March 31, 2023

Scott A. Brinks, Section Chief
Diversion Control Division
The Drug Enforcement Administration
8701 Morrissette Drive
Springfield, Virginia 22152

Submitted Electronically via http://www.regulations.gov/

**Re: Comments on the Expansion of Induction of Buprenorphine via Telemedicine Encounter (Docket No. DEA-948)**

Dear Section Chief Brinks:

I am writing on behalf of the National Health Care for the Homeless Council (NHCHC) to submit comments in response to the Drug Enforcement Agency's (DEA) federal register notice on the *Expansion of Induction of Buprenorphine via Telemedicine Encounter* (Docket No. DEA-948). **We write in opposition to the requirement for an in-person medical evaluation within 30 days of being prescribed buprenorphine—a Schedule III drug—through a telemedicine appointment.** This requirement is burdensome and likely to result in people running out of buprenorphine, returning to chaotic substance use, overdosing, and potentially dying.

NHCHC is a membership organization representing HRSA-funded Health Care for the Homeless (HCH) health centers and other organizations providing health care to people experiencing homelessness. Our members offer a wide range of services to include comprehensive primary care, mental health and addiction treatment, medical respite care, supportive services in housing, case management, outreach, and health education, regardless of an individual's insurance status or ability to pay. Last year, 300 HCH programs served approximately 1 million patients in over 2,000 locations across the country. **As a network of health care providers caring for very vulnerable people, we clearly see the risks to relapse and overdose this rule would cause our patients.**

The following discussion offers our rationale for our opposition to this rule on three key points:

1. This rule jeopardizes patient safety and pre-empts clinical decision-making.
2. This rule undermines access to care by wrongly prioritizing fear of diversion.
3. This rule goes against the President's stated policies and priorities.

## Key point #1: This rule jeopardizes patient safety and pre-empts clinical decision-making.

**Accessing an in-person visit with a buprenorphine-prescribing provider within 30 days is quite difficult for many people in many parts of the country.** Telehealth expanded access to a wide range of health care for many people living in rural areas—but for those living in the 40% of counties that have no prescribing buprenorphine provider, telehealth has become a lifeline. For those experiencing homelessness, transportation, inflexible employment with no paid leave, frequent interactions with law enforcement, and unstable housing are often barriers to accessing in-person care. Even if a patient does have an in-person visit scheduled within 30 days, the realities of life often get in the way: a bus that didn't come, a child that got sick, a job opportunity that arose, an encampment that was forcibly displaced overnight, a provider needing to reschedule, an arrest that occurred. Missing scheduled appointments is a common reality of homelessness, and rescheduling appointments can take more time (especially as the health care workforce shortage has exacerbated access)—likely missing the narrow 30-day window that this rule establishes. During the COVID-19 pandemic, the growth of telehealth expanded access to buprenorphine and specifically was an effective tool to overcome traditional barriers to care. Discontinuing this practice now ignores the improvements in care that have been achieved in the past three years.

### Provider Perspective:

*"Many of my patients are just being released from incarceration. From the moment they get out, they need to secure housing and income, report to a parole officer, and take on family obligations. To meet these demands, they need to keep their addiction under control as well. However, when it takes 1-2 buses to get to our clinic, then a wait to get seen for services, and then to go to the pharmacy—all this can take half a workday. Many of our patients are just getting entry-level jobs with no paid leave and are wary of losing their job by taking off to go a doctor's appointment. With telehealth, my patients can get needed support without forcing them to choose between financial stability and their health. Even in the midst of a big city with lots of buprenorphine prescribers, telemedicine can significantly increase access to care and improve health outcomes."*

**~ Joseph Muller, MD, Internal Medicine/Pediatrics Physician, Addiction Medicine Physician, Unity Health Care, Washington DC**

**This rule jeopardizes the fragile connection to recovery and critical need to continue buprenorphine with no disruption.** Dis-allowing a prescription refill after 30 days will mean that patients are not able to refill their medications—leading to relapse, overdose, and possible death. A study just published this month shows that telehealth improved access to buprenorphine and in turn reduced the risk of fatal overdose. Why impose new barriers to care when we should be *removing* obstacles to treatment?

**This rule disproportionately impacts health care access for Black people.** White populations are almost 35 times as likely to have a buprenorphine-related visit than Black Americans, even though communities of color have experienced the fastest growing rate of opioid overdose deaths in recent years. Black people also have worse outcomes when they do seek treatment for opioid use disorder, often due to racism in the health care system. This rule is likely to only further these existing racial disparities in access to treatment.

