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The impact of COVID-19 on opioid treatment program (OTP) services: Where do we go from here?

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A R T I C L E I N F O

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A B S T R A C T

Medication for opioid use disorder (MOUD) services is key to addressing the opioid crisis and COVID-19 has significantly impacted MOUD delivery. The need for social distancing and self-quarantining requires individuals to maintain personal physical space and limits face-to-face interactions, which are required for methadone dispensing and other regulated treatment activities. Mount Sinai Beth Israel, which has one of the largest opioid treatment service (OTP) delivery systems within the United States and included 10 OTP methadone clinics that responded rapidly by implementing procedures to address the additional challenges during the COVID-19 pandemic. This article discusses four key procedural areas: 1) verified identity in-person pick-up doses, 2) drug urine toxicology screens, 3) treatment interactions, and 4) discharges, which can inform future OTP operational procedures by encouraging out-of-the-box thinking in this new age.

The opioid crisis is a nationwide public health emergency (Centers for Disease Control, 2020; Hargan, 2018). Essential medication for opioid use disorder (MOUD) faces significant impacts from COVID-19 (Bell & Strang, 2020; Connery, 2015; Sun et al., 2020). Mount Sinai Beth Israel (MSBI) has one of the largest opioid use services within the country, including 10 opioid treatment programs (OTPs) that responded swiftly to COVID-19. Located within the pandemic epicenter, New York City (NYC), we knew the critical importance of promptly addressing the resulting challenges in delivering opioid treatment and impact to regulated operational procedures (Substance Abuse and Mental Health Service Administration, 2020; The Joint Commission, 2020).

Methadone is a controlled substance that physicians administer to individuals with opioid use disorders (OUDs); it requires a regimented treatment trajectory with regulations outlining training for prescribers, storage, dissemination, and continued evaluation (Atterman et al., 2018). Challenges to methadone dispensing arose due to the COVID-19 pandemic, stemming from the increased need for social distancing and isolation (Alexander & Stoller, 2020), which required personal space and limits on face-to-face interactions, necessary components of methadone dispensing and treatment. Reports indicate that COVID-19 has reduced onsite medication visits close to half, with patients continuing treatment having accommodations for take-home medication and delivery services (Peavey et al., 2020).

Within our addiction service delivery system's 10 OTP methadone clinics in 2020, we rapidly implemented procedures to address four key areas that COVID-19 impacted.

1) OTPs frequently use ***verified identity for in-person pick-up doses*** to avoid large distribution of a controlled substance so as to reduce overdose risks. Pre-COVID-19, patients picked up medication 6 days per week if new to treatment or actively using substances. During COVID-19, we implemented a rapid reduction in pick-up dose requirements, including 14-day and 28-day take home dose coverage for those patients not new to treatment or using who did not reach stability yet; transition varied depending on the individual patient's characteristics. Medication visits dropped 44% from the same time the previous year, primarily due to these changes and shifting resources. Most patients had their pick-up schedule frequency changed

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per clinical review, excluding active use and new patients, to ensure dosage stability.

Patients in quarantine, either at isolation hotels or elsewhere due to contracting or high risk for COVID-19, had courier-delivered medication, provided through NYC Department of Health and Mental Hygiene in coordination with the NYS Office of Addiction Services and Supports. The eligible patients were those who were symptomatic, tested positive, high risk, or exposed to someone with COVID-19.

