# Impact of COVID-19 on Treatment of Substance Use Disorders


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# Moderator Welcome

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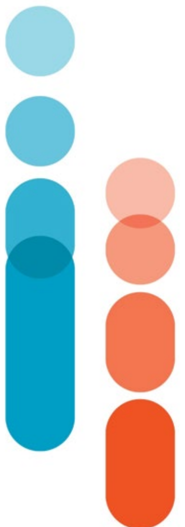
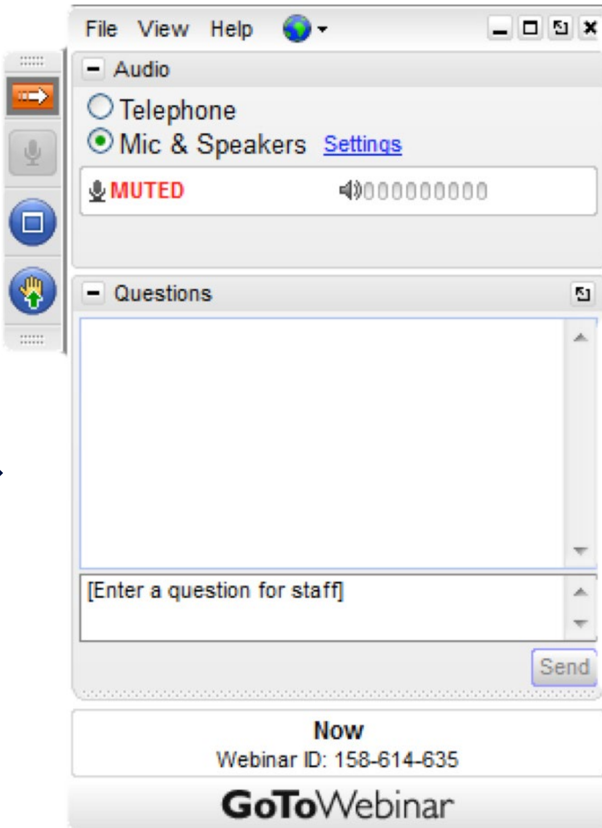
# Our Faculty

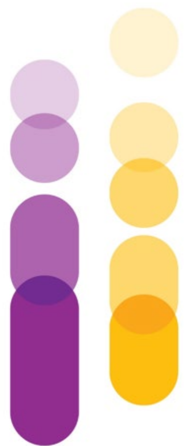
Kimberly Lenz, PharmD, FAMCP

Fulton Velez, MD, MS, MBA



# How to Ask Questions



# Learning Objectives

- Describe the impact of COVID-19 on Substance Use Disorders (SUD)
- Review some of the health care disparities noted in the COVID-19 cases
- Explain the associated mitigation measures for patients with SUD

# Impact of COVID-19 on Patients with Substance Use Disorders

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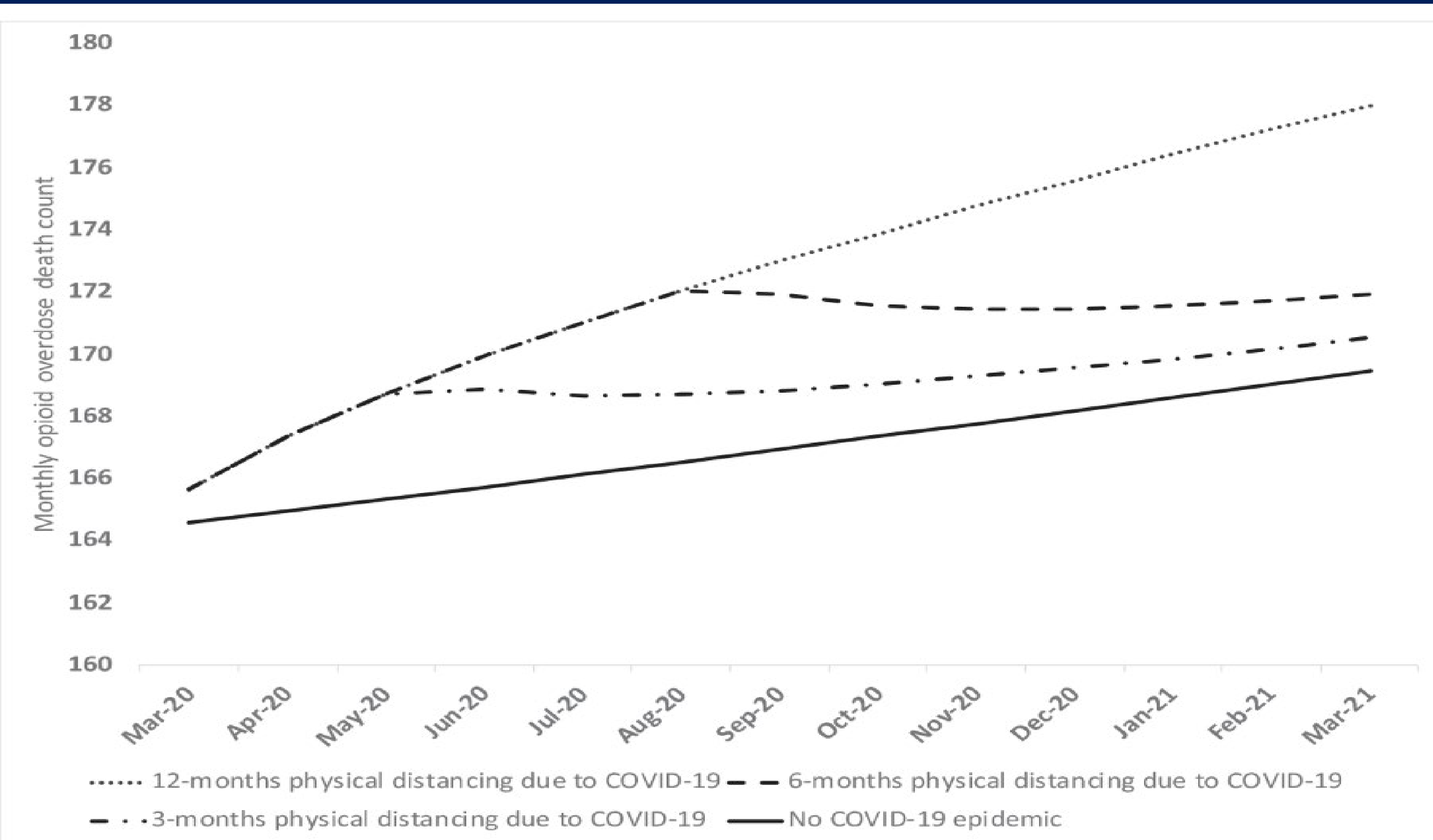
# Collision Course: Pandemic on an Epidemic

