Where Do We Go From Here? The Delivery of Addiction Treatment in a Post-COVID World

Molly McCann-Pineo, MS, PhD and Soteri Polydorou, MD

Many healthcare institutions across the nation experienced significant disruptions in addiction treatment services as a result of COVID-19. As restrictions now begin to loosen, there is an opportunity to transition towards a new treatment structure informed by the experience from both the current public health crisis and precrisis operations. However, there is currently limited information on how best to do so, leaving many providers and specialty programs searching for answers. The permanent integration of recent regulatory changes into routine clinical practice, specifically regarding prescribing flexibility and use of telehealth, is yet to be determined, but implementation experience highlights the adaptability within this field of medicine. Providing patients with a spectrum of care that is both clinically informed and technologically supported should be at the forefront as we settle into a postcrisis world.

Key Words: COVID-19, opioid policy, opioid use disorder, telehealth, treatment access

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Although the coronavirus pandemic continues to be a public health burden, we begin progressing towards our ''new normal,'' with states attempting to reopen and lockdown restrictions beginning to loosen. Going back to pre-COVID ways of providing care remains concerning, particularly with continual spikes in cases across certain regions, and the potential of a second wave. This issue is at the forefront of many healthcare systems and providers, who are now faced with providing services following what is hoped to be the worst of a global pandemic. It has become even more pronounced among health care professionals providing substance use disorder (SUD) treatment who have witnessed the rapid reorganization of clinical practice, federal regulatory changes, the deployment of telehealth (TH) services, and reallocations of inpatient and residential program space in support of pandemic relief efforts. The impact of these changes has yet to be quantified, but it goes without question that the field of addiction medicine is now at a crossroads, and in need of guidance on how best to move forward. There is currently limited information available on how to best reopen such services. It is, therefore, our aim to provide insight into some of the experiences faced among providers in this clinical discipline, and articulate the principles on which the continuity and delivery of SUD treatment and care could proceed in light of a postcrisis society.

Exposure mitigation and reallocation requirements resulted in significant disruption of inpatient rehabilitation services, such as detoxification and residential treatment, across many health systems, but specifically within New York State.[1] With this unfortunate interruption in SUD care delivery, the pressure to maintain access to outpatient services was critical. Thankfully, recent federal regulatory changes, namely the flexibility of prescribing and dispensing medication for opioid use disorder of buprenorphine and methadone, respectively, and the utilization of TH in order to do so, have undoubtedly changed routine addiction medicine practice and facilitated the continuity of outpatient, specifically opioid use disorder (OUD), care during COVID-19.[2–5] Providers are now able to initiate buprenorphine without first performing in-person medical evaluations.[3] Further, methadone could be dispensed within opioid treatment programs (OTP) to patients for extended periods of time, up to 4 weeks based on a clinical assessment of stability without required incorporation of the person's duration of treatment.[2,6] Additionally, there has been guidance supporting reductions in the frequency of toxicology sampling in order to reduce in-person and onsite visits.[7] These changes in normative practice procedures have enabled waivered providers the capability of expanding their clinical reach and patient monitoring, despite the overall reductions in face-to-face appointments resulting from the public health crisis. However, this has not come without caution.

As part of ongoing quality improvement initiatives, we distributed a survey amongst 5 SUD and addiction treatment sites offering inpatient and/or outpatient care across a large and diverse NY health system in July 2020. Inpatient services provided by sites include: detoxification (n = 3), residential rehabilitation (n = 4), and addiction consult services (n = 2). Outpatient services included ambulatory addiction specialty

From the Department of Occupational Medicine, Epidemiology and Prevention, Northwell Health, Great Neck, NY (MMC-P); The Feinstein Institutes for Medical Research, Northwell Health, Manhasset, NY (MMC-P); Joint Center for Disaster Health, Trauma and Resilience at Mount Sinai, Stony Brook University, and Northwell Health, Stony Brook, NY (MMC-P); Addiction Services, Northwell Health, Glen Oaks, NY (SP); Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, Hempstead, NY (SP).

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Send correspondence to Molly McCann-Pineo, MS, PhD, Department of Occupational Medicine, Epidemiology and Prevention at Northwell Health, 175 Community Drive, 2nd floor, Great Neck, NY. E-mail: mmccann1@northwell.edu.

