Carries in the post-pandemic world: What can we learn from COVID-OAT experiences?

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MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

What changed in OAT care during the pandemic?

On a global scale, 47 countries expanded take-home dose capacities for OAT during the pandemic

- Virtual care
- Medically supported isolation and shelters
- Mobile OAT
- US – SAMHSA
  - State may request blanket exceptions for all stable patients to receive 28 days of medication for OUD
  - State may request up to 14 days of take-home medication for those patients who are less stable but who the OTP believes can safely handle this level of take-home medication

US – Federal Opioid Treatment Standards

(i) During the first 90 days of treatment, the take-home supply (beyond that of paragraph (i)(1) of this section) is limited to a single dose each week and the patient shall ingest all other doses under appropriate supervision as provided for under the regulations in this subpart.

(ii) In the second 90 days of treatment, the take-home supply (beyond that of paragraph (i)(1) of this section) are two doses per week.

(iii) In the third 90 days of treatment, the take-home supply (beyond that of paragraph (i)(1) of this section) are three doses per week.

(iv) In the remaining months of the first year, a patient may be given a maximum 6-day supply of take-home medication.

(v) After 1 year of continuous treatment, a patient may be given a maximum 2-week supply of take-home medication.

(vi) After 2 years of continuous treatment, a patient may be given a maximum one-month supply of take-home medication, but must make monthly visits.

Connecticut

Table 2
Patient Level Changes in Clinic Practices During COVID-19.

Changes in clinic practices	Before COVID-19	After COVID-19	Change
Take-home Doses			
28-day take-home doses	0.1% (25)	16.8% (4076)	16,700%
14-day take-home doses	14.2% (3445)	26.8% (6499)	89%
4 to 6-day take-home doses	13.3% (3236)	15.3% (3710)	15%
3-day take-home doses	16.8% (4069)	20% (4853)	19%
2-day take-home doses	18.1% (4383)	11.5% (2789)	-36%
≤1-day take-home doses	37.5% (9103)	9.6% (2333)	−74%

No increase in methadone alone or methadone-involved fatalities

Brothers S, Viera A, Heimer R. Changes in methadone program practices and fatal methadone overdose rates in Connecticut during COVID-19. J Subst Abuse Treat. 2021 Apr 29;131:108449. doi: 10.1016/j.jsat.2021.108449. Epub ahead of print. PMID: 34098303.

Washington

Mean number of take-home doses increased from 11.4/30 days to 22.3

No differences in client demographics between those receiving increased take-home and not
Average increase 12.2 days/30 day period

