

Guidance for Treating Patients with Opioid Use Disorder (OUD) with Buprenorphine-Naloxone (B/N) in the COVID-19 Era via Telehealth: A Review of Previous Evidence, New COVID-19 OUD Treatment Guidelines, and a Case Report of their Application

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Potential conflict of interest: all authors are associated with the Bicycle Health telehealth company.

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Intro/Background

Prior to the COVID-19 pandemic, opioid use disorder posed its own endemic, with 115 people dying of an opioid overdose every day in the U.S.,¹ becoming the most common cause of accidental death.^{2,3} With only 10-14% of patients with opioid use disorder (OUD) receiving treatment, there is a great need for increased access to care.⁴ Buprenorphine-naloxone (B/N) has proven to be an evidence-based medication for the treatment of OUD (MOUD)⁵⁻⁷ and since it can be prescribed in a primary care setting, unlike methadone, it can potentially increase access to treatment.

During the COVID-19 pandemic, patients with OUD face additional challenges in accessing treatment with B/N in a safe way that minimizes exposure to COVID-19. Telehealth services that utilize audio and video phone technologies offer a venue for delivering addiction treatment to patients while eliminating person-to-person contact associated with travel and patient-provider encounters.

Bicycle Health (BH) launched in January 2019 as a telehealth company with a goal of providing B/N for opioid dependent patients across California using a combination of in-person and virtual, telehealth visits. Comprised of family medicine physicians, physician assistants, nurse practitioners, health coaches, and psychologists, BH uses a team-based approach to support patients struggling with OUD. Prior to the COVID-era, BH was enrolling an average of 5 new patients/week. With the COVID-19 outbreak, demand rapidly increased to 10 new patients/week. Patients in remote and rural areas, those looking to minimize risk of community exposure to COVID-19, and those no longer able to procure opioids “off the street” due to “stay-at home” orders and the restrictions on border crossings and hence suffering from opioid withdrawal, were looking for telehealth options for OUD treatment. To meet the increasing demand of treating patients with OUD in the COVID-19 era, BH was forced to both re-evaluate the evidence and new COVID-19 related guidelines that support decision points of delivering telehealth based services.

In this case report, we share what BH learned, reviewing prior evidence and new COVID-19 updates and highlight potential applications to guide frontline family medicine providers in implementing telehealth visits to treat OUD.

Lesson learned:

1. A need for timely telehealth services for B/N delivery

Evidence base:

Though limited by study number, several studies have suggested that compared to participants traveling for in-person treatment, telehealth visits may be associated with treatment retention⁸ and may increase access to MOUD, particularly among patients in underserved and remote rural areas.⁹

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New COVID-19-related guidelines:

The American Society of Addiction Medicine (ASAM) has recommended use of telehealth visits (in the form of audio or video phone calls) during the COVID-era. Federal and state regulators have made this possible by relaxing regulations: On January 31, 2020, the Secretary of the Department of Health and Human Services issued a public health emergency that created an exception to allow telehealth visits to occur without an in-person evaluation; on March 6, 2020, Medicare authorized reimbursement for telehealth services; on March 15, 2020, health care providers were enabled to use non-HIPAA compliant telemedicine applications, such as FaceTime or Skype, without HHS-associated penalties. Finally, providers were authorized to prescribe B/N across state lines without obtaining additional DEA registration in the state where the medication is being dispensed.

Bicycle Health's response:

To meet increased demand for enrollment and to decrease wait time, BH converted all new intake appointments (which were previously conducted as in-person appointments) to telehealth appointments and offered same or next-day appointments to increase timely access to care.

2. A need for B/N e-prescriptions & longer duration of prescriptions

Evidence base:

While little evidence guides the duration of prescribing, prior to COVID-19, the Substance Abuse and Mental Health Services Administration (SAMHSA)¹⁰ recommends weekly appointments during early treatment. Many clinicians subsequently space patients out to twice monthly and then monthly prescriptions once patients demonstrate greater stability.

