Opioids and Addiction in the Era of COVID-19

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Disclosures

- No financial or commercial interests to report

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- Assistance with addiction and behavioral health resources and referrals
- Technical assistance to practices implementing or expanding office-based addiction treatment services
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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 OUD clinical practices during COVID
- Identify 3 key practice-level questions to consider as COVID crisis evolves

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A Crisis Before A Pandemic

> The opioid crisis is one of the largest and most complex public health tragedies that our nation has ever faced. It remains the biggest public health crisis facing the FDA. The toll

FDA Commissioner Dr. Scott Gottlieb, Feb 26, 2019

OPINION - HEALTH AND SCIENCE

The decline in opioid deaths masks danger from designer drug overdoses in US

PUBLISHED WED, AUG 21 2019•7:30 AM EDT | UPDATED THU, AUG 22 2019•3:14 PM EDT

Scott Gottlieb, M.D.

SHARE

CNBC, Aug 21, 2019

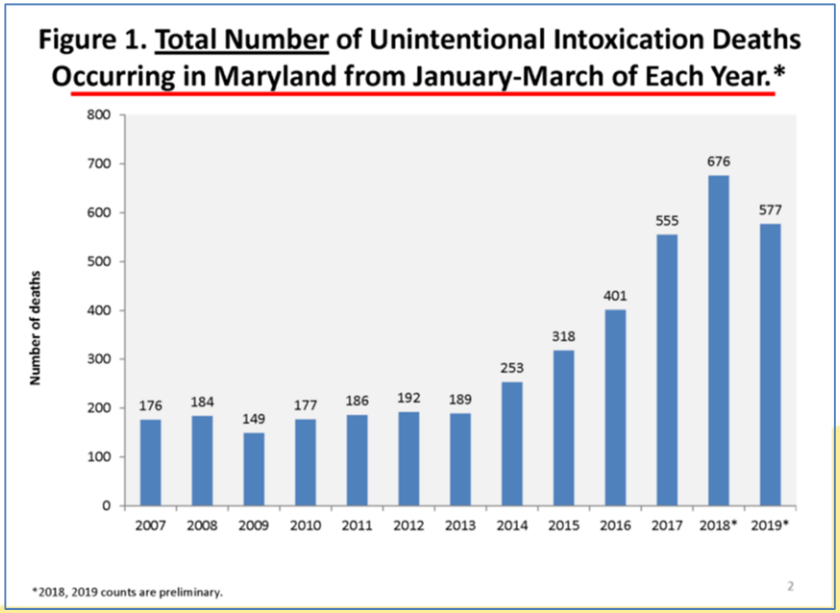
HEALTH

Oklahoma judge finds Johnson & Johnson fueled opioid crisis

By ASSOCIATED PRESS / AUGUST 26, 2019

Judge Thad Balkman announces his decision in the opioid lawsuit against Johnson & Johnson Monday in Norman, Okla.
SUE OGROCKI/AP

https://www.statnews.com/2019/08/26/oklahoma-judge-finds-johnson-johnson-fueled-opioid-crisis/



https://health.maryland.gov/vsa/Documents/Quarterly%20Drug_Alcohol_Intoxication_Report_2019_Q1.pdf

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: Prevent worsening addiction crisis within a pandemic

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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

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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

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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

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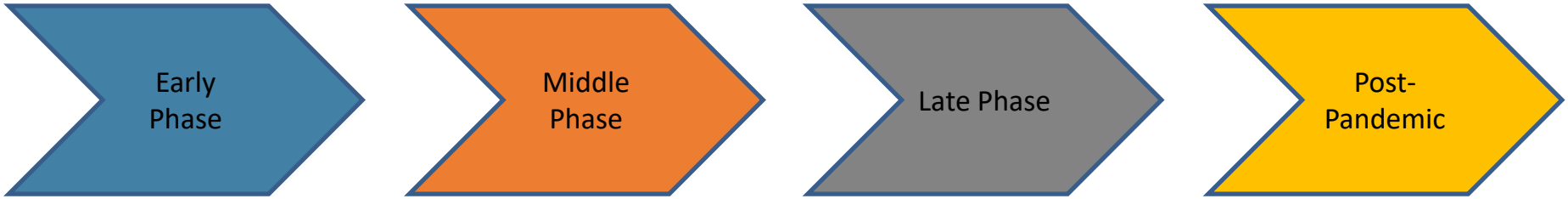
Phases of COVID-19 Pandemic and Response



