

March 13, 2023

## Improving Access

### NAM Action Collaborative on Countering the U.S. Opioid Epidemic Telehealth and Virtual Care Meeting Series

---

#### BACKGROUND

Throughout the course of the COVID-19 public health emergency (PHE), telehealth and virtual care have emerged as potentially paradigm-shifting tools for both pain management and substance use disorder (SUD), impacting patient access, care delivery, and quality of care for the millions of Americans affected by these related, but disparate, health conditions. Yet, several challenges remain to fully integrate these services into the continuum of care for patients suffering from chronic pain or substance misuse. These include policy, regulations, payment and reimbursement, health professional education and training, technology, digital literacy, and equity considerations.

To better understand these challenges and identify potential solutions, the Pain Management Guidelines and Evidence Standards (PM) and Prevention, Treatment, and Recovery Services (PTR) Working Groups of the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic (NAM, n.d.a)—a public-private partnership working to advance multisector, interprofessional solutions to reduce opioid misuse and improve outcomes for individuals, families, and communities affected by the opioid crisis—convened a four-part meeting series on telehealth and virtual care in the context of pain management and SUD care (NAM, n.d.b). The meeting series was planned by Action Collaborative members from both the PM and PTR Working Groups, including Helen Burstin, Council of Medical Specialty Societies (co-lead); Kelly J. Clark, Addiction Crisis Solutions (co-lead); Rhonda Robinson Beale, UnitedHealth Group; Elizabeth D. Bentley, Kaiser Permanente Northwest; Anna Legreid Dopp, American Society of Health System Pharmacists; Lewis Levy, Teladoc Health; Shari Ling, Centers for Medicare and Medicaid Services; Friedhelm Sandbrink, U.S. Department of Veterans Affairs; and Sarah Wattenberg, National Association for Behavioral Healthcare. A Discussion Proceedings summarizing the first meeting in the series, titled "Introduction to Improving Telehealth and Virtual Care for Pain Management and Opioid/Substance Use Disorder," is now available (Duff et al., 2022).

The second meeting in the "Improving Telehealth and Virtual Care for Pain Management and Substance Use Disorders" meeting series—and the subject of this Discussion Proceedings—focused on improving access (meeting agenda available here: <https://nam.edu/wp-content/uploads/2022/03/Telehealth-Meeting-2-Agenda.pdf>). The meeting was held virtually on March 11, 2022, and brought together more than 70 participants, including representatives across health professional groups, industry, federal agencies, advocacy groups, academia and research, health plan providers, and health systems. The primary objectives of the meeting were to (1) understand the current regulatory and policy environment as it relates to telehealth for pain management and SUD care; (2) identify access-related barriers and challenges, including regulatory, policy, payment, and others, for the adoption and use of telehealth for pain and SUD across care settings; (3) explore opportunities for telehealth to improve access to pain and SUD care and services; and (4) discuss strategies to overcome identified barriers and capitalize on opportunities for expanded access to telehealth services for pain management and SUD care.

The second meeting was composed of four sessions. The first two sessions reviewed the regulatory and policy environment for telehealth and pain and SUD care services at both the state and federal levels, respectively. The third session considered clinical perspectives for transitioning pain and SUD interventions from in-person to virtual care and the role of payment and reimbursement policies in increasing access to telehealth-enabled care. The final session explored the intersection of access to quality telehealth-enabled pain and SUD care with health inequities and social determinants of health, considering ways telehealth may exacerbate and ameliorate existing health disparities among diverse populations.

## MEETING SUMMARY

### State and Interstate Regulatory Policy Landscape

The first session brought together **Lindsey Browning**, program director of Medicaid operations at the National Association of State Medicaid Directors; **Ankit Gupta**, founder and chief executive officer of Bicycle Health, the largest online provider of medication-based treatment for opioid use disorder (OUD) in the United States; and **Doris K. Cope**, a pain management specialist in private practice in the state of Georgia, to discuss how state-level regulatory policies have impacted access to, and delivery of, telehealth-enabled pain management and SUD care.

