Transcript:

Office-Based Opioid Treatment Management and COVID-19

Presenter: Randall Brown

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PRESENTER: Hello. Welcome to our webinar today. My name is Ann Schensky, and I will be the moderator. Our webinar today is COVID and Opioid Use Disorder Management, presented by Randall Brown. Today's webinar is brought to you by the Great Lakes ATTC, PTTC, and MHTTC, and, of course, SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded by SAMHSA. This presentation today was prepared for the Great Lakes ATTC, MHTTC, and PTTC under a cooperative agreement from SAMHSA.

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Today's speaker is Randall Brown. Dr. Randall Brown is an associate professor in the University of Wisconsin Madison Department of Family Medicine. Dr. Brown's primary interests revolve around the treatment and prevention of substance use disorders and their complications and settings outside of specialist treatment environments.

He is board-certified in family medicine and addiction medicine, and he serves as a consultant in addiction medicine at the UW hospital, where he is the director of the Center for Addictive Disorders, William S. Middleton Memorial Veteran's Hospital, and UHS HIV and AIDS clinic, and at the Access Community Health Centers. Dr. Brown is also the founding director of the UW Addiction Medicine Fellowship Program, the director of the UW SMPH fourth year clinical addiction elective, and the medical director of the Overdose Prevention Program for the AIDS Resource Center of Wisconsin. He is the director of the American Board of Addiction Medicine and the Addiction Medicine Foundation, and the president of the Addiction Medicine Fellowship Directors Association. Welcome, Dr. Randall Brown.

RANDALL BROWN: Hello, everyone. And it's an honor to be here today. I hope all those listening are staying safe and well during these crazy times. I was asked to deliver a presentation on COVID and current recommended practices around opioid use disorder management. I should start by thanking a few individuals who collaborated in providing me some current information and preparing this presentation, including Elizabeth Collier, the Wisconsin State Opioid Treatment Authority, Dr. Elizabeth Salisbury-Afshar of the American Institute for Research in Chicago, and a couple of local to Madison opioid treatment program directors-- Dr. Christopher Harkin and Dr. Gail Hamilton.

So as I've already said and as you already know, we are in the midst of a crazy time. A number of populations are particularly vulnerable to issues related to COVID-19 itself and the precautions that are currently in place to end its spread. Individuals struggling with use disorders may represent a particularly vulnerable population in a number of ways.

If they're quarantined or isolated, they may have more difficulty getting a hold of their customary substance of use and experiencing dangerous withdrawal. They may be at greater risk to have difficulty accessing supplies used to prepare a drug and be reusing or sharing, conferring risk for blood-borne infections, such as hepatitis C, HIV, as well as skin and soft tissue infections like cellulitis and abscess. Their drug supply may also be interrupted, and they may feel compelled to obtain drug from new sources. And we know that this may increase the risk for overdose, since a change in supply may lead to an unpredictable concentration of more potent opioids, like fentanyl analogs.

In addition to that, there may be more risk to die due to overdose due to being more likely to use alone. So there aren't individuals present to recognize overdose and administer naloxone. And other populations, they may be more likely to live in communal environments such as shelters, the penal system, and residential programs. So they may be more likely to be getting exposed to virus and contract the illness.

We also know that this is a population more likely to have other illnesses that may complicate coronavirus infection. The majority are smokers, and that may have led to chronic obstructive pulmonary disease. Hepatitis C may confer risk for cirrhosis, though that's gone down a bit with the more effective treatments that are available, as well as, of course, HIV and vulnerability to infection as a function of that.

So what can we do to better keep our patients, providers, and the surrounding community safe by way of preventing spread? You all, I am sure, know by now that implementing social distancing into all aspects of life and patient care is of paramount importance. Regulatory agencies such as DEA and SAMHSA have offered guidance relaxing some customary guidelines to allow for some of this-- allow for practices to reduce in-person clinic visits to protect

vulnerable patients, and a particular move guidance allows for the initiation of office-based opioid therapy without there necessarily needing to be an in-person visit. And the initial visit prior to getting that going can actually be done over the telephone.

These days, DHS is communicating directly with opioid treatment programs so far as current best practices. So that's going to be a quickly moving target, so far as what's happening there. Federally, they are allowing for 28 day dispensaries for buprenorphine products such as suboxone out of opioid treatment programs. Things are still somewhat more restrictive by way of practices around methadone, understandably, since it's a schedule two substance coming with greater risk for sedation and overdose, so there is still guidance indicating that an in-person visit is required prior to initiating methadone. And supplies of up to two weeks can be dispensed, and some special exceptions may exist to get longer supplies.

There's also a strong recommendation, again, to minimize in-person contact and the likelihood of spread through using telehealth. And this can be done by telephone or video, conducting visits through those means and minimizing the extent to which they need to report to clinical sites in person for those visits. The situation with social distancing also leads to some considerations around our customary sorts of lab testing.

Guidance has been given that we should be suspending any oral fluid testing due to the droplet route of spread for COVID-19. And for urine testing, there's a bit more latitude there, indicating that clinical decisions should balance the risk of unnecessary exposure for patients and providers with concerns about an individual's persistent use or diversion. So that allows us a good deal of latitude, but again, we should be thinking carefully about the extent to which that testing is important at the current time or could potentially be deferred, again, depending on the clinical situation.

So many, if not all, treatment agencies around my area have canceled any in-person groups. A number of agencies are moving to group visits via video or teleconferencing means in effort to maintain social distance. There are a number of online meeting groups to which patients can be directed-- the 12-step programs and SMART Recovery have online discussion groups and support that patients can be tied into.

In addition to canceling those in-person meetings, there are some strategies that we should be thinking about to reduce the instances in which a patient would need to go to the pharmacy. So extending prescriptions to their maximum length possible, moving to month-long prescriptions when possible, and seeing what's happening at your local pharmacies by way of their ability to deliver to patient homes, or whether they are offering curbside pickup to reduce the risk of in-person contact.

So what about the injectable preparations? So a lot of what we've been talking about up to now, but we have pharmacy pickup and OTPs or oral preparations, that there are monthly injectable formulations of naltrexone, vivitrol, or buprenorphine, sublocade. And the recommendation from our Department of Health Services in Wisconsin is that these should be continued in patients as long as providers at the sites administering them have appropriate PPE, or personal protective equipment. If that runs out, an option to consider is moving to oral preparations. Buprenorphine, we know, is quite effective. Oral naltrexone comes with some challenges by way of adherence and effectiveness, but it is an option as we're trying to minimize contact.

So far as other general preparations for clinics, clinics should be thinking about procedures for their clients that have respiratory symptoms, not having them waiting in lobbies with others. Clients should be informed that if they have those symptoms, they should notify the clinic's setting. in advance so the plans can be made for appropriate social distancing. We should be making plans for possible staff shortages and implementing practices around social distancing on site when staff and clients are in the same location, and to be thinking about plans for your self-pay clients that may be out of work in these current circumstances, particularly those that may not have sick or vacation pay and benefits.

So included in the slides, I direct you to a number of resources with additional information by federal agencies and other agencies concerned with people struggling with use disorders, clearinghouses that can be particularly helpful. And that is what I have for you today. I hope that was helpful. And again, be well.