- COVID-19
  - Many direct and indirect effects on people
    - Physical distancing, quarantine, isolation
    - Change in how we access care: telehealth, missed appointments
- Epidemic
  - People actively using substances may experience potentially more lethal substances because of drug supply disruption
  - Physical distancing may make naloxone administration less likely
  - Recovery population- Negative impact on mental health (especially depression and anxiety) in a population who may be more likely to use drugs for coping

*Journal of Substance Abuse Treatment 120 (2021) 108158*

# Impact of Physical Distancing - MA

Various durations of physical distancing interventions on overdose deaths in MA March 2020-2021




*Journal of Substance Abuse Treatment 120 (2021) 108158.*

- Decreasing initiation and retention rates result in higher overdose deaths
- Physical distancing duration plays a large role in overdoses as compared to no COVID-19 epidemic

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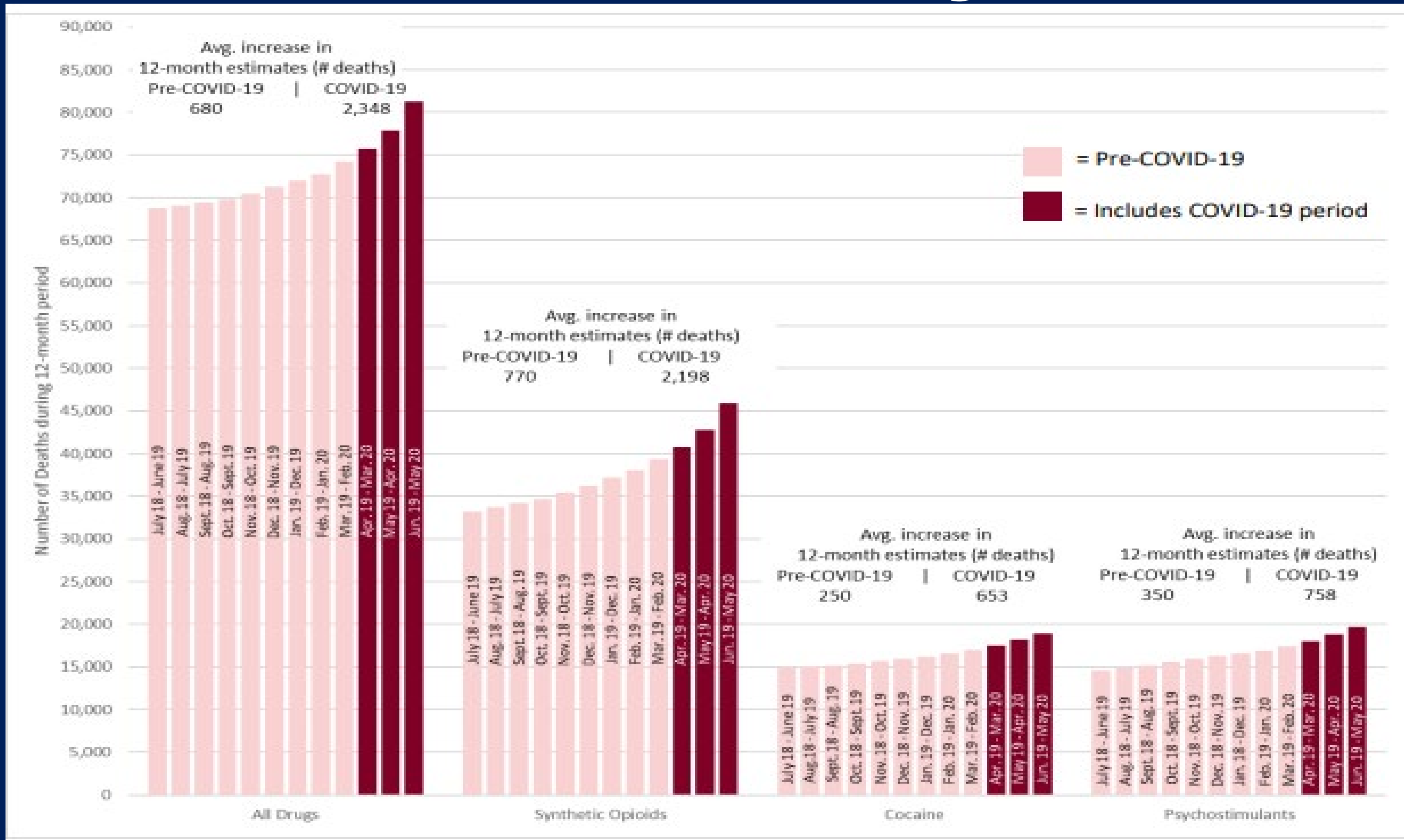
# Increased Mortality




https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html
http://publichealth.lacounty.gov/lahan/alerts/CDC-HAN-00438%20Opioids12172020.pdf