- Low population prevalence
- Preventing viral transmission using physical distancing
- Implement protocols for identifying and managing individual cases of infectious patients /staff

- Higher population prevalence makes isolating individuals impractical
- Physical distancing and universal face masks
- Screening protocols can continue but assume infectiousness
- Designate entire areas/systems, including community housing, as available to either infectious or non-infectious persons.

- Continue mitigation strategies and aggressive measures as reopening efforts slowly begin
- Metric being used in MD: hospital admissions
- Updated best practices are implemented based upon lessons learned
- Prior phases may repeat

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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
- Implemented Incident Command management structure
- 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
- PPE acquisition efforts

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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

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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

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Clinic Practice Example

- Phase 3:
- Limited drug testing restarted
- Alternative medication delivery systems developed

- Not fully there yet

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Key Principle #2

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

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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

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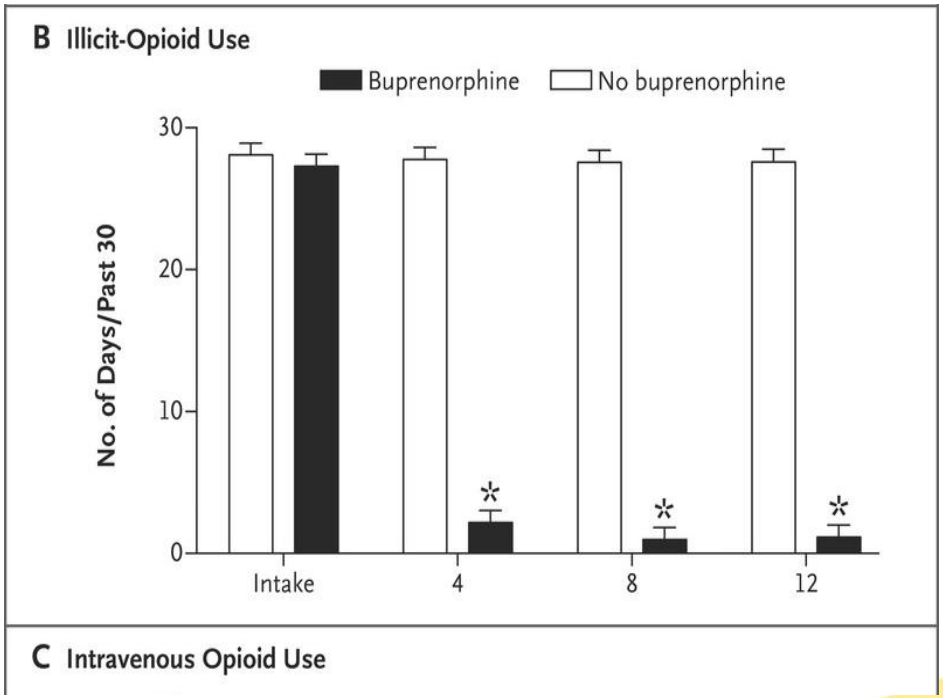
Abstinence from Illicit Opioids over 12 Weeks with Buprenorphine and No Counseling

- 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

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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

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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

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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

