COVID-19, many states temporarily waived controlled medication prescribing barriers. However, a few states passed legislation expanding use of telehealth for OUD without a prior in-person, face-to-face visit while other states adopted stricter rules.³⁰ Some states have expanded other policies (e.g., parity in reimbursement), to extend telehealth coverage for SUD care. Given the wide array of state- and federal-level regulations that apply to telehealth delivery of OUD care, it is important for clinicians to monitor and adjust to changing policies. Table 1 describes resources relating to policies and telehealth for SUD care that may provide guidance.

Table 1. Resources for Tele-OUD

General resources on telehealth	
SAMHSA’s Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders	https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf
Virtual Community Support Resources (AA, Smart Recovery, etc)	https://www.samhsa.gov/sites/default/files/virtual-recovery-resources.pdf
Guidance on implementing telehealth (regulations, reimbursement, best	
Center for Connected Health	https://www.cchpca.org/all-telehealth-policies/
American Medical Association Telehealth Implementation Playbook	https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf
American Psychiatric Association Telehealth Toolkit	https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit
COVID-19 Related	
Substance Abuse and Mental Services Administration (SAMHSA) COVID-19 related	https://www.samhsa.gov/coronavirus
DEA guidance on controlled	https://www.dea diversion.usdoj.gov/coronavirus.html
SAMHSA technical assistance for SUD treatment during COVID-19	https://www.samhsa.gov/sites/default/files/training-and-technical-assistance-covid19.pdf



Reimbursement

Medicaid/Medicare

The rules for Medicare reimbursement for outpatient telehealth changed prior to COVID-19 with the SUPPORT Act. The SUPPORT Act lifted the location restrictions so patients could access care from home. After the start of the COVID-19 pandemic, the requirement for video was dropped to allow telephone-only visits. Medicare cost sharing was also made more flexible,³¹ but it is unclear how this will change in the future.

Unlike for Medicare, federal Medicaid regulations do not limit how telehealth can be reimbursed by states. States have broad flexibility to deliver and pay for telehealth services. However, states vary widely in types of telehealth-delivered SUD services covered and many states are experimenting with a range of services, including assessment, medication management, and both individual and group psychotherapy. Differences exist at all levels from where a service can be provided, to what technology can be used, to what location billing codes are applied, and can even depend on whether patients are covered by fee-for-service Medicaid or a Medicaid managed care plan.³²

Commercial insurance

For commercial health insurance, before COVID-19, most states had requirements to cover telehealth if the equivalent in-person care is covered, although only 10 states required reimbursement to be at the same rate as in-person visits.³¹ About half of states required cost-sharing to be the same for in-person and telehealth visits. During the COVID-19 public health emergency, many of the largest commercial payers loosened their telehealth requirements. Rules around payment parity and telephone-only encounters are highly variable, and it is unclear what changes will stay in place.³¹

In summary, COVID-19 decreased federal and state regulatory barriers and increased reimbursement options for telehealth services. Some of these policy changes may continue after COVID-19, but clinicians will need to continue to adjust to the changing regulations and reimbursement policies relevant to OUD treatment.



Clinical practices - Adapting OUD treatment practices for telehealth

Multiple guidelines are available to help clinicians provide high-quality OUD care.^{13,14} SAMHSA has also recently released broad guidance to support use of telehealth for treating serious mental illness and SUDs (see Table 1).³³ These recommendations are the foundation of high-quality OUD care delivered both in-person and by telehealth, but telehealth for OUD raises additional considerations. This toolkit should be used in conjunction with these guidance documents, which describe key elements of OUD treatment, including induction/maintenance phases, symptom monitoring, and combining medication with non-medication interventions. The sections below describe additional considerations for tele-OUD.

Monitoring (including urine toxicology testing)

Biological drug testing is a mainstay of OUD treatment. Generally, drug testing during outpatient treatment for OUD is done for a variety of reasons: 1) to provide an assessment of the response to buprenorphine (i.e., decrease in use of other opioids), 2) to detect other substance use that could impact treatment recommendations (both known and unknown by the patient), 3) to detect possible buprenorphine diversion, and 4) to monitor for adherence to prescribed medication.³⁴ However, evidence is limited to guide many aspects of drug testing, including frequency of testing and the best approach to handling positive results for other substances or the unexpected absence of prescribed medications. Additionally, it is not known if drug testing improves patient outcomes during OUD treatment with buprenorphine and whether this differs for patients seen via telehealth.