- Overdose deaths already increasing prior to COVID-19 pandemic, there is a clear surge during the pandemic
- 81,230 drug overdose deaths (April 2019 to May 2020)
  - Worst 12-month period ever (18.2% increase)
  - Previous declines noted from 2017-2018 (4%)
- Main driver (38.4%) is synthetic opioids- mostly illicit fentanyl

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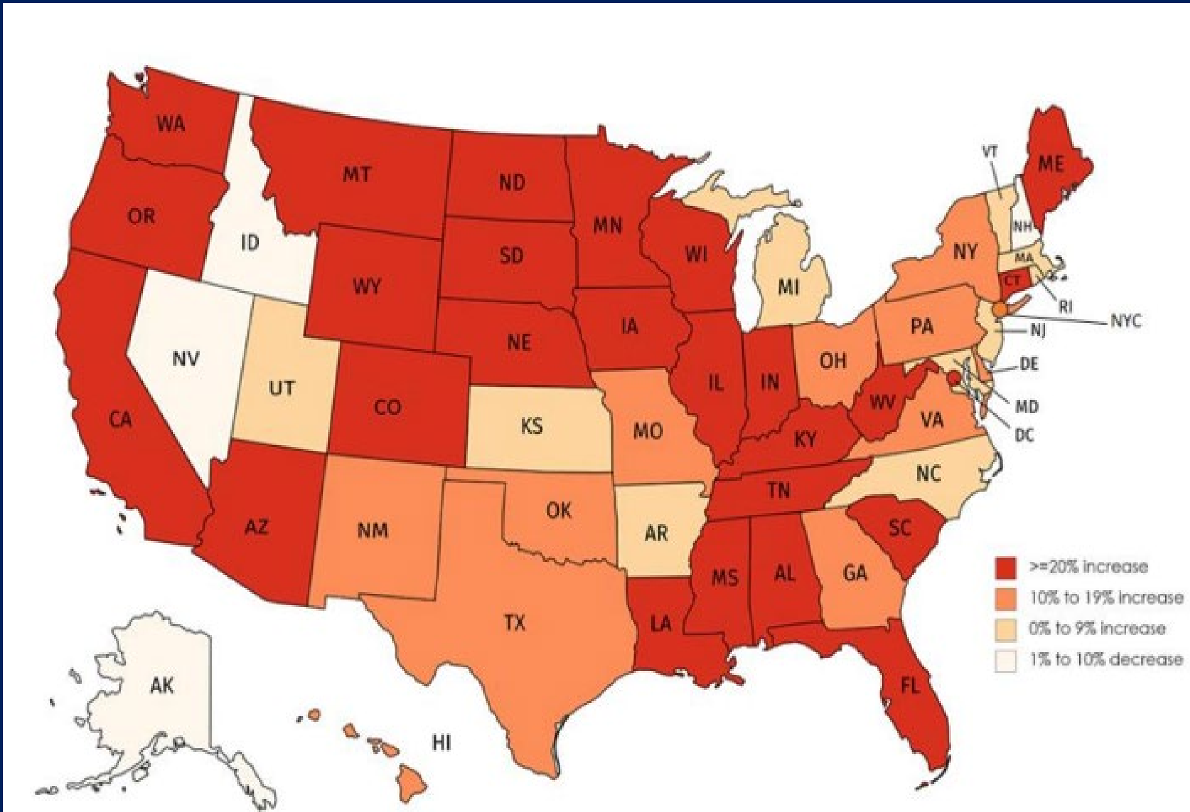
# Fatal Overdose Data June 2019-May 2020

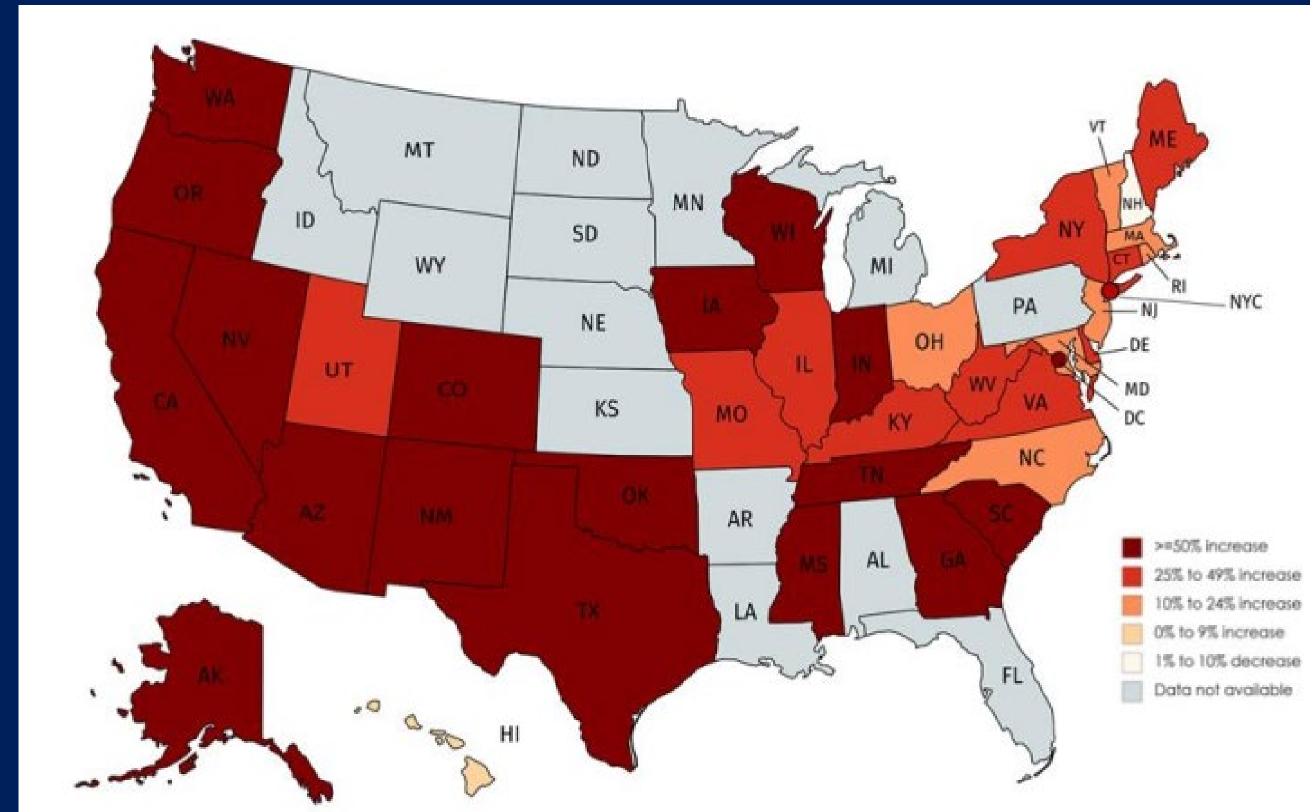
Percent Change (June 2019-May 2020) of all fatal drug overdoses