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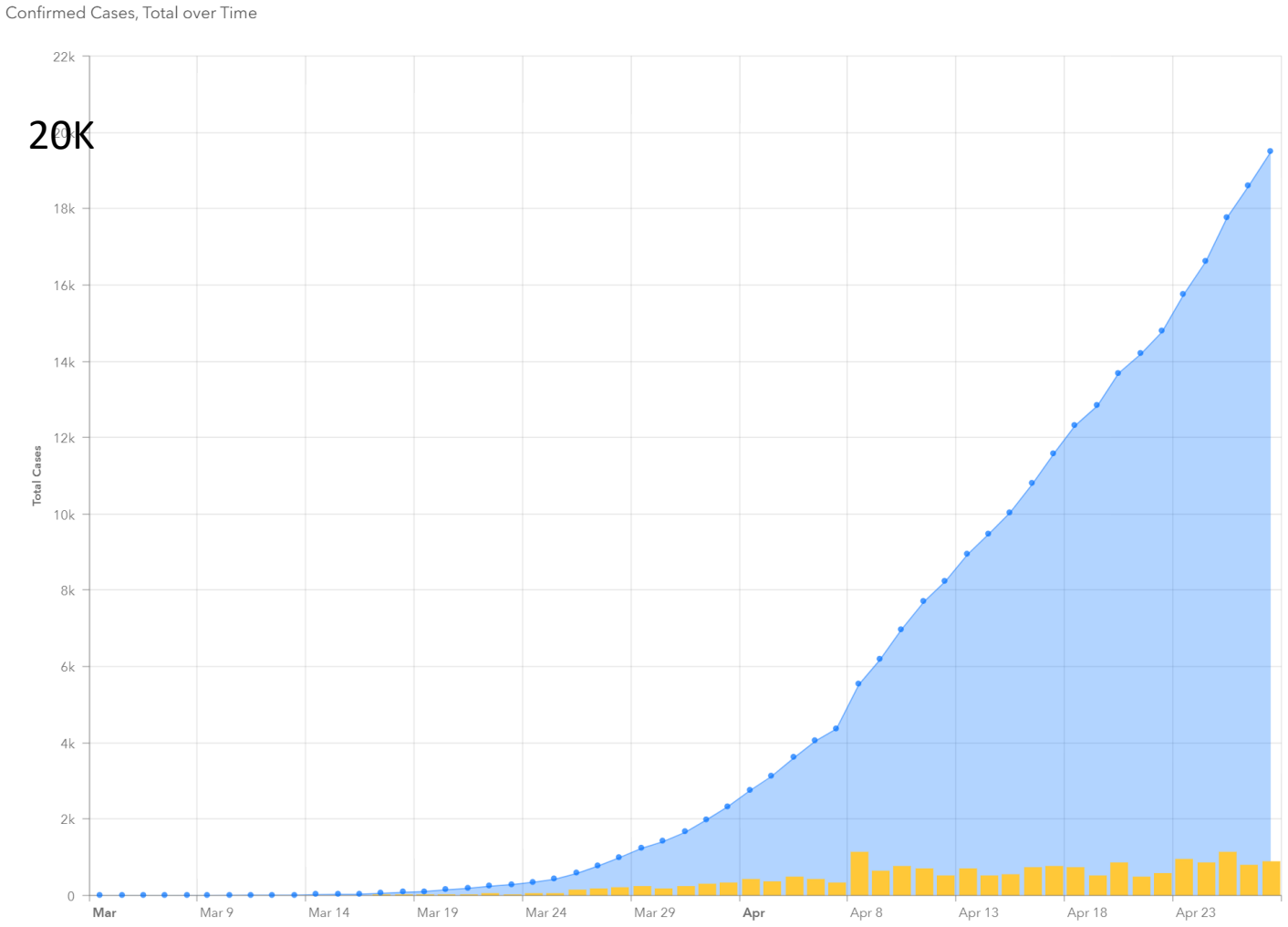
COVID Evolution in MD



Total Confirmed Cases

Time (March 9, 2020 through April 27, 2020)

