ACMT Position Statement: Caring for Patients with Opioid Use Disorder during Coronavirus Disease Pandemic

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The position of the American College of Medical Toxicology (ACMT) is as follows:

To provide treatment for patients with opioid use disorder (OUD) while protecting staff and patients from coronavirus disease 2019 (COVID-19), we recommend modifying regulations and practices related to providing treatment for OUD while reducing the need for in-person visits. Government agencies should take steps to facilitate administration of medications for opioid use disorder to patients who may be quarantined. To prevent virus transmission, healthcare systems should expand use of telehealth. When in-person evaluations are required, healthcare systems should maintain physical distance between patients and cohort patients based on infection status. Payers should offer parity in telehealth payments and coverage for telehealth resources including telephone support when direct audio-video is not available to patients. Healthcare providers should take steps to minimize or eliminate the need for in-person visits, and increase use of strategies including remote buprenorphine inductions, administration of long-acting injectable medications, telehealth assessments, and minimization of urine drug screening.

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Background

The coronavirus pandemic overlies the ongoing opioid crisis in the USA. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, spreads among individuals in close contact with each other. The virus can be transmitted by those who are asymptomatic or minimally symptomatic. Medical and governmental authorities recommend physical distancing measures to minimize person-to-person contact [1].

Historically, treatment for OUD has relied upon in-person visits to perform physical assessment and toxicology testing, and to provide medications and behavioral therapy. Another component of OUD treatment is support groups, which usually occur in person, with multiple individuals present. To decrease the risk of fatal overdose, we have encouraged patients who continue to use opioids not to do so alone. This practice brings people who use drugs in close proximity to one another and those who provide care to them.

This traditional care model is not feasible during the current pandemic. In-person encounters risk spread of infection to both patients and providers. Providers and clinic staff may be affected by illness. Additionally, many patients on methadone attend treatment programs daily for their medication, which may not be feasible if they are in isolation or quarantine because of COVID-19 illness or exposure.

At the same time, pandemic-related stressors make people with OUD more vulnerable. Fear of illness and economic loss may predispose to relapse. Financial loss or loss of health insurance will place medications and services out of reach for certain patients. Some patients will not have access to the technology required for telehealth services. All of these factors can lead to lack of access to care, resumption of hazardous use, and mortality.

Regulatory Response

Regulatory authorities have responded to these needs by adapting existing rules to these new circumstances. Programs like the federal Coronavirus Aid, Relief, and Economic Security Act of 2020 (CARES) provided cash flow to businesses, which relieved financial stress for many Americans. The CARES act also made changes to 42 CFR part 2, the federal regulations that address the confidentiality of records relating to substance use disorder. The new regulations allow for confidential sharing of medical records as easily as other medical records, while expanding patient protections against discriminatory behavior related to OUD.

Centers for Medicare and Medicaid Services (CMS) waiver now allows Medicare to pay for telehealth (the remote delivery of health care using telecommunications) visits for OUD treatment [2]. Under the waiver, SAMHSA has temporarily exempted providers from the requirement that an in-person evaluation is required for the first administration of buprenorphine [3]. Practitioners treating OUD patients with buprenorphine and methadone (through an opioid treatment program) may continue to do so via telehealth. The requirement that patients starting methadone for OUD receive an in-person medical evaluation remains in force, although patients can receive more flexible take-home doses, including multiple days' doses after a single in-person evaluation.

We support the above regulatory responses and recommend further changes in regulations and practice related to treatment for OUD.

Methodology

This document was reviewed and approved by the ACMT Position Statement and Guidelines Committee, and was sent to the ACMT Board of Directors. After revision by the task force, final approval was made by the ACMT Board of Directors.

Recommendations

Government/Drug Enforcement Agency

- Increase funding to combat the opioid epidemic.
- Remove waiver requirements for prescribing buprenorphine to simplify access [4].
- Ease restrictions on take-home naloxone.
- Allow individuals with OUD access to a sufficient supply of medication if they require quarantine as they are at higher risk of severe illness from COVID-19.
- Provide housing for COVID-19 patients with OUD.

Healthcare Systems and Facilities

- At inpatient facilities, conduct preadmission coronavirus testing and cohort patients with positive test results.
- Allow for ambulatory detoxification centers to expand the number of patients they may treat.
- Expand telehealth resources and infrastructure and maintain a reasonable payment structure for the management of OUD.
- Stagger visit times at opioid treatment programs to allow for physical distancing between patients.
- Maintain availability of residential and inpatient beds for patients who cannot be managed as outpatients. When safe and practical, procedures should be modified to allow family contact, behavior therapy, and recreation while maintaining physical separation of inpatients.
- Allow for access to community resources and family if hospitalized including access to technology such as iPads and the Internet to support contact with Peers, and 'virtual resources' such as Internet-accessed AA/NA/HA meetings.

Payers and Local Initiatives to Increase Access to Care

- Remove co-pay requirements for prescription naloxone and medications to treat OUD.
- Provide funding for increased minutes for cellular phones or online access so that patients may use telehealth services and therapy sessions.
- Provide additional assistance (including Medicaid enrollment) for those who are unable to afford their medications.
- Provide parity in telehealth payment for care delivered by telephone when audio-video not an option.

Health Care Providers

- Consider using long-acting injectable agents, such as XR-naltrexone and SC-buprenorphine.
- Pause urine toxicology testing for stabilized patients.
- Perform remote buprenorphine inductions when appropriate.
- Evaluate patients intermittently via telehealth to assess for treatment tolerance, misuse, and diversion.
- Use appropriate PPE for in-person assessment.
- Conduct group meetings remotely with telehealth. These can be supplemented (if necessary, substituted) with telehealth platforms and apps that offer remote counseling by a third party.
- Prescribe naloxone to patients treated for OUD.
- Coordinate with pharmacy services to ensure delivery of medications to quarantined patients.

- Provide pregnancy testing for women with OUD and refer to pregnant women to prenatal care.

Compliance with Ethical Standards

Conflicts of Interest None

Sources of Funding None

Disclaimer While individual practices may differ, this is the position of the American College of Medical Toxicology at the time written, after a review of the issue and pertinent literature.

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