- 25 states and DC with ≥20% increase
- 11 states and NYC had 10-19% increase
- 10 states with 0 to 9% increase

http://publichealth.lacounty.gov/lahan/alerts/CDC-HAN-00438%20Opioids12172020.pdf

Percent Change (June 2019-May 2020) of fatal overdoses from synthetic drugs




- 18 jurisdictions with ≥50% increase
- 11 jurisdictions with 25-49% increase
- 7 jurisdictions with 10-24% increase
- 1 jurisdiction with <10% increase

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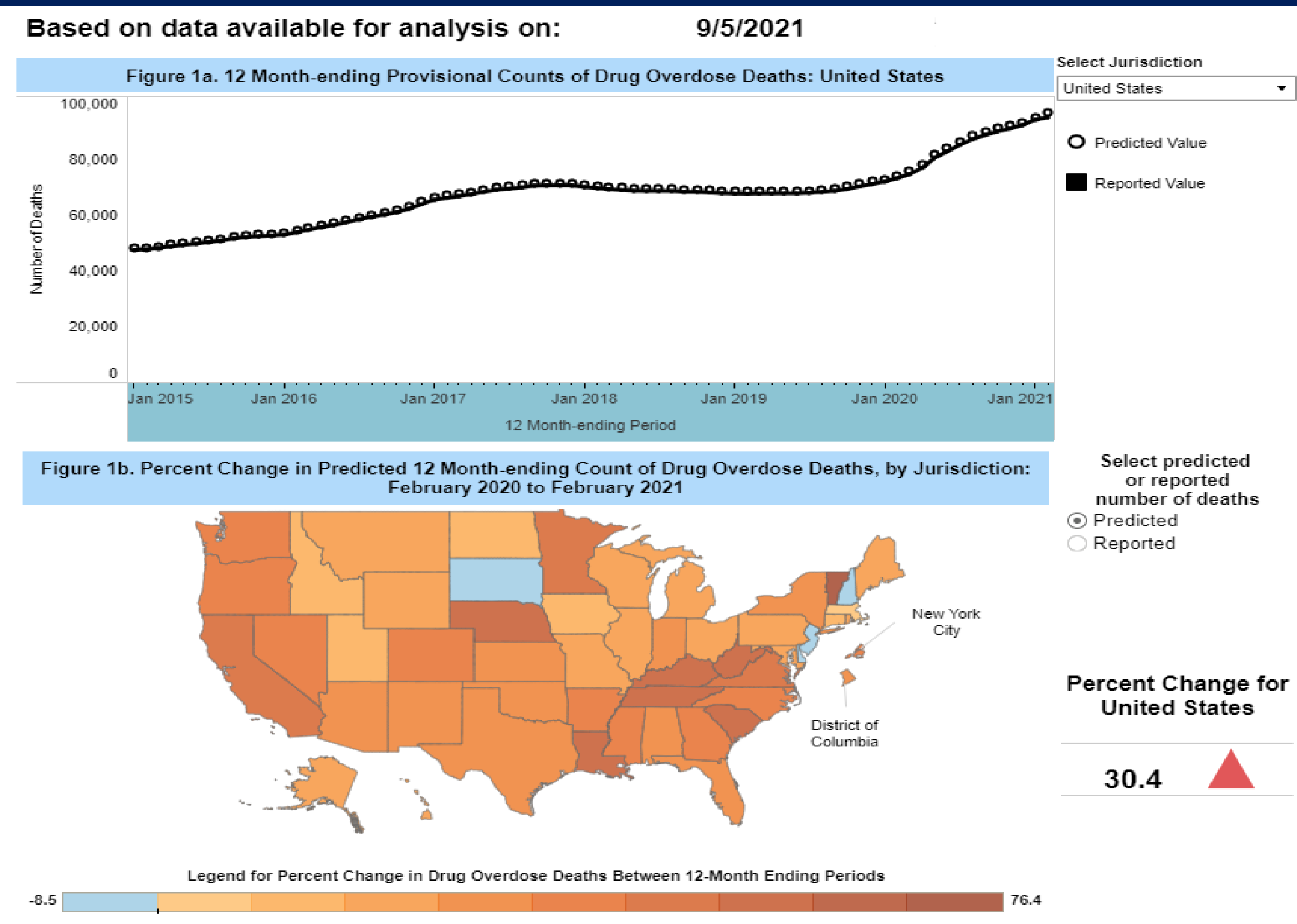
# Are we any better in 2021?




