LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

Covid-19 and the Changes to Policies and Guidelines for Treating Substance Use Disorders

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On January 31, 2020, the Secretary of the Department of Health and Human Services (HHS) declared a nationwide public health emergency due to the emergence of the Coronavirus Disease 2019 (COVID-19). COVID-19 has affected almost every aspect of daily life in the United States, and in attempt to "flatten the curve," the government is urging all Americans to practice social distancing and remain at home as much as possible. Individuals who have contracted COVID-19 are asked to remain in isolation until they are no longer contagious, and people who have been in contact with a COVID-19-positive individual are asked to quarantine themselves for 14 days. While these methods are needed to stop the spread of COVID-19 across the country, they have also brought life to a halt. To ensure the safety of the community, restaurants, businesses, and schools have been closed, and many individuals are now unemployed or forced to work from home while simultaneously overseeing their children's "distance learning."

The COVID-19 pandemic is an unprecedented public health crisis, but before COVID-19, America was already dealing with another unprecedented public health crisis, the opioid epidemic. As the world continues to fight COVID-19, it is crucial that it not lose sight of those struggling with substance use disorder (SUD). While adapting to this "new normal" has not been easy for anyone, it has been exceptionally difficult for those with SUD. Social distancing, isolation, and quarantine measures make it hard, if not impossible, for some individuals with SUD to continue their treatment and recovery routines and for those with opioid use disorder (OUD) to access their SUD is a "disease of isolation," and experts warn that the measures used to contain COVID-19 may exacerbate SUDs by causing more relapses and overdoses. In an effort to continue treating the individuals who rely on daily treatment programs, particularly OUDs, the federal government has modified some of its drug treatment policies in light of the pandemic. Additionally, treatment and recovery programs have been trying to convert their in-person programs into virtual ones.

This document reviews COVID-19's impact on American drug policy and how individuals with SUD will be able to receive treatment and services in the age of social distancing.

ACCESS TO MEDICATION-ASSISTED TREATMENT FOR OPIOID USE DISORDER

Take-home Doses

Prior to the COVID-19 pandemic, several policies were in place regarding an individual's access to medication-assisted treatment (MAT) medications for OUD. These policies limited the ability of individuals with OUD to take home extra doses of their prescriptions and required them to frequently visit a clinic to obtain extra doses. When social distancing measures were put in place due to COVID-19, concerns arose that individuals with OUD and clinic staff would be at higher risk of infection due to the frequent visits to the clinic necessary for these individuals to obtain their medications. To reduce this risk, the Substance Abuse and Mental Health Services Administration (SAMHSA) released guidance on March 19, 2020 for all states regarding opioid treatment programs OTPs),[1] allowing states to request blanket

[1] https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf.

exceptions for all stable patients in an OTP to (receive 28 days of take-home doses of the patient's MAT medication. For patients who are less stable, but who the OTP believes can safely handle take-home medication, the state may request up to 14 days of take-home medication. Prior to this guidance, federal rules required two years of OTP enrollment to receive a month's worth of take-home medication and one year of OTP enrollment to receive a 14-day supply. Individuals who are just starting MAT will likely not qualify for take-home doses and will still need to visit the clinic in person. To ensure the safety of patients and staff when individuals come to the clinic to obtain their doses, clinics should implement practices to ensure patients can be six feet apart while they wait for their medication.

In-person Medical Evaluation

Under 42 C.F.R. § 8.12(f)(2), an individual is required to undergo a complete physical evaluation before he or she is admitted to an OTP. However, under 42 C.F.R. § 8.11(h), SAMHSA has the authority to grant exemptions to OTPs from certain requirements of the OTP regulations. To encourage social distancing, SAMHSA has decided to exempt OTPs from the requirement to perform an in-person physical evaluation on a new patient who will be treated by the OTP with buprenorphine if the program physician, primary care physician, or an authorized health care professional under the supervision of a program physician determines that an adequate evaluation of the patient can be accomplished via telehealth. On March 19, 2020, SAMHSA announced that telephone (audio only) evaluations were also acceptable. On March 31, 2020, the Drug Enforcement Administration (DEA), updated its policy to coincide with that of SAMHSA and allow for audio only examinations.[2] This exemption, however, does not apply to new OTP patients treated with methadone. The requirement of an in-person medical evaluation for new OTP patients that are treated with methadone will remain unchanged. SAMHSA stated that eliminating the in-person physical examination requirement for new methadone patients could present significant issues for a patient because individuals starting methadone treatment are not permitted to receive escalating doses for induction as take-home medication. Because of the risk of infection associated with in-person physical examinations, OTP staff should use personal protective equipment (PPE), such as masks, gloves, and gowns during these examinations.

Telehealth for Existing Patients and Patient Confidentiality

Practitioners working in OTPs can continue to treat existing OTP patients using methadone and buprenorphine via telehealth, assuming applicable standards of care are met. Telephone (audio only) appointments are also acceptable for existing patients being treated for methadone or buprenorphine. Under 1135 waiver authority, the Center for Medicare and Medicaid Services has expanded coverage for telehealth services to include patients across the country, not just in rural areas or under other limited conditions, as was previously the case.

