What Have We Learned from Prior Sessions?

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Key Themes

1. We need **standard terminology and definitions** to promote a shared understanding and common language

2. **Patients and families with lived experience** need to be partners in transforming new systems of care

3. **Hybrid integrated models** are the likely future of pain management and SUD care

4. We need to address **clinical challenges** to virtual care for pain management and SUD and share best practices

5. **Regulatory and payment challenges** continue to limit consistent access to quality virtual care for patients with pain and SUD care, but must also focus on community protection

6. The **digital divide** risks worsening inequities if not addressed

7. **More data and research** on value, effectiveness, and implementation requirements of telehealth-enabled pain and SUD care are needed

8. **Joint accountability** across policymakers, regulators, employers, purchasers, payers, systems, providers and patients is needed to build strong systems and improve outcomes
Terminology & Definitions
Defining Terms
What are we talking about?

• Given the rapid expansion and adoption of telehealth and virtual care services, there is a need for standardized telehealth-related terminology to ensure clear communications and understanding among healthcare professionals, researchers, policymakers, and patients.


  o *BUT, who will standardize?*
Just a Few Federal Definitions…

- HSRA defines telehealth as: “The use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration, and public health.”
- CMS states telemedicine is: “A two-way, real-time interactive communication between a patient and physician”
- National Institute of Standards and Technology (NIST) defines telemedicine as: “The electronic exchange of medical information”.
- Of the organizations and federal agencies reviewed, only 1/3 represented telemedicine as having a clinical care focus, while “the other half” included CME and admin processes.
Key terms defined

**Digital Diagnostics**
- Broadly defined as algorithm-enabled diagnostic support
- Can help anticipate a patient's reaction to a certain course of treatment or assess risk

**Digital Therapeutics (DTx)**
- Use evidence-based techniques, such as cognitive behavioral therapy, to deliver therapeutic relief, particularly the prevention, management, or treatment of chronic, behavior-modifiable disease (continued on next slide)

**Remote Patient Monitoring**
- Encompasses the collection, evaluation and transmission of health data from a patient to their provider/team using personal health technologies (e.g. wireless devices, wearable sensors, and mobile apps)
- Clinicians can use the measurements to adjust medications and prevent adverse events, like relapses or overdoses

**E-Consultations**
- Enables providers to get input and support from specialists, which may help prevent unnecessary travel and reduce wait times

**Telepharmacy**
- Uses telecommunication and other technologies to provide pharmaceutical services to outpatients remotely; helps address pharmacist shortages in underserved areas
What are DTx ... and what are they not?

- Use *software and data science* to prevent, manage or treat a medical disorder or disease

- Can provide *behavioral interventions in a standardized, scalable and cost-effective manner*

- Have the potential to augment OUD treatments by *improving medication adherence, or treatment retention*

- Are *not* general wellness apps
Reimagining the New Continuum of Virtual Care

Telehealth “Virtual Care” exists on the care continuum

Increasing Technical and Human Resource Requirements

- SMS Alerts
- Store-and-Forward
- Chat & ChatBot
  - Asynchronous allows for Multitasking
- Phone Call
- Tele-presenter (tele-stroke, tele-ICU)
- Video Visit
- Remote Pt Monitoring
- Group Visits
  - Synchronous allows for High Fidelity Info Exchange
Who Will Standardize?

Telehealth

Telemedicine   Virtual Care
Asynchronous   Digital Health   Synchronous
Store-and-Forward   mHealth   Remote Patient Monitoring
Treatment vs. Wellness   Digital Therapeutics   Prevention vs. Stress Management

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Lived Experience Perspectives
With greater use of telehealth and virtual care services during the COVID-19 PHE, individuals with chronic pain and SUD have highlighted several benefits of virtual care, including:

- Increased access to peer support, case management, counselling, and care providers, especially in rural areas with limited workforce.
- Improved flexibility to schedule, manage, and attend appointments.
- For those with pain, decreased travel time can mean decreased pain experienced due to long car rides, bright lights, etc.
- For those with SUD, regulatory flexibilities and teleMOUD eased some of the logistical burdens and increased access (e.g., remote medication counts, take-homes, waiving drug testing and counselling, etc.)
Lived Experience Perspectives

