

# Optimizing Medication Treatment of Opioid Use Disorder During COVID-19 (SARS-CoV-2)

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The COVID-19 health crisis joined, rather than supplanted, the opioid crisis as the most acutely pressing threats to US public health. In the setting of COVID-19, opioid use disorder treatment paradigms are being disrupted, including the fact that methadone clinics are scrambling to give “take-home” doses where they would typically not. The rapid transition away from in-person examination, dosing and group therapy in an era of social isolation calls for adjustments to clinical practice, including emphasizing patient-provider communication, favoring new inductees on buprenorphine and leveraging technology to optimize safety of medication treatment.

**Key Words:** access to care, buprenorphine, methadone, opioid overdose, public health

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The COVID-19 health crisis joined, rather than supplanted, the opioid crisis as the most acutely pressing threat to US public health. COVID-19 (SARS-CoV-2) is disrupting opioid use disorder (OUD) treatment paradigms, which have traditionally relied on in-person examination, medication dispensing, counseling sessions, and group therapy. Consistent with physical distancing guidelines, the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends maximizing tele-health and minimizing in-person and inpatient treatment.<sup>1</sup> Clinicians must be mindful that this rapid shift in practices may introduce new risks to patients, many of whom benefit from in-person accountability. We review and provide guidance for clinicians regarding 3 prongs of medication treatment of OUD affected by COVID-19 healthcare mandates: methadone take-homes, buprenorphine treatment, and antagonist therapy.

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## METHADONE TAKE-HOMES

OUD treatment centers have applied physical distancing principles by providing larger amounts of take-home methadone.<sup>2</sup> The sudden move to dispense larger quantities of methadone effectively treats all patients like the most stable patients. Thus, a substantial portion of patients face the responsibility of a potentially lethal privilege that they did not earn and for which they may not be prepared. To dispense increased take-homes as a substitute for daily in-person visits without adding back behavioral treatment mistakenly views methadone treatment as merely medication therapy.

Remote management of OUD requires clinicians to leverage tele-health to be more, not less, in touch with patients. Phone and video conferencing are the primary modalities, each with benefits and drawbacks. For example, patients could be required to check-in via telephone prior to taking their dose on a set daily schedule (eg, if they typically show up to the clinic at 7 AM, they should call at 7 AM). Likewise, this approach could be reinforced by clinic staff reaching out to patients who miss their dosing window. Clinics may decide to use video-conferencing for daily dose monitoring when available. These video conferences would ideally be done on HIPAA compliant technologies, such as video applications embedded in the electronic medical record. If necessary, patients can use private video-conferencing platforms, such as FaceTime, Zoom or Google Duo. Social media platforms which can be accessed by others (Zoom without a password, Facebook live) should be discouraged. Another advantage of a video conferencing modality that can accommodate multiple participants (ie, Zoom) is that patients may participate in group sessions with other patients for collective accountability and sharing of experiences.

These solutions, while beneficial for many, may further marginalize patients without access to a phone or video platform. One solution is to dispense pre-paid phones or phone cards with sufficient minutes for this purpose. Another challenge of moving clinical encounters to the virtual space is that patients may lack secure or private settings from which to conduct these meetings. For example, if a patient cohabitates with people who do not know that they take methadone, this requirement puts an additional burden on them. Clinicians need to be aware of the sensitive nature of these meetings and strategize in advance with patients how to best avoid potential consequences of virtual visits. This may include establishing a code word between the clinician and patient signaling that another person has entered the room. At the beginning of every encounter, the provider should remind the patient to

seek a private space. If that is not available, text messaging may be more appropriate. It seems that the advantages of sending and receiving important health-related text messages outweigh the risk of sending them unencrypted; however patients should be reminded to delete sensitive text messages.

Another option is to leverage technology, such as novel “smart” pill bottles/lock boxes that dispense doses on a remotely set timescale. Notwithstanding their promise, these technologies are costly, experimental, subject to other vulnerabilities, and, most critically, not widely available in mass production. If this technology is not available, with patient’s permission, family members may be asked to store and dispense methadone, just as lethal antidepressants are kept out of the hands of suicidal patients. This practice needs to be individualized so as not to put family members at risk.

For the highest risk patients from whom large amounts of take-home doses present the greatest liability, the methadone clinic itself will have to remain open. In this case, entering the clinic can be much like entering a grocery store, where masks and gloves are required and patients must maintain a 6-foot distance between themselves and another patient or staff member. Regimented schedules, text message notifications, and potentially a clinic lockbox could be used to make this option as safe as possible and minimize staff exposure.

There are risks and benefits to enforcing virtual dosing, just as enforcement of treatment has risks during non-pandemic times. The benefit of enforcing virtual dosing is to ensure the safe use of methadone; the disadvantage is that it may make dosing less accessible to patients who need the medication. This will be further complicated because patients will not be coming to clinic for regular urine toxicology screens. While these tests could be done offsite lab, the results may not be as reliable or timely. Critical conversations between clinicians and patients, as well as cost-benefit for continued treatment to individual patients is crucial.