- 96,801 deaths Feb 2020-Feb 2021

Percent change data (Feb 2020- Feb 2021)

- South Dakota: -6.9%
- New Hampshire: -2.1%
- New Jersey: -0.4%
- Vermont: +76.4%
- WV, KY, TN, SC, LA, NE: +≥50%

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

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# Naloxone

- Naloxone programs have significantly reduced fatal overdoses
- During COVID-19 there has been disruptions in naloxone distribution and access
  - Many drop-in services were reduced
  - Many trainings previously in person are now digital with kits mailed after
  - Street efforts have been challenging given more isolation since the pandemic (closure of many parks, buildings, etc.)
- Survey of over 150 syringe service programs in the US
  - 43% reported a reduction in services
  - 25% reported a site closure

*International Journal of Drug Policy 83 (2020) 102872*

# Naloxone Access-Managed Care Role

- Ensure members have full access at pharmacies
  - As of January 2019, the National Alliance of State Pharmacy Associations (NASPA) reported that there is now access to naloxone through community-based pharmacies in all 50 states
- Reduce stigma
  - Barriers remain: Fear of offending patients, insurance costs, payer logistics, and dispensing logistics
- Encourage co-prescribing

| Organization | Naloxone Recommendations Pertaining to Opioid and Benzodiazepine Use |
|---|---|
| DHHS | Naloxone prescribing includes: Those who have been prescribed benzodiazepines (regardless of opioid dose) |
| SAMHSA<br>CDC | Offer naloxone when factors present that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (more than 50 MME/day), or concurrent benzodiazepine use |
| AMA | Naloxone for those with a history of substance use disorder, prescribed opioid dosage, concomitant benzodiazepine therapy, and other medical conditions that may increase risk of potential overdose. |

- Special support for rural areas
- Hospital/ED role in naloxone distribution and starting MOUD

*MOUD= Medication for Opioid Use Disorder*

Pharmacist Prescribing: Naloxone. NASPA. Available from: https://naspa.us/resource/naloxone-access-community-pharmacies/ [cited Mar 5, 2021]

# Morbidity

- People who use drugs are more likely to have unstable housing, face health care access issues, and are more likely to be living with underlying chronic conditions that could be exacerbated by COVID-19
  - Opioids can decrease respiratory rate; smoking and vaping have been shown to cause pulmonary complications
  - Worsening behavioral health conditions (i.e., anxiety and depression)

*International Journal of Drug Policy 83 (2020) 102872*
*National Institute on Drug Abuse 2017*

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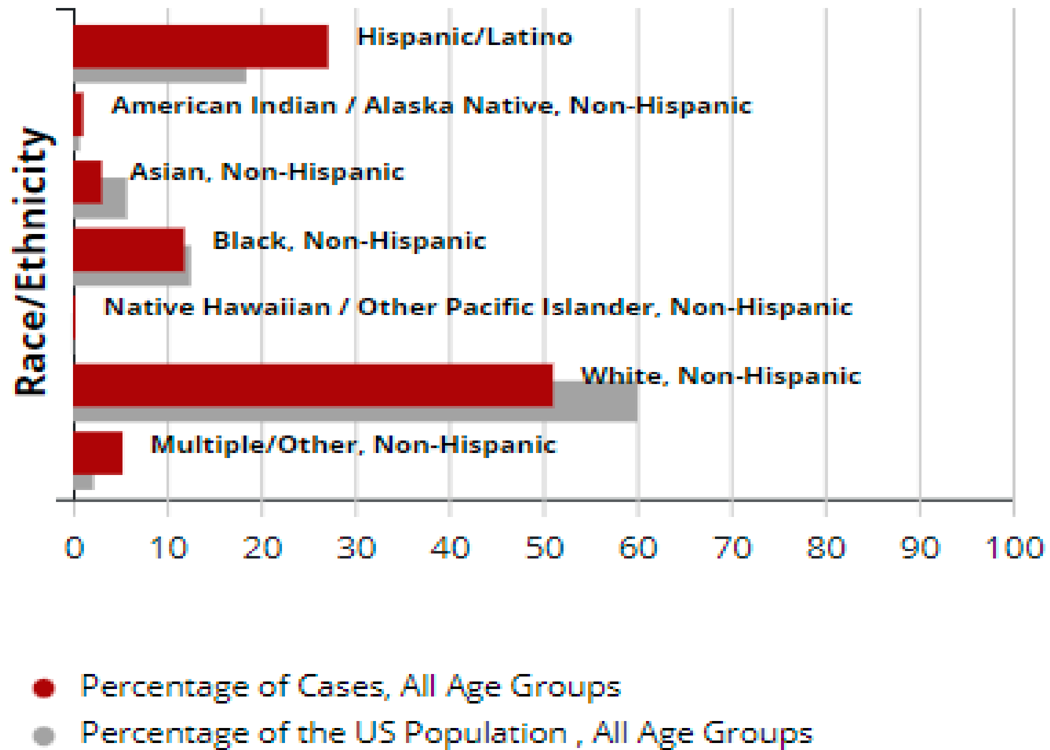
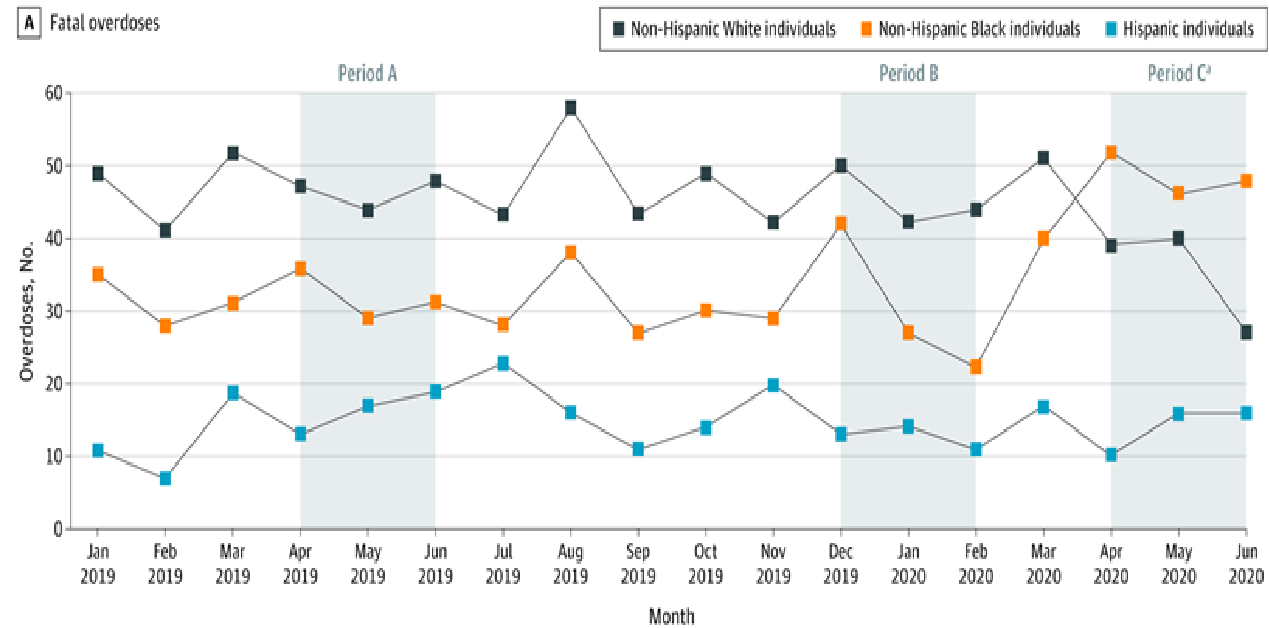
# Health Disparities - Race and Ethnicity