• However, individuals with chronic pain and SUD have also raised several challenges which must be addressed, including:
  • Lack of ability to access care due to governmental regulations on high levels of security of information and exchange of information
  • Problems with privacy, including a lack of faith in security of devices and software and a need to have access to a secure and private place for appointments (e.g., work-place rooms, community centers, etc.)
  • Issues related to interstate licensing resulting in patients having to drive to cross a state line to see a provider in a neighboring state
  • Difficulties navigating different systems and processes across providers (not exclusive to telehealth)
  • Potential for misdiagnoses, which may occur without full in-person physical examination
  • Issues of digital literacy
Lived Experience Perspectives

• To leverage these benefits and address these challenges:
  • We need hybrid care with in-person and virtual care components
  • Payers and policymakers need to ensure patients can have access to whatever types of care leads to best outcomes
  • Patients and providers need to co-design systems to determine how telehealth and virtual care can best meet their needs
  • We need to break down silos, remove unnecessary requirements, and emphasize best practices on best use of telehealth-enabled pain and SUD care
Patient Level Implications

• Telehealth as a tool in integrating care and extending the reach of specialty providers\(^1\)

• High levels of satisfaction with the use of telehealth services among people treated with buprenorphine\(^2\)

• No significant differences between starting buprenorphine via telehealth and in-person in:\(^1,2\)
  • The rate of continued substance use
  • Retention in treatment
  • Engagement in services

• No significant difference in client and provider ratings of therapeutic alliance when using telehealth technology.\(^2\)

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Telemedicine saves chronic pain patients time and money

Patients highly satisfied with virtual care, study shows

CHICAGO – Patients who saw a pain medicine specialist via telemedicine saved time and money and were highly satisfied with their experience, even before the COVID-19 pandemic, according to a study being presented at the ANESTHESIOLOGY® 2020 annual meeting.

• By going virtual UCLA Pain Clinic patients saved:
  • Median 69 minutes of traffic time per visit
  • Median $22 in gas and parking fees per visit
Hybrid, Integrated Models
Hybrid, Integrated Models

- The future should not be either-or, but instead hybrid, integrated care delivery—combining in-person, virtual visits, and care coordination and navigation

- A hybrid approach can improve care by:
  - Enabling higher coordination of multidisciplinary care teams
  - Improving integration of behavioral health services
  - Reducing disparities in healthcare delivery
  - Expanding access to specialized care
  - Increasing compliance with treatment
  - Driving better outcomes
  - Lowering cost of care
  - Reducing care fragmentation
  - Incentivizing collaborative care

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Hybrid, Integrated Models

• Examples of comprehensive hybrid pain and SUD care models:
  o VA Clinical Resource Hub’s TelePain Program
  o CommonSpirit-Bright Heart Health teleMOUD clinical partnership
  o Rush University Medical Center’s Substance Use Intervention Team (SUIT)

• Key learnings:
  → Focus on workflow
  → Clinical pharmacists are a key link to the hybrid care team
  → There are a broad set of virtual tools – not just video appointments—including remote patient monitoring, digital therapeutics, telepharmacy, etc.
  → Alternative payment models, including value-based contracting, can support the scaling of hybrid care models
Improving care through a hybrid approach

- Higher coordination of multidisciplinary care team
- Better integration of mental health services
- Reduces disparities in healthcare delivery
- Greater accessibility and less stigma
- Drive better outcomes for many conditions
Continuity of Pain Care Model

PSH Care Team

Preop Clinic
Pain Service
Physical Therapy
Mental Health

Support Services
PCP
Anesthesiologist
Surgeon

Pain Specialist

Post Discharge

- Rehabilitation
- Opioid management
- Chronic pain

POSTOP

- Transition techniques
- Facilitate recovery
- Plan discharge
- Communicate with PCP

INTRAOP

- ERAS Protocols
- Pre-emptive, individualized intervention

PREOP

- Evaluate
- Educate
- Optimize

Mariano, Walters, Kim, Kain. A&A 2015
Walters, Mariano, Clark. Pain Med 2015
Work Flow

Patient admitted for a medical or surgical complaint who also has opioid use disorder

MD places consult to opioid stewardship PharmD for management

PharmD will initiate an evidence-based opioid agonist to treat opioid use disorder + monitoring + adjunctive meds for withdrawal

PharmD will take BHH kiosk to the patient’s room and help the patient self-refer to BHH for comprehensive and appropriate transitions of care to the outpatient space

