AETC AIDS Education & Training Center Program Mountain West

The Epidemic and the Pandemic: Treating Opioid Use Disorder in the COVID Era

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Logistics

- This webinar is being recorded.
- All participant microphones are muted.
- Type in questions or comments through the question box. We will be compiling the questions and sharing them with our presenter and panelists during the Q&A portion of the program. Please do not submit your questions directly to the presenter. He will be not be monitoring the question box.
- After today's session you will receive an email with a link to an evaluation for today's session- we would appreciate you filling this out.

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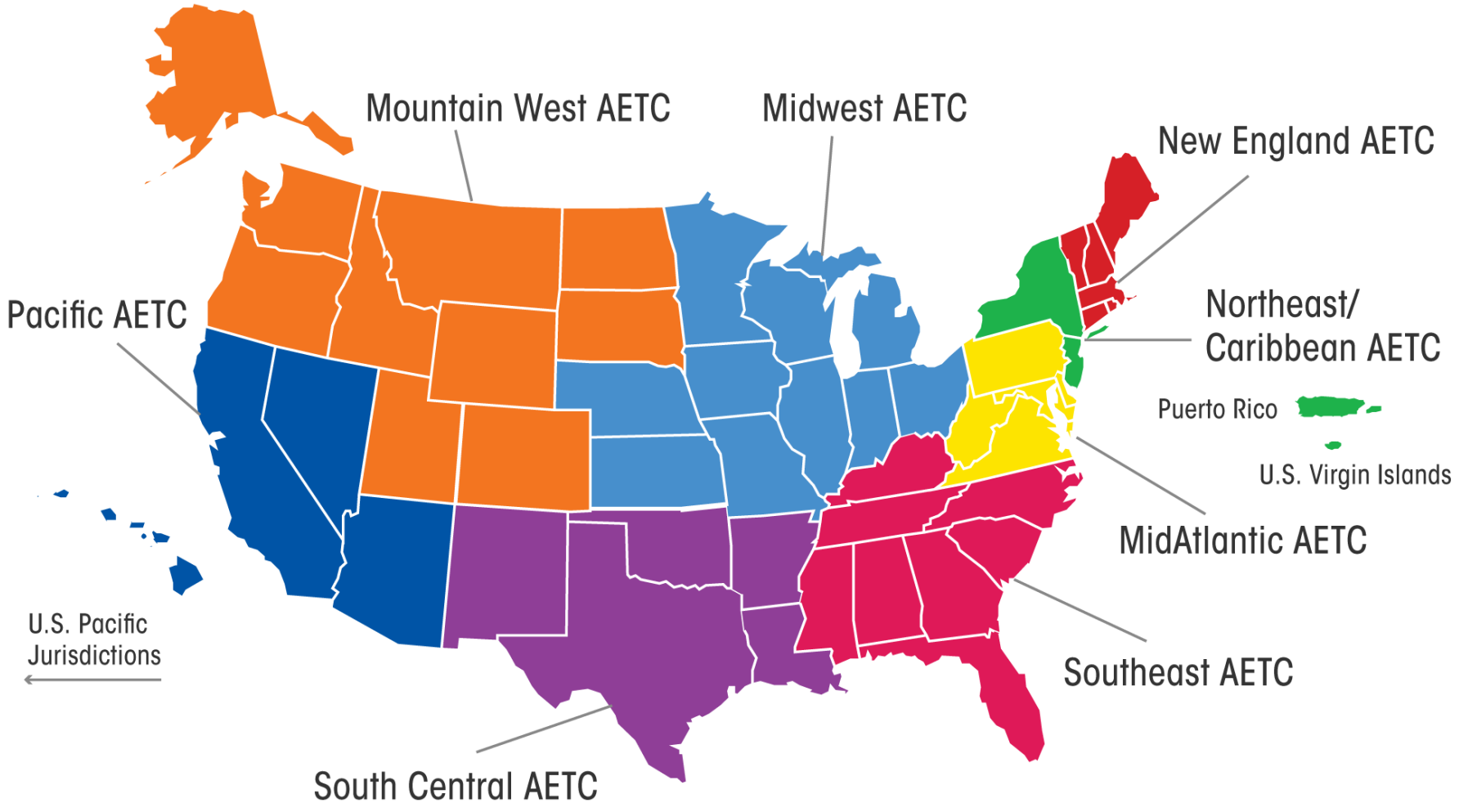

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Disclosures

No conflicts of interest or relationships to disclose

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- “Unfortunately for mariners, the total amount of wave energy in a storm doesn’t rise linearly with wind speed, but to it’s fourth power. The seas generated by a forty-knot wind aren’t twice as violent as those from a twenty-knot wind, they’re seventeen times as violent.”
- Sebastian Junger, *The Perfect Storm*

OUTLINE

- Epidemiology
- Unique concerns for patients with Opioid Use Disorder (OUD) in the COVID era
- Regulatory changes for Opioid Treatment Programs (OTPs)
- Regulatory changes for Office Based Opioid Treatment (OBOT) programs
- Best Practices for OBOT programs during the pandemic
- Peer support and Harm Reduction
- Panel Discussion

