Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/neurofrontiers/prescribing-controlled-substances-through-telehealth-post-pandemic-considerations/15448/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Prescribing Controlled Substances Through Telehealth: Post-Pandemic Considerations

Dr. Cheeley:
During the COVID-19 Public Health Emergency, flexibilities were granted regarding the prescription of controlled medications during telehealth visits. So how can we continue to do this safely in the post-pandemic world? And when is it time to refer to in-person practitioners?

Welcome to *NeuroFrontiers* on ReachMD. I'm Dr. Mary Katherine Cheeley, and I'm speaking with Psychiatric Nurse Practitioner Ashley Baker. She's the co-founder of Ascend Integrative Medicine in Boston. Ashley, welcome to the program.

Ms. Baker:
Thank you so much for having me.

Dr. Cheeley:
So let's start with some background because I think maybe some of our folks and listeners don't quite know what it was like before the pandemic. So before COVID-19, were healthcare providers permitted to prescribe controlled substances via telemedicine?

Ms. Baker:
Yes, they were, and this largely follows with the Ryan Haight Act, which is a national law and set of guidelines for telemedicine prescribers. I think the difference that came out after the pandemic and during the pandemic was that pre-pandemic, we really didn't live in a virtual world as much as we may have thought that we did. We had so much access to technology and virtual healthcare, but we weren't necessarily using it, and our patients weren't necessarily able to use it just based on training and functionality and education. And then with the pandemic, we were forced into all going virtual, really testing the limits of how far we could take things and how much access we could really give to our patients in the virtual world, and so everything changed, and then the Ryan Haight Act almost became more important, more in the spotlight because now it was so much more relevant to our providers and our patients.

Dr. Cheeley:
So what new regulations were put in place during the pandemic?

Ms. Baker:
So during the pandemic, they basically took the Ryan Haight Act, which is a set of guidelines, very detailed, about what telemedicine prescribers can and cannot do. And they made a modification that controlled substances were able to be more freely prescribed during the pandemic without in-person visits, and that's really the change that we're seeing now. That's where the spotlight in the legislation is now—should providers see patients at least once in person before prescribing any of the controlled substances, and if so, to what extent? There's been a lot of conversation about this. There was supposed to be a date in May where a decision was made, and that's been postponed until November.

Dr. Cheeley:
So currently, with the expiration of the Public Health Emergency, has anything changed in your practice with how you deal with controlled substances?

Ms. Baker:
Not yet. Pre-pandemic—I'll share my experience—I worked at a large academic facility in Boston that largely served Mass Health, Medicaid, Medicare patients, high volume, very sick in the addiction space, a lot of suboxone prescribing, and pre-pandemic, we had pretty rigid prescribing standards of seeing patients weekly, biweekly, or monthly in person depending where they were in their disease state and urine drug screens every week, checking the MASPAT. Even paper prescriptions I think were still a thing at one point. And during the pandemic, no one was able to come in, and we were seeing thousands of patients, a huge clinic, and so, as you can probably guess, urine drug screens were not as frequent, sometimes not even at all because patients couldn't come in due to the pandemic. We were still able to check the MASPAT; everything turned to e-prescribe, and a lot of our patients, just given the socioeconomic level of these patients, they didn't have access to video, so a lot of this was done via brief phone calls. And that was a really big harm reduction model because the decision was made that we needed to continue patients in care. It's a huge risk to just abruptly stop a medication like suboxone, and so it was just the go-go-go model without too much regulation, without too much testing. And now we are able to do those things again, so there has been a shift back into re-educating our patients, "Patients, you do need to do that weekly or monthly or biweekly urine drug screen. We do need to see you face-to-face at least on a video in some capacity to really make that contact." So we are getting back to normal. I think there is still some hesitation due to the learning curve in some capacities in some settings with patients, but we are trying to bring that standard back because that is best care; but also, as a nation, we're moving towards that legislation really being put into place and much stricter.

Dr. Cheeley:
I think you make a great point. When we all think about how connected we are virtually, we think about that from the social space and from the information space but not necessarily from the access to healthcare space. So what do you think from your perspective are the benefits and risks of being able to prescribe these medications? We'll take it both from the telephone side and from the video side because to me they're two totally different practices.

Ms. Baker:
So if we're looking at using suboxone as an example, what we want to make sure is that the patient is taking the medication as prescribed; that there's no gaps in treatment; that they're not using other substances or alcohol with the medication, and I think seeing somebody, right? you can tell a lot by seeing somebody to really be able to see how they're talking, how they're engaging, where they're looking, where they are even can really tell a lot about where the patient is at that we don't so much gather over the phone.

It's much less personal, so it's often a shorter appointment, and maybe you miss things along the way. But the benefit to having both options is that for the patients that maybe their Wi-Fi is down, maybe they can't get a ride to the clinic, maybe they don't know how to use a computer, they have never had a computer maybe, and for those patients what it does come down to then is don't treat them at all or treat them over the phone and take a risk, but as long as you can still do things to check in, to make sure the patient's compliant, it could yield a pretty good outcome for that patient.

