Sign-on letter requests more flexibility in methadone treatment during COVID-19

A sign-on letter spearheaded by the National Alliance for Medication Assisted Recovery (NAMA), and harm reduction groups, including the Urban Survivors Union (USU) and the Drug Policy Alliance (DPA) is calling for reducing restrictions on methadone and opioid treatment programs (OTPs), so that patients don’t have to go to the clinics so often. Included in the over 100 signatories are Patty McCarthy Metcalf of Faces & Voices of Recovery, Ben Levenson of the Levenson Foundation (and former founder of Origins) and many addiction physicians, as well as drug user organizations. Many of the signers have said for months that OTPs should be eliminated entirely.

Last month, the Substance Abuse and Mental Health Services Administration (SAMHSA) said stable patients should be given 28 days of take-homes and “less stable” patients be given 14, based on treatment provider judgment (see “DEA, SAMHSA relax OTP/OBOT regulations due to COVID-19,” ADAW, March 20, https://onlinelibrary.wiley.com/doi/10.1002/adaw.32664). However, patients in some programs reported that they were not getting these extra take-homes and that social distancing rules weren’t being adhered to.

Substantial death rates post-overdose reinforce call for rapid intervention

Having worked for two decades in emergency medicine, Scott Weiner, M.D., M.P.H., has seen the stark contrast with which the system treats overdose victims and others who present for lifesaving care. A typical overdose patient may get stabilized, sent to the clinic hallway, and left to leave almost at will, often with no information about follow-up care. For the stroke victim or trauma survivor, however, “We have whole teams at the ready,” Weiner told ADAW.

The disparity becomes all the more maddening when research shows relatively high death rates for overdose victims in the months following rescue. A study co-authored by Weiner and published online April 3 in the journal Substance Abuse showed a one-year mortality rate of 7.5% in overdose patients in Massachusetts who survived beyond three days after naloxone administration by emergency medical services (EMS) personnel.

Among those who did not die in the first three days after naloxone administration but died within one year, the highest death rates were however, “We have whole teams at the ready,” Weiner told ADAW.

A retrospective study of Massachusetts overdose survivors found one-year death rates similar to those seen for other conditions that are addressed in emergency medicine.

Bottom Line…

A sign-on letter seems to pit OTPs against methadone patient advocates, but there is more agreement than disagreement.

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However, the American Association for the Treatment of Opioid Dependence (AATOD), the membership organization of OTPs, did not sign the letter, taking issue with some of the requests for change.

The requests are only for the duration of the COVID-19 national emergency, according to Zachary Talbott, president of NAMA. However, some of the other signatories have been arguing in favor of making permanent changes that go way beyond this sign-on letter, including eliminating the x-waiver (which the letter does not recommend) and putting methadone in primary care.

Below are the requests, along with AATOD President Mark Parrino’s responses — many of which are in agreement — and reasons for not signing.

• NAMA: The only acceptable standard for discharge of patients from OUD treatment during the COVID-19 outbreak shall be violent behavior that would endanger their own health and safety or that of other patients or staff.

• AATOD: We agree.

• NAMA: Administrative detox shall be fully suspended during the pandemic, and patients shall be provided the opportunity to request dose increases as needed, given that the illicit drug market will continue to experience fluctuations and patients need access to these lifesaving medications. Patient doses shall not be reduced during the transition to take-home care unless they request adjustments to their doses, or documented medical emergencies require it and patients cannot consent due to medical crises, as may be the case with severe respiratory distress resulting from COVID-19 infection.

• AATOD: We also agree that administrative medication withdrawal should be suspended during this epidemic. We also asked SAMHSA to develop a special fund for self-pay patients who cannot afford treatment at the present time or who have lost their jobs.

• NAMA: Referrals for COVID-19 testing shall be made available at all OTPs, as well as syringe service programs. Staff shall receive training to recognize the symptoms of COVID-19 and be familiarized with protocols to refer patients for further testing. Harm-reduction providers can also play an essential role in “flattening the curve” of transmission by identifying cases, making medical attention available to those who test positive and teaching lifesaving harm-reduction skills to help people stay safe during this crisis. Plain language and evidence-based public health materials about COVID-19 prevention, symptom identification and treatment should be available in locally prominent languages at all locations for participants and their communities.

