ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

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Session Date: Friday, July 21, 2023

Didactic Topic and Presenter:
Telehealth to Deliver Addiction Medicine Services in Rural Communities

Jillian Landeck, MD
Associate Professor of Family Medicine
University of Wisconsin Department of Family Medicine and Community Health

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- 12:15 PM: Attendance text-in – Introductions
- 12:25 PM: Case Presentation and Discussion
  - Presenter: Jensena Carlson, MD FAAFP - *Associate Professor of Family Medicine, University of Wisconsin Department of Family Medicine and Community Health*
- 1 PM: Didactic Presentation
  - Presenter: Jillian Landeck, MD
- 1:15 PM End of Session

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UNIVERSITY OF WISCONSIN–MADISON

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ECHO ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics
2022-2024
Telehealth to Deliver Addiction Medicine Services in Rural Communities
7/21/23
Didactic Presenter: Jillian Landeck, MD
Case Presenter: Jensena Carlson, MD FAAFP

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:

Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

Objectives:

As a result of this educational regularly scheduled series, learners as members of the healthcare team will be able to:

- Describe the use of telehealth in addiction medicine over time and policies that impact its use and prevalence
- Identify the advantages, barriers and limitations around using telehealth
- Describe best practices for telehealth visits, specifically in regards to rural health

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Randall Brown	RSS Chair	Usona Institute (Grant / Contract), multi-disciplinary association for psychedelic studies (Grant / Contract)	Yes	1/30/2023
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Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	1/29/2023
Paul Hutson	Planner	No relevant financial relationships to disclose	Yes	1/28/2023
Susan Mindock	Planner	No relevant financial relationships to disclose	No	1/31/2023
Sheila Weix	Planner	No relevant financial relationships to disclose	No	2/3/2023
Kellene Eagen	Planner	No relevant financial relationships to disclose	No	1/27/2023
Joseph Galey	Planner	No relevant financial relationships to disclose	Yes	1/27/2023
David Leinweber	Planner	No relevant financial relationships to disclose	No	4/13/2023

Jensena Carlson	Presenter	No relevant financial relationships to disclose	No	7/17/2023
Jillian Landeck	Presenter	No relevant financial relationships to disclose	No	6/27/2023

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Case Presentation

Jensena Carlson, MD
University of Wisconsin - DFMCH

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For this educational activity there are no reported conflicts of interest

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Case Introduction

- One-liner (including age/sex):

  36 year old male with cerebral palsy with spastic hemiplegia, recent testicular cancer, and history of multiple orthopedic injuries with an extended history of chronic pain and opiate use disorder.

- Primary question for discussion:

  How to balance is chronic pain from spasticity and orthopedic injuries with significant opiate dependency

Medical & Behavioral Health Diagnosis:	Current Medications:
• Spastic Hemiplegia • Chronic bilateral knee pain secondary to previous MVA • Hx testicular cancer s/p orchiectomy • Daily marijuana use	• Morphine 30 mg TID • Oxycodone 5 mg every 4-6 hours prn (taking 30 mg daily) • Trazodone 100 mg nightly • Gabapentin 600 mg am and noon, 900 mg qhs • Meloxicam 15 mg daily (recently started) *Previous treatment trials:* *Duloxetine to 60 mg daily* *Amitriptyline to 100 mg daily* *Tizanidine up to 4mg TID*

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Substance Use

- History:
  - Initially prescribed in high school (by our clinic) for orthopedic injuries from sports
  - Increasing doses over time, with substantial increase after MVA with multiple fractures
  - 2013 “violation of pain contract” with multiple providers and increasing use
    - Tried to reestablish care in 2016 and 2018 but did not follow up
  - Progressive elicit oxycodone use up to 180 mg daily (per report, UDS with fentanyl)
- Consequences of Substance Use:
  - Social/occupational/educational:
    - Physical occupation (freelance contractor/maintenance) but no longer able to maintain employment
    - Multiple OWI, upcoming trial
  - Physical (including evidence of tolerance/withdrawal): Withdrawal symptoms (n/v, diarrhea, pain, runny nose, cravings) when using only prescription opiates

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Substance use

- Past treatments:
  - Methadone clinic 6 months and then 8 months
    - Left as he was unable to maintain employment
    - Started illicit use within a week of leaving the methadone clinic
  - Suboxone induction x2 with significant withdrawal and never made it to sustained therapy