As panelists noted throughout the discussion, states have considerable authority over the regulation of health care practice and coverage within their borders and have played an outsize role in determining what types of telehealth-enabled care are allowable within certain settings. In fact, according to the American Telemedicine Association, state legislators introduced more than 300 telehealth-related bills in the first two months of 2022 alone (American Telemedicine Association, 2022). As Browning noted, this significant abundance of legislative activity demonstrates that “telehealth is here to stay.”

However, Gupta pointed out that this uptick in state-level telehealth legislation adds to an already complex web of OUD-specific regulations across federal and state government as well as state medical boards. Gupta noted that providers must also navigate varying messages from different Drug Enforcement Administration (DEA) divisions. While the temporary federal suspension of the Ryan Haight Act (DEA, 2020)—which requires an in-person examination before any health care provider can prescribe controlled substances via telehealth (including medications for OUD like buprenorphine and methadone)—helped to increase access to some telemedicine-based opioid treatment (TBOT), some states continue to discourage TBOT. This occurs either by continuing to require an initial in-person exam, not allowing the prescribing of controlled substances via telehealth, or having overly restrictive licensing pathways that discourage TBOT providers.

Similarly, Cope highlighted that for providers in Georgia, both the patient and provider must be in a licensed health care facility within the state to conduct a telehealth visit. This may soon change though, as Georgia has recently joined the Interstate Medical Licensure Compact, which allows providers to deliver care across state lines, either in-person or via telehealth (Interstate Medical Licensure Compact, 2019). However, state regulations still prohibit providers from prescribing controlled substances via telehealth, require that random urine drug screenings occur in person, and necessitate written consent prior to a telehealth visit for those insured by the state Medicare and Medicaid program.

Browning noted six domains of telehealth impact that the state Medicaid directors are evaluating: member experience, access to care, equity, quality, cost, and program integrity. Program integrity includes protections against fraud, waste, abuse, and potential for diversion of controlled substances. A participant noted that many regulations are in place to protect the patient and minimize the risk of diversion. Browning agreed, stating that Medicaid directors have long been concerned about diversion and therefore are more likely interested in using telehealth to provide counseling and wrap-around supports, including care coordination and linkages to community services. However, Gupta shared diversion control tactics that can translate to the virtual environment; for example, Bicycle Health distributes at-home kits to its patients that allow providers to perform random drug screenings. Additionally, providers can conduct live-video pill counts through Bicycle Health’s app, and all prescribing occurs during a live audio-visual visit. Gupta suggested that strategies such as these should continue to be scaled and explored, especially as many of the regulations being discussed can restrict access to care over the long term.

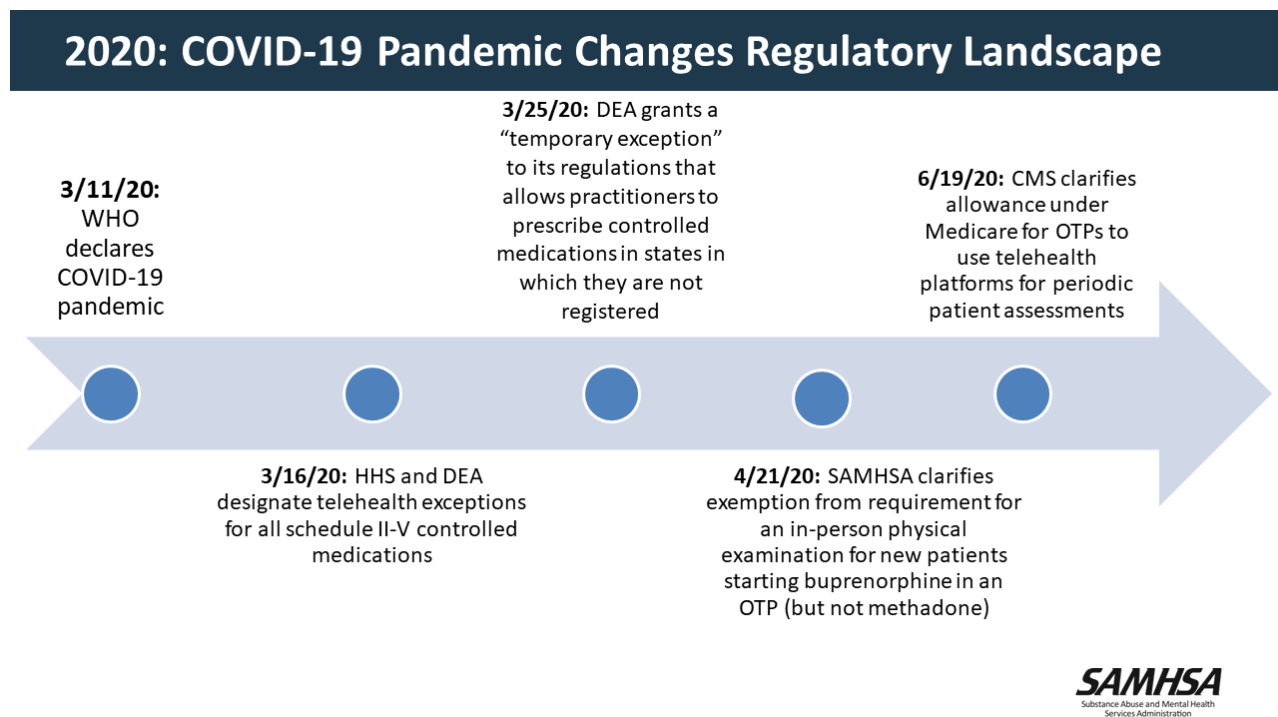
Another issue that states are considering is coverage of audio-only care, which Browning identified as a “double-edged sword,” as it can potentially increase access to care but may limit the quality of care. States will weigh these concerns (access versus quality) differently, with some choosing to maintain audio-only coverage following the end of the COVID-19 PHE while others will discontinue coverage. Browning indicated that states need more data on audio-only care to help inform these decisions.

