



CLINICAL GUIDELINES PROGRAM

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Guidance: Opioid Use Disorder Treatment During COVID-19

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Contents

Purpose of This Guidance	2
Regulatory Changes	3
Telemedicine vs In-Person Visits	3
Medication Access	4
Drug Testing	4
Access to Naloxone and Sterile Syringes	4
Counseling	5

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Guidance: Opioid Use Disorder Treatment During COVID-19

The COVID-19 pandemic has magnified the toll of the opioid epidemic. Across the United States, overdose-related mortality increased by nearly 20% by mid-2020, with synthetic opioids as the primary driver of the increase (see *Centers for Disease Control and Prevention Health Advisory > Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic, Dec. 17, 2020*). In May 2020, overdose-related cardiac arrests reached a historical high that was more than double those that occurred in 2018 and 2019 [Friedman, et al. 2020]. In particular, overdose deaths occurred disproportionately among Black people and among people who are publicly insured or uninsured [Ochalek, et al. 2020]. Against the backdrop of the racial, ethnic, and socioeconomic disparities made clear by COVID-19 mortality rates, rates of overdose also expose the stigma, racism, and structural barriers that have long affected the health of people who use drugs.

Purpose of This Guidance

It is essential that clinicians recognize the effect of COVID-19 on people who use opioids and think creatively to help ensure access to treatment for opioid use disorder (OUD). Telehealth, extended prescriptions or take-home medications, and reduced drug testing frequency are 3 approaches that can be implemented to meet the needs of people with OUD during the COVID-19 pandemic. In addition, access to naloxone and sterile syringes should be preserved and promoted throughout the course of OUD treatment.

Adaptations to clinical practice: Clinical components that should be adapted for OUD treatment during the pandemic are outlined in *Table 1: Adaptations in Opioid Use Disorder Treatment During COVID-19*, below. Suspending in-person visits and drug testing is particularly important during a local surge in COVID-19 infections, which is defined by metrics such as the 7-day rolling average of test positivity rates and hospital admission rates (see *NYSDOH COVID-19 Micro-Cluster Strategy* for more information on surge metrics and cluster designations). There is no “one-size-fits-all” model of care that will meet the spectrum of patient needs and clinical practice settings. Harm reduction should be the underlying principle that guides the delivery of care during this pandemic.

Table 1: Adaptations in Opioid Use Disorder Treatment During COVID-19		
	Standard Practice Before COVID-19	Adaptations for Management During COVID-19
Medical visits	Require in-person visits for all patients.	<ul style="list-style-type: none"> • Suspend in-person visits if there is a local surge in COVID-19 cases, with in-person visits required only for new admission to methadone treatment. • When using telehealth, offer telephonic visits for all patients and incorporate video when possible.
Medication access	Limit buprenorphine prescription duration to 7 to 14 days for new or unstable patients.	<ul style="list-style-type: none"> • Buprenorphine: <ul style="list-style-type: none"> – Extend prescription duration up to 30 days for all patients, including new or unstable patients. – Consider refills for patients who are consistently engaged in care. – Utilize mail-order pharmacies if needed. • Methadone: <ul style="list-style-type: none"> – Reduce clinic visits and increase take-home doses as permitted by federal and state regulations. – Allow for surrogate pick-up or delivery if needed.

Table 1: Adaptations in Opioid Use Disorder Treatment During COVID-19		
	Standard Practice Before COVID-19	Adaptations for Management During COVID-19
Drug testing	Urine or oral drug testing required at initial visit and at follow-up visits.	<ul style="list-style-type: none"> Suspend all drug testing if there is a local surge in COVID-19 cases. Focus on self-report of medication adherence, substance use, and treatment progress.
Access to naloxone and sterile syringes	<ul style="list-style-type: none"> Dispense or prescribe naloxone at all initial visits and at follow-up visits as needed. Prescribe sterile syringes or refer to syringe service programs for all patients who are injecting drugs. 	<ul style="list-style-type: none"> Naloxone: <ul style="list-style-type: none"> Dispense naloxone during in-person visits whenever possible. Mail naloxone kits to patients through local distribution programs. Utilize mail-order pharmacies if needed. Sterile syringes: <ul style="list-style-type: none"> Prescribe sterile syringes at all in-person and telemedicine visits. Coordinate referrals to local syringe service programs in context of modified operations or services. Utilize mail-order pharmacies if needed.