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services (n = 7), OTP (n = 5) and ambulatory withdrawal center (n = 3). (The study was reviewed by an Institutional Review Board and was determined not to be human subjects research). Programs included in our sample offer treatment and care for all substances of misuse, but our survey captured mainly services for OUD. It was reported among OTP providers that, from their experience, substance misuse and/or overdose, as well as diversion, were of clinical concern regarding their patients (44% and 33%, respectively; data not published). However, we were unable to decipher reason for such concerns, such as limited patient access to such medication for opioid use disorder. Nonetheless, outpatient ambulatory and OTP providers also reported that at least 50% or more of their patients receiving ambulatory treatment had medication focused attendance schedules reduced due to the public health crisis. This is information is critical, particularly among OTPs, who serve large populations of patients with OUDs, and are simultaneously still facing one of the largest social crises of our time (ie, the opioid epidemic). Although we are only drawing information from a small sample (n = 10 out of 18 providers), understanding how medication delivery has been specifically impacted during the pandemic can be incredibly useful and informative, especially as health systems prepare for subsequent waves.

The adaptation among providers to the aforementioned regulatory and clinical changes have been further compounded by significant disruptions in workflow, ensuring patient and staff safety, as well as the rapid uptake of TH for the provision of ambulatory SUD services. Results from our sample indicated that almost 80% of providers perceived the disruption in workflow as the most significant challenge experienced during the pandemic (data not published). The delivery and utilization of TH has generated mixed perceptions among providers, with many reporting technical issues as burdensome, for both themselves and, more importantly, their patients. Overall, perceptions on the effectiveness of TH for therapy sessions were also varying, with more providers in its favor for the delivery of individual, rather than group therapy (85% vs 50%, respectively). This could perhaps be contributed to by lower levels of engagement among patients when utilizing TH compared to in-person sessions, of which a third of providers reported among their group therapy sessions. Despite the differences in perceptions, almost 90% of providers were in favor of the permanent integration of TH services into routine practice (data not published). Further, 78% also wanted to continue with the expansion of TH for the delivery of group and individual therapy sessions, highlighting the need of integrating telemedicine as part of a clinical practice model moving forward. However, before doing so, addressing the barriers to its permanent integration, such as ensuring access to those who are disadvantaged or marginalized, as well as addressing issues regarding reimbursement, are necessary to ensure its longevity and success.

Perhaps the most important principle we can take away from our provider's experiences throughout this pandemic was that there is a need to provide a spectrum of SUD treatment, one that offers different intensities of care, tailored by the needs of each patient. Among clinician assessed lower risk patients, TH is seemingly the most sensible option, for it continues to minimize exposure as we progress into phases of reopening, and may align with patient preference and clinician assessed level of care. Recent regulatory changes can also be incorporated into higher levels of care for patients deemed at higher risk, by generating more opportunities for monitoring and support. Such patients could receive the added benefit of ongoing TH assessments while still incorporating increased onsite, in person services, including essential toxicology testing, to provide the necessary level of care that may generate longer lasting treatment engagement and recovery.

Further integrating telemedicine as a component of addiction services in the aftermath of COVID-19 will be perhaps the most valuable supplement to the delivery of such care. We have seen firsthand the utility of TH through the ability to continue treatment and services under extremely socially challenging circumstances–of which has drastically improved since previous disasters.[8–11] Its use, however, can extend beyond just virtual or telephonic ''visits,'' and can be formally integrated into electronic medical records, off-site toxicology testing and patient outreach to improve overall care. Given the unpredictability of the pandemic and our heavy reliance on technology, integrating TH through the uptake of mobile health applications should be further developed. Mobile health is an emerging area of TH, and goes beyond traditional modalities by offering increased usability and flexibility, for both provider and patient, is rather inexpensive and has the capability of reaching large populations.[12] Currently, there is only one FDA approved digital therapeutic for OUDs, and it has been used to improve retention in outpatient rehabilitation programs, in conjunction with normative treatment management.[13] In light of recent events, perhaps integrating TH with such mobile health applications, providers and the discipline as a whole, would be better equipped to handle any number of future disruptions in care, all while providing uninterrupted support and treatment for our patients. The pandemic has clearly impacted patient care delivery, and therefore, providing a spectrum of care that is clinically informed and technologically supported will be the key to success and longevity in a post-COVID world.

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