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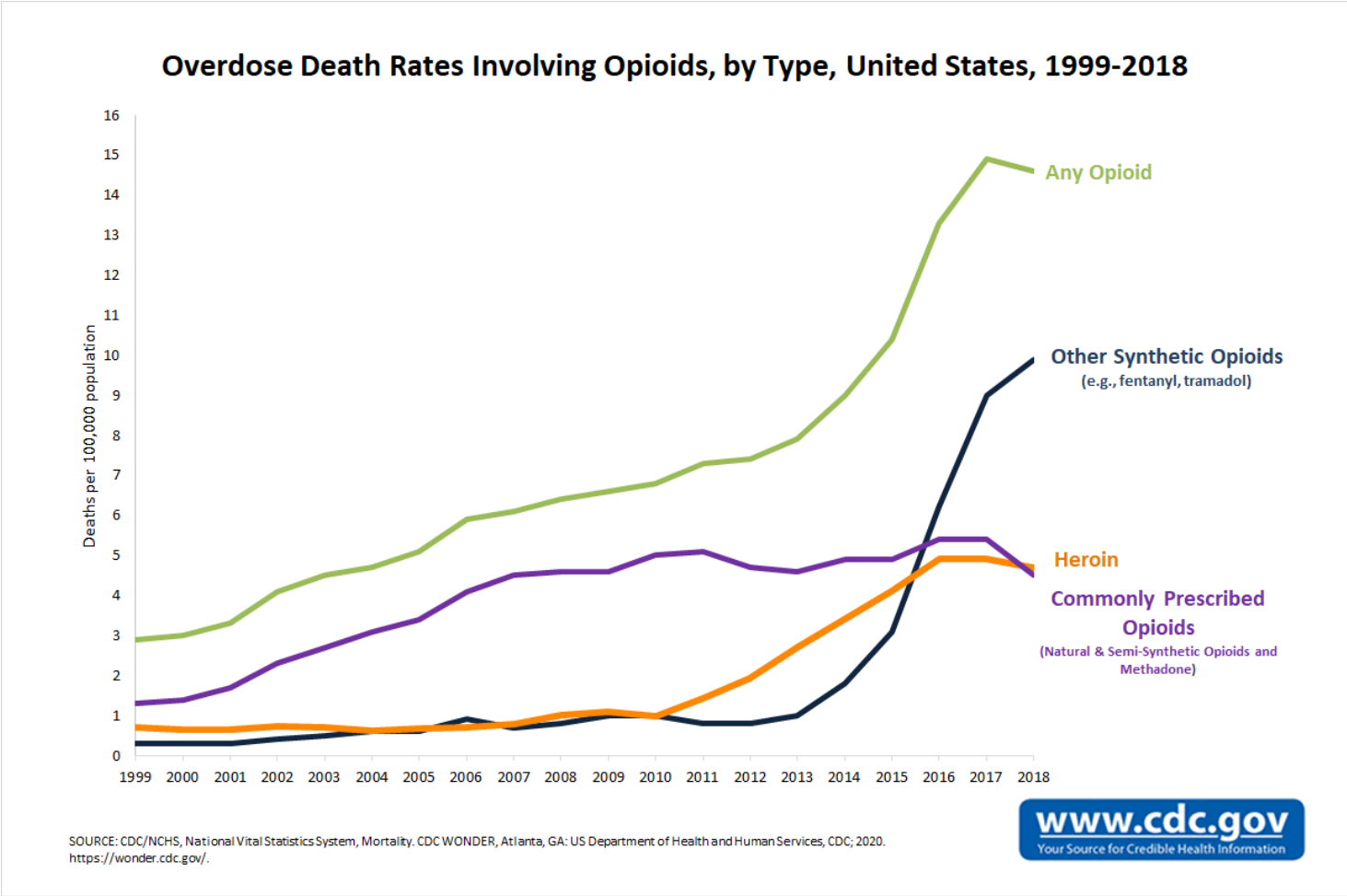
The Overdose Epidemic - Pre-pandemic