• AATOD: We agree with several points in this recommendation in having OTPs refer patients for COVID-19 testing. In my communications with OTPs, staff understand how to recognize COVID-19 symptoms.

• NAMA: During the COVID-19 national emergency, health care professionals — including doctors, nurse practitioners, physician assistants and pharmacists — shall not be required to complete the previously mandated training and waiver to prescribe these medications, thereby making medication-assisted treatment (MAT) available in all settings. Prescribers shall not have limitations on the number of patients they can treat. Naloxone and other overdose prevention tools (i.e.,...
fentanyl test strips) shall be prescribed or made available with all dispensed medications in compliance with state law.

- **AATOD:** We disagree with the recommendation with regard to eliminating training requirements under DATA 2000. We recommend that State Opioid Treatment Authorities, working in conjunction with other state agencies, should be able to monitor if there is increased need for buprenorphine through DATA 2000 practices and respond to increased demand. Training can be expanded quickly since it is online.

- **NAMA:** OTPs, prescribing clinicians and pharmacies shall actively agree to expand access to methadone treatment through the medical maintenance/office-based and pharmacy-delivery methods currently allowed by federal exception/waiver. The existing OTP regulations for the dispensing of MAT shall be temporarily adjusted to require all pharmacies to dispense these medications. This will reduce the risks of transmission associated with daily clinic attendance and person-to-person contact. In accordance with SAMHSA recommendations, lockbox requirements for take-home dispensing shall be suspended. Standard dispensing protocols for other opioid medications are deemed sufficient, since child- and tamper-proof bottles are already in use for methadone and buprenorphine. (Per SAMHSA’s TIP 43, Chapter 5: “Some programs require patients to bring a locked container to the OTP when they pick up their take-home medication to hold it while in transit. This policy should be considered carefully because most such containers are large and visible, which might serve more to advertise that a patient is carrying medication than to promote safety.”)

- **AATOD:** While we support the increased use of medical maintenance, we do not believe it can be implemented in the short term. It is important to keep in mind that OTPs are providing increased take-home medication to patients with 14-day supplies or greater. Once again, this is a risk/benefit assessment. I expect that medical maintenance will get greater support as we learn more about the impact on patients and community. I do not believe that it is realistic to expect pharmacies to dispense methadone products, since they do not have the clinical experience in evaluating patients. Additionally, pharmacies do not stock 40 mg tablets.

- **NAMA:** Take-home exception privileges shall be expanded to the maximum extent possible, limited only by available supply and operations for delivery. Any bottle checks clinics wish to conduct shall be conducted by telemedicine. Take-home schedules shall be authorized for individuals in all medical settings, including pharmacies and mobile vans. In light of new SAMHSA guidelines, clinics shall allow 14 to 28 days of take-home privileges to as many patients as possible. Patients testing positive for benzodiazepine or alcohol use shall be allowed the take-home privileges outlined in SAMHSA guidelines but may be additionally required to check in via telemedicine for the purpose of decreasing the risk of adverse reactions, including overdose. Access to take-home doses is critical to keep patients engaged and retained in treatment.

- **AATOD:** In my judgment, this recommendation poses great risk. Giving unstable patients more take-home medication when testing positive for benzodiazepine or other drugs does pose a great danger. The leading cause of methadone-related overdoses occurs in patients who are drinking alcohol and using benzodiazepines. The ultimate responsibility in providing take-home medication to such patients rests with the clinical decision-making of OTP personnel. They are responsible for any negative outcome. Clearly, responding to the challenges of the patients with COVID-19 must be balanced against such considerations. It is also important to keep in mind that many patients will not have access to smartphones or other telehealth devices. OTPs are increasing curbside medication administration in addition to providing take-home medication to family members or friends as designated by the patient. There are protocols for doing this. The issue of locked boxes for take-home medication is related to dealing with pediatric exposure. In some cases, patients may be living in unstable home environments. There may be some OTPs that are able to establish working relationships with local pharmacies, and that may come into greater use.

