COVID-19 Response and OTPs: One Clinic's Experience

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Disclosures

- No financial or commercial interests to report

Learning Objectives

By the end of this webinar, participants should be able to:

- Describe 3 key principles in caring for patients with opioid use disorder (OUD) during COVID
- Apply 3 lessons learned from OTP clinical practices during COVID
- Identify 3 key practice-level questions to consider as COVID situation continues to evolve

COVID-19 Pandemic in Maryland

- First case of COVID-19 identified in MD week of March 2nd in overseas traveler

- First community spread detected March 12th

Thought #1:“The world turned upside down”

Thought #2: How are we going to keep patients and staff safe and ensure medication continuity?

Regulations Changed Quickly

- **Federal Policy Changes**
  - Flexibility for Take Home Medication for OTPs (SAMHSA)
  - Flexibility for Prescribing Controlled Substances via Telehealth (SAMHSA/DEA)
  - Waiver of regulatory requirements related to HIPPA compliant telehealth platforms (OCR)
  - Expansion of Medicare Coverage for Providing Services through Telehealth (CMS)
  - Compliance with Addiction Treatment Confidentiality Regulations – 42 CFR Part 2 (SAMHSA)

- **State Policy Changes**
  - Executive Order authorizing telehealth services
  - Executive Order stay-at-home order

Just because policy allows for a certain practice, still need to apply it based on sound clinical rationale

Key Principle #1

- Balancing risks is at the core of clinical reasoning for treatment of opioid use disorder
  - Duration of take-home medication
  - Frequency of in-person visits
  - Drug testing

- New risks added during COVID

- Moved from 2-factor to 3-factor balance:
  - Risks of inadequately or untreated OUD/SUDs
  - Risks of opioid agonist adverse effects, misuse, or diversion
  - Risks related to COVID exposure and transmission to patient, staff, and public

Patient Example: Mr. W

- 58 yo male, homeless, wheelchair bound due to AKA, ESRD on HD, schizoaffective disorder, severe OUD, no h/o OD
- Also uses illicit benzodiazepines
- OUD stable on methadone 100mg daily until early Feb
- Seen in ED twice in last 7 weeks for cough and SOB; COVID-negative tests x2

Risk Balance Assessment: Mr. W

Risks Favoring Longer Duration of Take-Home Medication	Risks Favoring More Frequent In-Person Visits
High risk of severe COVID illness	High risk of complications from ongoing OUD recurrence
Moderate/high risk of COVID exposure	High risk of OD
Transportation difficulties due to broken wheelchair	Moderate risk of diversion due to poverty and homelessness

Resulting Plan:

- Contacted homeless outreach agency for shelter/transportation/wheelchair repair assistance
- Continued methadone dose of 100mg daily
- Clinic frequency established as M/W/F for now
- Provided locked canvas bag for medication storage and reviewed storage in-person with patient
- Assured naloxone kit on-person
- Educated on COVID symptoms, physical distancing other COVID exposure prevention measures; also overdose risk reduction education
- Obtained drug test once after last ED visit

Clinic Practice Example

Phase 1 response:

- Initial reduction in number of patients presenting for in-person visits
  - Stable patients coming twice monthly switched to once monthly
  - Stable patients coming once weekly switched to twice monthly
  - Longer durations of buprenorphine/naloxone take homes

- Created structured, specific protocols and procedural algorithms

- Incorporated physical distancing into all clinical encounters
  - Halting ASAM Level 1 group sessions
  - Individual and ASAM Level 2.1 (IOP) sessions only when 6 feet of distance could be ensured
  - Discontinued drug testing

Clinic Practice Example (cont)

Phase 2 response:

- Discontinued IOP group sessions and all individual non-crisis sessions
- Implemented brief screening protocol at building entry
- Further reductions in number of patients in building at any given time
  - Use of 1 week and 2 week take home supply frequency
  - Shifting patients to assigned days of week based on counselor algorithm

Clinical Practice Example (cont)

Phase 2 response:

- Initiated phone outreach and counseling to established patients
- PPE prioritization algorithm
- Staggering staff
- Communications to patients and staff electronically and virtually

Clinic Practice Example

Phase 3 response:

- Some drug testing restarted
- Alternative medication delivery systems developed
- Limited bloodwork resumed
- Re-assess take home duration for unstable patients
- Universal face masking policy continued
- Front door screening protocol continued
- Reduced meeting of ICS team to weekly

Key Principle #2

- During an unprecedented crisis filled with uncertainty, apply the evidence for effective treatment of opioid use disorder

Methadone Alone Reduces Opioid Use

Study of people in Baltimore taking methadone only (no other treatment services) for 4 months