Dr. Cheeley:
I love that you talk about making sure that there's no gaps in their treatment and their compliance to the medication, and I think that's so important, especially when you're talking about telehealth for patients because, like you said, you don't have a urine drug screen,you don't have that objective data, so to fill that objective data gap, we need to make sure that we're getting really good fill histories. We're calling pharmacies making sure did they fill it on time? did they pick it up? is it still on the shelf? That is huge for us to be able as providers to make sure that our patients are still not only engaged in coming to see us in the clinic or over the phone or whatever but actually getting their medication therapy, which is what makes the difference in treating their disease.

For those just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm Dr. Mary Katherine Cheeley, and I'm speaking with Ashley Baker, who is a psychiatric nurse practitioner, about telemedicine and the prescribing of controlled substances.

So, Ashley, let's fast-forward a couple of years. We're out of the Public Health Emergency for COVID-19. How can we continue to safely prescribe controlled substances using evidence-based medicine in this new world?

Ms. Baker:
So I think that there's going to be a movement here with the federal guidelines and the change that they're doing with the Ryan Haight Act. I do think there's going to be some change that is made there with guidelines that all providers have to follow, which I think is useful to have something set in stone, a standard of care because the goal is patient safety and best outcomes, so I think that will be helpful just moving away from that and going into a clinical space.

So my practice is 95 to 97 percent virtual, and how do we function now in creating a safe place for our prescribers to prescribe safely and our patients to receive good care is really allowing for an adequate amount of time with our patients. We're not a high-turnover, 10-minute appointment kind of place where we do spend time with our patients, and I think that's an important thing to note is spend the time with your patient—tough to do in your healthcare model today and making sure that you are checking all of the boxes, so making every effort to get on video with your patient. If it's a pattern of them just doing the phone but they do have access to a video, really having the support staff or taking the time yourself to help that patient figure out what is the barrier to getting them on the video platform, and then looking at bringing back the drug screens, any sort of labs. Take that extra five minutes and put in a lab order. We use local labs, so we fax orders basically anywhere in Massachusetts, any lab that our patients want to go. If they have had recent labs with their own treatment providers, such as primary care or cardiology, whoever it is, we also accept those labs, and we can upload those to the chart, and that fits so the patient doesn't have to be driving all over to go to all these different labs for different appointments. We can create some continuity there. And checking your MASPAT for whatever state you're in, checking the online registry of what the patient's picking up. I also think just using rating scales, talking to family members if it would be useful, collaborating with other physicians to make sure that everybody is on the same page because oftentimes you see when someone's on a controlled substance, maybe they're on another controlled substance from a different doctor; maybe they're on five other medications from their primary care; and just making sure the entire treatment team, even if you're not located at the same facility, is on the same page and checking the boxes to making sure that the patient is being safely treated.

Dr. Cheeley:
In your opinion, when should patients be absolutely seen in person?

Ms. Baker:
So just to start this conversation off, the litigation is that the patient should be seen initially. The initial visit would be seen by the provider who's going to take over care or by a referring provider who's then going to refer the provider to a telemedicine-based care, and that's really what we're looking at, so that initial visit. In a perfect world, would it be great to have that? Sure. You get to see the whole patient; they're in person; and you can pick up on really everything about that patient and where they're at in that moment. But is it needed? I don't know. I think that it's probably too soon to tell, and we'd have to look at that data of what benefit that brought.

I certainly think that if somebody is not totally being honest about what they're feeling and when, and maybe there's a small or large track record of this, if there's concerns with speech or with presentation over the audio or the visual that maybe bringing them in would be beneficial. If they're very medically complex and there's a physical reason of why we would want to see the patient, I can understand that if we need vital signs, if this patient has a history of being hemodynamically unstable in any way, that might be a reason to bring them in for testing and vital signs before initiating treatment. The downside of it is that it could limit access to care, especially in rural areas or in areas where there is less access to transportation and getting in.

Dr. Cheeley:
So you mentioned the litigation. Let's stick on that for a second before we close. What is the current litigation about telehealth and prescribing of controlled substances?

Ms. Baker:
It largely follows the Ryan Haight Act. There are seven components to it, and it really structures who can prescribe, what licenses are needed, what documentation is needed in terms of the visit, what schedules can be prescribed. But because of COVID—and this just

ended, it's changing now from being able to do everything over telemedicine. There was no requirement. It was lifted because of the pandemic for the in-person visits. So all of the other parts of the Act pretty much still stand in terms of documentations, licensure, who can prescribe, following the schedules, but that case of the in-person visit was the difference here, and now I think there will be a decision about frequency of in-person visits and when that actually comes into play.

Dr. Cheeley:
This has been such a great conversation and very timely with the use of telemedicine and the prescribing of controlled substances to our patients who need them for disease states that require controlled substances to be treated. So thank you so much to my guest, Ashley Baker, for sharing her experiences and insights. Ashley, it was such a pleasure to chat with you today.

Ms. Baker:
Likewise. Thank you so much for having me.

Dr. Cheeley:
For ReachMD, I'm Dr. Mary Katherine Cheeley. To access this and other episodes in our series, visit ReachMD.com/NeuroFrontiers where you can Be Part of the Knowledge. Thanks for listening.