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

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The novel coronavirus, COVID-19, has upended all facets of American life and placed an unprecedented strain on the U.S. health care system. Extreme measures, including continued social distancing and coordinated suppression efforts, may be required to reduce catastrophic mortality (1). Although the pandemic threatens everyone, it is a particularly grave risk to the millions of Americans with opioid use disorder, who—already vulnerable and marginalized—are heavily dependent on face-to-face health care delivery. Rapid and coordinated action on the part of clinicians and policymakers is required if these threats are to be mitigated.

For persons already in treatment, one of the biggest threats is disruption of care, particularly access to medications for addiction treatment. Such challenges are especially acute for patients who receive methadone through opioid treatment programs, because historically the dispensing of methadone has been tightly regulated, requiring many patients to receive no more than 1 directly observed daily dose at a time (2). Recognizing the imperative to address potentially dire disruptions in care, the Substance Abuse and Mental Health Services Administration (SAMHSA) recently released new guidance increasing the ability of opioid treatment programs to transfer as many patients as possible to take-home methadone maintenance protocols (3). To address concern that SAMHSA's new guidance might spur an increase in nonmedical methadone use, as well as to improve quality of care, persons receiving take-home methadone should be coprescribed naloxone, an opioid reversal agent that may mitigate the risks of fatal overdose among those at high risk (4).

Fortunately, patients receiving buprenorphine, another medication approved by the U.S. Food and Drug Administration for opioid addiction, face fewer access barriers, because 30-day medication supplies are routinely dispensed through retail pharmacies. Public and private payers should nevertheless reduce barriers further in the coming months by temporarily shortening buprenorphine refill windows, eliminating prior authorizations, and granting exemptions to face-to-face fill requirements. Pharmacy benefits, including state Medicaid formularies, also may be expanded to include newer, long-acting injectable formulations of buprenorphine.

Efforts also are desperately needed to reduce face-to-face clinical encounters to treat opioid use disorder during the pandemic. Medicaid and Medicare waivers, made possible by national emergency declarations, can support these changes. For example, the recent declarations expand options for the remote prescription of controlled substances without an initial in-person evaluation (5). Likewise, Medicare rules have been relaxed to increase reimbursement of telehealth services, and SAMHSA has clarified that although the regulations around sharing of protected health information between addiction and general medical providers have not been suspended, providers can use their discretion to determine whether a bona fide medical emergency exists (such as a hospital needing more clinical information about an unconscious patient). In this case, the normal requirement to obtain informed consent may be waived (6). States also can request Medicaid reimbursement for telehealth services, including those used for opioid addiction treatment, and modes of communication that enable most patients to participate, such as telephone sessions. States also might relax licensure or other legal barriers to controlled substance prescribing via telemedicine during this national emergency (7). Additional waiver requests could support block grants for telemedicine infrastructure, including virtual counseling capabilities, remote delivery of medications, and additional wraparound support services to persons isolated, quarantined, or at risk due to COVID-19.

Some treatment programs are introducing or expanding other approaches to reduce the demand for in-person care. For example, for patients with continued drug use, cognitive impairment, or severe mental illness, some programs may engage with a patient surrogate—identified by the patient and vetted by program staff—to pick up, secure, and supervise home dispensing of medication. Such technologies as automated, secure pill dispensers also may be used, unlocking daily medication doses and alerting programs about missed doses or device tampering. Other programs have initiated video-based "directly observed therapy" by using approaches first developed for treating tuberculosis that provide a video record of medication ingestion at home for confirmatory viewing by program staff (8).

During the pandemic, the specialty substance use disorder treatment system must be integrated with other service providers who can help ensure the safety of patients with opioid use disorder. Now more than ever, patients need comprehensive case management with linkages to housing and social services programs. Because many of these patients are unstably employed, disruptions to their work also may lead to adverse outcomes, such as loss of housing, food insecurity, and ultimately a downward spiral that increases relapse risk

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and damage to recovery. Such prospects underscore the urgent need for emergency pathways, including through Medicaid waivers, to housing and social services.

Disruptions in medication access are not the only threat facing persons with opioid use disorder. Despite efforts to augment take-home medications and other treatment, those with opioid use disorder—whether in opioid treatment programs or other treatment settings—will continue to require some in-person contact with health care providers for treatment assessments and to manage changes in care. Yet these contacts place both patients and providers at risk for COVID-19 infection and its sequelae. Treatment settings must rapidly implement safety plans to limit infection risk for patients and staff. Recommendations regarding patient screening, use of personal protective equipment, and maintaining workforce wellness have already been issued by some professional societies and should be broadly implemented to protect patients and providers (9).

The COVID-19 pandemic strikes at a moment when our national response to the opioid crisis was beginning to coalesce, with more persons gaining access to treatment and more patients receiving effective medications (10). COVID-19 threatens to dramatically overshadow and reverse this progress. Some disruptions in the care of patients with opioid use disorder are inevitable during the weeks and months to come. However, extraordinary planning and support can limit excessive disruption and its dire consequences. These efforts will require new partnerships, unprecedented use of technology, and the dismantling of antiquated regulations. The greatest strength of the treatment system has always been compassion and care for the most vulnerable—qualities needed now more than ever.

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