New COVID-19-related guidelines:

ASAM recommends and the Drug Enforcement Administration (DEA) has enabled the prescribing of B/N via e- prescriptions, given its safety profile and that the benefits for providing B/N outweigh the risks of patients not receiving it and subsequently relapsing and overdosing.¹¹ In the era of COVID-19, providing longer duration of prescriptions is recommended to minimize community exposure associated with retrieving prescriptions from pharmacies. The Centers for Disease Control recommends that patients maintain a 2-week supply of all medications as part of a "household plan of action in case of illness in the household or disruption of daily activities"¹² due to COVID-19. While providers may be concerned about the possibility of diversion with longer B/N prescriptions, the rate of this is much lower than that of other opioid agonists¹³ and most diverted B/N is used for self-treating opioid withdrawal rather than achieving euphoria.¹⁴

For patients who are not stable or those without access to telephones (such as homeless patients), the benefits of providing shorter prescriptions and in-person visits may outweigh risks associated with COVID exposure; however, this must be tailored to the individual's risk for a

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COVID-19 infection. In particular, those patients at highest risk should minimize community exposure, including those 65 years or older and those with chronic medical conditions including lung disease, heart disease, immunocompromised and morbidly obese (BMI >40).

Bicycle Health's response:

For new patients going through B/N induction, BH increased touchpoints through more telehealth visits and produced a simplified home induction guide to promote consistency in the home induction process. After reaching maintenance dose (usually about 1 week after induction), BH then spaced out stable patients to receive 2-week to 4-week-long B/N prescriptions.

3. A need to decrease urine toxicology testing requirements while promoting accountability

Evidence base:

There is no agreed upon standard regarding the frequency or duration of testing, though gathering a baseline drug screen prior to initiation of B/N and some form of continued drug monitoring for overall compliance is recommended.¹⁵⁻¹⁷ Additionally, the use of random (compared to scheduled) drug screens has shown significant reductions in illicit drug use and is recommended as a best practice.¹⁸ It is recommended to set the frequency of testing higher at the start of treatment, when patients are known to more frequently engage in continued drug use.¹⁷

New COVID-19-related guidelines:

In general, ASAM recommends avoiding urine drug testing in the era of COVID, given the harms associated with community exposure for patients traveling to and presenting at health care facilities and for staff who collect urine samples with limited personal protective equipment. Patients who might benefit from urine drug testing are those for whom there is suspected diversion, intoxication, overdose, or very unstable OUD. Though, clinicians can generally take other strategies to support patients, such as increasing the frequency of telehealth visits, providing daily virtual observed self-administration of B/N, leveraging family members/loved ones, and reducing the amount of B/N prescribed at once. As a general rule, any test that will not change a patient's management should be avoided.

Bicycle Health's response:

Consistent with ASAM's recommendations,¹⁸ BH uses toxicology testing to hold patients accountable and to augment their care when unexpected results are detected, thus supporting their recovery rather than using testing for putative purposes (such as discontinuing or tapering of B/N prescriptions); however, these tests are performed and interpreted without the patient leaving their house: BH ships urine cups to the patients, the patient collects a sample during their televisit, and the results are viewed via video (with a temperature indicator confirming authenticity). If the test is not completed during the appointment, providers will not fill the B/N

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prescription without a photo confirmation of the test results. In the future, BH plans to provide saliva tests to further enhance compliance.

4. Is there a need for behavioral support?

Evidence base:

While behavioral approaches for managing OUD are encouraged, previous research has demonstrated that individual counseling does not have a consistent impact above high-quality standardized medication management approaches alone.¹⁹

New COVID-19-related guidelines:

In the COVID-19 era, the associated stress and anxiety and social isolation may be a trigger for patients struggling with OUD, and they likely would benefit from enhanced mental health support. However, lack of access to individual or group-based therapy should not preclude prescribing B/N. ASAM guidelines recommend that B/N providers: do not mandate participation in counseling (virtual or in-person) in order to receive B/N, convert therapeutic support to virtual platforms when possible, and if conducting in-person group visits, limit these to 10 individuals or less in a large room where patients can engage in social distancing (ie spaced out 6 feet apart).

Bicycle Health's response:

To decrease social isolation and increase access to behavioral support, in addition to individual psychotherapeutic support previously offered, BH opened free virtual group visits facilitated by a trained behavioral health provider not only to BH patients but also anyone struggling with OUD. Patients can join at:

<https://www.bicyclehealth.com/free-opioid-support-group>.

Conclusion

This case example from Bicycle Health illustrates practical application of providing MOUD with B/N in the COVID-19 era. Understanding the evidence and current COVID-19-related guidelines can help front line primary care providers employ new approaches that support patients by providing B/N in a safe way that minimizes COVID-19 exposure risk and maximizes recovery support.

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