Title

Providing Low-barrier Addiction Treatment Via a Telemedicine Consultation Service During the COVID-19 Pandemic in Los Angeles, County: An Assessment 1 Year Later

Journal

Journal of Addiction Medicine, 17(1)

ISSN

1932-0620

Authors

Kennedy, Amy J
George, James S
Rossetti, Gina
et al.

Publication Date

2023

DOI

10.1097/adm.0000000000001034

Peer reviewed

Providing Low-barrier Addiction Treatment Via a Telemedicine Consultation Service During the COVID-19 Pandemic in Los Angeles, County: An Assessment 1 Year Later

Amy J. Kennedy, MD, MS, James S. George, MD, Gina Rossetti, MD, Christopher O. Brown, MD, MPH, Kyle Ragins, MD, MBA, David Dadiomov, PharmD, BCPP, Rebecca Trotzky-Sirr, MD, Gloria Sanchez, MD, Herman Llamas, BA, and Brian Hurley, MD, MBA, DFASAM

Background: Los Angeles County Department of Health Services provides medical care to a diverse group of patients residing in underresourced communities. To improve patients' access to addiction medications during the COVID-19 pandemic, Los Angeles County Department of Health Services established a low-barrier telephone service for DHS providers in March 2020, staffed by DATA-2000–waivered providers experienced with prescribing addiction medications. This study describes the patient population and medications prescribed through this service during its initial 12 months.

Methods: We performed a retrospective evaluation of a provider-entered call registry for the telephone consult line. Information was collected between March 31, 2020, and March 30, 2021. The registry includes information related to patient demographics, the reason for visit, and which addiction medications were prescribed. We conducted descriptive statistics in each of these domains.

Results: During the study period, 11 providers on the MAT telephone service logged 713 calls. These calls represented a total of 557 unique patients (mean age of 40 years, 75% male, 41% Latino, 49% experiencing homelessness). Most patients either had Medicaid insurance (77%) or were uninsured (20%). The most prescribed addiction medication was buprenorphine-naloxone (90%), followed by nicotine replacement therapy (5.3%), naltrexone (4.2%), and buprenorphine monotherapy (1.8%).

Conclusion: A telephone addiction medication service is feasible to deliver low-barrier medications to treat addiction in underresourced communities, especially to individuals experiencing homelessness. This can mitigate but does not eliminate disparities in access to addiction medications for communities of color.

Key Words: buprenorphine, COVID-19, homelessness, telehealth, telemedicine

(*J Addict Med* 2023;17: e64–e66)

Substance use increased and access to substance use disorder (SUD) treatment was disrupted during the COVID-19 pandemic, particularly for people experiencing homelessness and individuals in underresourced communities.[1,2] National agencies established emergency policies to facilitate access to telemedicine services for patients with SUDs, and preliminary studies support that the pivot from in-person to virtual services has been successful.[3–6]

Los Angeles County is home to 10 million residents, 66,436 of whom experienced homelessness in 2020.[7] The Los Angeles County Department of Health Services (LAC DHS) is the United States' second largest municipal health system, which operates an extensive network of public hospitals and clinics in LAC and serves approximately 500,000 patients annually. During the COVID-19 pandemic, LAC DHS established a telephone consultation service for DHS providers in March 2020 to facilitate low-barrier access to addiction medications for DHS patients.

We recruited a team of 15 DATA-2000-waivered providers who were regular participants in the DHS SUD workgroup and

From the Division of General Internal Medicine, VA Puget Sound Healthcare System, University of Washington School of Medicine, Seattle, WA (AJK); Department of Emergency Medicine, Harbor-UCLA Medical Center, Torrance, CA (JSG); Department of Population Health and Accountable Care, University of California, Davis, Sacramento, CA (GR); Department of Medicine, Harbor-UCLA Medical Center, Torrance, CA (COB); Ambulatory Care Network, Los Angeles County Department of Health Services, Los Angeles, CA (KR); Department of Clinical Pharmacy, University of Southern California, Los Angeles, CA (DD); Whole Person Care, Department of Health Services, Los Angeles, CA (DD); Department of Emergency Medicine, University of Southern California, Los Angeles, CA (RT-S); Department of Family Medicine, Harbor-UCLA Medical Center, Torrance, CA (GS); Department of Health Services, Los Angeles, CA (HL); Substance Abuse Prevention and Control, Department of Public Health, Los Angeles, CA (BH); and Department of Family Medicine, University of California, Los Angeles, Los Angeles, CA (BH).

Received for publication October 18, 2021; accepted March 20, 2022.

This manuscript was developed without external funding. Funding for the telephone MAT service described in this article was provided by the Sierra Health Foundation in partnership with the National Health Foundation and the LAC+USC Medical Center Foundation, Inc.

Preliminary results from this study will be presented in abstract form at the Association for Medical Education and Research in Substance Abuse National Conference in November 2021.

The authors report no conflicts of interest.