  - No previous inpatient and firmly declines at this time

Social History:	Family History:

• Social Factors/History:
  • Partner of 5 years also with opiate dependency and currently living abroad with her family
  • Living at home with mother
• Education/Literacy: Finished high school
• Income source: No longer employed, previously off the books maintenance
	• Longstanding maternal family history of alcohol dependency, including in mother who is currently sober

Patient strengths & protective factors:	Risk factors:
• Strong family support • Good sense of humor • No mental health comorbidities	• Consistently relapses when he travels into Madison • Previous experiences with medication assisted treatment • Very high dose opiate use

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Labs

- No abnormalities
  - Normal LFTs
  - Negative Hepatitis/HIV panel

- UDS intermittently positive for fentanyl/norfentanyl

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Patient Goals & Motivations for Treatment

- Ultimate goal is complete sobriety without MAT

- Motivations
  - Partner to be able to return to live with him in the US
  - Would like to find full time employment he enjoys
  - Meeting family expectations

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Proposed Diagnoses

- Severe Opiate Use Disorder
- Spastic hemiplegia

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Proposed Treatment Plan

- Plan for managing spasticity
  - Gabapentin helps some
  - Tizanidine was helpful but with sedation
  - Possible botox?

- Taper current opiate prescription
  - Likely start with oxycodone and then morphine
- Initiate suboxone with micro induction

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Discussion:

- Primary question: How to balance is chronic pain from spasticity and orthopedic injuries with significant opiate dependency?

- Other questions:
  - Is suboxone our best treatment option?
  - Is this possible without inpatient/partial inpatient program?

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DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} Physical Dependence ≠ Use Disorder

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2-3 = mild
4-5 = moderate
≥ 6 = severe

By initialing here _JMC_ you have acknowledged that Project ECHO case consultations do not create or otherwise establish a provider-patient relationship between any ECHO clinician and any patient whose case is being presented in a teleECHO clinic.

Telehealth Delivery of Addiction Services in Rural Communities

Dr. Jillian Landeck
University of Wisconsin-Madison
Department of Family Medicine and Community Health

Department of Family Medicine and Community Health
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Background/objectives

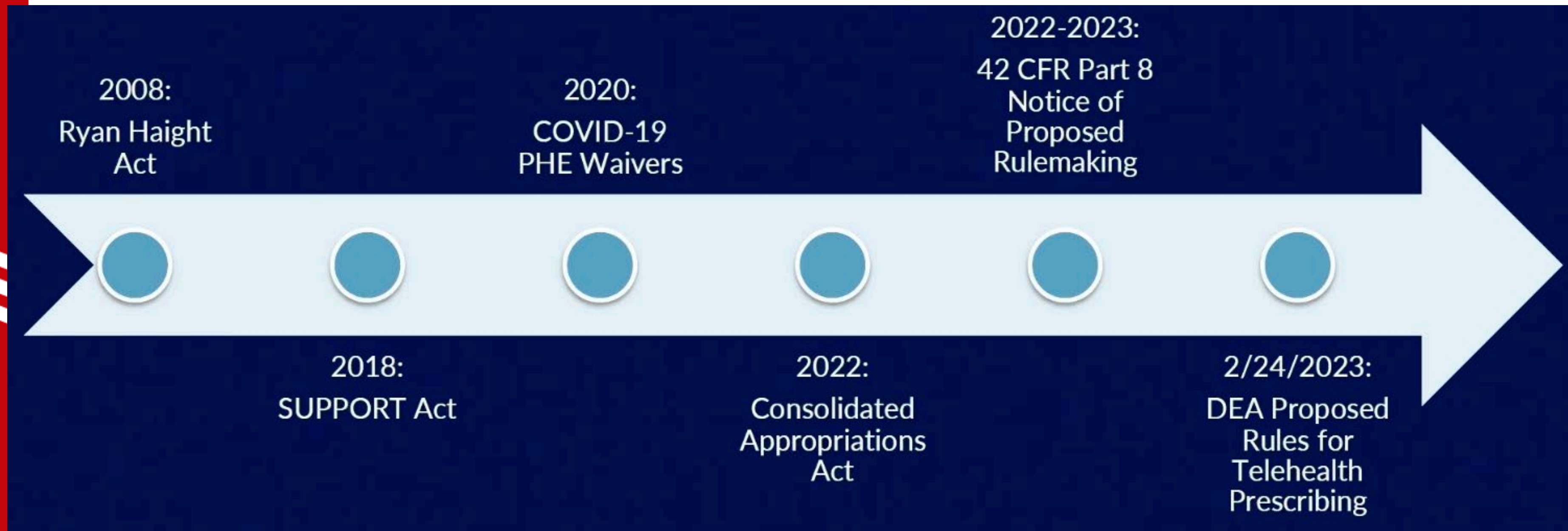
- Many examples of telehealth services being offered for many years
  - E.g. Mental Health/SUD Crisis Hotlines, Tobacco Quit Line
- Applications across SUD management
- Use expanded rapidly under the PHE during COVID
- New Models to reduce barriers to MOUD
- More research needed to understand the impact of telehealth on SUD treatment in rural areas
- Education and advocacy needed to ensure ongoing access and increase acceptance amongst physicians