Regulatory Changes

During the COVID-19 public health emergency, federal regulations have been updated to allow for more flexibility in the delivery of OUD treatment. Telemedicine, including telephonic and video visits, is now allowed for prescribing and dispensing controlled substances, including buprenorphine and methadone. For buprenorphine treatment, new and existing patients can be evaluated through telemedicine; in-person visits are no longer required to initiate treatment. For methadone treatment, in-person medical visits are required only for new patients; patients in methadone treatment before the pandemic began can be evaluated through telemedicine. Other regulatory changes regarding take-home medication and drug testing frequency have also been enacted for opioid treatment programs.

- For more information, see *SAMHSA: FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency (4/21/2020)*.

Telemedicine vs In-Person Visits

Models of care should be adjusted based on local COVID-19 prevalence and associated local restrictions, clinic capacity, and patient needs. Clinicians may determine whether care should be delivered fully through telemedicine or through a blend of telemedicine and in-person visits. For example, clinicians may choose to alternate telemedicine visits with in-person visits or offer only telemedicine visits, particularly during a local surge in COVID-19 cases. Whereas all patients were required to engage in in-person visits prior to the pandemic, priorities for in-person visits may be established to best triage patient needs and utilize clinical resources, including personal protective equipment.

Clinical priorities for in-person visits may include patients who:

- Request an in-person visit.
- Are new to OUD treatment.
- Have experienced a recent overdose.
- Are at high risk of overdose (e.g., ongoing use of illicit opioids, co-morbid alcohol or benzodiazepine use disorder).
- Prompt a persistent concern for diversion.
- Have an unstable medical or mental health illness.

For buprenorphine treatment, telemedicine should be used whenever possible to reduce wait times between treatment referral and treatment initiation. In-person visits for new patients may be helpful to establish rapport and assess for any medical or mental health needs. In-person visits can be arranged according to an expected timeframe (e.g., within 2 to 4 weeks) without delaying treatment initiation.

Clinicians should also be vigilant in recognizing potential disparities in telemedicine access for patients. Digital literacy may be lower among patients who are older or have low socioeconomic status, limited health literacy, or limited English proficiency. Some members of racial or ethnic minority groups may also have limited access to telemedicine. In addition, structural barriers to digital access are likely to disproportionately affect people who use drugs and may not have electronic devices, internet or data access, or privacy. To ensure telehealth equity, clinicians should offer telephonic visits to all patients and incorporate video visits whenever it is feasible for patients.

In-person visits can also be offered to patients who face significant barriers to telehealth use that cannot otherwise be mitigated. Treatment should not be withheld on the basis of patient preferences for telemedicine or in-person visits.

Medication Access

Ensuring access to medication should be a priority during any COVID-19–related changes in the delivery of OUD treatment. Clinicians should account for structural disruptions to medication access, such as reduced pharmacy hours, pharmacy closures, limited public transportation, or financial difficulties to keep up with personal transportation. COVID-19–related quarantine after an exposure or isolation while a person is symptomatic can also interfere with timely access to medication access.

Buprenorphine: For buprenorphine treatment, clinicians are encouraged to write prescriptions of longer duration to minimize the travel and exposure entailed in pharmacy visits. During a local surge in COVID-19 cases, clinicians should provide up to 30 days of medication for all patients. In addition to 30-day prescriptions, refills should be considered for patients who are otherwise stable in buprenorphine treatment. Partnering with local pharmacies can help clinicians to identify options for mail order or home deliveries and recommend these options for patients whenever needed.

Methadone: Methadone treatment programs should understand and implement regulatory exemptions for take-home medications to allow for up to 28 days of methadone for stable patients and 14 days for less stable patients. The capacity to safely manage self-administration of methadone as well as individual risk for COVID-19 infection should be primary factors in decisions related to provision of take-home medication. In addition, surrogate pick-up or delivery as allowed under federal regulations should also be utilized.