### Federal Regulatory and Policy Landscape

In the second session, **Shari M. Ling**, deputy chief medical officer of the Centers for Medicare and Medicaid Services (CMS), and **Yngvild K. Olsen**, director of the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration (SAMHSA), discussed the federal regulatory-policy response to ensure access to, and continuity of, pain management and SUD care during the COVID-19 PHE.

As Ling noted, prior to the COVID-19 pandemic, the United States was already two years into battling the federally declared opioid crisis PHE. In an effort to battle these two emergencies simultaneously, CMS sought to implement the maximum flexibilities within the agency's authority to enable access to care and services for beneficiaries with pain, including granting Medicare 1135 waivers and issuing a new Medicare Physician Fee Schedule final ruling that enhanced access to telehealth services, including for mental health services (CMS, 2021).

Olsen noted that SAMHSA, too, pivoted very quickly to increase flexibilities that allowed for the use of telehealth in SUD care and treatment (see *Figure 1*), recognizing that many of the economic, social, and political conditions that can contribute to substance use were being exacerbated by some of the pandemic response measures. In addition to the temporary suspension of the Ryan Haight Act done by the Department of Justice/DEA in collaboration with SAMHSA, SAMHSA revised the federal regulation 42 CFR to exempt certified opioid treatment programs from requiring an in-person physical examination before starting new patients on buprenorphine (SAMSHA, 2020). However, Olsen pointed out that this exemption did not apply to methadone, which is an issue that may need to be reconsidered in the future.



**Figure 1 |** COVID-19 Pandemic Changes to the Federal Regulatory Landscape (2020)

SOURCE: Olsen, Y. K. 2022. *Implications of Changes to Federal Telehealth Policy and Regulations during COVID-19 Public Health Emergency on Delivery of SUD Care* [PowerPoint slides]. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Available at: [https://nam.edu/wp-content/uploads/2022/04/5.-YOlsen\\_Federal-TH-Policies-for-SUD.pdf](https://nam.edu/wp-content/uploads/2022/04/5.-YOlsen_Federal-TH-Policies-for-SUD.pdf). Reprinted with permission.