During this time, automatic and universal dispensing of naloxone, with appropriate patient and family education, offers an essential safety net. Finally, this health crisis represents an opportune moment to readdress with patients the risks, benefits and alternatives of ongoing methadone treatment.

### **FAVOR NEW PATIENTS ON BUPRENORPHINE**

The pandemic setting should bear on choice of initial agent. For many years, both buprenorphine and buprenorphine plus naloxone have been far safer to administer as take-homes, hence they have been prescribed in office-based settings. As of March 2020, SAMSHA relaxed its requirement for an in-person exam to initiate buprenorphine,<sup>3</sup> whereas methadone continues to require an in-person exam. This difference gives buprenorphine-based medications a clear advantage with regards to physical distancing.

However, buprenorphine, as a partial agonist, may not be adequate for a patient with a longer, more complex OUD history who may typically require a full agonist. Furthermore, the increased prevalence of extremely high opioid tolerance caused by fentanyl derivatives is an essential feature of the current opioid epidemic. In patients with high tolerance,

standard buprenorphine dosing may be inadequate as 24 mg total daily dose is frequently required as an initial dose – leaving little room to titrate based on current FDA guidelines. We may consider revisiting FDA limits on dosing considering current epidemiology.

Novel ways of administering buprenorphine-based alternatives must also be considered. For example, monthly depot injections, patches, and implants may offer additional advantages for patients who are in the maintenance phase of treatment. As with patients on methadone, buprenorphine protocols which decrease clinical encounters should be supplemented with tele-health and other strategies to support behavioral components of therapy. Likewise, for those who present during the crisis requiring re-initiation of medication, the benefits of buprenorphine-based therapy should be considered.

### **EXPAND THE USE OF INTRAMUSCULAR NALTREXONE**

Where clinically appropriate and feasible, IM naltrexone may be offered to patients to help reinforce abstinence among those who do not desire opioid agonist therapy. Though evidence is less robust and the therapy is costly, the stresses of the pandemic environment may increase benefits of added protection offered by IM naltrexone. Notably, oral naltrexone is available as a back-up. Although IM naltrexone is primarily administered in specialized centers, given pandemic-related closures and decreased access to in-person treatment, the pathways for this medication’s use merit reconsideration.

### **POLICY CONSIDERATIONS FOR CLINICIANS**

Each of the medication modalities mentioned above have corresponding regulations that may thwart optimal utilization of treatments for OUD in the setting of COVID-19. For methadone, the restriction of prescribing and dispensing methadone by opioid treatment programs that are required to follow federal and state guidelines may be a barrier.<sup>4</sup> For buprenorphine, dosing limitations as dictated by the FDA may not meet the needs of patients who have extremely high opioid tolerance. For IM naltrexone, its absence in hospital formularies presents a disadvantage particularly as the centers that typically dispense it may be inaccessible. Furthermore, each of the solutions raises issues for traditional structures of reimbursement and management continues to be affected by medication pricing. There may be challenges to reimbursing care given the need for a patient signature to share information for billing; however this may be mitigated by patients being able to virtually download, sign and share treatment documents through their phones or other available technologies. As patient advocates, clinicians should leverage their influence to promote resolutions of these policy issues that may inhibit optimal patient care.

### **CONCLUSION**

COVID-19 arrived on the heels of the opioid epidemic. In 2020, these 2 crises have already each claimed upwards of 20,000 US lives.<sup>5,6</sup> We provide practical guidance for clinicians regarding optimal approaches to methadone, buprenorphine

and naltrexone during the pandemic. Success during this time will require genuine collaboration between patients and clinicians. Our hope is that the novel approaches necessitated by the crisis will both minimize harms now and help advance treatment of OUD in the future.

### REFERENCES

1. “Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic: March 20, 2020.” Substance Abuse and Mental Health Services Administration Website. Available at: <https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf>. Accessed 27 March 2020.
2. Substance Abuse and Mental Health Services Administration. Opioid Treatment Program (OTP) Guidance. Available at: [www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf](http://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf). Accessed April 16, 2020.
3. “FAQs: Provision of methadone and buprenorphine for the treatment of Opioid Use Disorder in the COVID-19 emergency.” Substance Abuse and Mental Health Services Administration Website. Available at: <https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf>. Accessed March 27, 2020.
4. Samet JH, Botticelli M, Bharel M. “Methadone in primary care – one small step for congress, one giant leap for addiction treatment”. *N Engl J Med*. 2018;379:7–8.
5. “Provisional Drug Overdose Death Counts.” Vital Statistics Rapid Release, National Center for Health Statistics, Centers for Disease Control Website. Available at: <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>. Accessed March 27, 2020.
6. “Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University. Available at: <https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6>. Accessed April 6, 2020.