On March 17, 2020, the Office of Civil Rights at HHS announced that it would waive potential penalties for Health Insurance Portability and Accountability Act (HIPAA) violations against health care providers that use non-HIPAA compliant communication technologies (*ex.* FaceTime or Skype) during the COVID-19 pandemic, regardless of whether the telehealth service is directly related to COVID-19.[3] Additionally, SAMHSA released guidance on 42 C.F.R. Part 2, stating that under 42 U.S.C. §290dd-2(b)(2)(A) and 42 C.F.R. §2.51, patient identifying information may be disclosed by a Part 2 program or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained.[4] Under the Part 2 medical emergency exception, providers make their own determinations as to whether a bona fide medical emergency exists for the purposes of providing needed treatment to patients.

DATA 2000 Waiver Requirements

Under the Drug Addiction Treatment Act of 2000

[2] https://www.samhsa.gov/sites/default/files/dea-samhsa-buprenorphine-telemedicine.pdf
[3] https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html.
[4] https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf.

(DATA 2000)[5] practitioners must obtain authorization from the DEA to dispense buprenorphine for maintenance or detoxification treatment. This authorization is referred to as a DATA waiver. While this waiver allows the practitioner to prescribe buprenorphine to patients, there is a limit as to the number of patients to whom they are allowed to prescribe. The DEA has not removed the DATA waiver requirement or the limitations on how many patients a prescriber can treat in response to COVID-19.

OTP Guidance for Patients in Quarantine and Isolation

SAMHSA has released guidance for OTPs dealing with patients who are in quarantine or isolation at home due to COVID-19.[6] When a patient is medically ordered to be under isolation or quarantine, this information should be documented in the patient's OTP record. A trustworthy, patient-designated, uninfected member of the household should be identified to deliver the medications to the patient using the OTP's established chain of custody protocol for take home medication. If a trustworthy member of the household is unavailable or unable to come to the OTP, then the OTP should prepare a doorstep delivery of the take home medications. Any medication taken out of the OTP must be in an approved lock box. To reduce the risk of diversion, the OTP staff member delivering the medication should retreat a minimum of six feet to observe that the medications are picked up by the patient or the designated person to receive the medications. The OTP staff person must ask the person who is retrieving the medication to identify him or herself to determine that the person appearing to retrieve the medication is the patient or the household member named by the patient as having permission to do so. The OTP staff member is required to remain with the medication until the patient or designated household member arrives and retrieves the medication. If the person does not arrive in a reasonable period of time, then the staff person is required to bring the medication back to the OTP where it will be stored in the pharmacy area until a determination is made as to whether another attempt will be made to deliver the medication.

Drug Testing

While urine drug testing is often a part of MAT, the American Society of Addiction Medicine recommends that urine drug testing not be a required part of treatment during the COVID-19 pandemic. Requiring patients to present at a clinic to provide a urine sample for testing may be more harmful than beneficial and can place patients and staff at risk of infection. In lieu of urine drug testing, other information can be obtained from patients that can be used to adequately inform treatment strategies, including self-reported use of substances, timing of refill requests, and checking of the state prescription drug monitoring program. For patients for whom it is deemed necessary to have drug testing done, OTPs should consider collecting specimens for drug testing outside of the treatment facility, at a third party testing site, or allow for drug testing at home using oral fluid-based tests and/or home breathalyzer tests monitored via telehealth.

INPATIENT AND OUTPATIENT TREATMENT SERVICES

During the COVID-19 pandemic, SAMHSA recommends that outpatient treatment options for SUDs be used to the greatest extent possible. Telehealth and/or telephone services are also recommended, if available. Inpatient treatment facilities should be reserved only for patients for whom outpatient treatment measures would not be considered an adequate clinical option. Inpatient/residential treatment programs that plan on remaining open during the outbreak are urged to follow the Centers for Disease Control and Prevention's guidance on precautions in admitting new patients, management of current residents, and visitor policies.

Whenever possible, patients should be pre-screened by telephone for symptoms consistent with COVID-19 or recent contact with anyone who has tested positive or who has symptoms of COVID-19 before the patient arrives at the facility. Screening and triage should also occur when the patient arrives to determine if a patient needs to be placed in isolation. Waiting rooms and

[5] 21 U.S.C. § 823(g)(2).
[6] https://www.samhsa.gov/sites/default/files/otp-covid-implementation-guidance.pdf.

common areas should be supplied with tissues, trash receptacles, and alcohol-based hand sanitizer. All unnecessary items in these areas, such as toys and reading materials, should be removed, and seats should be placed six feet apart, if possible. Staff should also be regularly screened for COVID-19 symptoms and asked to remain at home if they are feeling sick. If a staff member must provide physical care to a patient with known or suspected COVID-19, he or she should be provided with appropriate PPE. Whenever possible, non-urgent patient appointments should be deferred or converted to a telehealth visit, if appropriate. Visitors to treatment facilities should be restricted or limited.