- 35% of participants had no opiate-positive drug test results in 4 months
- Another 37% of people had only 1 opiate-positive test result
- On average, opiate-positive drug test results dropped by 45%

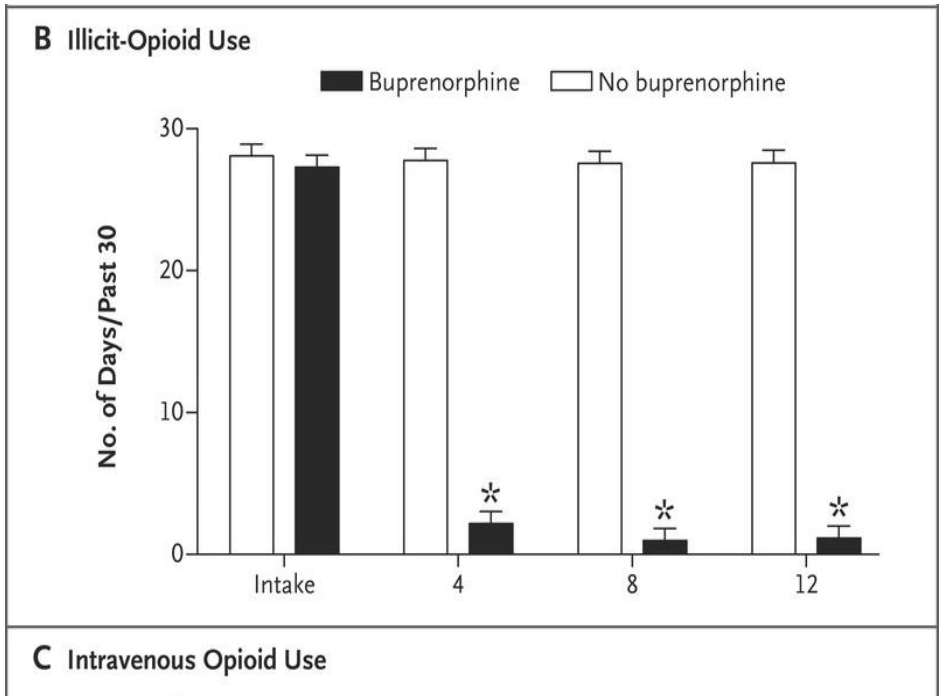
Schwartz, R. et al. Arch Gen Psychiatry, 2006;63:102-109

Abstinence from Illicit Opioids over 12 Weeks with Buprenorphine and No Counseling

- 50 people waiting for full services
- 78% injected opioids and 30% prior OD
- 25 people buprenorphine and daily phone call check in with automated system
- 25 people stayed on waiting list

Results:

1. Significant reductions in number of days spent using opioids; significantly less injecting in buprenorphine arm
2. 68% of participants had opiate-negative drug test results at 12 weeks in buprenorphine arm; 0% in waiting list only



Sigmon et al, NEJM, 2016;375:2504-2505

Risk Factors for Substance Use

- Stress
- Anxiety
- Reliving adverse childhood experiences and past trauma

These risk factors are amplified in people with substance use disorders

May impact patients and providers

Strength in Partnerships

- Partnered with 17 recovery houses with dedicated recovery house coordinator
- Distributed 150 naloxone kits obtained from MDH Center for Harm Reduction Services
- Provided 158 syringe services kits on behalf of Baltimore City Harm Reduction Coalition

Connectedness

- Increased school connectedness associated with reduced nicotine, marijuana, and alcohol use among high school students (Weatherson KA, et al. J Adolesc Health. 2018)

- Studies across different countries, ethnic, and age groups find engagement with positive social support networks associated with less substance use

Lessons Learned on Telehealth

- Involvement of counselors with trainee status crucial
- 50% of patients only have access to phone
- Patients justifiably worry about their COVID risk
  - 60% over age 50
  - High percentage of high-risk health conditions for severe COVID illness
- Extremely valuable addition to in-person visits

Key Principle #3

- COVID-19 pandemic is a rapidly evolving public health crisis. So related guidance may change quickly.

- What is discussed today, may change tomorrow……so keep abreast of updates from reliable sources

Reliable Sources

- CDC:
  https://www.cdc.gov/coronavirus/2019-ncov/index.html
- Maryland Department of Health:
  https://coronavirus.maryland.gov/
- Local Health Departments
- MACS Resources:
  http://www.marylandmacs.org/Resources/COVID-19-Resources/
- ASAM COVID webpage:
  https://www.asam.org/Quality-Science/covid-19-coronavirus
- PCSS Roundtables:
  https://pcssnow.org/resources/covid-19-resources/

THANK YOU!

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