BHH ensures adequate, comprehensive follow-up and treatment
Substance Use Intervention Team - Workflow

**In-Patient Nurses**
- Consult to Social Work
  Via Column Notification

**In-Patient Social Workers**
- Complete full AUDIT/DAST Questionnaire
- Brief Intervention and Follow Up

**In-Patient Consult Team**
- The Inpatient consult team will round on identified patients
- Medication Assisted therapy
- SUIT SW/RN Coordinator will be responsible for orchestrating appointment to outpatient Clinic and other Resources

**Outpatient Clinics**
- Outpatient Clinics:
  - Rush Addiction Medicine Clinic
    (Patient must have a Dual Psychiatric Diagnosis)
  - Toxicology Clinic
    (This will be a medicine clinic available to patients who do not have an existing psychiatric diagnosis.)
  - NOWPOW resources

**Consult to In-patient Consult Service Via Addiction Medicine Service Order**

**Referral to Outpatient Resource**

**Patients can be referred to outpatient clinic for follow up, psychotherapy and to continue Medication assisted therapy**
Pager 85-7848 (85-SUIT)
Clinical Challenges
Clinical Challenges

- While telehealth helped to ensure access to care for many during the COVID-19 PHE, moving from in-person to telehealth presented challenges for pain and SUD providers, including:
  - Less structure and accountability
  - Less information to inform clinical decision-making, including limited ability to perform physical examination
  - Difficulty connecting / establishing a therapeutic relationship for some
  - Technological challenges
  - Layered digital divide
  - Concerns about patient risk and liability
  - Concerns about quality implications
  - Potential financial implications for a providers' hospital or clinic
  - Over-regulation of what is required to provide care, leading long intake times and stifling rapid patient engagement in care
    - “My patients say it is easier to walk out the door and access fentanyl than to access buprenorphine or methadone treatment”

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Clinical Challenges

- To address these challenges, consider:
  - Determining what limitations on in-person physical exams are acceptable for appropriate quality patient care
  - Providing training and education for providers on telehealth and other digital technologies
  - Ensuring reimbursement for telehealth-related services
  - Addressing sociodemographic differences / barriers, including the digital divide
Table 1. Benefits of telemedicine (audio and video) in chronic pain

Benefits of Audio and Video Telemedicine in Chronic Pain Medicine

Psychosocial and motivational factors
Convenience and improved access
Gaps in medical care can be bridged by telemedicine
Comprehensive evaluations can be performed remotely

Table 2. Drawbacks of telemedicine (audio and video) in chronic pain

Drawbacks of Audio and Video Telemedicine in Chronic Pain Medicine

Diminished quality of the provider/patient interaction
Limited ability to perform a physical exam
Psychological/social history challenges
Patient engagement issues
Potential financial implications for a provider’s hospital or clinic
Key Takeaways and Next Steps

- TelePain Care improves access to specialized pain care and MOUD
- Interprofessional TelePain Care Teams benefit underserved areas and may improve health equity
- A mixture of on-site care (labs, procedures, CIH therapies) and telehealth care (diagnosing, evaluation, medication management, behavioral therapy) is optimal for a multi-modal approach to specialized pain care
- CDC 2022 Guideline Update: In practice contexts where virtual visits are part of standard care (e.g., in remote areas where distance or other context makes follow-up visits challenging), follow-up assessments that allow the clinician to communicate with and observe patient through telehealth modalities may be conducted.
- VA CRH Interprofessional TelePain Teams are in their infancy. Anticipate this model will add to the evidence needed to support the delivery of comprehensive pain care via telehealth
Regulatory & Payment Challenges
Regulatory & Payment Challenges

• Further, many regulatory and payment challenges exist that challenge the broader use, integration, and access to telehealth and virtual care services for pain management and SUD, including:

  o Competing focus on diversion of controlled substances versus access to treatment
  
  o Concerns about discontinuing waiver to the Ryan Haight Act in-person examination requirement
  
  o Large regulatory differences in state requirements for telehealth providers (>300 telehealth-related bills filed in states the first two months of 2022)
  
  o Variation in credentialing and interstate licensing of providers

→ Cont. next slide
Regulatory & Payment Challenges

- Discrepancies in language, terminology, and definitions used by legislators, regulators, and federal agencies, leading to legal requirements that may be inappropriate or unclear
- Reimbursement and coverage of audio-only telehealth
- Lack of guardrails around evidence-based care and fraud/waste/abuse
- Lack of metrics on appropriate care
The CY 2022 PFS Final Rule provided enhanced access to telehealth services for Medicare beneficiaries, including mental health services which will have a positive impact on access to care for mental health conditions and contribute to overall health equity.