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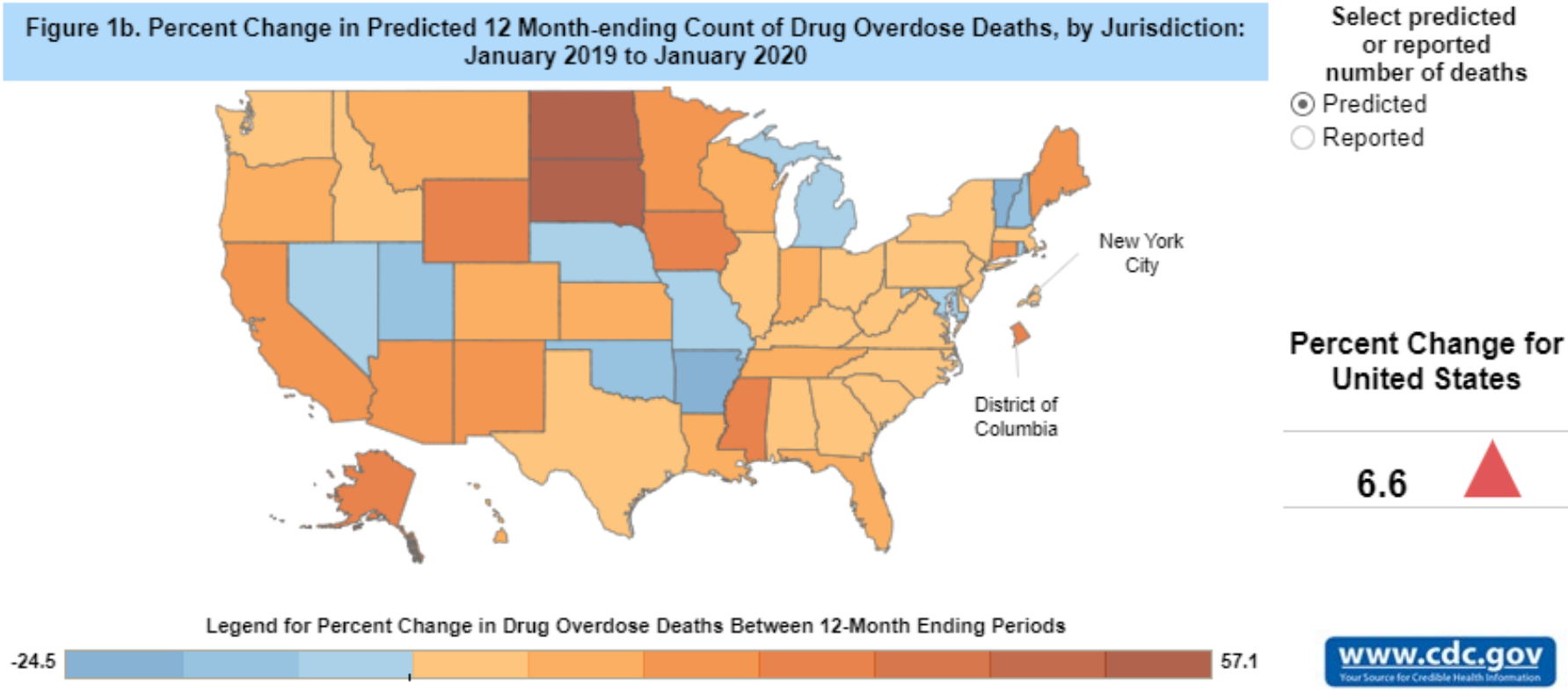
Provisional CDC data 2019



Provisional Fatal Overdose Deaths in 2020: 72,707

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Concern about particular vulnerabilities of patients with OUD.

Annals of Internal Medicine®

An Epidemic in the Midst of a Pandemic: Opioid Use Disorder and COVID-19

G. Caleb Alexander, MD, MS; Kenneth B. Stoller, MD; Rebecca L. Haffajee, JD, PhD, MPH; and Brendan Saloner, PhD

Collision of the COVID-19 and Addiction Epidemics

Nora D. Volkow, MD

When Epidemics Collide: Coronavirus Disease 2019 (COVID-19) and the Opioid Crisis

William C. Becker, MD, and David A. Fiellin, MD

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OUD as a risk factor for severe COVID-19?

- People with opioid use disorder may be
  - More likely to be infected by (and transmit) SARS-CoV 2
    - Over-representation in congregant living settings like homeless shelters, supportive housing, jails and prisons.
    - Intensive face-to-face demands of certain OUD treatment modalities (residential treatment facilities and opioid treatment programs).
  - More likely to get SEVERE disease
    - Higher rates of chronic disease which predispose to severe illness (chronic lung disease, chronic liver disease, cardiovascular disease).
    - Often socially marginalized with poor access to comprehensive medical care.

Volkow 2020; Doran, 2018; Becker, 2020; Schulte 2013

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COVID-19 and the response could increase opioid related harms

People with and Opioid Use Disorder may:

- Be more likely to relapse or increase use of substances due to stress and social isolation.
- Have interruptions in access to opioids (illicit or via treatment) resulting in decrease in tolerance.
- Need to seek out opioids from unknown suppliers.
- Have interruption in access to treatment.
- Have interruption in access to syringe services, case management, MH and other medical care.
- Use drugs more frequently while alone.
- See an increase suicidal or parasuicidal risk-taking in drug use.

Volkow 2020; Alexander 2020; Becker, 2020

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Precedents? Hurricane Sandy . . .

Patients: Of 300 people treated in OTPs in new York City[1]:

- 60% experienced withdrawal
- 27% shared drug injection or preparation equipment or injected with people they normally would not inject with
- 70% of those on opioid maintenance therapy could not obtain sufficient doses
- 43% of HIV-positive participants missed HIV medication.

Providers[2]: Methadone providers reported more barriers to continuity of care than buprenorphine providers. Similar barriers were documented following the 9/11 attacks and Hurricane Katrina.