Inability to arrange timely drug testing is a recognized barrier in expanding telehealth for OUD. The COVID-19 pandemic has brought this issue into clearer focus. The American Society of Addiction Medicine (ASAM) published guidance early in the pandemic to consider pausing drug testing in clinical situations where the risk of testing outweighed the benefits.³⁷ The guidance also reminded clinicians to “avoid ordering tests the results of which will not change a patient’s management.”³⁷ During the first three months of the pandemic, the rate of urine drug screening declined while prescribing and clinic visits remained unchanged.¹² Urine drug testing remains a mainstay of OUD treatment and provides important clinical information. However, the optimal frequency of testing is unknown, and it is not clear if a decrease in drug testing during outpatient treatment for OUD will change patient outcomes. Functional improvement and keeping patients engaged in treatment should be prioritized as the most important measures of effective treatment. Some requirements may create additional barriers to treatment and should only be considered when the benefits to patients clearly outweigh the risks.



In addition to point-of-care urine drug testing, alternative and adjunctive methods can help assess for substance use (Table 2). Testing can be ordered at an outside lab with transmission of results to the clinician or over-the-counter saliva or urine testing can be supervised by video or a trusted family member, although practical issues

of home testing, including cost and test transport, can make this challenging.³⁷ Remote pill counts via video, along with routine use of state prescription drug monitoring programs (PDMPs), can help assess adherence to prescribed medications. Collateral information can be obtained from family members and others to provide nuanced information on not only substance use but also patient functioning. In-person, point-of-care testing is an important tool and will likely remain a standard of care, but in cases where it creates a barrier for patients, it is important to use additional tools to assess the response to treatment. The most fundamental tool is assessing the patient’s condition and progress via clinical interview and assessment.

Use of medication combined with non-medication and other treatments via telehealth

Psychosocial and medication treatment can be effectively delivered via telehealth for mental health conditions and substance use disorders (as well as other medical conditions).^{16,17,33} Although psychotherapies for OUD have not been shown to be effective above and beyond high quality medical management with the prescribing clinician,³⁸ many patients, especially those with comorbid conditions, benefit from additional counseling, and many patients strongly prefer it. Psychosocial interventions should be offered and made available to patients, including those receiving telehealth. Clinicians should consider the entire array of psychosocial intervention options depending on patient preferences and accessibility of care, including formal group or individual psychotherapy/counseling, community supports (e.g. Smart Recovery, Narcotics Anonymous, Alcoholics Anonymous, etc.), care management with nurses or social workers, peer recovery services, etc. These options, either in-person or via telehealth, should be considered alongside medication treatment to augment care.

Table 2. Adjuncts & alternatives to point-of-care urine toxicology testing

Clinical interview and functional assessment
Urine toxicology testing at an outside, more accessible lab, with results transmitted to clinician
Supervised home testing (e.g., patient displays results via video visit)
Remote pill counts via video
Routine use of state prescription drug monitoring program
Collateral information from family and friends



Patient rapport and feeling connected

Clinicians note a mixture of advantages and disadvantages to remote medicine. It can be more difficult to detect subtle physical signs of withdrawal and intoxication,³⁹ other physical problems related to co-occurring conditions, and harder to pick up other non-verbal cues. On the other hand, seeing patients in the context of their own home can illuminate challenges and opportunities that are easily missed in an office visit. A number of easily learned skills and practices can improve the experience of telehealth for both patients and clinicians, including ensuring a private setting, minimizing multi-tasking, and adjusting the camera and light to create an optimal viewing angle (See Table 1 - Guidance on implementing telehealth).³³ Recent experience with telehealth during COVID-19 suggests that delivering care to patients at home may decrease the stigma of treatment,^{40–42} lower no-show rates, and may lead to better retention in care.⁴³ Telehealth offers other advantages that can enhance connections with patients including more flexible and convenient check-in visits early in treatment while trust is being developed. In addition, specific practices can be used that enhance connection and monitoring. For example, more frequent phone and video visits with either the medication provider or other clinicians (clinic nurse or therapist) may improve rapport and provide more information for clinicians during treatment.