Mental Health (Consolidated Appropriations Act (CAA) Section 123)
- CMS removed the geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services when used for the purposes of diagnosis, evaluation, or treatment of a mental health disorder.
- CMS finalized the requirement of an in-person, non-telehealth service be provided by the physician or practitioner furnishing mental health telehealth services within six months prior to the initial telehealth service, and at least once every 12 months thereafter.

Audio-only
- CMS finalized the creation of a service-level modifier for use to identify mental health telehealth services furnished to a beneficiary in their home using audio-only communications technology.
- CMS amended our regulation to specify that an interactive telecommunications system can include interactive, real-time, two-way audio-only technology for telehealth services furnished for the diagnosis, evaluation, or treatment of a mental health disorder under certain conditions:
- CMS clarified that SUD services are considered mental health services for purposes of the amended definition of “interactive telecommunications system” to include audio-only services.
The Sudden Pivot to Virtual Services

The adoption of virtual care for SUD and pain treatment was low, <1%, of all claims prior to March 2020.

Between March and April of 2020 UHC/Optum network received over 11K applications from providers wanting to provide and reimbursed for virtual services.

The opportunity for the plan was not only to maintain but to increase access to specialty care including medication assisted treatments.

The initial challenge was squarely in the technology. It is the technology platform HIPAA complaint and protecting member privacy?

The second challenge was risk management. What is the plan to treat members at risk, medication diversion control, accessing labs and general health related risk management when you are not face to face with your patient.
The pandemic story: the problems were amplified...exponentially

**The threat of the virus**
- Fear of illness, death
- Overload on the health care system

**Youth mental health**
- Increased anxiety, depression
- Increased BH-related ER admissions

**Surge in demand, finite access**
- MH and SUD treatment need outpaces care supply
- Virtual as growing care standard

**Explosion of innovation**
- Surge in interest
- Surge in support of new hybrid models
- Surge in care alternative innovation
- Explosion of Venture Capital funding

**Major life impacts**
- Loss of life, loved ones
- SDOH: Loss of housing, employment, food insecurity
- Schools closed
- Social movements, systemic racism
- Stigma decrease around mental health needs

** Substance use**
- Increased alcohol use, fewer social constraints (drinking at home)
- Loss of community recovery supports, enhanced isolation
- Non-opioids contaminated with lethal synthetic opioids (fentanyl)
- Record high overdose deaths

**Increased engagement**
- Increased penetration, first timers
- Increased frequency in behavioral health visits
The “endemic” story: we’re amid an industry transformation

The virus is more contagious
- Fear of illness, death
- Ongoing strain on the health care system

A mental health epidemic
- National youth mental health crisis - surgeon general advisory

Redefinition of care services
- Lack of evidence, regulation, oversight, or consumer protection
- Too few providers, but saturated market of those trying to aggregate providers
- Many direct-to-consumer options

Darwinism: survival of the fittest, or is it the loudest?
- Providers/vendors hungry for customer acquisition
- Focus on profitability & domination in the market
- Lack of evidence-based guard rails

Life reflections
- Hybrid models for work, school
- The Great Resignation
- Consumer choice
- Wellness as a priority for all

Worsening of the substance use epidemic
- New challenges:
  - Contaminated drugs & use in isolation increasing fatalities
  - Increased alcohol use

Increased demand & expectations
- For personalization: consumer choice, rapid care access and diversity
- For options: both the what & the how
- For employee wellbeing support
Reimbursement Models for Virtual and Tech-Enabled Care

Create the optimal model, combining coverage/care/digital capabilities to meet patients where they are and serving them with the best clinical solutions

• Fee For Service (FFS) is the traditional model of reimbursement for medical and behavioral health Services. Members will have a cost share for each service rendered in this model. Downside- limits care to traditional professional services

• Alternative Payment Models (APMs) aka bundled models where the plan reimburses a flat fee for all services – medical and behavioral -where only Rx is carved out and paid separately. In this model the member’s cost share is reduced to a single cost share for a bundle of services. Goal is to reduce member financial liability to keep member engaged in care longer. Can reimburse non traditional services like peer coaching