1. Pouget, 2014; 2. McClure, 2015

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Stress/Depression/Isolation as trigger

MMWR Survey Data from June:

- 5,412 panel surveys conducted for adults >18 across US from June 24 – 30, 2020.
- 25.5% reported symptoms of anxiety disorder (8.1% in 2019)
- 24.3% reported symptoms of depressive disorder (6.5% in 2019)
- 13.3% reported that they started or increased Substance Use because of COVID-19
- 10.7% reported seriously considering suicide in the last 30 days (vs. 4.3% than in 2018 when asked about previous 12 months)
- Disproportionally affecting young adults, Hispanic persons, black persons, essential workers, unpaid caregivers for adults, and those receiving treatment for pre-existing psychiatric conditions

MMWR, Vol 69, 2020

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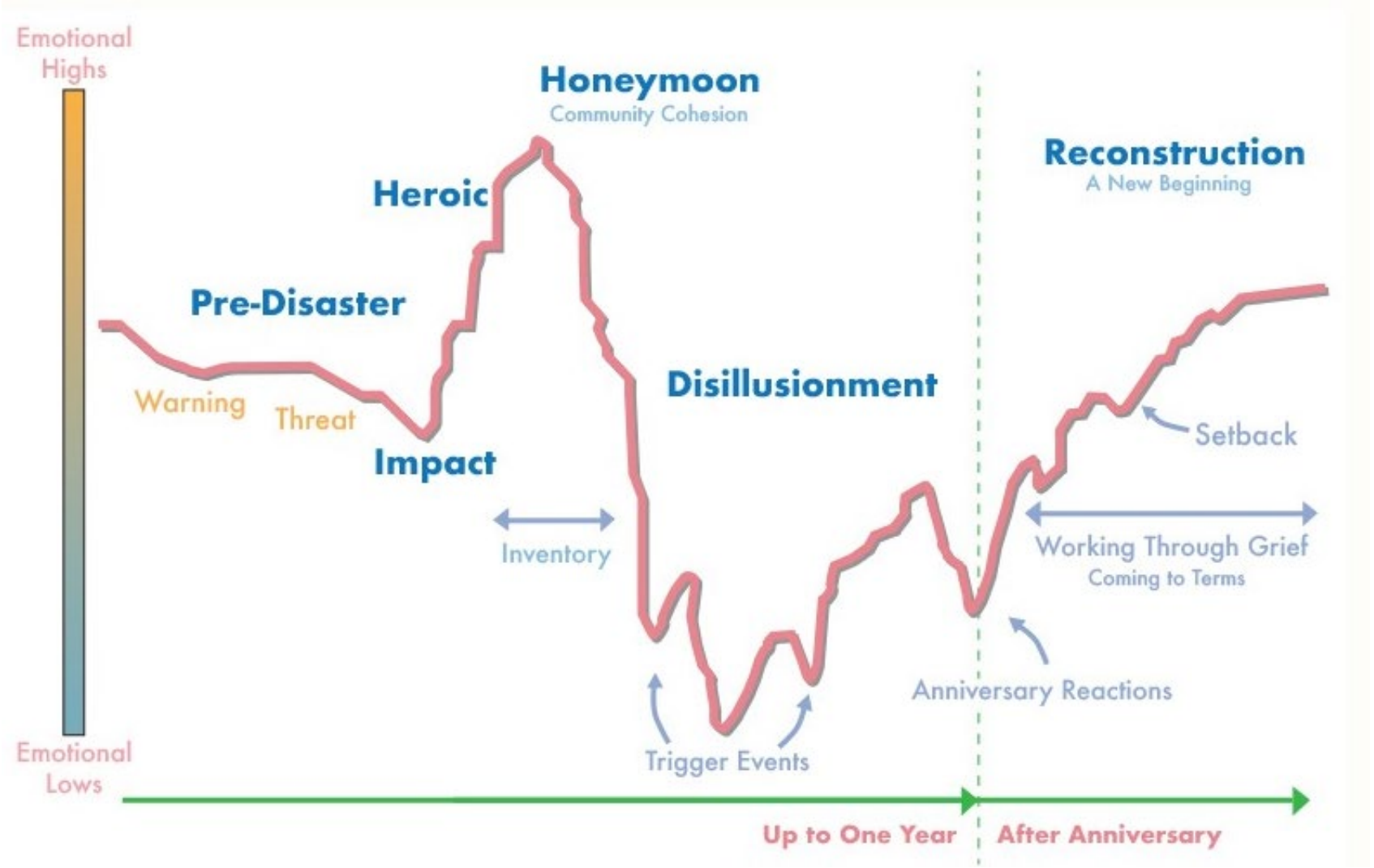

Adapted from Zunin & Myers as cited in DeWolfe, D. J., 2000. Training manual for mental health and human service workers in major disasters (2nd ed., HHS Publication No. ADM 90-538).