A recent case…

- Tamara is a 42 yo female with hx of OUD. Snorts heroin/fentanyl daily, 1/2 gram. 3 prior overdoses. No car, unemployed. Previously worked in clothing manufacturing. Lives with elderly mother and brother. 2 teenage children. Brother has a car but works full time. Brother also uses heroin. Has Medicaid.
- Calls clinic, endorsing moderate withdrawal symptoms
- Attempted to start buprenorphine 1 year ago, didn't disclose use prior to visit and took too soon when only in mild withdrawal, likely dose was also too low.
- Added to afternoon schedule for video visit.
- Confirmed symptoms via objective findings on video exam and SOWS score of 18.
- Prescribed 8mg q1h up to 4 doses on day 1
- Continue on 8mg BID.
- Follow-up in 5 days.

- Calls clinic on morning of visit, unable to come, doesn't have gas money
- Switched to telephone visit
- Doing pretty well. Relieved induction went well. Ran out early because needed to take extra ½ film daily for cravings. Snorted cocaine yesterday. + Mild w/d and cravings now. Anxiety is high.
- Open to seeing counselor at County Human Services, worried about transportation
- Has initial phone visit with counselor 1 week later. Also seems open to trying NA groups online.
- Come to OV 1 week later. UDS expected. Goal of every other telemed and office visit schedule. Reminded to call in if unable to come in person and can be switched to telemed.

Overview of policies impacting use of Telehealth for SUD management



Adapted from presentation by Jeanine Perrone, MD; ASAM, 2023

MOUD via Telehealth

- Physician perception of effectiveness is low compared to evidence base
  - perception of having less information to inform clinical decision making

  → Underutilized strategy
- Effective, patient-centered, high patient satisfaction

- COVID era Cohort study (Jones et al): 175K Medicare recipients
  - Receipt of OUD-related telehealth services in the pandemic cohort was associated with increased odds of MOUD retention (aOR 1.27) and lower odds of medically treated overdose (aOR, 0.67)
- Rural OUD Treatment Retention (Lira et al 2023):
  - N=1816 across 14 states, WorkIt Health App Video visits
  - 74.8% of participants were retained in care, and 69.0% of participants were adherent

Jones et al. Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. *JAMA Psychiatry.* 2022

Lira MC, Jimes C, Coffey MJ. Retention in Telehealth Treatment for Opioid Use Disorder Among Rural Populations: A Retrospective Cohort Study. Telemed J E Health. 2023 May 15. doi: 10.1089/tmj.2023.0044. Epub ahead of print. PMID: 37184856.

Beyond MOUD

- 58% of patients in SUD treatment receive some form of telehealth (SAHMSA 2021)
- Telehealth counseling
- Online mutual support groups/ apps