Addressing treatment disparities

Telehealth is promising particularly as the digital divide closes with fewer disparities in technology access. Nearly all (90%) U.S. adults use the internet (86% in Black/African Americans; 82% in low-income⁴⁴) and smartphone ownership is similar by racial/ethnic group (Black/African Americans: 80%, Latinx: 79%, Whites: 82%).^{45,46} Since the start of COVID-19, clinicians and patients have grown more comfortable with these modalities.²² Unfortunately, significant disparities still exist for nonmetropolitan/rural households, racial/ethnic minority households and lower income households, who are less likely to have reliable digital access.⁴⁷ Early COVID-era data show telehealth is underutilized in the care of Black patients and other under-represented groups, and many patients may be able to engage only via phone rather than video.^{48,49} These disparities highlight the importance of considering patient-specific factors, including access to reliable internet and technology in the implementation and use of telehealth.

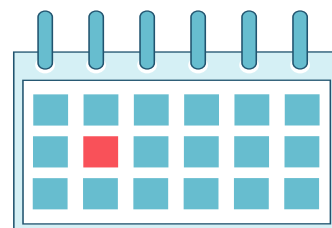


Patient case example - Considerations in tele-OD care

Starting treatment

You are scheduled for a video visit to see a new patient, LT, a 63-year-old divorced man with a history of depression, alcohol use disorder, and chronic back pain. His chief complaint is that he is “struggling with depression and opioids.” During the visit, he breaks down and says he has not been doing well. He recently lost his job as a restaurant manager. He has been at home, feeling socially isolated, and has been buying prescription opioids on the street. He started using them for back pain but now is using them to cope with his depression and to try to feel better.

He is constantly thinking about taking opioids and has not been able to cut down or stop. He also describes worsening depressive symptoms, including depressed mood and insomnia. He reports intermittent cannabis use but denies other substance use. He has used buprenorphine/naloxone from a friend and found it helpful but has not been able to take it consistently. In discussing different treatment options, you both agree starting buprenorphine/naloxone is the best next step. Below are several important considerations and steps for starting treatment for his OUD via telehealth.