- **NAMA:** Telehealth and service by phone shall replace any and all in-person requirements and appointments as the primary means of service provision until social distancing guidelines change. Toxicology requirements shall be suspended for the duration of telehealth-based services.

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Telemedicine services shall include waivered platforms, such as telephone intakes and video-conferencing, as some patients may have different access needs.

• AAAD: We agree that tele-health and services by phone should be used whenever possible as an alternative to in-person requirements. We made this point in our guidance of March 20, 2020, as referenced above. Our guidance recommended the suspension of oral fluid toxicology testing. It is also recommended that such toxicology testing, including urinalysis, be suspended for stable patients. It would be irresponsible to suspend urine toxicology testing for newly admitted or clinically unstable patients, especially if take-home medication is being provided. Harm-reduction approaches must be balanced against sound clinical judgment.

• NAMA: The regulatory in-person requirements for methadone inductions shall be lifted in order to be consistent with the new policy changes for buprenorphine inductions. Clinic-based in-person appointments shall conform to social distancing requirements and OSHA guidelines for the management of the COVID-19 pandemic.

• AAAD: We agree and have suggested this to federal regulatory agencies.

• NAMA: Drug Enforcement Administration (DEA) restrictions on mobile medication units shall be revised to accommodate delivery of medications to individuals who are sequestered in their homes, are quarantined or live in rural communities that are 15 miles or more from the nearest opioid treatment program.

• AAAD: We would agree with the recommendation on mobile medication; however, there are very few operating vans in the United States. AAAD has been working with the DEA for the last several years in getting mobile van regulations released. The DEA did this, and we are still in an open comment period, which ends on April 27, 2020.

• NAMA: State and federal Medicaid dollars shall be expanded to cover all costs for take-home medications not otherwise covered by insurance for patients experiencing financial hardship due to COVID-19. In states that did not expand Medicaid, the state shall be the payor of last resort.

• AATOD: We also agree with the recommendation with regard to federal Medicare funds and state Medicaid funds covering the costs for medication and other services. CMS Medicare has issued guidance indicating that OTPs will be reimbursed when providing up to 28-day supplies of medication, even if the patient appears at the OTP for one visit. Individual programs are seeking guidance from state Medicaid, and that is still evolving.

“I have cautioned some of my associates in other organizations to be more judicious in making recommendations that will dismantle the existing system,” said Parrino. “A number of policy groups are making recommendations about OTP operations without understanding the mechanics of how OTPs function. I am certain that OTPs and AATOD will come under increasing criticism. What seems to be forgotten are the risks that OTP staff are taking, especially without protective gear.”

The release of the letter was being organized by Ben Levenson and was supposed to take place April 9.

Next week: More on methadone and buprenorphine reform.

ASAM recommends virtual treatment of SUD for some patients

The American Society for Addiction Medicine (ASAM) says residential substance use disorder (SUD) programs should treat patients with COVID-19 virtually, not in person. The organization also says to screen new patients by phone before admission and upon arrival, screen current patients and staff, and, if visitors are permitted, screen them as well. Screening is done clinically, not by test.

If current patients have emergency COVID-19 symptoms (turning blue), there needs to be a protocol established by the program for treatment of those symptoms. If patients have symptoms but they are not serious, there still needs to be a protocol for following that patient medically.

Telephone screening for new patients

• Symptoms: According to ASAM, COVID-19 symptoms can range from mild symptoms to severe illness. Screening should be for fever (subjective or confirmed at 100.4 or more), new or worse cough, new or worse shortness of breath, sore throat, and muscle aches.

• Contacts: Patients should be asked about close contacts with individuals with confirmed COVID-19 or others who have symptoms of COVID-19 but have not yet been tested. A close contact is someone the patient lives with or cares for, has been within