Total COVID-19 Cases by Race/Ethnicity (US)




Philadelphia: Opioid overdose deaths During COVID-19




https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.htm

*JAMA Netw Open.* 2021;4(1):e2034878. doi:10.1001/jamanetworkopen.2020.34878/

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# Strategies to Improve Substance Use Disorder Programs and Treatment Access

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# Treatment of Substance Use Disorders (SUD)

- No approved medications for certain substances (meth, cocaine, cannabis, inhalants, BZDs, etc.), so treatment consists of neurobehavioral therapy (to avoid substances and rebuild personal, social and vocational aspect of one's life), ideally in combination with contingency management (near-term reward for behaviors consistent with recovery, such as testing negative for substances)
- For opioids (prescription or illicit [e.g., heroin, fentanyl]), treatment consists of Medication-Assisted Treatment (MAT): i.e., Neurobehavioral therapy assisted by medications for OUD (MOUDs: Methadone, Naltrexone or buprenorphine)



https://ncsacw.samhsa.gov/files/understanding-treatment-508.pdf

# Components of SUD Care

| | Use prior to pandemic | Post-Pandemic | Impact/Issues |
|---|---|---|---|
| Counseling | Face-to-face | Telehealth | Potentially fewer patients with access to counseling; restrictions on number of participants due to mandates (Wilson, 2021) |
| Overdose prophylaxis: MAT/MOUD | Restricted to 14-28 days depending on time in treatment | 28-day take-home supply for stable patients | Continuity in supply chain<br>Possibility of diversion |
| Harm reduction: needle exchanges, syringe disposal, etc. | Available to interested patients | Less available due to closure of facilities | Increased harm exposure for patients |

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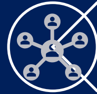
2020 Del Pozo, *J Subst Abuse Treat*, Revising our attitudes towards agonist medications and their diversion in a time of pandemic.

# Access to Care for SUD: COVID-19 Impact

Disproportionate impact on rural communities due to reliance on hourly employment which has been severely impacted

Childcare responsibilities as learning went online


Mutual aid groups restricted to only 10 individuals

Early-refill red flags

Stigma

Telehealth/ limited patient connectivity

Closure of judicial systems, shelters

PCPs rescheduling chronic disease management visits / Patients need for monthly visits

Depression and anxiety from social isolation

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**Wilson, et al,. 2021. *J Rural Health*, A primary care response to COVID-19 for patients with an opioid use disorder.**

# Elements of an Evolving Opioid Epidemic

- Increased availability of illicit opioids
- Limitations of prescription opioids
- Lower cost of illicit opioids
- Increased potency of illicit opioids
- Reduced therapeutic index of illicit opioids

**Pandemic**

Reduced clinic hours
Social distancing
Withdrawal, loss of tolerance,
and return to use
fear/anxiety

Perfect Storm for worsening SUD/OUD epidemic

Increased mortality from SUD

Increased morbidity/mortality from COVID-19

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# SUD: COVID-19 Impact, Barriers, and Opportunities