https://coronavirus.maryland.gov

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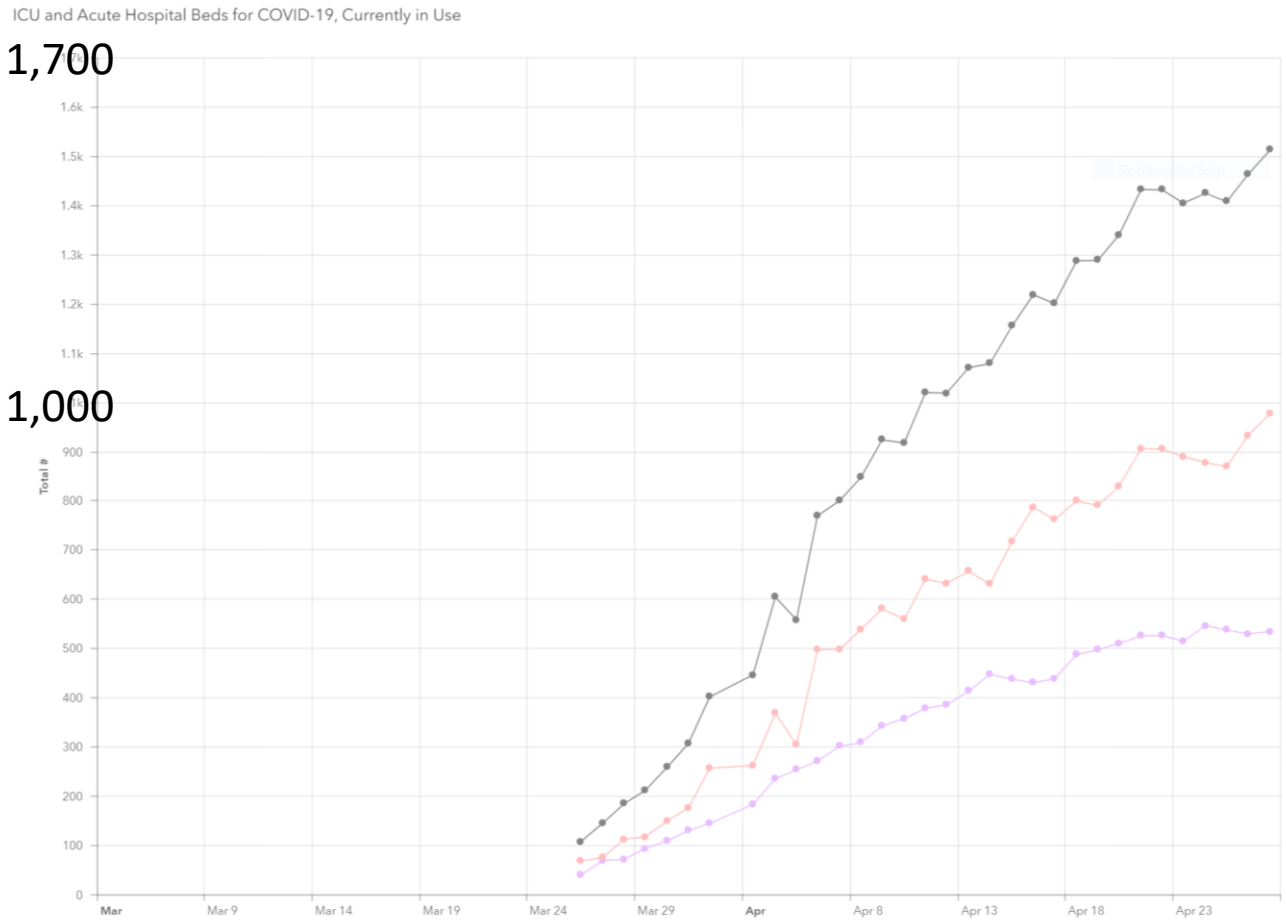
Flattening the Curve in MD

Total ICU and Acute Hospital Beds for COVID-19, Currently in Use



Total Beds

Acute Beds

ICU Beds

Time (March 9, 2020 through April 27, 2020)

https://coronavirus.maryland.gov

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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/

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Lessons Learned….to Date

- During crises, incident command type structures for clinic management organize chaos
- Physical distancing and infection control practices need to happen quickly
- Balancing multiple risks and uncertainty is the new normal
- Taking time to connect is important for everyone

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Looking Ahead…..

- What is happening with overdoses and the addiction crisis?

- How do addiction treatment providers ensure readiness for phase 3 and potential new waves of viral transmission?
  - Procuring sufficient PPE
  - Role in COVID testing
  - Role in contact tracing

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QUESTIONS?

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