Ling and Olsen emphasized that while the initial focus of these regulatory-policy actions was on ensuring access to care, the impact and effectiveness of these changes on outcomes and quality of care are equally important to understand. When comparing in-person- versus telehealth-initiated buprenorphine, no significant differences in rate of controlled substance use, retention in treatment, engagement in services, patient and provider rating of therapeutic alliance, or levels of patient satisfaction have been demonstrated (Guille et al., 2020; King et al., 2014). However, for patients with pain, Ling stressed the importance of ascertaining diagnostic clarity, suggesting that not all patients can fully meet their needs through telehealth. Ling shared that the Dr. Todd Graham Pain Management Study, section 6086 of the SUPPORT Act, is already collecting and reporting some effectiveness data on telehealth-enabled pain management (Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, 2018).

In closing the session, Olsen underlined the importance of taking lessons from the COVID-19 pandemic to determine the necessary guardrails to ensure telehealth and virtual care services produce the best outcomes possible for pain and SUD patients. Ling noted that one of the core lessons of the last two years has been that we need to “meet people where they are . . . in a more person-centered way, and telehealth helps us get there.”

## Clinical and Payment and Reimbursement Considerations

Building on the previous regulatory-policy discussion, the third session focused on clinical payment and reimbursement considerations for transitioning pain and SUD care to a hybrid environment. Panelists included **Edward R. Mariano**, chief of anesthesiology and perioperative care services at the Veterans Affairs Palo Alto Health Care System and chair of the American Society of Anesthesiologists Committee of Regional Anesthesia and Pain Medicine; **Haiden A. Huskamp**, the Henry J. Kaiser professor of health care policy at Harvard Medical School; **Debra Nussbaum**, senior director of behavioral health products at Optum; and **Chad Ellimoottil**, medical director of virtual care at the University of Michigan Medical Group.

As panelists reflected on the rapid pivot to telehealth at the onset of the COVID-19 pandemic, they noted that both payers and providers had to quickly adapt policies and practices to ensure continuity of care for patients, at times before guardrails had been established. For example, Nussbaum shared that in the first month of the pandemic period, from March to April 2020, UnitedHealth Group (of which Optum is a subsidiary) saw a 2000% increase in tele-behavioral health service claims among commercially insured members. There was discussion among panelists that this may be because tele-counseling services appear to be more readily amenable to the virtual environment than other types of care.

However, Huskamp noted that, based on a national survey of clinicians managing patients with OUD, telehealth use has been lower for OUD care than for other types of behavioral health care, including initiation of buprenorphine. This is despite the temporary suspension of the Ryan Haight Act (Huskamp et al., 2021). Further, Huskamp highlighted a recent claims data analysis, which found that use of telehealth initiation for buprenorphine treatment was less likely in Black, rural, and dual-eligible Medicare beneficiaries; commercially insured populations in lower-income counties; and those treated by a primary care provider versus specialists, or by a solo provider versus within a larger practice setting (Barsky et al., 2022). The top three barriers to telehealth visits to treat OUD were: (1) lack of patient readiness (e.g., lack of devices, digital literacy, or broadband); (2) technology problems of the clinic (e.g., hardware, software, or broadband); and (3) lack of infrastructure (e.g., HIPAA-compliant equipment). Other key clinical barriers to telehealth-enabled pain and SUD care include:

- Limited ability to perform physical exams
- Patient engagement issues
- Potential financial implications for a provider's hospital or clinic
- Insufficient staff to facilitate video visits
- Reimbursement concerns

Ellimoottil presented data on several myths of telehealth appointments, including (1) payment parity will lead to runaway health care utilization; (2) the cost of delivering telehealth is lower than in-person care, and clinicians have lower marginal costs; and (3) telehealth will lead to billing for low-value care. He stated there is a need for data on whether inadequate telehealth visits will lead to increased secondary visits. The use of the new audio-only billing codes will allow data gathering on cost and quality outcomes of audio-visual versus audio-only services.

Nussbaum recommended that more data is also needed to help inform how payment models can support the integration of telehealth into systems of care while also incentivizing improved outcomes. However, she offered that alternative payment models, such as bundled payments and value-based contracting, continued to be used during the pandemic and can include a range of services. Mariano agreed, noting that alternative payment models can capture elements of care coordination that are important to interdisciplinary care and—when combined with the opportunity to leverage telehealth to bridge gaps in transitional care—may decrease unexpected health care utilization downstream.

In closing the session, panelists suggested that policy makers, payers, health systems, and clinicians work together to gather the needed data and evidence that could lead to thoughtful, evidence-based policy solutions to address telehealth issues.