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Financial triggers (macroeconomics)

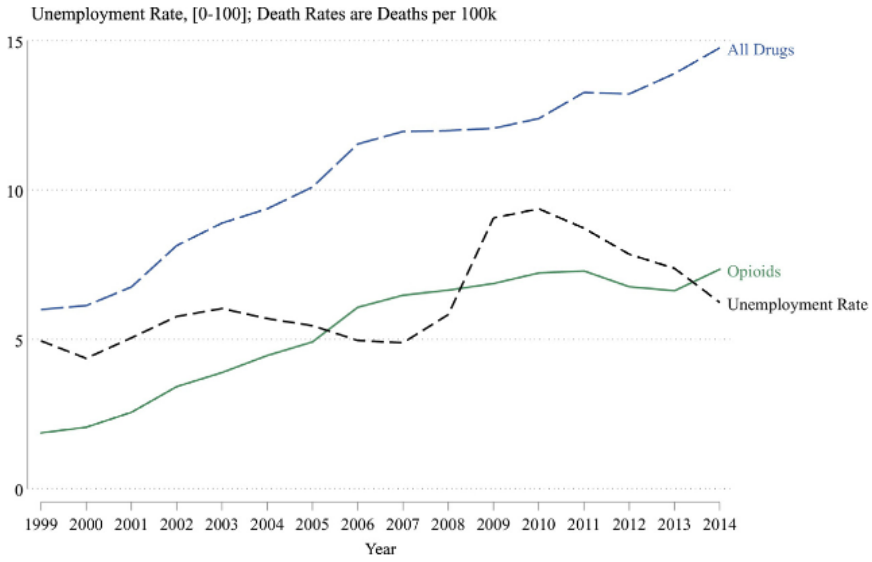

Fig. 1. U.S. unemployment rate and drug death rates by type, 1999–2014.

- As the county unemployment rate increases by one percentage point, **the opioid death rate per 100,000 rises by 0.19 (3.6%)** and **the opioid overdose ED visit rate per 100,000 increases by 0.95 (7.0%)**. Macroeconomic shocks also increase the overall drug death rate, but this increase is driven by rising opioid deaths.

Hollingsworth, 2017

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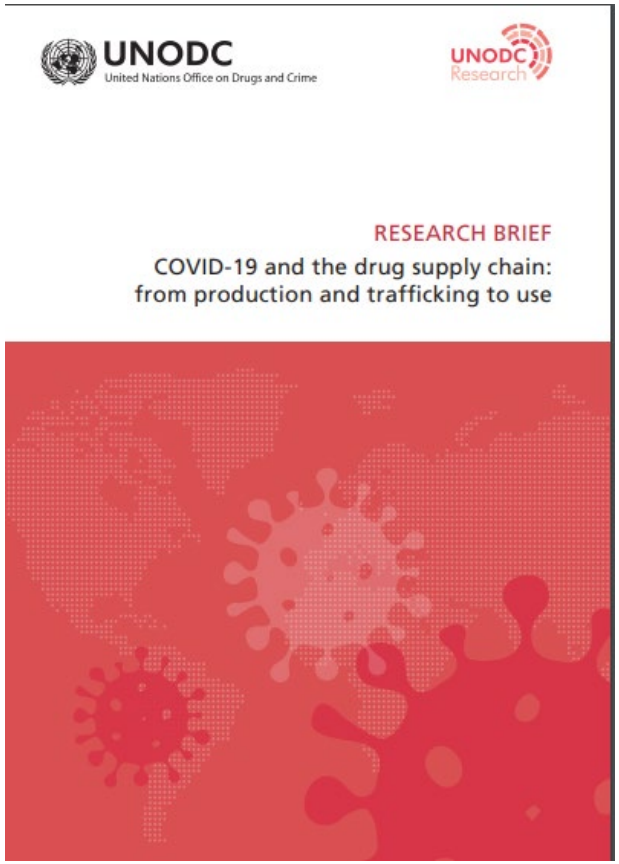
Interruption of Drug Supply



- Disruption of precursor supply chains.
- Shut down of overseas synthesis facilities.
- Disruption of drug shipping routes due to border closures.

Can result in the instability of illicit drug market – uncertainties in the supply and quality of drugs sold on the street.

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Reduced Access to Treatment

Addiction Policy Forum -- web-based survey of patients and family members, April 27 - May 8, 2020, completed by 1,079 SUD patients and family members.

- One in three respondents (34%) report changes or disruption in treatment or recovery support services due to the COVID-19 pandemic.
- 14% say they were unable to receive any needed services.
- ...7% say they are unable to access in-person support groups.
- …2% and 3%, respectively, say they were unable to access syringe or naloxone services specifically.

Hulsey, J; *COVID-19 Pandemic Impact on Patients, Families & Individuals in Recovery from a SUD*. Addiction Policy Forum, 6/8/2020.