Drug Testing

During the pandemic, clinicians should re-examine existing practices and policies for drug testing. Historically, substantial bias and racism influenced who, when, and where patients were required to complete drug testing during the course of substance use treatment. Normalizing urine and/or oral drug testing as a routine part of all medical visits has typically been a best practice to minimize care provider bias. With COVID-19, however, drug testing has been challenging to implement given limited in-person visits and reduced laboratory capacity.

Clinicians should adopt a consistent approach to drug testing throughout the duration of the COVID-19 public health emergency. The approach may vary based on local restrictions and clinic capacity; regardless of the approach, it should be communicated clearly to clinical staff and patients to set expectations and minimize bias.

For buprenorphine treatment, urine drug testing should no longer be required prior to treatment initiation. Instead, urine drug testing can be deferred to the next in-person visit for patients who initiate treatment through telemedicine. For existing patients, urine drug testing should be performed periodically depending on the availability of in-person visits. During a local surge in COVID-19 cases, urine drug testing may have to be suspended or halted.

In all scenarios, clinicians should focus on self-report of medication adherence, substance use, and any progress or challenges to engaging in treatment. Patients who are struggling can be supported with increased frequency or intensity of services without burdensome requirements for drug testing.

Access to Naloxone and Sterile Syringes

Access to naloxone is more important now more than ever as rates of opioid-related overdoses have increased throughout the COVID-19 pandemic. Naloxone distribution efforts have been disrupted by the reduced availability of in-person care. However, alternative methods to ensure naloxone access should be integrated into clinical practice. Clinicians should consider the following strategies:

- Mailing naloxone kits to patients.
- Referring patients to local pharmacies that offer free naloxone (e.g., *NYC Health > New York City Pharmacies Participating in the NYC Emergency Overdose Rescue Kit Program*).
- Partnering with local pharmacies to ensure that naloxone is in stock and naloxone co-pay assistance programs (e.g., *N-CAP*) are used.
- Prescribing through pharmacies that offer mail order or home delivery of prescription medications, including naloxone.
- Referring to harm reduction services that facilitate mailing of free naloxone (e.g., *Next Distro > Naloxone State Finder*).

Similarly, access to sterile syringes and injection equipment is critical to reduce transmission and prevent outbreaks of viral hepatitis and HIV during the COVID-19 pandemic. Access to sterile syringes and injection equipment is also important to prevent acute complications that may necessitate hospital admissions (e.g., skin and soft tissue infections, infectious endocarditis, and osteomyelitis), particularly when there is a local surge in COVID-19 cases. Strategies to facilitate access to sterile syringes and injection equipment include:

- Prescribing syringes, needles, alcohol swabs, and sharps containers to local pharmacies, particularly those that offer mail order or home delivery of prescription medical supplies.
- Coordinating referrals to local syringe service programs by verifying any modifications to operating hours and service delivery as a result of the pandemic.
- Referring to harm reduction services that facilitate mail-order syringe access (e.g., *Next Distro > Accessing Mail-Based Harm Education Supplies*).

Counseling

Similar to best practices prior to the pandemic, counseling should not be a prerequisite for buprenorphine treatment. Brief psychosocial counseling related to acute stress, grief, and loss experienced during the public health emergency should be integrated into every medical visit.

For patients who are referred to individual or group counseling, clinicians should be aware that individual counseling may be available only through telehealth, especially during a local surge in COVID-19 cases. A blend of in-person and telehealth visits may be appropriate for some patients. Additionally, group counseling may have been suspended for many programs in the context of patient- and system-level barriers to video visits.

References

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- Ochalek TA, Cumpston KL, Wills BK, et al. Nonfatal opioid overdoses at an urban emergency department during the COVID-19 pandemic. *JAMA* 2020;324(16):1673-1674. [PMID: 32945832] <https://pubmed.ncbi.nlm.nih.gov/32945832>