## Intersection of Access to Quality Care and Social Determinants of Health

In the final session, **Nicol Turner Lee**, director of the Brookings Institution's Center for Technology Innovation; **Hannah Snyder**, director of CA Bridge; **David Kan**, chief medical officer at Bright Heart Health; and **Chris Fore**, director of the Indian Health Service Telebehavioral Health Center of Excellence, explored the potential for telehealth to both exacerbate and ameliorate health disparities for those with pain and SUD.

To start the session, Turner Lee encouraged participants to consider, “How do we embrace, as a medical imperative, that people [need to be] connected?” Turner Lee noted that 38% of those living in Black communities in the rural U.S. South lack internet access, making access to audio-only and asynchronous telehealth visits vitally important for those with unstable internet connections (Turner Lee, 2022). Fore contextualized this further, noting that an estimated 35% of American Indian and Alaska Native (AI/AN) reservations lack access to electricity and running water (Tanana and Bowman, 2021; DigDeep. n.d.). As the U.S. healthcare system continues to advance toward more integrated, hybrid systems of care, these populations, along with those that are older, rural, and lower income, risk being left behind.

However, panelists unanimously agreed that telehealth offers a vitally important access point to reach underserved communities. Snyder stated that telehealth for SUD treatment—including audio-only and asynchronous communications—can be a tool for improving accessibility and equity. She noted that older adults, BIPOC (Black, Indigenous, and people of color), rural communities, and those with lower education and incomes have less access to audio-visual medical visits as compared to individuals who are White, reside in urban areas, and/or belong to middle- or upper-class households.

Offering lessons from her CA Bridge program to initiate emergency department buprenorphine and continue treatment, Snyder recommended the following tactics to increase equitable access to care for a safety net population:

- Availability of audio-only care
- Flexible visits, in terms of length, formality, and time
- Integration of telehealth with brick-and-mortar clinics (e.g., hybrid care delivery model)
- Rapid access and “drop-in” telehealth visits
- Telephonic language interpretation services
- Telehealth harm reduction

Kan noted that Bright Heart Health has found success in reaching carceral populations through telehealth by developing partnerships with jails, courts, state prisons, and detention centers. It was also suggested that in addition to harm reduction, offering access to other safety net supports (such as bus passes that are often available at in-person clinic settings) in community-based settings could be an important link and access point for hybrid-based care moving forward.

In terms of recommendations for policy makers, Fore stressed the importance of audio-only care for AI/AN populations, asserting that “oftentimes it’s [audio-only] or nothing at all.” Kan advocated that the Ryan Haight Act exemptions should be made permanent, as the exemptions expand access to buprenorphine for pain and SUD patients alike. Turner Lee proposed that federal partners be encouraged to support and invest in online connectivity, particularly for populations whose health is most adversely impacted by isolation. Snyder underscored the need for flexibility to meet patients where they are, regardless of circumstance.

As a final call to action, the panelists urged participants to continue to recognize the digital divide as a health disparity. In doing so, Turner Lee urged that “we must ensure that innovations in telehealth be made available to everyone, not just those who are the most advantaged.”

## AREAS OF FUTURE FOCUS AND PRIORITIES FOR ACTION

**Helen Burstin**, Council of Medical Specialty Societies, and **Kelly J. Clark**, Addiction Crisis Solutions

This series’ second meeting on telehealth for pain management and OUD/SUD treatment identified various areas where attention will be needed on state and federal regulation changes to allow virtual health care delivery to become a routine part of treating pain and SUD/OUD. This is particularly true in areas related to the prescribing of controlled substances, as opposed to psychotherapy and psychosocial support delivery, that is part of a multi-disciplinary approach to both pain and SUD/OUD management.

The authors of this section have identified the following priorities for further discussion and action:

- **Gather data and evidence from beyond traditional government-funded and academic processes.** Academic studies and modeling of data are important mechanisms to gain insight into costs and quality of care for telehealth and virtual care delivery. But information regarding the costs and quality of telehealth and virtual care in contrast to brick-and-mortar care delivery must be gathered in real-world environments. Due to the need for increased access to care during the pandemic, telehealth expanded faster than an organized data collection approach for access, cost, and quality data could be developed. Given the continued reliance on audio-only telehealth, new data approaches, such as analysis of new billing codes for audio-only care, should provide the data required for

evidence-based policy making. Important information about these areas should be obtained from private sector organizations delivering care and through claims data of public and private payers.