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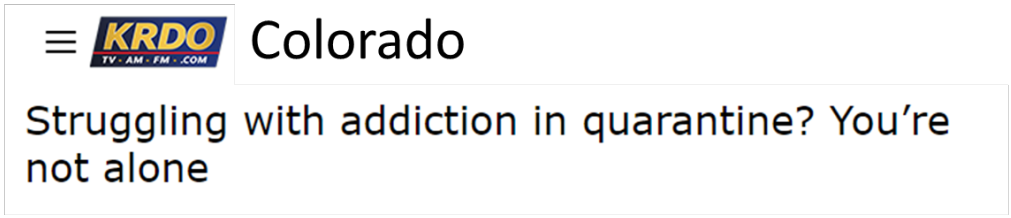
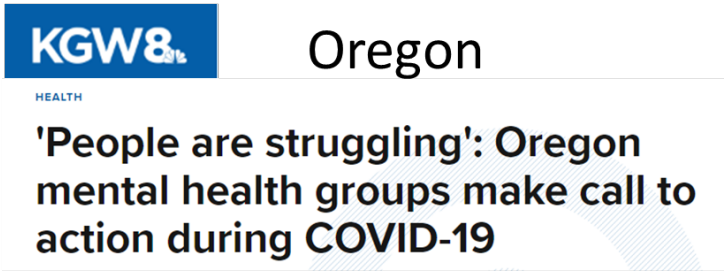
Early evidence suggests increasing rates of fatal and non-fatal overdoses.

Even provisional CDC overdose data is not expected for several more months.

The American Medical Association (AMA) is tracking news reports of increases in opioid-related mortality in 40 states.





AMA Issue Brief: Reports of increases in opiod-related overdose and other concerns during COVID pandemic, update 9/8/2020.

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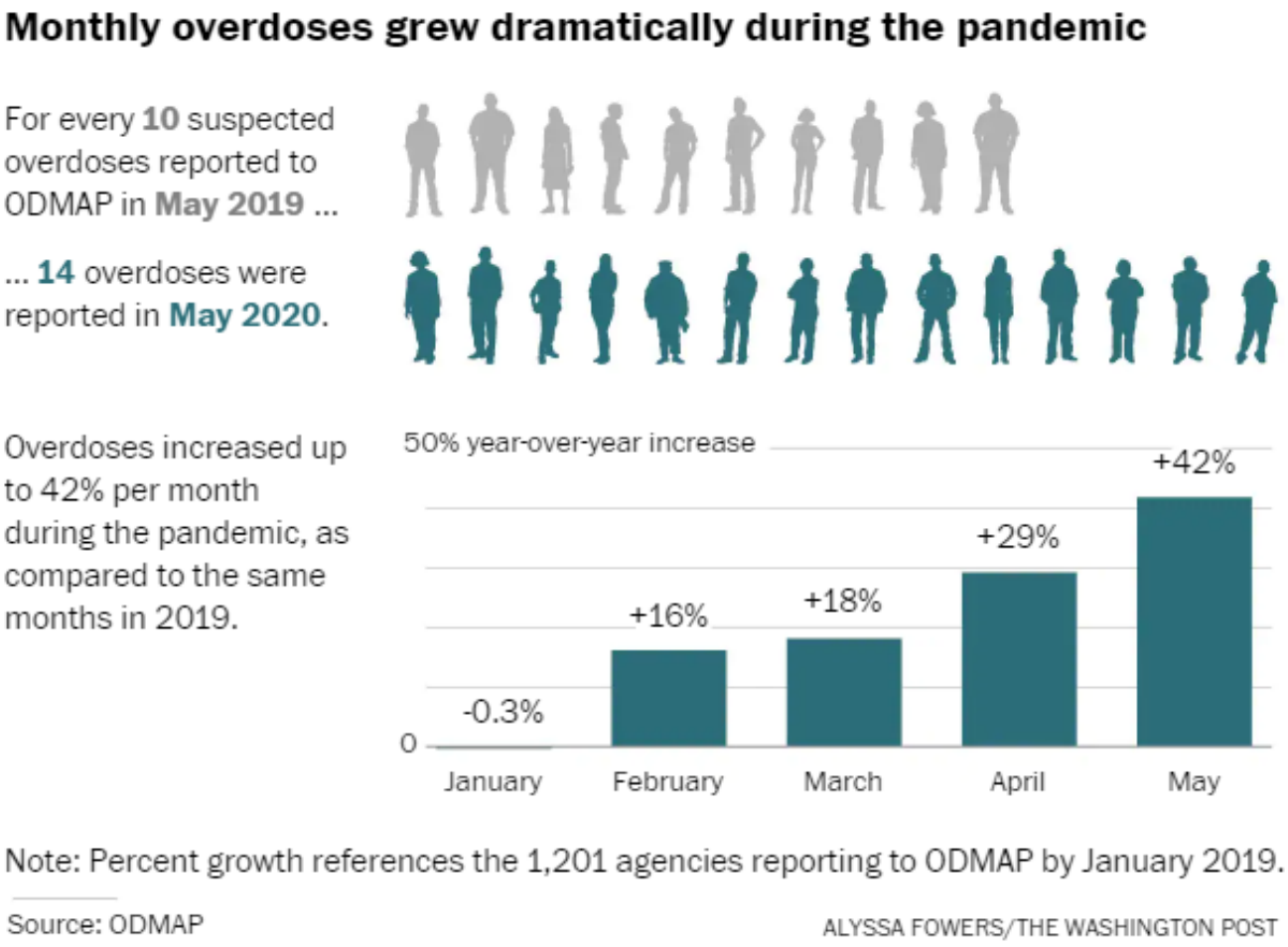
- The Washington/Baltimore High Intensity Drug Trafficking Area (W/B HIDTA) is housed within the University of Baltimore Center for Drug Policy and Enforcement (CDPE). It developed and maintains the Overdose Detection Mapping Application Program (ODMAP), a syndromic surveillance system that provides near real-time suspected overdose data nationally.
- Since it began in 2017, ODMAP has forged agreements with a patchwork of about 3,300 agencies in 49 states that voluntarily provide data.