2) Our OTPs use ***drug urine toxicology screens*** to ensure abstinence from all substances and to determine treatment course. Urine toxicology screens are more frequently conducted at treatment onset to capture use when initially becoming acquainted with new patients' use patterns and when suspecting substance use. Frequency of drug screens remained the same during COVID-19 for patients new to treatment or for those suspected of use, as they were already frequent. The OTPs required additional monthly urine toxicology screens for all, rather than random assessment, due to the increased take-home doses to ensure safety. Future guidance should explore virtual urine toxicology immediate result screens and potential for outside local lab specimen screens.
3) Accrediting bodies require ***treatment interactions*** to safely deliver MOUD (e.g., intakes, treatment plans, therapy, physicals). At the onset of the COVID-19 pandemic, we promptly shifted toward phone and virtual interactions where appropriate, with many of our staff working remotely and those in clinic wearing protective equipment. The clinic provided telephonic services, as all clinicians have telephone access. To limit social contact in the clinic, except for necessary in-person contact such as a physical exam or biological tests, staff conducted counseling sessions telephonically from their office to the patient seated in another room, often scheduled with dose pick-up visits. We are exploring obtaining broader access to additional technology/devices such as smartphones and iPads to conduct virtual treatment interactions broadly across our OTP clinics. As patients might experience challenges with or barriers to access of personal devices, future guidance should consider public use devices stationed at places within the community where patients reside (e.g., homeless shelters, safe havens, residential facilities).
4) The OTPs met ***discharges*** with more leniency amid the COVID-19 pandemic, as local and state government reduced and limited mobility. The OTPs made every effort to retain patients with no forced administrative discharges during this time. However, given that we are a large system, if patients posed a safety risk to others or treatment was contraindicated, we transferred patients to other MSBI OTPs, to provide patients with an alternative environment.

As all MSBI OTPs are part of the same system, they were able to consistently roll out new procedures across all clinics with no approach variations. Starting at the end of March 2020, the team worked diligently to adjust all patients' pick-up schedules, the process for which lasted 2 weeks. The OTPs had approximately 5400 patients at the time, with approximately 85% of patient's medication schedules revised. Less than 1% of our patients received home delivery via courier services. We saw a drastic drop, 21% decrease from March to April, in medication visits and subsequent drop in patient engagement that began to increase again in July. Interestingly, the percentage of positive toxicology results during this time was similar to the pre-pandemic period. Many staff acclimated to the change rapidly, but for some, the switch to virtual treatment was initially challenging as some preferred in-person visits to obtain additional input on status through direct observation (e.g., smell of alcohol on breath, marijuana odor). OTPs provided support groups for staff to help them adjust to the rapid changes in operational procedures and to mitigate the stress of the pandemic. The OTPs extended additional support to patients; however, many welcomed the increase in take-home medications and seemed to do well with the changes, which has prompted us to explore this approach as a sustainable model. Overall, the patient population tends to be disenfranchised and socially isolated, leading some clients to continue daily pick-ups, stating that clinic visits, including group/peer counseling, are a main source of their social interaction.

Pre-COVID-19 payment rates were based on fee-for-service, in which each type of clinical service was associated with a different amount, excluding at-home medication administrations. Given that the OTPs reduced on-site medication dispensing as well as a decrease in ancillary services such as counseling, Medicaid and OASAS established a bundled rate that provided payment for take-home medications. Our facility is currently working with our billing vendor to accommodate this change and determine its sustainability.

Individuals with OUD are at risk during the COVID-19 pandemic due to an increase in stress, feelings of isolation, and concerns such as economic insecurity and job loss, compounded with the health concerns in the population (Clay, 2020; Volkow, 2020). These concerns are particularly harmful to individuals with OUDs as they are shown to influence use, relapse, and increased vulnerability to contracting the COVID-19 virus (Clay, 2020; Volkow, 2020). While individuals with OUD have increased service needs, the strict regulations and clinician involvement created a need for flexibility and adaptation for MSBI OTPs (Alexander & Stoller, 2020; Peavey et al., 2020). We have reached a new era, one requiring out-of-the-box thinking to ensure the safety of those we treat, our providers, and surrounding community. We must continue to find ways to build upon our initial adaptations and pave the way for a future vision, one that might look very different from what we once knew but that is marked by creativity and hope.

CRediT authorship contribution statement

Kathlene Tracy, Ph.D.: Conceptualization, Methodology, Writing - Original draft, Writing - Review & editing
Leah Wachtel, M.A.: Methodology, Writing - Original draft, Writing - Review & editing
Teri Friedman, M.S., C.R.C.: Methodology, Formal analysis, Writing - Review & editing, Project administration.

Declaration of competing interest

None.

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