Send correspondence to Amy J. Kennedy, MD, MS, VA Puget Sound Healthcare Center, 1660 S. Columbian Way, Seattle, WA, 98108. E-mail: amy.kennedy@va.gov

ISSN: 1932-0620/23/1701–0e64

DOI: 10.1097/ADM.0000000000001034

who, seeing the gap in treatment access, agreed to participate. The service was available to all staff within DHS-affiliated hospitals, clinics, correctional services, and contracted programs and outreach workers to call when they encounter a patient appropriate for addiction medication. Health care providers working in any DHS-affiliated care setting were encouraged to call the telephone line to connect their patients (whether housed or unhoused) with a telephonic evaluation for addiction medication. Services were advertised to DHS directly operated and contracted programs via screensavers, e-mailed fliers, and presentations at virtual staff meetings.

The consultation service was not made available to current or prospective patients to call directly. A field engagement specialist and team delivered a brief training program for 150 community health workers about addiction medications and how to access the line. Local pharmacies near high-density areas of opioid overdose were identified and given education on dispensing addiction medications to our target population.

The aim of this study was to describe the first 12 months of the addiction medication telephone consultation service including characterizing which calls were received, which patients were treated, and which medications were prescribed.

METHODS

Data Collection/Analysis

Registry information was collected from March 31, 2020, to March 30, 2021. After each telephone visit, providers were directed to log patient information including name, date of birth, housing status, and reason for call into a secure registry. These data were fact checked by a coinvestigator (JSG) who cross-referenced the inputted information with demographic data previously inputted into the electronic medical record (EMR). Additional information including age, race/ethnicity, and insurance status was also extracted from the EMR.

Information on which medications were prescribed was collected from the EMR during the study time period. All Federal Drug Administration–approved addiction medications delivered from a physician office for opioid use disorder (OUD) (buprenorphine, buprenorphine-naloxone, naltrexone), alcohol use disorder (naltrexone, acamprosate, disulfiram, and off-label topiramate and gabapentin), and tobacco use disorder (nicotine patches, gum, and lozenges; varenicline; and bupropion) were included. We excluded patients who received only nicotine replacement therapy and no other addiction medication. We conducted an analysis using descriptive statistics to help characterize the patient population.

Institutional Review Board

This study was deemed exempt by the LAC DHS institutional review board.

RESULTS

There were 713 calls logged in the addiction medication telephone consultation registry by 11 providers during the study period. These calls represented a total of 557 patients (mean age of 40 years, 75% male, 41% Latino, and 49% experiencing homelessness) (Table 1). Most patients had either Medicaid insurance (n = 427 [77%]) or no insurance (n = 110 [20%]). Although multiple patients (n = 142 [20%]) utilized the consultation service via a clinical intermediary more than once, the majority (78%) accessed it a single time. Fourteen calls (2%) had no specific patient associated with them.

TABLE 1. Demographics of 519 Patients Evaluated by the Telephone Consultation Service Over 713 Calls During March 2020–March 2021

	Sample (n = 557), n (%)	DHS Comparison, %
Gender, male	420 (75)	46
Age, mean (SD), y	40 (11)	51
Insurance		
Medicaid	427 (77)	65
Uninsured	110 (20)	23
Private	6 (1)	3
Other	14 (2.5)	9
Homeless	272 (49)	13
Race/ethnicity		
White	204 (37)	9
Black	75 (13)	15
Latino	227 (41)	65
Other	55 (10)	11

DHS indicates Department of Health Services.

There were 662 addiction medications prescribed during our study time period (Table 2). The most prescribed addiction medication was buprenorphine-naloxone (598 prescriptions [90%]), followed by any form of nicotine replacement therapy (35 [5.3%]), naltrexone (28 [4.2%]), and buprenorphine alone (12 [1.8%]) (Table 2). Disulfiram was prescribed one time.

DISCUSSION

In this retrospective study of a telephone consultation service for low-barrier addiction medications, we found that the intervention served a high volume of patients, approximately half of which were experiencing homelessness. Patients who accessed care were more often younger, male, and White, compared with the general DHS population.

Low-barrier addiction treatment interventions and telemedicine initiatives have become catalysts for improving access to addiction treatment during the COVID-19 pandemic.[8,9] More than one-third of clinicians have reported starting buprenorphine for patients with OUD without an in-person examination.[8] Relaxed guidelines on prescribing have allowed for innovation in telemedicine addiction services, which have demonstrated feasibility and favorable treatment outcomes,[3–5,9] although previous interventions most often describe single-site pilot programs with significantly fewer patients served than via our service.

We were initially surprised by the number of patients experiencing homelessness who accessed our consultation service. Although most prior addiction medication interventions for patients experiencing homelessness have relied on either mobile van services or on providing their patients with cell phones,[7,8] this population has less access to stable phone numbers with operational data plans, especially with unlimited minutes.[10] To our knowledge, this is among the first interventions utilizing community health workers to enter encampments and interface directly with patients linking them with providers

TABLE 2. Number of Calls, Caller Location, Patients, and Medications Prescribed Via the Telephone Consultation Service From March 2020 to March 2021

Calls	713 Total calls
	142 Calls from patients calling more than once
	14 Calls not involving patients
Caller location	338 Outreach
	139 County jail
	132 Ambulatory clinic
	57 Patient calls
	29 Other
	18 Hospital/urgent care
Patients	557 Total patients
	369 Patients with documented medication services
	188 Patients without documented medication services
Medication	662 Total medications prescribed
	589 Buprenorphine/naloxone
	35 Nicotine replacement therapy
	18 Oral naltrexone
	12 Buprenorphine monotherapy
	1 Disulfiram

telephonically. In addition, this is one of the first broadly implemented interventions to serve every DHS site and contracted program, spanning the full continuum of care from acute care hospitals and ambulatory clinics to street-based outreach teams. Interestingly, we noted very low rates of medication prescription for medications other than buprenorphine-naloxone and naltrexone. This was in large part because most patients served had OUD.