Washington Post Analysis of ODMAP dataset



Washington Post; *"Cries for help;" Drug overdoses are soaring during the coronavirus panedmic*.7/1/2020.

Treatment Options for OUD

Opioid Agonist Treatment with methadone and buprenorphine is highly efficacious for OUD, shown to:

- Increases overall survival (>50 - 60% all-cause mortality reduction)
- Increases treatment retention
- Decreases illicit opioid use
- Decreases hepatitis and HIV seroconversion
- Decreases criminal activity
- Increases employment
- Improves birth outcomes

Joseph, 2000;67:347-364, Sordo L et al. BMJ 2017

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Opioid Treatment Programs (OTPs): Background

- Methadone, developed during WW2, has been approved for maintenance use for OUD since 1974.
- Discontinuation of methadone (especially involuntary), is associated with high rates of recurrence of illicit opioid use and is a uniquely vulnerable time for overdose.
- Methadone cannot be prescribed for the indication of OUD, it can only be dispensed in an Opioid Treatment Program, which is subject to intensive federal and state regulation.

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OTPs: Usual Care

- Normally, according to Federal Law, patients cannot be granted more than 1 take-home dose of medication a week, unless they meet the following criteria:

Time in Treatment	# of Take home doses
0-90 days	One dose/week
91-180 days	Two doses/week
181-270 days	Three doses/week
271-365 days	6 doses/week
>1 year	Visit clinic q2 weeks
>2 years	Visit clinic q4 weeks

- Absence of extra medical substance use
- Regular attendance, adherence to counseling
- No behavioral problems at program
- No criminal activity
- Stable home environment, social situation
- Safe storage
- Rehab benefit> Risk of diversion
- Time in treatment (see across)

42 CFR § 8.12

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Regulatory Changes for OTPs

On March 19th, SAMHSA issued national guidance indicating states may request blanket exceptions for

- Stable patients to receive 28 days of Take-Home medication.
- “Less stable” patients can receive up to 14 days of take-home medication.

It is up to the OTP medical director to determine which patients are stable and unstable.

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Regulatory Changes for OTPs

SAMHSA's guidance for OTPs regarding TELEHEALTH:

- New patients who will receive METHADONE must still have "face-to-face" encounter
- New patients who will receive Buprenorphine can be evaluated via telehealth (or telephone).
- Established patients can be seen via telehealth or telephone.

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Regulatory Changes for OTPs

For patients in quarantine or isolation:

- Patients can identify (through appropriate chain of custody protocol) a “trustworthy, uninfected” member of the household to pick up and deliver the medication.
- DEA allows that OTPs can arrange for delivery of medication by “authorized [OTP] staff, law enforcement official, or national guard personnel.”
- For patients in supervised, controlled settings (jails, SNFs), the facility may hold and dispense 14 days worth of medication.

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Case study: Large OTP in Seattle

- Evergreen Treatment Services, largest OTP in Washington State, serves 2630 patients.
- Case-by-case determinations made around patient stability, attempting to balance patients' vulnerability to COVID-19 with risks posed by providing potentially unstable patients with large doses of methadone.
- Discussions revolved around key risk factors, heavily emphasizing drug poisoning risks (e.g. recent drug poisoning events, documented drug impairment incidents).

Peavy 2020

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Case study: Large OTP in Seattle

- "Before COVID" February 24-29 and "After COVID" March 30-April 4th. Before COVID, an average 0f 61.9% of patients were on site for dosing each day. This dropped to 31.1%, representing a 49.2% decrease.
- There have been a small increase in "take-home incidents" such as reports of lost or damaged medication. There has not been an increase in methadone related overdoses in our population.

Peavy 2020

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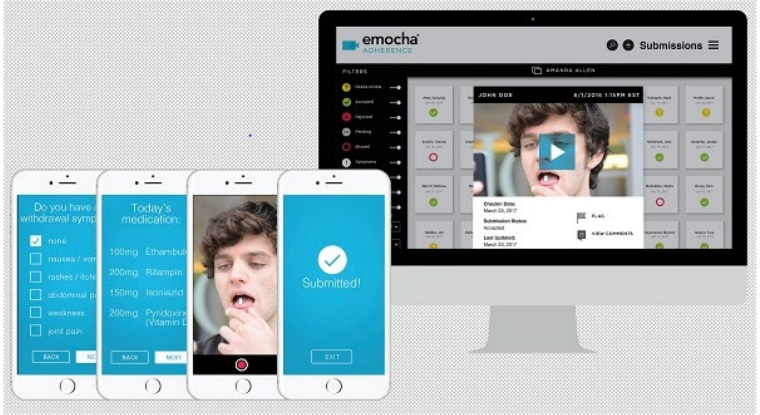
Leveraging Tech?