Among the Association for Multidisciplinary Education in Substance use and Addiction (AMERSA) membership are a growing number of pharmacists

| Impact | Barriers | Opportunities |
|---|---|---|
| Reduced access to medications, counseling | Long-standing rules and regulations around medications such as methadone and buprenorphine. | Expand access to MOUDs (early fills, extended refills) while implementing telehealth patient support solutions. |
| | How to operationalize physical/social distancing when face-to-face group treatment is a dominant modality and in-person 12-step and other mutual support groups are such an important part of recovery support. | Expanded access to virtual support groups through online meetings, virtual support groups demonstrate the impacts of telehealth for initiating and monitoring patients on buprenorphine. |
| More barriers to continuity of care (Methadone > Buprenorphine) | Of those on methadone or buprenorphine, only 30.1% were able to obtain sufficient take-home doses of those medications. | Past experiences such as 9/11, Hurricane Katrina, Hurricane Sandy all showed significant reductions in access to care; time to implement definitive policy changes. |
| | Risk from illicit opioids has increased while access to treatment has remained restricted. | Improving recovery, addressing comorbid conditions, reducing per capita health care costs |
| Limited coordination of care, leveraging of pharmacists (224,000 across 60,000 community locations) | Limited consideration of the capacity of pharmacies (Pharmacies remained open during pandemic; are sources of treatment and medication provision). | • The addition of pharmacists supervising the consumption of the medications combined with other safety protocols prevented the increase of methadone-related deaths as prescribing of these opioid-related medications increased.<br>• Consistent with how other chronic diseases are managed.<br>• Could also help mitigate the stigma experienced by this population and free the patient from the confines of a heavily regulated and controlled care environment. |

**Green, et al,. 2020. *Subst Abus*, Opioid use disorder and the COVID 19 pandemic: a call to sustain regulatory easements and further expand access to treatment.**

# Rhode Island Buprenorphine Hotline

- **“Common sense approach” addressing the complex problem of access to treatment only now permissible due to regulatory changes due to COVID-19**
  - Clinic faced reduced hours, social distancing, compounding already limited access to treatment
    - Limited supply chain, opioid withdrawal and loss of tolerance, using alone and resumed use; patients have faced anxiety about leaving home
  - SAMHSA, DHHS, and DEA issued guidances that allowed audio-only telehealth encounters
    - Research has shown similar rates of retention in treatment, ratings of therapeutic alliance, and medication adherence comparable to in-person care
  - Solution:
    - In conjunction with the RI DOH, and DoBH, developmental Disabilities and hospitals, established a “Tele-bridge” clinic for patients with moderate-to-severe OUD
    - Linked with a DATA 2000-waivered provider
    - Provider conducts initial assessment
    - If appropriate, prescribes buprenorphine for unobserved induction
    - Also provides linkage to outpatient treatment, naloxone, and harm reduction education
  - Opportunity to study efficacy of this low-threshold solution

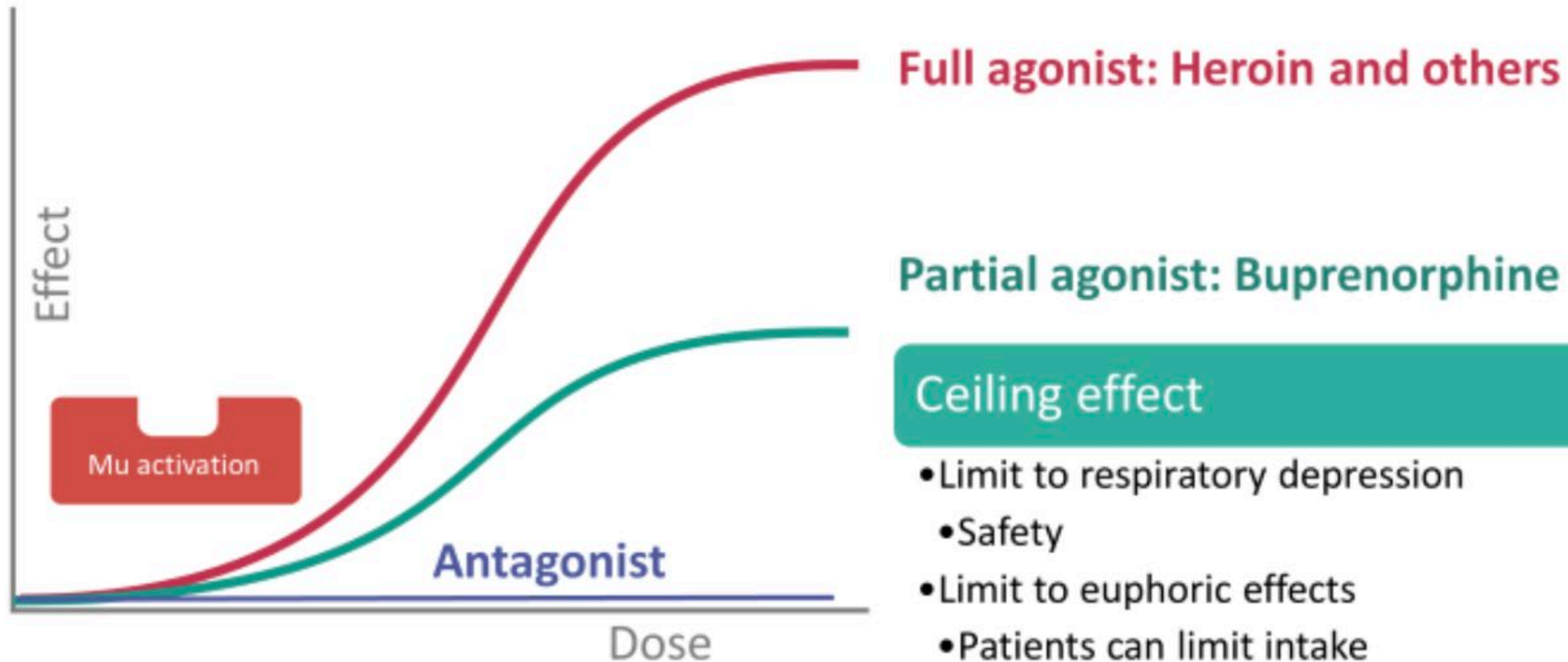
**Samuels et al., 2020. *J Addict Med*, Innovation during COVID-19 – improving addiction treatment access.**