- **Integrate telehealth into systems of care for pain management and OUD/SUD.** The panelists clearly demonstrated that telehealth increased access to care for these patient populations. However, there was a recognition that care should be provided where and when it would lead to the best patient outcomes. It was acknowledged that a comprehensive, hybrid approach, that combines telehealth and in-person care, would allow systems of care to meet people where they are and offer the best care available.
- **Balance the public health concerns related to telehealth by appreciating the underlying issues.** The panelists repeatedly showed that telehealth has enormous potential to reach underserved communities, including American Indian and Alaska Natives and carceral populations. In underserved rural areas with poor broadband coverage and for populations with difficulty accessing visual telehealth services, audio-only visits may be the only way care can be delivered. Although initial markers for quality showed no difference between audio-visual TBOT and office-based care delivery for OUD patients, concerns about quality will only be fully addressed by the use of data gathered from the wide range of sources noted above. The adoption of a broad-based approach to monitoring and evaluating telehealth impact is needed to fully address the cost, quality, and equity issues of pain and SUD/OUD care. An example is the approach of the National Association of State Medicaid Directors described by Browning in the first session, which focuses on member experience, access to care, equity, quality, cost, and program integrity (Browning, 2022).
- **Address concerns about potential diversion of controlled substances prescribed through telehealth by the wide clinical adoption of diversion control protocols.** Telehealth is particularly restricted in the prescription of controlled substances. While there were repeated calls for COVID-19 PHE exceptions to the Ryan Haight Act permanent, there are reasonable concerns about the practices that led to its adoption. In the intervening years, the legitimate practice of medicine has expanded to include telehealth as well as group practice models, and an initial in-person examination by a specific prescriber has become a significant barrier to treatment access. The use of medical societies' clinical guidelines and professional norms of practice should guide care delivery, whether care is performed virtually or in person. Similar to in-person care, robust diversion control protocols can and should be implemented through audio-visual telehealth, including use of Prescription Drug Monitoring Programs, photo identification verification, urine or saliva drug screening with validity testing, pill counts, and monitored self-dosing. The wide adoption of these practices within telehealth would provide the same assurances regarding diversion control as are provided by in-person care delivery. While some states do not allow any prescribing of controlled substances via telehealth, and some have moved to require an in-person visit with the prescriber before a telehealth prescription, states must use the same multipronged approach of balancing program integrity with access, quality, cost, and equity as state Medicaid directors are embracing to improve community health.
- **Bridge disparities in national broadband deployment and provide assistance in accessing it.** The research presented by panelists in the final session indicates that the lack of broadband infrastructure impedes adoption of synchronous telehealth visits but that significant barriers persist related to both patient and provider ability to access broadband itself. This impedes access to the wide range of telehealth and virtual care technologies, with some areas showing wide disparities. The most recent data from the Federal Communications Commission estimates that more than 17% of rural Americans and 21% of Tribal lands still lack broadband connectivity (Federal Communication Commission, 2021). Further, lack of patient readiness, including lack of devices and digital literacy, as well as lack of available technology for providers, were identified as critical barriers by panelists and participants. Without a focus on user-friendly technology and patient and provider assistance in using it, telehealth and virtual care will not achieve its potential.