Asynchronous, Video-

Directly observed therapy:



Automatic Pill Dispenser:

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Office Based Opioid Treatment (OBOT): Background

- With the passage of the Drug Addiction Treatment Act in 2000 and the FDA's approval of buprenorphine as a schedule III medication, buprenorphine is able to be prescribed in an office based setting for Opioid Use Disorder.
- Providers must undergo an 8 hour training to obtain their "waiver" to prescribe.
- The law (and subsequent amendments) provides "caps" on the number of patients who can be prescribed buprenorphine by a provider at any one time.

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OBOT Programs: Usual Care

- Medication initiation requires in-person medical assessment before prescribing.
  - A provision of The Ryan Haight Act of 2009
  - There are seven “telemedicine exceptions” to the act
- Clinical practice varies broadly. Visits are often weekly until patient demonstrates stability on medication.
- Frequent urine drug testing (often weekly) at first.
- Counseling requirements vary by program.
- Public and private payers may set buprenorphine refill windows, prior authorizations, and institute face-to-face fill requirements.

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Regulatory Changes for OBOT Programs

- Medicare has expanded coverage for providing services through Telehealth
- SAMHSA and DEA guidance states OK for practitioners with DATA 2000 waiver to treat new and existing patients with buprenorphine via telehealth (including use of telephone), without an in-person exam.
- HHS has waived potential penalties for HIPAA violations against healthcare providers using non-HIPAA compliant communication technology (eg. FaceTime or Skype).
- DEA exception to cross state DEA licensure

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Best Practices for OBOT (American Society of Addiction Medicine – ASAM)

1) Leverage Telehealth

- As above, new patients can be evaluated for the first time via telehealth of telephone, if appropriate.
- For established, stable patients, the risk of in-person visits likely out-weighs the benefits.
- Two-way, real-time interactive communication preferred, but telephone-based visits may be considered, especially for patients without technical capabilities for video visit.

2) Prescriptions and Refills

- Provide buprenorphine refills to stable patients without requiring in-person visits or urine toxicology testing.
- Patients who are unstable may benefit from having less medication on hand and more frequent contact with providers (remote or in-person).

Consider the following (when making decisions about frequency of in-person visits or prescription lengths):

- Does the patient fall into a high risk group for COVID-19 illness?
- Is the patient under quarantine or isolation (due to exposure, symptoms or a positive test)?
- What capability does the patient have for safely storing the medication?
- Who has potential access to medications in the home, including children and pets?
- How stable is the patient's OUD and/or other substance use disorders, if present?
- ASAM COVID-19 Task Force Recommendations.

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3) Psychosocial treatment

Four RCTs found that enhanced psychosocial counseling provided no additional benefit than typical medical management in OBOT.

“A patient’s decision to decline psychosocial treatment should not preclude or delay pharmacotherapy . . . This guidance is even more applicable right now when patient may need to be under self-quarantine or have other risk factors that lead them to want to minimize external interactions.”

Offer access to therapy if desired by the patient, via telehealth when possible.

ASAM COVID-19 Task Force Recommendations.

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Peer Support

There are a wide range of options for online support groups including discussion groups, chat and live meetings via teleconferencing technology:

- AA: online
- NA online
- Buddhism-based Recovery
- Refuge Recovery
- SMART recovery
- LifeRing

- Recovery Support Apps: Sober Grid, SoberTool, AA Big Book, I Am Sober, Pink Cloud.

Patients new to treatment

- WA State Opioid Treatment Authority recommending considering buprenorphine as the treatment modality of choice for patients new to treatment during the pandemic.
- Can use telemedicine for initial visit.
- No initial dose limitations.
- Easier to adjust dose.
- Easier to deliver to patients who are isolated.
- Less risk for treatment interruption in emergencies.
- Can switch to methadone in the future.

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Harm Reduction

Discuss with patients the factors which might put them at greater risk of overdose or other opioid-related harms during this time.

- Some folks may have stocked up on drug supply due to concerns about losing access, and having more ready access might mean using more than normal.
- Disruptions in drug supply followed by resumption after a period of abstinence.
- Extended take-home doses of methadone.
- Fentanyl in the illicit pill and heroin market.
- Social distancing mandates might make using alone more common.

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Harm Reduction

- Help patients explore ways to reduce their risks of overdose and disease transmission
  - Whenever possible, don't use alone. You can call the "Never Use Alone" hotline at 1 800 484 3731 before using.
  - If possible, prepare and administer your drugs yourself.
  - Start low and go slow.
  - Recognized signs of an overdose.
  - Call 911 if someone may be overdosing. Remind patients of the Good Samaritan Law that prohibits legal ramifications of doing so.
  - Prescribe naloxone and educate on how to use it.
  - Engage interested patients in treatment (methadone or buprenorphine).

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Panel Discussion

- What particular challenges have you or your patients encountered these last 6 months in the treatment of OUD?
- What role can the primary care provider play in mitigating risks to patients with OUD during the pandemic?
- Are there any silver linings here? How will the pandemic inform how we treat OUD in the future?

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