Expansion of Treatment With Tele-Buprenorphine

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**Tele & SUDs**

**ADVANTAGES**

- Chronic nature of substance use disorders
- Extends provider’s availability
- Offers potential immediate resource
- Removing barrier of geography
- Removing barrier of stigma
Tele & SUDs

LIMITATIONS

• Disparate State Regulations
• Insurance Parity
• Federal Regulation of Controlled Substances
  - The Ryan Haight Online Pharmacy Consumer Protection Act of 2008
    • Amendment to the Controlled Substances Act
    • Regulates anyone who “delivers, distributes or dispenses a controlled substance by means of the Internet.”
    • Does not apply to “videoconferencing” but not totally clear
“Types” of Tele

- Telephone-based services
- Interactive Voice Recognition (IVR)
- Web-based services
  - CBT4CBT
  - Mutual aid groups
- Videoconferencing
  - Therapy
  - Recovery Support
    - A-CHESS
  - Specialty Services/Medication
  - Adherence monitoring
  - Clinical consultation/supervision
- Virtual Worlds/Avatars
Tele & Buprenorphine

- Increasing opioid misuse and use disorders and overdose
- Increasing opioid problems in rural areas
  - Many far from methadone programs
- 30/100 patient limit on buprenorphine prescribing
- Long travel times in rural and non-rural areas
- Weather
- Stigma related to receiving treatment in a specialized program (ie. a methadone program)
  - Often in very marginalized areas
Wells House

- Halfway house in Hagerstown, Maryland
  - IOP/OP program
  - Many live there but some in own housing
  - IOP/OP level of care
  - No medical staff
- Had M.D. prescribing Suboxone but retired
Wells House-Preparation

• Preparation
  o Internal
    • Meetings with Dept. tele-group
    • Meetings amongst ourselves
  o External
    • Brief in-person visit to Wells House
    • IT coordination
    • Logistical coordination- charting, labs, clinical, pharmacy, back-up plan

• Ongoing
  o Periodic communication with Wells House point-person
  o Periodic communication with Wells House counselors
  o Tele-meeting with clinical/administrative staffs- January, 2016
  o In-person visit- March, 2016
  o Fredrick sites added (tele-auto hybrid)- March, 2016
  o 3rd 2-hour block added with an Addiction Fellow- May, 2016

@150 patients seen in first year; > 170 to-date
Wells House: Challenges

- Peripheral role in treatment team
  - Organizational
  - Geographic
- Transition of patients
  - Stable, at end of treatment
  - Abrupt, for rule violations, etc.
- EMR
- Coordination of care with other providers
  - Psychiatry, Primary Care
- Scheduling issues
Wells House: Retention

1 week 98% still in care
1 month 91% still in care
2 months 76% still in care*
3 months 59% still in care*

*at Wells House; those in care elsewhere not known
<table>
<thead>
<tr>
<th>Time Period</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>1 week</td>
<td>12%</td>
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<tr>
<td>1 month</td>
<td>11%</td>
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<tr>
<td>2 months</td>
<td>11%</td>
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<tr>
<td>3 months</td>
<td>6%</td>
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Expanding The Program

- Adapting to other clinical models
  - Dispensing vs observed vs prescription
  - “Rapid response”
- Addition of consultation/supervision capability
  - To Primary Care Physicians, OB-GYN, Pediatrics
- Increasing flexibility of scheduling
  - Desk-top set-up
  - System compatibility
  - EMR
- E-prescribing
- Expanding medication capabilities (ie. Vivitrol)
- Billing
Charlie & Paul