## REFERENCES

1. American Telemedicine Association. 2022. *ATA Action's State Legislative Tracker 2022*. Available at: <https://www.americantelemed.org/policies/atas-state-legislative-and-regulatory-tracker/> (Accessed March 11, 2022).
2. Barsky, B. A., A. B. Busch, S. Y. Patel, A. Mehrotra, and H. A. Huskamp. 2022. Use of Telemedicine for Buprenorphine Inductions in Patients with Commercial Insurance or Medicare Advantage. *JAMA Network Open* 5(1):e2142541. <https://doi.org/10.1001/jama-networkopen.2021.42531>
3. Browning, L. 2022. *Insights from State Medicaid Leaders* [PowerPoint slides]. National Association of State Medicaid Directors. Available at: [https://nam.edu/wp-content/uploads/2022/04/1.-LBrowning\\_Insights-from-State-Medicaid-Leaders.pdf](https://nam.edu/wp-content/uploads/2022/04/1.-LBrowning_Insights-from-State-Medicaid-Leaders.pdf) (Accessed April 19, 2022).
4. Centers for Medicare and Medicaid Services. 2021. *Calendar Year (CY) 2022 Medicare Physician Fee Schedule Final Ruling* [Fact sheet]. Available at: <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule> (Accessed April 19, 2022).
5. DigDeep. n.d. *Navajo Water Project*. Available at: <https://www.navajowaterproject.org/home-2020> (Accessed January 20, 2023).
6. Drug Enforcement Administration. 2020. *Use of Telephone Evaluation to Initiate Buprenorphine Prescribing*. Available at: [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-022\)\(DEA068\)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20\(Final\)%20+Esign.pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20(Final)%20+Esign.pdf). (Accessed April 19, 2022).

7. Duff, N., E. Freiling, H. Burstin, K. J. Clark, and A. Salman, rapporteurs. 2022. *NAM Action Collaborative on Countering the U.S. Opioid Epidemic Telehealth and Virtual Care Meeting Series: Introduction to Improving Telehealth and Virtual Care for Pain Management and Opioid/Substance Use Disorder*. Discussion Proceedings, National Academy of Medicine, Washington, DC. Available at: <https://nam.edu/programs/action-collaborative-on-countering-the-u-s-opioid-epidemic/introduction-to-improving-telehealth-and-virtual-care-for-pain-management-and-opioid-substance-use-disorder/>. (Accessed June 29, 2022).
8. Federal Communications Commission. 2021. *Fourteenth Broadband Deployment Report*. Available at: <https://www.fcc.gov/reports-research/reports/broadband-progress-reports/fourteenth-broadband-deployment-report> (Accessed April 19, 2022).
9. Guille, C., A. N. Simpson, E. Douglas, L. Boyars, K. Cristaldi, J. McElligot, D. Johnson, and K. Brady. 2020. Treatment of Opioid Use Disorder in Pregnant Women via Telemedicine: A Nonrandomized Controlled Trial. *JAMA Network Open*, 3(1):e1920177. <https://doi.org/10.1001/jamanetworkopen.2019.20177>.
10. Huskamp, H. A., L. Riedel, L. Uscher-Pines, A. B. Busch, M. L. Barnett, P. Raja, and A. Mehrotra. 2021. Initiating Opioid Use Disorder Medication via Telemedicine during COVID-19: Implications for Proposed Reforms to the Ryan Haight Act. *Journal of General Internal Medicine*, 37: 162-167. <https://doi.org/10.1007/s11606-021-07174-w>
11. Interstate Medical Licensure Compact. 2019. *Georgia Joins the Interstate Medical Licensure Compact Commission* [Press release]. Available at: <https://www.imlcc.org/wp-content/uploads/2020/02/IMLCC-Georgia-joins-the-ILMCC-4-25-2019.pdf> (Accessed April 19, 2022).
12. King, V. L., R. K. Brooner, J. M. Pierce, K. Kolodner, and M. S. Kidorf. 2014. A Randomized Trial of Web-based Videoconferencing for Substance Abuse Counseling. *Journal of Substance Abuse Treatment*, 46(1):36-42. <https://doi.org/10.1016/j.jsat.2013.08.009>.
13. National Academy of Medicine. n.d.a. *Action Collaborative on Countering the U.S. Opioid Epidemic*. Available at: <https://nam.edu/programs/action-collaborative-on-countering-the-u-s-opioid-epidemic/> (Accessed April 19, 2022).
14. National Academy of Medicine. n.d.b. *Improving Telehealth and Virtual Care for Pain Management and Substance Use Disorders*. Available at: <https://nam.edu/programs/action-collaborative-on-countering-the-u-s-opioid-epidemic/improving-telehealth-and-virtual-care-for-pain-management-and-substance-use-disorders/> (Accessed June 29, 2022).
15. Olsen, Y. K. 2022. *Implications of Changes to Federal Telehealth Policy and Regulations during COVID-19 Public Health Emergency on Delivery of SUD Care* [PowerPoint slides]. Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration. Available at: [https://nam.edu/wp-content/uploads/2022/04/5.-YOlsen\\_Federal-TH-Policies-for-SUD.pdf](https://nam.edu/wp-content/uploads/2022/04/5.-YOlsen_Federal-TH-Policies-for-SUD.pdf) (Accessed April 19, 2022).
16. Riedel, L., L. Uscher-Pines, A. Mehrotra, A. B. Busch, M. L. Barnett, P. Raja, and H. A. Huskamp. 2021. Use of Telemedicine for Opioid Use Disorder—Perceptions and Experiences of Opioid Use Disorder Clinicians. *Drug and Alcohol Dependence*, 228:108999. <https://doi.org/10.1016/j.drugalcdep.2021.108999>.
17. Substance Abuse and Mental Health Administration. 2020. *FAQs: Provision of Methadone and Buprenorphine for the Treatment of Opioid Use Disorder in the COVID-19 Emergency*. Available at: <https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf> (Accessed April 19, 2022).
18. Substance Use—Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, 21 U.S.C. § 6086 (2018). <https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf> (Accessed April 19, 2022).
19. Tanana, H., and W. Bowman. 2021. *Energizing Navajo Nation: How Electrification Can Secure a Sustainable Future for Indian Country*. Available at: <https://www.brookings.edu/blog/how-we-rise/2021/07/14/energizing-navajo-nation-how-electrification-can-secure-a-sustainable-future-for-indian-country/> (Accessed January 20, 2023).
20. Turner Lee, N. 2022. *Why Closing the Digital Divide is a Health Equity Matter* [PowerPoint slides]. Center for Technology and Innovation, the Brookings Institution. Available at: [https://nam.edu/wp-content/uploads/2022/04/10.-NTurner-Lee\\_Digital-Divide.pdf](https://nam.edu/wp-content/uploads/2022/04/10.-NTurner-Lee_Digital-Divide.pdf) (Accessed April 19, 2022).