# Addressing Stigma in SUD

- **Overwhelming majority of overdoses are accidental**
  - These are fueled by substances being increasingly being laced with Fentanyl and other synthetic opioids
- **Recovery journey is often long, and patients require sufficient time to heal (chronic disease model)**
  - You can't get to long-term retention without short-term retention in treatment
  - Patients experience significant stigma, so "soft" and understanding approach is needed from all health care professionals
  - For patients with SUD:
    - There are no FDA-approved medications (except for alcohol use disorder and opioid use disorder)
    - Neurobehavioral therapy incorporating contingency management is currently the only evidence-based treatment available
  - For patients with OUD:
    - Therapy with **partial opioid agonists or antagonists** is key to interrupting dependence on **full agonists** (oxycodone, heroin, fentanyl)
    - 2 vs 3 mg of fentanyl can mean the difference between life and death, so reducing/avoiding exposure to these with MAT/MOUD will help reduce risk of accidental overdose
    - Helping patients avoid illicit opioids is central to achieving long-term recovery

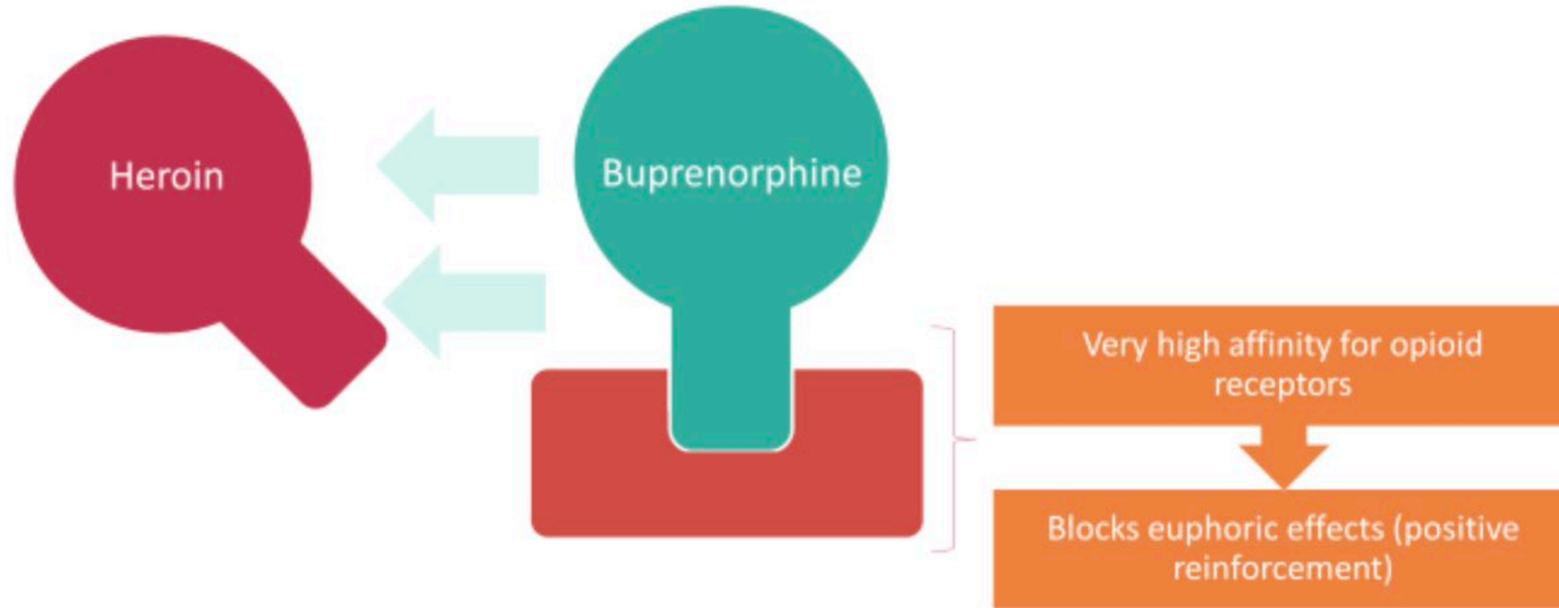
**Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways fo Opioid Use Disorder. *JAMA Netw Open*. 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622**

# MOUD Mechanism of Action



Walsh, S. L., & Eissenberg, T. (2003). The clinical pharmacology of buprenorphine: extrapolating from the laboratory to the clinic . Drug and alcohol dependence, 70(2), S13-S27.

# MOUD Mechanism of Action

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# Addressing Stigma in SUD

- **Retaining patients in treatment offers the best chances of long-term recovery**
  - Treated patients cost the health care system less due to a reduction in use of emergency room visits and hospitalizations. Untreated patients (including those who drop out of therapy) are **several times** more expensive.
  - Direct health care costs: $89.1B from 1.6 million patients with OUD*
  - Complete abstinence is a long-term goal (like the healing of a fracture), so we can't expect patients to be completely abstinent from the very start of treatment.
- **Optimize neurobehavioral treatment for patients in recovery**
  - Without it, there are limited opportunities to influence patient's ability to distance themselves from sources of illicit opioids and rebuild interpersonal and vocational relationships.
- **Worsening SUD crisis underscores the need to improve delivery and coordination of care**
  - We must learn from previous failure to act during past crises.
- **Patients with SUD are often marginalized by society**
  - However, these patients were functional members of society before they became dependent and can return to being functional with the right support.

***Murphy SM. The cost of opioid use disorder and the value of aversion. *Drug Alcohol Depend*. 2020 Dec 1;217:108382. doi: 10.1016/j.drugalcdep.2020.108382. Epub 2020 Oct 26. PMID: 33183909; PMCID: PMC7737485.**

# QUESTIONS

## Mission

To improve patient health by ensuring access to high-quality, cost-effective medications and other therapies.