Acute Treatment of People Who Use Drugs in the Era of COVID-19

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What are the top challenges/ barriers in the treatment of OUD patients that you are dealing with right now at your organization?

Please type your answer in the chat box.
Please share your tools and resources!

Email mkenyon@haponline.org
Leigh’s Story

Leigh Chapman
PA Certified Recovery Specialist
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The GateHouse Behavioral Health Services
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Hannah Snyder, MD
Co-PI & Director, California Bridge
UCSF at Zuckerberg San Francisco General
Family Medicine & Addiction Medicine
www.bridgetotreatment.org/covid-19
Disclaimers

- Not a legal scholar
- Check with your health system
- Check with your public health department
- Rapidly changing
Revolutionizing the system of care

Rapid, Evidence-based Treatment

Culture of Respect

Connection to Community & Care

24/7 MAT ACCESS ACROSS THE HOSPITAL
BUP OR METHADONE, WITHDRAWAL RELIEF AND LINKAGE

OFFERS TREATMENT THROUGH OUTREACH
MAT, NALOXONE IN HAND & RESPECT

CARE INVOLVES ACTIVE SUPPORT AND FOLLOW UP
CLINICS, HARM REDUCTION & OPEN DOOR
Why start in the ED?

- Treating emergency of withdrawal
- Frequent site of care for patients with OUD
- Often otherwise not engaged in care
- 24/7 Access to Care
- Treatment in the ED with BUP and referral DOUBLES the likelihood that a patients will be in treatment at 1 month
Why start in the Hospital?

- 67% of hospitalized people who use drugs state that they would like to cut back or quit
- Treat withdrawal, prevent AMA, linking to care
- 6x increase in linkage to MAT when start inpatient
- Decreases readmission rates by 43-53% (30 vs 90 day)
1. Patient with SUD is identified
2. SUN talks to patient
3. SUN consults with provider to start treatment
4. SUN guides patient through next steps of ongoing care
- Over 50 hospitals
- Over 3,500 patients started on buprenorphine
- Low barrier, high support
COVID-19 Vulnerabilities

- People experiencing homelessness
- People with comorbidities
- Stigma, racism, fear of healthcare system
COVID-19 Risks

- Withdrawal with quarantine/isolation
- Drug supply chain disruption
- Syringe supply disruption
- Overdose with social distancing
Anecdotal observations

- Increased overdoses
- Increased withdrawals
- Increased treatment seeking
Hospitalization

- Fear of medical system, stigma
- Withdrawal management
- Discharge planning
  - Residential treatment
  - Isolation & Quarantine, Shelter in Place sites
Case: Heroin, Tobacco + COVID

- 40 yo F w injects 1 g heroin daily (last 8 h ago), 2 packs cigarettes daily, occasional smoked cocaine
- Sent from shelter for fever and cough, found to be COVID +
- In ED, develops nausea, anxiety, muscle aches
Uncomplicated* opioid withdrawal?**

YES (stop other opioids)

Administer 8mg Bup SL

NO

Start Bup after withdrawal
Supportive meds pm, stop other opioids
Administer 8mg Bup SL

Withdrawal symptoms improved?

YES

Administer 2nd dose
Inpatient: 8mg. Subsequent days, titrate from 16mg with additional 4-8mg prn cravings.
ED: 8-24mg. Consider discharge with higher loading dose.

Maintenance Treatment
16 mg Bup SL/day
Titrates to suppress cravings;
Usual total dose 16-32mg/day
If discharged to outpatient

- COWS score 12
- 8 mg buprenorphine SL (any provider) ➔ COWS score 4
- In 1 hr: 8 mg buprenorphine SL (any provider)
- Discharge with Rx
If not in withdrawal

- Bup/nal 8/2 mg film
- 3 films SL qday, 14 days, #42, 0 refills
- Instructions:
  - Wait at least 12 hours until you feel sick
  - Take ½ film SL
  - If it helps take another ½ film in 1 hour
  - Take up to 24 mg on day 1 (probably 16)
If admitted to inpatient

- Any provider: COWS score 12 → 8 mg buprenorphine SL → COWS score 4 → 1 hr later 8 mg buprenorphine SL
- 16 mg qday during hospitalization, increase by 4-8 mg if ongoing withdrawal
Any scenario

- Discharge Rx (X waived provider)
  - Bup/nal 8/2 mg film, 2-3 films SL qday, 14 days, #42, 0 refills
- Telehealth follow up in next week
- Naloxone & harm reduction supplies
- NRT:
  - 1 patch per pack + nicotine gum
Isolation & Quarantine

- Goal of cessation?
  - Harm reduction
  - MAT: opioids, alcohol, tobacco, stimulants

- Goal of craving/withdrawal control?
  - Harm reduction
  - Making sure supply lasts
Treatment and Social Distancing

- Extend prescriptions
  - Patient selection & safe storage
  - CURES for >7 d
  - SubQ buprenorphine
- Home starts
- Urine toxicology
- Pharmacy home delivery
- Linkage to clinic w telehealth capability
Telehealth

- Increased access
- Window into home/family
- Rapport challenges
- Technical issues
- Limited phones
- Privacy
Privacy

- Consent to telehealth
- Safewords
- Yes/no questions
Regulations During Pandemic

- HHS: waive penalties for good faith telehealth provision \( \rightarrow \) Zoom, Skype, FaceTime
- DEA: telephone is sufficient for buprenorphine evaluation if DATA 2000
- SAMHSA: Do not need written consent for 42CFR in medical emergency
Harm Reduction

- Overdose prevention:
  - Naloxone
  - Fentanyl test strips

- Safe consumption supplies
  - Deliveries, open air
  - Physician dispensing (CA)
Harm Reduction

- Cleaning space and supplies
- Withdrawal from other substances: medications and self taper
  - Nicotine
  - Alcohol
  - Stimulants
Patients in Opioid Treatment Programs

- Notify immediately if patient quarantined
- Medication delivery
- Clinic-wide approval for take homes: 14 vs 28 days
- Phone counseling
- Decreased urine toxicology
Well Being

- Counseling & groups
- Phone & text support
- Stigma
- Finances
- Patients & providers
Navigators and Peers

- Working remotely
  - Vulnerable workers
  - EHR, phone consultations, patient materials on site
- PPE & COVID policy training
Big Picture

- Physical distance, social embrace
- Increase access
- Reduce harms
- Protect caregivers
Resources

www.bridgetotreatment.org/covid-19

www.harmreduction.org

Substance use warmline (855) 300-3595 M-F 9am-8pm ET
Take Care of Yourself!
Thank You For Your Work!
Questions?
Future Opioid LAN Events

Office Hour: Use of your OLAN Data—May 7 at 11 a.m.
  Graycen Hunt, The Hospital and Healthsystem Association of Pennsylvania
  Jordan Barbour, Geisinger Medical Center

Webinars:

Telehealth and the COVID-19 Response: Policy Changes and Implementation Strategies—May 5 at 11 a.m.
  Jean Glossa, MD, David Bergman, MPA, and Zach Gaumer, Health Management Associates

Treatment of Substance Use Disorders During the COVID-19 Pandemic with a focus on MAT Data—May 11 at 11 a.m.
  Scott Haga and Shannon Robinson, Health Management Associates

Review of Harm Reduction Strategies—May 14, 2020 at 11 a.m.
  Allison Herens, LSW, Philadelphia Department of Public Health

Regional Meetings (Virtual):
  Central Regional Organizations Only - May 28, 2020 11-12:30 pm
  Northeast Regional Organizations Only - June 18, 2020 11-12:30 pm