• Value Based Contracts (VBCs) where incentive payments are made in accordance with predefined quality outcome and/or access measures. Goal is to incent provider to manage the member’s care with a focus on outcomes and member retention. Can be paired with either FFS or APM
Six Domains of Telehealth Impact

1. Member Experience
2. Access to Care
3. Equity
4. Quality
5. Costs
6. Program Integrity
1. **Payment Parity**: understanding costs to providers; incentivizing appropriate utilization of telehealth

2. **Audio Only**: potential double-edged sword on equity
Guide for Future Directions for the Addiction and OUD Treatment Ecosystem

By R. Corey Waller, Kelly J. Clark, Alex Woodruff, Jean Glossa, Andrey Ostrovsky, and the Prevention, Treatment, and Recovery Working Group of the Action Collaborative on Countering the U.S. Opioid Epidemic
April 5, 2021

Delineates at depth the necessary areas of focus as

The 4 Cs: Capacity, Competency, Consistency, and Compensation
What the U.S. Needs for Tech Deployment

1. New Billing Codes & Reimbursement Levels
2. Collaborative Care Incentives; Better SUD-Primary Care Cooperation
3. Resolution of Federal & State Regulatory Obstacles
4. Upgrade Licensure/Funding to Drive Standards, Data, & Outcomes QI
5. Facilitate EHR Interoperability
6. Build Standards & Quality Review – But DON’T Over-regulate
   • Not prescription-required, not necessarily FDA approval required
   • Some expectation, e.g., peer-reviewed study publication
   • For the consumer, provider, but esp. the payer
Digital Divide
Digital Divide

While telehealth and virtual care offer solutions to increasing access to care, there are concerns that they may also risk exacerbating existing health disparities, due to a lack of broadband access and digital literacy, particularly for rural, low-income, and older adult populations.

For these communities, coverage of audio-only care is an important option to help overcome these barriers.

- However, audio-only may be a potential “double-edged” sword for equity, as it may result in lower quality and poorer outcomes.

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Majorities of Americans have a smartphone, subscribe to broadband, but this varies by education, income.

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Factors Associated with Buprenorphine Initiation Via Telehealth vs. In-Person

• Use of telehealth not related to:
  • Clinical severity/comorbidity (e.g., moderate or severe OUD, severe mental illness, non-OUD SUD, recent OUD ED visit, recent benzo Rx fill)

• Use of telehealth less likely among:
  • Black, rural, and dual eligible Medicare beneficiaries
  • Beneficiaries with solo practitioner (vs. larger practice) or primary care physician (vs. psychiatrist) as their prescriber
  • Commercially insured in lower income counties
Barriers to Implementing Video Visits for Patients with OUD Reported by OUD Clinicians (n=602)

Fig. 2. Barriers to Implementing Video Visits for Patients with OUD (N = 602).
Note: Clinicians were asked to select their three main barriers to using video from these options.

Majorities of Americans have a smartphone, subscribe to broadband, but this varies by education, income

% of US adults who say they have or own the following
Data & Research Needs
Data & Research Needs

• To inform policy and practice, more data and research is needed to determine:
  o What quality outcomes should be the targets for managing pain and SUD?
    o Then we can look at audio-only vs. audiovisual vs. in-person treatment utilization for value (cost vs quality) metrics
  o Will inadequate telehealth visits lead to more secondary visits?
  o EHR interoperability
  o Standards and quality review for virtual care modalities
• The ideas research ideas generated in today's discussion will be given to the NAM Action Collaborative's Research, Data and Metrics Needs Working Group

• The AC's Research Agenda will be updated with this and other new identified research needs
Joint Accountability
Joint Accountability

• To advance hybrid care delivery for pain management and SUD care, we need to promote joint accountability across policymakers, regulators, employers, purchasers, payers, systems, providers, and patients

• This will require:
  o Coordinated alignment of measures and metrics across the delivery system for Treatment As Usual as well as virtual care
  o Focus first on baseline process measures before value-based / pay for performance measures
  o Investment in infrastructure supports to ensure accountability and drive improvement (examples: state oversight of licensed providers, payer focus on quality utilization management, regulations built with clinician input, flexible payment paradigms)