**In addition, this rule pre-empts clinical decision-making.** Determining when telehealth and in-person visits are needed should be made by a patient's clinical provider—not by the Drug Enforcement Administration. Burdening providers by tying their hands with arbitrary timelines that bypass their training and clinical

expertise undermines their professional training and clinical expertise while creating situations where providers are unable to continue life-saving medications because of an inability to have an in-person appointment.

### Provider Perspective:

*"Telehealth access to buprenorphine has been a lifeline for my patients—and adding these restrictions could further contribute to rise of overdose deaths. Rural communities and individuals with barriers like access to transportation could be disproportionately affected by this proposed rule. Additionally, for individuals who are working, telehealth helps minimize work interruptions and supports individuals maintain employment. This proposal would do harm, and not move us in the right direction of turning the tide of overdose mortality."*

**~ Courtney Pladsen, DNP, FNP-BC, RN, NHCHC Director of Clinical and Quality Improvement**

## Key point #2: This rule undermines access to care by wrongly prioritizing fear of diversion.

**This rule is unnecessary because buprenorphine is not causing overdose deaths.** Studies show that buprenorphine is present in a very small number of toxicology reports where other drugs are the reason for the overdose. Because of buprenorphine's chemical make-up, people do not take it to "get high." Instead, buprenorphine helps end withdrawal symptoms, and allows people to "feel normal" so they can continue with employment, family obligations, and other life functions. Buprenorphine also decreases the likelihood that a person would overdose from opioids. Limiting access to buprenorphine is the ultimate in irony given the pervasive access to drugs—fentanyl in particular—that are actually causing overdose deaths.

**Law enforcement fear of possible diversion only prevents access to life-saving treatment.** Making buprenorphine more broadly available actually *reduces* the likelihood of diversion, as people are able to more easily access treatment on their own. Evidence shows that people use nonprescribed buprenorphine to self-treat or prevent withdrawal, and diversion is likely the result of a lack of access to treatment—suggesting that better access to buprenorphine from a provider would reduce diversion of this medication. Furthermore, surveys of patients receiving low-threshold treatment find that they have prior experience using buprenorphine, often not prescribed, before entering treatment. **The irony of this rule is that clamping down on access to and availability of treatment only INCREASES diversion as patients are unable to access direct care.**

### STIGMA ALERT!

Insulin (and other prescriptions for chronic conditions) are also "diverted" to others either because people cannot afford or cannot access treatment. Yet **no one** has suggested clamping down on access to insulin—a substance that is far more fatal than buprenorphine when misused.

### Key point #3: This rule goes against the President's stated policies and priorities.

**This proposal goes against the Biden Administration's stated priority on access to substance use treatment using a harm reduction approach.** The National Drug Control Strategy explicitly states that the "North Star" is to save lives and calls for "immediate actions that will save lives in the short term and outlines long-term solutions to reduce drug use and its associated harms, including overdose." This rule does just the opposite—it only serves to limit treatment, which will *increase* overdoses and deaths. Just in December 2022, the Substance Abuse and Mental Health Services Administration (SAMHSA) made permanent a COVID-19 provision that allows continued access to buprenorphine via telehealth without an in-person visit. This proposed rule rolls back provisions other federal agencies have promulgated. Furthermore, the Biden Administration has prioritized the role of community health and peer workers in engaging people who use drugs. Flexible telehealth access allows these individuals to leverage the trust and rapport they have built with clients to initiate and maintain buprenorphine treatment by connecting individuals with a prescribing provider on the spot.

**Provider Perspective:**

*"* I have been prescribing buprenorphine at our clinic for over 5 years now—often for patients who are homeless or live in more rural areas in our community. The flexibility of telehealth has made it easier to reach these populations, lowered the barriers to care, and allowed me to adopt more harm reduction approaches to opioid use disorder. As mortality rates continue to rise with the influx of fentanyl, the last thing we should be doing is putting up more barriers to patients*."*

**~ Amelia Rutter, ARNP, Medical Provider, Yakima Neighborhood Health Services, Yakima, Washington**

From this discussion, it should be clear why we are opposed to this proposed rule. Jeopardizing patient safety, pre-empting clinical decision making, undermining access to care due to fear of diversion, and going against Administration priorities are all legitimate reasons why this rule should be withdrawn. We need to prioritize access to care, not be driven by a false fear of buprenorphine diversion.

Thank you for considering our comments in opposition to this proposed rule. Please contact me at bdipietro@nhchc.org if you have any questions or would like to discuss further the impact of this rule on the Health Care for the Homeless community.

Sincerely,

Barbara DiPietro, Ph.D.
Senior Director of Policy