Like prior studies, we noted disparities in access to care among racial/ethnic minorities.[11–13] Even with a low-threshold addiction treatment approach within a safety net institution, we had a largely White population, compared with Los Angeles County as a whole. This highlights that telephone delivery of addiction medication does not erase the disparities in addiction treatment among Black and Latino populations.[11,12] There are many structural factors shaping the availability of addiction medication in communities in the United States, and the demand for and acceptability of addiction medication are shaped by factors that may include a lack of Black and Latino providers offering these services as well as a lack of culturally specific and responsive outreach, education, and treatment initiatives.[12]

Our study has limitations. Not every provider consistently utilized the call-line registry so we may have missed encounters that were not captured using standard processes. Similarly, not all prescriptions were documented through the standard process. Certain medications, such as varenicline and naltrexone, have multiple use profiles, and we were not able to differentiate reason for use. Our comparison group included all DHS patients, not only those with SUD, and thus, we were not able to draw firm demographic conclusions. Finally, we did not have a mechanism to assess data on individual providers, medication receipt, or continuity of ongoing care.

In summary, an addiction medication telephone consultation service can be a feasible approach to deliver low-barrier treatment to high-risk patients, including those experiencing homelessness, during the COVID-19 pandemic. More research is needed to improve access to addiction treatment for Black and Latino communities.

ACKNOWLEDGMENTS

The authors thank Simmi Ghandi, CRNP, Spencer Liebman, MD, Department of Emergency Medicine, Los Angeles, CA, and Isabel Chen, MD, MPH, Kaiser Permanente Bernard J Tyson School of Medicine, Los Angeles, CA, for their help staffing the MAT call line.

REFERENCES

1. Alexander GC, Stoller KB, Haffajee RL, et al. An epidemic in the midst of a pandemic: opioid use disorder and COVID-19. *Ann Intern Med*. 2020; 173(1):57–58.
2. Volkow ND. Collision of the COVID-19 and addiction epidemics. *Ann Intern Med*. 2020;173(1):61–62.
3. Harris M, Johnson S, Mackin S, et al. Low barrier tele-buprenorphine in the time of COVID-19: a case report. *J Addict Med*. 2020;14(4):e136–e138.
4. Mehtani NJ, Ristau JT, Snyder H, et al. COVID-19: a catalyst for change in telehealth service delivery for opioid use disorder management. *Subst Abus*. 2021;42(2):205–212.
5. Wang L, Weiss J, Ryan EB, et al. Telemedicine increases access to buprenorphine initiation during the COVID-19 pandemic. *J Subst Abuse Treat*. 2021; 124:108272.
6. Wenzel K, Fishman M. Mobile van delivery of extended-release buprenorphine and extended-release naltrexone for youth with OUD: an adaptation to the COVID-19 emergency. *J Subst Abuse Treat*. 2021;120:108149.
7. Los Angeles Homeless Services Authority. 2020 Greater Los Angeles Homeless Count—Los Angeles Continuum of Care (CoC). Available at: https://www.lahsa.org/documents?id=4585-2020-greater-los-angeles-homeless-count-los-angeles-continuum-of-care-coc-. Accessed March 3, 2022.
8. Jones CM, Diallo MM, Vythilingam M, et al. Characteristics and correlates of U.S. Clinicians prescribing buprenorphine for opioid use disorder treatment using expanded authorities during the COVID-19 pandemic. *Drug Alcohol Depend*. 2021;225:108783.
9. Aboujaoude E, Gega L, Parish MB, et al. Editorial: digital interventions in mental health: current status and future directions. *Front Psych*. 2020;11:111.
10. Harris R, Rosecrans A, Zoltick M, et al. Utilizing telemedicine during COVID-19 pandemic for a low-threshold, street-based buprenorphine program. *Drug Alcohol Depend*. 2022;230:109187.
11. Goedel WC, Shapiro A, Cerdá M, et al. Association of racial/ethnic segregation with treatment capacity for opioid use disorder in counties in the United States. *JAMA Netw Open*. 2020;3(4):e203711.
12. Schuler MS, Dick AW, Stein BD. Growing racial/ethnic disparities in buprenorphine distribution in the United States, 2007–2017. *Drug Alcohol Depend*. 2021;223:108710.
13. Lagisetty PA, Ross R, Bohnert A, et al. Buprenorphine treatment divide by race/ethnicity and payment. *JAMA Psychiatry*. 2019;76(9):979–981.