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Nation's Leading Drug Policy Experts Demand Medication Assisted Treatment and COVID-19: Treatment Reforms

During the COVID-19 pandemic, it is critical to remember that we are still in the midst of an overdose crisis. While many regulators have argued that methadone and buprenorphine policies must be deliberately restrictive due to the risk of overdose, adverse medication effects, and medication diversion, the COVID-19 crisis has forced many regulating bodies to re-evaluate these policies in order to comply with the urgent need for communities to practice social distancing and sheltering-in-place. Multiple government agencies including SAMHSA, the DEA, Medicare, and Medicaid have recently announced policy changes to allow for more flexible prescribing and dispensing. While these changes are a step forward, clinics have been either reluctant or resistant to fully implement them to the extent allowable under law. In light of the evolving pandemic and the needs of the community, we must not allow fears of overmedication and diversion to outweigh the health risks caused by patients being forced daily to congregate in large groups, or being driven to an adulterated illicit drug supply.

Close person-to-person contact and group assembly are currently actions deemed hazardous to public health. Unfortunately, "sheltering in place" is unrealistic for many people who use drugs. People who use opioids are either forced to continue to engage with the illicit drug market or must comply with prohibitive and insurmountable requirements to receive medications for Opioid Use Disorder (OUD). Many opioid users are at an increased risk of COVID-19 infection due to being immunocompromised and/or having comorbid health conditions.

In order to reduce the risk of COVID-19 infection, involuntary withdrawal, and drug poisoning, the Urban Survivors Union and the undersigned organizations strongly recommend the following measures be taken immediately:

1) 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.

2) 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 life-saving 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.

3) Referrals for COVID-19 testing shall be made available at all opioid treatment programs (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 life-saving 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.

4) During the COVID-19 national emergency, healthcare 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 MAT available in all settings. Prescribers shall not have limitations on the number of patients that 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.

5) Opioid treatment programs (OTPs), prescribing clinicians, and pharmacies shall actively work 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.")

6) Take-home exception privileges shall be expanded to the maximum extent possible, limited only by available supply and operations for delivery. Any bottle checks that clinics wish to conduct shall be conducted by tele-medicine. 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.

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

8) 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.

9) 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.

10) 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.

In the interest of saving lives and adhering to existing public health protocol for management of COVID-19 transmission, it is necessary to make significant revisions to existing regulatory standards. This is a critical time to take decisive action for the protection of patients, providers, their families, and the community. As our healthcare system reaches full capacity and becomes overburdened by COVID-19-related emergencies, as seen in Italy and Spain, providers on the front lines will be forced

to make life and death choices. These recommendations outline a plan of primary prevention that will minimize the burden on our healthcare system and save lives during this national emergency.

We, the undersigned, are a coalition of direct service providers, community advocates, public health officials, medical professionals, human rights groups, people in recovery, treatment professionals, members of impacted communities, and many others. We ask SAMHSA, the DEA, and all other federal, state, and local regulatory bodies and health authorities to adopt these recommendations fully and immediately in light of the COVID-19 pandemic.

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