- Jail visits
- Home based Hospital care models

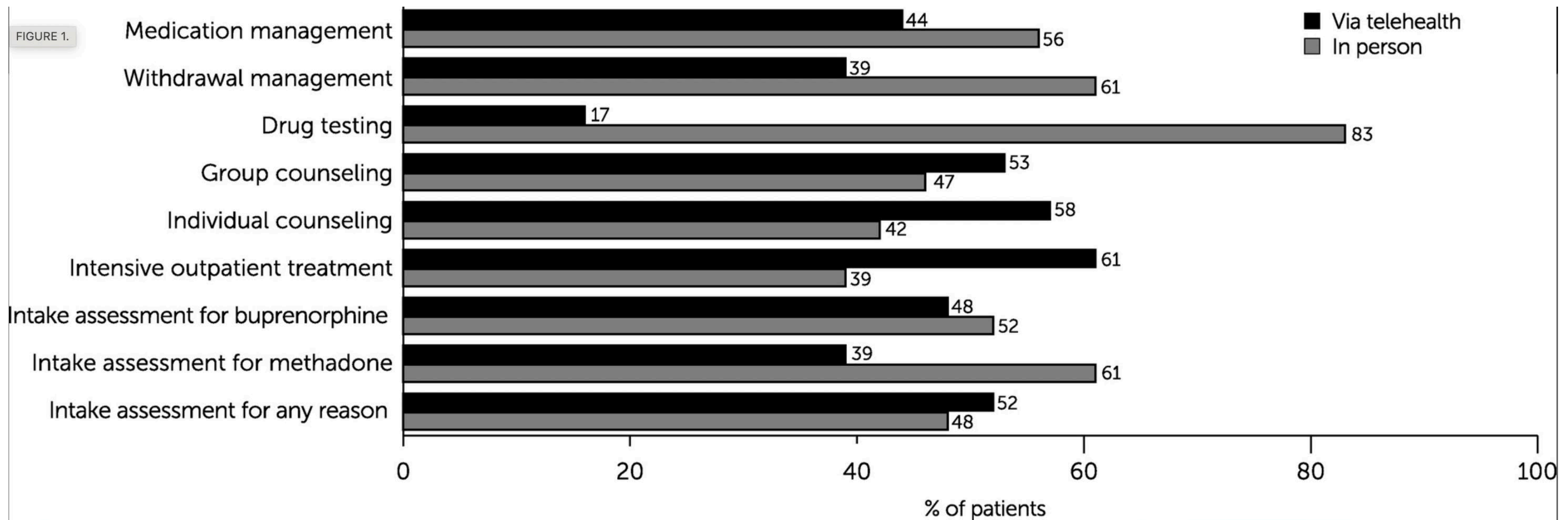
Clinical support

- Specialty care e-consults (psychiatry, ADM) and phone or video consults
- Hotlines

Additional Supporting Evidence

- Systematic Review (2022)- Seven published studies that compared addiction treatment delivered via telehealth with in-person treatment (four on individual counseling, one on group counseling, and three on medication management) found no difference in retention, satisfaction with treatment, therapeutic alliance, and substance use.
- Systematic Review (2022)- Equally effective in reducing alcohol consumption, but lower cost and higher patient satisfaction

2020 survey of California addiction providers (n=100)