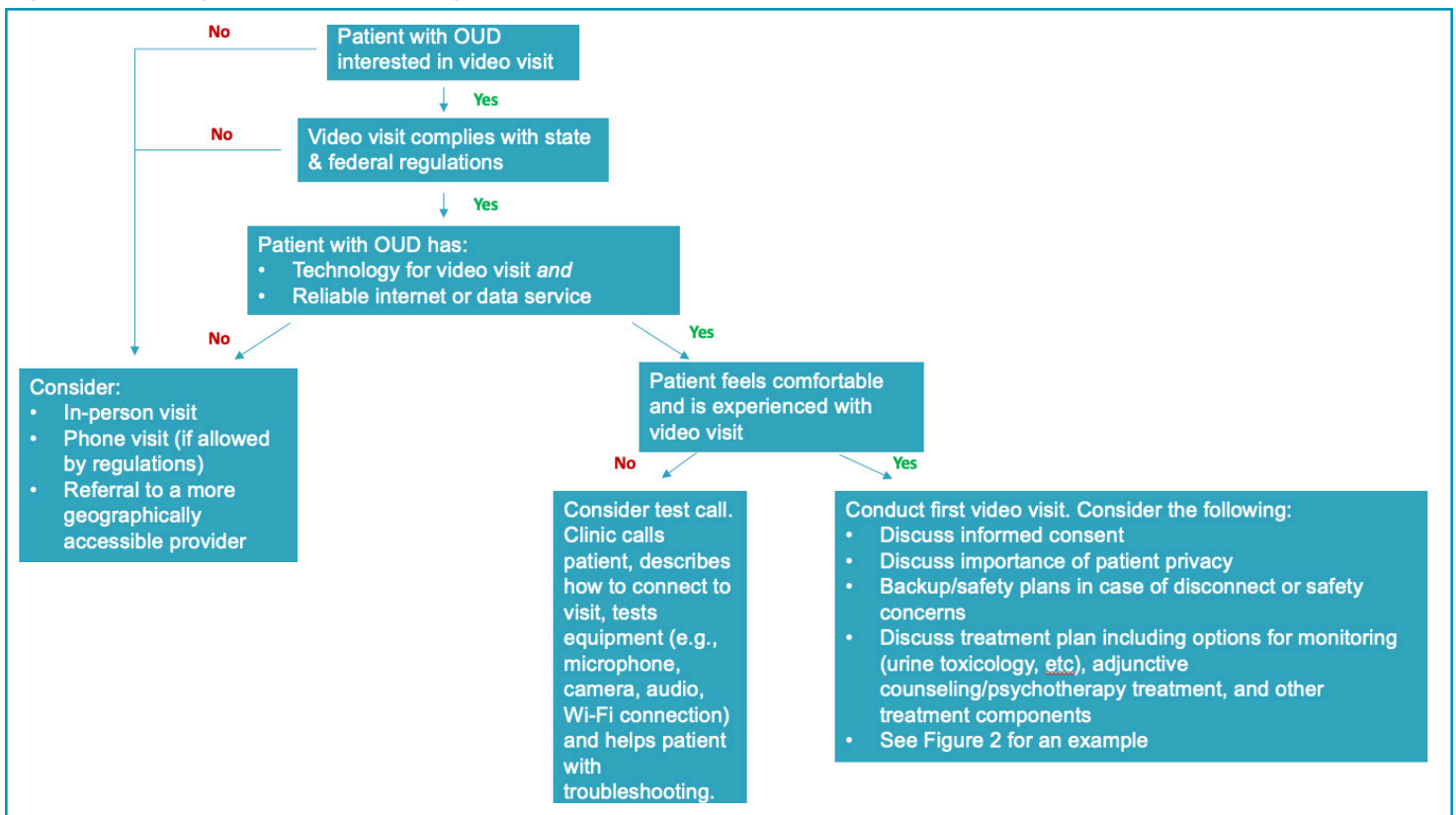


- 1) Is this patient a good candidate for starting OUD treatment via telehealth? Telehealth can remove one of the many barriers for patients to receive treatment. In general, the best candidates for tele-OD treatment have barriers to receiving in-person care and have the desire and ability to work with their clinician remotely. Other patients prefer to be seen in person for a variety of reasons, including lack of technological access, easier communication, or their own experience connecting structured, in-person visits, with recovery. *LT reports that he would need to drive 30 minutes to see you and is worried about the cost of gas now that he has lost his job. He has a smartphone and occasionally uses FaceTime with his granddaughter. He is interested in following up from his home as much as possible, supplemented with occasional in-person visits when needed.*
- 2) How do you plan to use urine drug screening as part of the initial evaluation? Most clinicians elect to do point-of-care drug testing at in-person visits. The best approach to urine drug screening for remote visits is unknown. Options include testing when clinically necessary (i.e., when results would impact decision-making), arranging for a lab test at a separate time or urine or saliva testing at home. Home testing results can be shared via video during a visit, but the reliability of home tests vary. *To start him on effective treatment without delay, you elect to prescribe buprenorphine without drug testing, with plans to do point-of-care urine drug screening, confirmatory testing for norbuprenorphine, and recommended blood testing for comorbid medical conditions soon (i.e., the next time he is near the lab). You decide to start buprenorphine with plans for a follow-up telehealth visit in one week.*



- 3) What role does the physical assessment play during telehealth evaluation and follow-up visits? The diagnosis of opioid use disorder does not require physical exam findings. Some guidelines recommend a physical exam as part of the initial evaluation when considering starting buprenorphine,⁵⁰ including assessment for infections, liver disease and neurological problems, but it is uncommon for physical exam findings to alter the plan for initial treatment. Signs of intoxication and withdrawal can be visible (e.g., altered behaviors, rhinorrhea) and a thorough review of systems can be obtained remotely. *During your remote visit with LT, you review how to start buprenorphine using a list of subjective withdrawal symptoms used for home inductions.*
- 4) How do you plan to encourage retention in treatment? Retention in treatment is a strong predictor of improved patient outcomes.⁵¹ It is important to prioritize a pragmatic and compassionate approach to care, by individualizing the frequency and flexibility of visits (prioritizing feasibility for the patient), utilizing frequent contacts with multiple modalities when needed (e.g., phone check-ins with you or your staff), remotely delivered case management, and other remotely delivered supports and treatments. See Figure 1 for additional guidance on the decision to use telehealth and Figure 2 for a sample note section that can be added to existing documentation of treatment.