Support Group Meetings

An important part of recovery for those with SUD is participation in support groups and programs, such as Alcoholics Anonymous and Narcotics Anonymous. However, with COVID-19, the close contact associated with in-person support group meetings has the potential to put individuals at risk of infection. Current federal guidance recommends that gatherings be limited to no more than 10 people and provide enough space to allow for social distancing. In an effort to keep people safe, while still providing support, many support groups have transitioned from in-person meetings to virtual meetings. These support groups are now taking the form of online discussion groups, chatrooms, and live meetings via teleconferencing software. SAMHSA has put together a list of virtual recovery resources, which can be found here.

While virtual support groups can provide a viable replacement for in-person meetings for some individuals, not everyone in recovery has access to the technologies that would enable them to participate in these virtual meetings. For those that are unable to access virtual resources, support group leaders and participants should work together to plan small group meetings with proper social distancing measures. To reduce the risk of infection during in-person meetings, meetings should be limited to 10 or fewer participants, and individuals who are at high risk for complications due to COVID-19 or who feel sick or have been exposed to a suspected or confirmed case of COVID-19 should be asked to stay home. Effort should be made to ensure that participants are not in close contact and can maintain a distance of six feet from one another. Infection control hygiene practices should be implemented, and participants should be encouraged not to share food, drinks, or other personal items with each other.

HARM REDUCTION

Infection with COVID-19 can cause a respiratory infection and lead to health problems. While the infection can be mild for some individuals, the infection can be very serious for those with stressed immune systems, underlying medical conditions, or older adults. Individuals with SUDs are considered a high-risk group when it comes to COVID-19, particularly those who smoke tobacco or marijuana, vape, or use opioids or methamphetamine, because of the negative effect these substances have on the respiratory and pulmonary systems. Some individuals with SUDs may not even realize that they are infected with COVID-19 because they might confuse the symptoms of the virus with symptoms of withdrawal.

All individuals should practice proper hand hygiene and social distancing, but there are additional steps active drug users should take to reduce the spread of infection during the COVID-19 pandemic.[7] Active drug users should not share consumption supplies, such as pipes or nasal tubes, with others, but if sharing is necessary, individuals should use a disposable mouthpiece or wipe down the mouthpiece with an alcohol swab before each use. Individuals should prepare their own drugs for consumption and ensure that their hands and surfaces are clean while preparing their drugs. Drug users should also stock up on consumption supplies, naloxone, and other medications to deal with a withdrawal so that they can limit the time they need to spend in close contact with other people.

SPECIAL CONSIDERATIONS FOR ALCOHOL USE DISORDER

In response to COVID-19, bars and liquor stores have been shut down in many states. The lack of

[7] https://harmreduction.org/miscellaneous/covid-19-guidance-for-people-who-use-drugs-and-harm-reduction-programs/.

availability of alcohol in some areas, will likely create problems in individuals with significant alcohol dependence. When an individual with alcohol use disorder stops drinking "cold turkey," there is a risk of the person experiencing physiological withdrawal. Complicated alcohol withdrawal can result in seizures, delirium, high blood pressure, increased heart rate, and possibly death. Benzodiazepines are often used in a tapering manner for medical withdrawal from alcohol. However, due to COVID-19, it is likely that individuals will have difficulty being admitted to a facility that could safely administer these medications; therefore, there will be a need for outpatient management of alcohol withdrawal. With limited access to treatment during the COVID-19 pandemic, SAMHSA is urging crisis centers that are able to remain operational and dispense medications in an unsupervised manner to administer anticonvulsant medications for the treatment of alcohol withdrawal and use benzodiazepines only in situations in which they believe that the individual would not benefit from anticonvulsant medication.[8] Anticonvulsant medications are useful in preventing seizures related to alcohol withdrawal and in comparison to benzodiazepines, have a much lower potential for abuse.

CONCLUSION

COVID-19 poses unique challenges for individuals suffering from, and treating those with, SUDs and has forced the country to change some of the ways it approaches SUD treatment and recovery. As the United States continues its attempts to contain the spread of the virus, it must continue to support individuals with SUD to decrease the likelihood of relapse and overdose in communities throughout America. Through the implementation of policy changes and technology, many individuals will continue to be able to access their medication and support services while staying safe from COVID-19. Please contact info@thelappa.org if you have any questions about the information presented in this document.

ABOUT LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

The Legislative Analysis and Public Policy Association (LAPPA) is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

LAPPA produces up-to-the-minute comparative analyses, publications, educational brochures, and other tools ranging from podcasts to model laws and policies that can be used by national, state, and local criminal justice and substance use disorder practitioners who want the latest comprehensive information on law and policy. Examples of topics on which LAPPA has assisted stakeholders include naloxone laws, law enforcement/community engagement, alternatives to incarceration for those with substance use disorders, medication-assisted treatment in prisons, and the involuntary commitment and guardianship of individuals with alcohol or substance use disorders.

For more information about LAPPA, please visit: https://legislativeanalysis.org/.

[8] https://www.samhsa.gov/sites/default/files/considerations-crisis-centers-clinicians-treatment-alcohol-benzodiazepine-withdrawal.pdf.