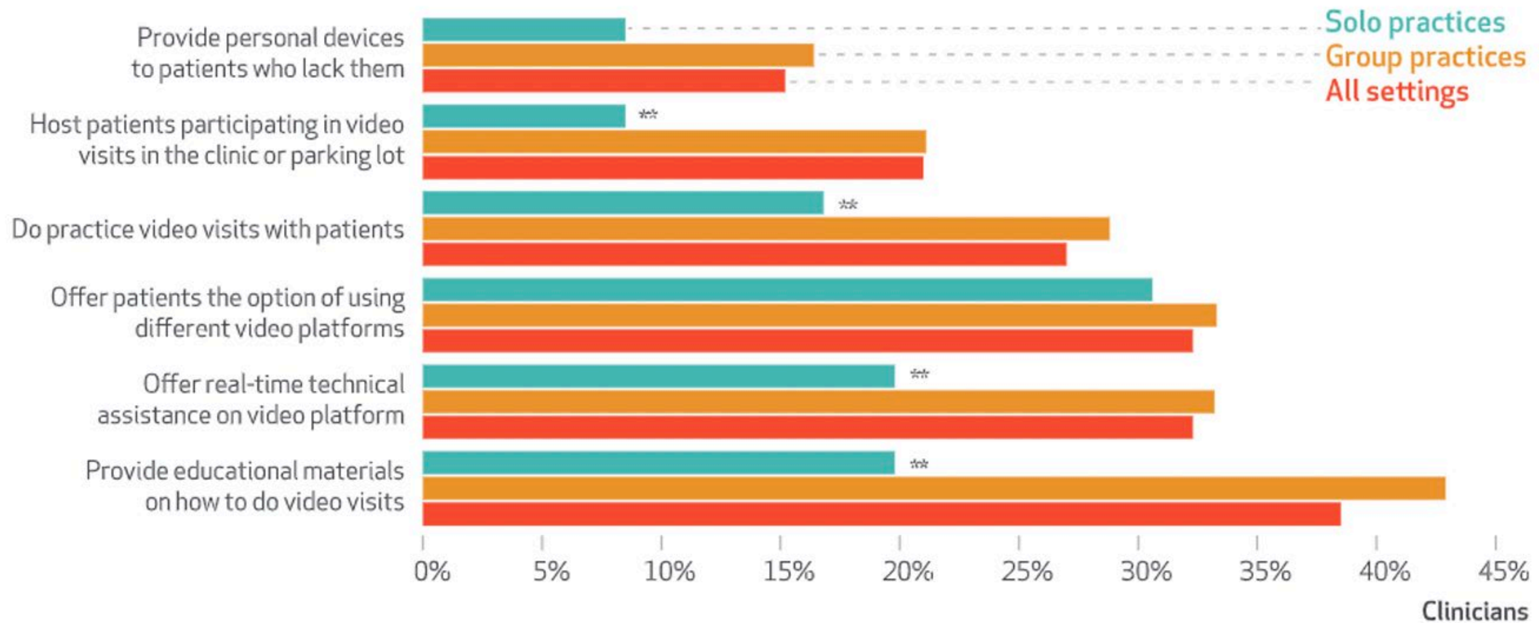


Mark TL, Treiman K, Padwa H, Henretty K, Tzeng J, Gilbert M. Addiction Treatment and Telehealth: Review of Efficacy and Provider Insights During the COVID-19 Pandemic. Psychiatr Serv. 2022 May;73(5):484-491;
Caballeria E, López-Pelayo H, Matrai S, Gual A. Telemedicine in the treatment of addictions. Curr Opin Psychiatry. 2022 Jul 1;35(4):227-236.

Equity

- Expands geographic reach
- Access to Technology and Broadband creates barriers
- Diversity of patients
  - Significantly less telehealth utilization amongst Black patients (Jones et al 2022)
  - Audio-only encounters more common in rural and marginalized patients (older, low-income, minority, unstable housing)
    - May be viewed as lower quality by some patients and providers
    - 430,000 people in WI (25% of the state's rural population) lack access to high speed internet (DHS 2021)

Frost MC, Zhang L, Kim HM, Lin L. Use of and Retention on Video, Telephone, and In-Person Buprenorphine Treatment for Opioid Use Disorder During the COVID-19 Pandemic. JAMA network open. 2022;5(10):e2236298-e2236298.



Uscher-Pines L, Riedel LE, Mehrotra A, Rose S, Busch AB, HuskampHA. Many Clinicians Implement Digital Equity Strategies To Treat Opioid Use Disorder. Health Aff(Millwood). 2023;42(2):182-186. doi:10.1377/hlthaff.2022.00803

Promising low barrier models

- Bicycle Health- online video and telephone MOUD
- UPMC Medical Toxicology Bridge Program
  - 96% filled first rx
  - 77% filled 2+ additional rxs
  - 50% 6 month retention
- CA Bridge
  - Harm reduction warmline connected to 20+ Bridge Centers
- Rhode Island Buprenorphine Hotline
  - 24/7 telephone only bridge clinic with link to maintenance care
  - Initial visit not billed

- Colorado Mobile Health Unit Model
  - Department of HHS, SOR funded
  - 6 RVs, Serve 32 counties
  - Staffed by nurse, addiction counselor, peer
  - SSP, naloxone, HCV/drug testing, counseling, referrals, telehealth MOUD

Considerations for practice

- Significant variations in practice and comfort exist in primary care
- Essential components of visit do not differ for virtual vs inperson
- Urine toxicology only indicated when impacts clinical decision making
- Use of Subjective Opioid Withdrawal Scoring (SOWS)
- Get a reliable phone number in case video fails
- Increase flexibility by offering that visits can be switched to telemedicine if unforeseen barriers arise (transportation, childcare, etc)
- Useful for low-risk patients during outpatient alcohol withdrawal management
- Be clear with expectations (e.g. frequency of visits, how often in-person is expected)

Needed Telehealth Policy Changes

- Extend or create permanent waiver of Ryan Haight in-person evaluation requirement
- Payment parity, including audio-only, for public and private payers
- More research needed to understand differences in rural vs urban utilization of telehealth for SUD management

Resources

https://pcssnow.org/wp-content/uploads/2021/10/OUD-Toolkit_FINAL_10.2021.pdf

Questions?

How have you been using telehealth in your practice?
Any tips or favorite virtual resources for patients?

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