Figure 1. Flow diagram on decision-making considerations in tele-OUD initiation





When a patient is struggling

You have been conducting telehealth visits with LT for the past 8 months and he has been functioning and feeling well. However, he missed his last telehealth appointment and missed his last lab visit for urine toxicology. You call him, and he reports he has been struggling financially, which has worsened his mental health and triggered him to use opioids. You discuss several treatment options, and he says he wants help but no longer has a car.

1) How can you further optimize his OUD treatment? With a patient who is struggling with substance use during buprenorphine treatment, many options to optimize treatment are available, including changing dose or formulations, increasing frequency of visits and monitoring, and expanding adjunctive psychosocial interventions. These approaches are outlined in treatment practice guidelines (SAMHSA Tip 63 and ASAM Guideline for Treatment of OUD^{13,14}). Telehealth may provide an additional tool to minimize disruptions in care by lowering barriers for patients to continue to engage in care.

2) What are different approaches to monitoring for substance use and minimizing risk for diversion? Transportation is often a barrier for both in-person visits and laboratory testing.

When a patient is struggling with ongoing substance use during telehealth treatment, it may be important to consider multiple different options for monitoring including the approaches in Table 2. Assessing a patient's condition clinically is a critical tool that can be further strengthened by ensuring good rapport. The key to this rapport may include a clear understanding with the patient that you will continue to work with them and make appropriate recommendations as they encounter barriers and challenges. Increasing frequency of telehealth visits with a patient may help with clinical assessments and may be one of the more feasible options for patients. It is important to discuss these contingency plans when discussing telehealth with patients (see Table 3 Checklist for Tele-OUD)





3) What are additional treatments to consider? It is important to explore the specific contributors to a patient’s instability, which often include psychosocial stressors that exacerbate comorbid mental and physical conditions, and prioritizing additional treatments focusing on these comorbid conditions (e.g., psychotherapy or medication treatment for mental health and comorbid SUDs and community support programs such as AA and SMART Recovery). One potential advantage of tele-OUD treatment is familiarizing patients with remote care in general. In many areas, access to mental health services is limited. It is important to consider referral to additional treatments, including evidence-based psychotherapies and more intensive treatments (e.g., specialty SUD programs, inpatient treatment, residential programs, etc.). It is also critical to consider if the patient can access and engage in these additional treatment options to inform recommendations and next steps in their treatment plan. Clinicians should avoid discontinuing care, especially when a recommended treatment option is not feasible for the patient.

Table 3. Checklist of considerations and steps for tele-OUD treatment

<input type="checkbox"/>	<p>Determine what telehealth services are supported</p> <ul style="list-style-type: none"> • Check current federal and state regulations • Check reimbursement based on patient's insurance
<input type="checkbox"/>	<p>Discuss what technologies patient has access to and is comfortable using</p> <ul style="list-style-type: none"> • Has device with camera? • Has phone with adequate minutes/service? • Has used videoconference before? • Has consistent Wi-Fi services or willing to incur data usage/costs? • E-mail or text for scheduling visits/reminders? • Consider performing a test video call with clinic staff
<input type="checkbox"/>	<p>Discuss back-up plan if patient gets disconnected from telehealth visit (e.g. provider will call patient's phone number or patient should contact clinic).</p>
<input type="checkbox"/>	<p>Discuss approaches to assess how patient is doing</p> <ul style="list-style-type: none"> • Options for biological drug testing: toxicology screening at the clinic, toxicology screening at an outside laboratory, home toxicology monitoring • Additional strategies (e.g., collateral info from family, subjective symptom scales, self-report of substance use, adherence to treatment visits) • Discuss plans for adjusting assessment methods and frequency with changes in clinical status (e.g., substance use impacting functioning, missing appointments, other signs of clinical instability)
<input type="checkbox"/>	<p>Discuss and document safety practices and safety plan (e.g., concern about suicide or overdose risk)</p> <ul style="list-style-type: none"> • Importance of patient being in safe/private location during visit • Patient provides their location and contact number at beginning of visit • Family or other contact available in case there are acute safety concerns • Provide local and national crisis hotline numbers • Ensure patient has access to naloxone in case of overdose • Instructions for patient to contact 911, present to nearest ED for any medical emergency
<input type="checkbox"/>	<p>Discuss and document additional treatment options and accessibility (e.g., telehealth and in-person psychotherapy if needed, encourage psychosocial support groups, and higher levels of care if needed)</p>
<input type="checkbox"/>	<p>Provide telehealth patient instruction and OUD treatment agreement (e.g., with the above information that can be e-mailed/texted/mailed to patients)</p>