---

**DISCLAIMER:** This Discussion Proceedings was prepared by Noah Duff, Aisha Salman, and Emma Freiling as a factual summary of what occurred at the meeting and areas of future focus and priorities for action. The statements made are those of the rapporteurs or individual meeting participants and do not necessarily represent the views of all meeting participants; the planning committee; members of the associated program; the National Academy of Medicine; or the National Academies of Sciences, Engineering, and Medicine.

**CONFLICTS OF INTEREST:** The planning committee for the “Improving Telehealth and Virtual Care for Pain Management and Substance Use Disorders” meetings series, in developing the agenda for this convening, determined that in order to properly understand the current landscape, players, and pain points of telehealth as used to treat substance use disorder and pain, individuals with financial conflicts of interest would need to participate in the discussion. To this end, Kelly J. Clark has a financial conflict of interest in that she reports personal

fees from Bicycle Health. These discussion proceedings are not conclusions or recommendations of the National Academy of Medicine or the National Academies of Sciences, Engineering, and Medicine and are but a faithful summarization of discussions held at the convening named above. All statements within are attributable only to the individual they are attributed to or the named author of a section.

**REVIEWERS:** To ensure that it meets institutional standards for quality and objectivity, this Discussion Proceedings was reviewed by **Joanna Katzman**, University of New Mexico and **Mary R. Grealy**, Healthcare Leadership Council.

For additional information, please visit <https://nam.edu/programs/action-collaborative-on-countering-the-u-s-opioid-epidemic/improving-telehealth-and-virtual-care-for-pain-management-and-substance-use-disorders/>.

**SUGGESTED CITATION:** Duff, N., E. Freiling, H. Burstin, K. J. Clark, and A. Salman, rapporteurs. 2023. *NAM Action Collaborative on Countering the U.S. Opioid Epidemic Telehealth and Virtual Care Meeting Series: Improving Access*. Discussion Proceedings, National Academy of Medicine, Washington, DC.



NATIONAL ACADEMY OF MEDICINE