The future of telehealth for OUD

Tele-OUD care will continue to evolve as policies change in the post-COVID-19 era and additional research examines the impact of telehealth on access to care and patient outcomes. The goal of this toolkit is to support clinicians to continue tele-OUD care. However, if changes in treatment modality are needed, clinicians should consider the following to help patients manage the challenges of a transition: 1) Initiate treatment planning and discussions with patients about planning for changes in care delivery well ahead of time. For example, some patients who are now accustomed to phone visits or who have transportation barriers or other family responsibilities may need to adjust to traveling for some in-person treatment visits. Rather than changing abruptly or completely to in-person care, many patients may need the flexibility of a hybrid model with telehealth visits at times, especially during the transition. It is critical to minimize even brief disruptions in care, particularly for the treatment of OUD. 2) Monitor changes in policies and guidelines at the state and federal level. We encourage policymakers to create and maintain a transparent central repository of policies. Clinicians can also work with their own healthcare system to ensure they are adhering to policies and advocate for changes as needed.

Any policy changes may have substantial impacts for many of our patients, some of whom have only known buprenorphine treatment via telehealth. Some disadvantaged groups of patients may have only accessed care via telephone and could be at serious risk of treatment disruption, depending on how regulations and reimbursement change.

COVID-19 has changed how SUD care is delivered in the United States. Prior to COVID-19, telehealth for SUD was rarely used; during the pandemic, care in much of the U.S. transitioned to telehealth as the primary modality. For many patients, the ideal model may be a hybrid of in-person and virtual care that is individualized based on patient needs and preferences. For example, a patient who does not have reliable access to transportation may do best starting buprenorphine treatment virtually, have frequent video and phone visits with the prescribing clinician and other staff, but have intermittent in-person visits as needed when it is feasible for them to travel to the clinic. The optimal balance will need to be informed by future research to determine which patients benefit from varying mixtures of in-person and virtual care.

High quality care is the goal of OUD treatment regardless of where or how that treatment is delivered. The current challenge is to improve access and utilization of evidence-based treatments that are currently only used by a minority of patients. A related challenge is to improve the quality of care delivered to patients with OUD. The foundations of high-quality OUD care are the same regardless of how and where it is delivered. What telehealth for OUD care should NOT be is brief, occasional phone or video visits with the sole purpose of providing a prescription. The goal is patient-centered and evidence-based treatment focused on understanding and addressing the needs of patients. The expansion of telehealth is an opportunity to reassess which aspects of our current practice improve patient outcomes and which create barriers that further stigmatize patients with OUD and limit access to effective treatment.



Summary recommendations

- Prioritize a patient-centered approach in which decisions about treatment plans and treatment modalities are informed by individual patient needs.
- Use multiple tools to assess and monitor patients' response to treatment, including but not limited to urine toxicology screens.
- If considering transitions in treatment modality, work closely with patients and offer adaptability to minimize any disruptions in care.
- Communicate with your healthcare system and stay up to date with changing telehealth policies.

Figure 2. Sample note section on tele-OUD to be edited and combined with usual OUD treatment note

This visit was conducted with the use of: Telephone Real-time audio and video

Originating site: Patient's home Another location: _____

Distant site: Clinical site Another location: _____

Patient's contact phone number during visit: _____

Patient consented to telehealth visit. We discussed importance of patient being in a private and safe location during visit. We discussed a contingency plan if we are disconnected (e.g., I will call patient at contact number and/or patient will call clinic). Patient has been provided crisis resources and instructions in case of emergency (call 911, crisis lines, present to nearest emergency room).

Plan for assessing clinical status (check all that were assessed)

Clinical interview and patient self-report

Observe patient presentation (signs of mood stability, signs of intoxication, symptoms/signs of intravenous drug use)

Toxicology screening:

Toxicology testing at clinic

Toxicology testing at outside lab

Home toxicology testing

Collateral information from family and friends

Remote pill counts via video

Check state prescription drug monitoring program

Other: _____

Discussed with patient plan for changes in care if there is worsening of symptoms including:

Increase frequency of telehealth visits Add in-person visits

Additional psychosocial treatment/counseling Additional care management

Other: _____



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