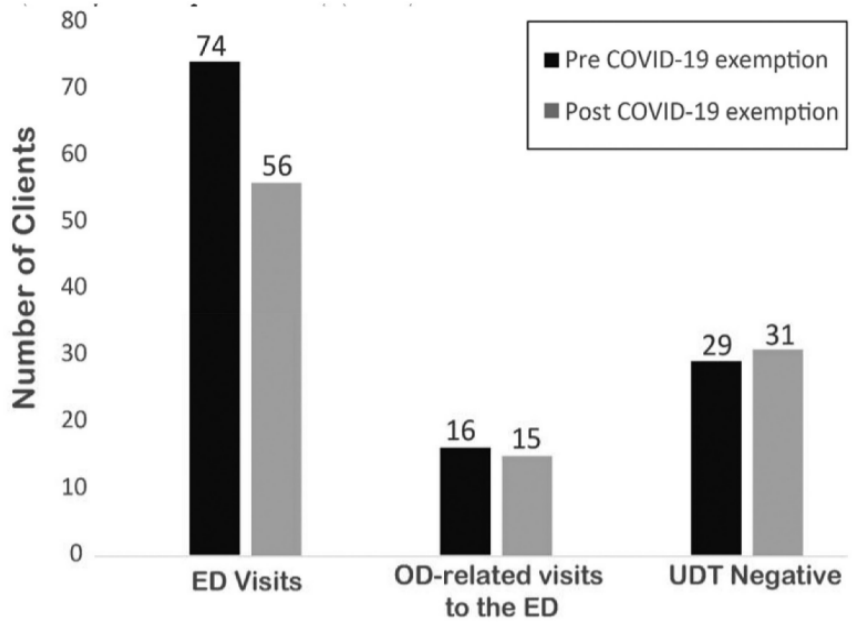

Figure 1. Change in the number of clients experiencing ED visits (p = <0.001), OD-related visits to the ED (p = 1) and negative UDT methadone results (p = .59) between the pre COVID-19 SAMHSA exemption period (270 days prior to March 1st, 2020) and post COVID-19 SAMHSA exemption (270 days after April 1st, 2020) (n = 183). ED – Emergency Department; OD – Overdose; UDT – Urine Drug Test; SAMHSA – Substance Abuse and Mental Health Services Administration

Amram O, Amiri S, Panwala V, Lutz R, Joudrey PJ, Socias E. The impact of relaxation of methadone take-home protocols on treatment outcomes in the COVID-19 era. Am J Drug Alcohol Abuse. 2021 Oct 20:1-8. doi: 10.1080/00952990.2021.1979991. Epub ahead of print. PMID: 34670453

North Carolina

- 91.6% received take home doses during the pandemic vs 68.3% at any time prior to the onset of COVID 19

  - 71.3% reported storing methadone in a locked container
  - 3.4% reported that others in the home could access their doses
  - 14.4% reported knowing someone who gave away doses to help someone else
  - Hypothetical reasons for giving away doses:
    - Needing money or drugs (38.5%)
    - Helping someone else like a friend (37.5%)
    - Saving up for travel (28.8%)

Figgatt MC, Salazar Z, Day E, Vincent L, Dasgupta N. Take-home dosing experiences among persons receiving methadone maintenance treatment during COVID-19. J Subst Abuse Treat. 2021 Apr;123:108276. doi: 10.1016/j.jsat.2021.108276. Epub 2021 Jan 8. PMID: 33612201; PMCID: PMC8060693

Ontario COVID-19 OAT Guidelines

- **Purpose:** Maintain continuity of OAT during the pandemic while supporting physical distancing measures by reducing high-contact interactions where appropriate, through:
  - Adjusting office visits
    - Frequency of visits determined by clinical need
    - Remote assessments emphasized whenever possible
  - Increased access to carries
    - Eligibility based on social stability not abstinence
    - Increases beyond usual maximums
  - Reduced frequency of UDS
    - Required only in the context of a clinical assessment

Pre-COVID-19 "Carry Level"	"Carry Ladder" during COVID-19 community transmission	Nomenclature
0 and unsuitable for carries	No carries	COV-0
0 and suitable for carries	Only non-consecutive carries (up to 3 per week) *	COV-3
1	Up to 2 consecutive carries (up to 4 per week) *	COV-4
2	Up to 3 consecutive carries (up to 5 per week) *	COV-5
3	Up to 6 carries per week	COV-6
4	Up to 1 to 2 weeks	COV-13
5 or 6	Up to 2 to 4 weeks**	COV-27***

* No clear UDS required.

**Monthly carry limits are a Ministry of Health recommendation regarding prevention of stockpiling of all medications during COVID-19.

***Irrespective of diluent (i.e., Tang, apple juice, Crystal Light or Kool-Aid), microbial growth is likely to occur after two weeks of storage at room temperature. There should be refrigeration of carries if more than two weeks are provided.

- **COV-0 to COV-5 (i.e., up to 5 carries per week; max. 3 consecutive doses):**
  - Do not require clear UDS.
  - If assessed remotely, the patient does not need to provide a UDS.
  - Positive UDS should always be a discussion point regarding safety, stability, and harm reduction. In most circumstances, level of take-home doses **should not be reduced**, if the patient remains suitable for carries. Carries may still be increased as per the "Ladder" up to COV-5.
  - The prescriber may adjust the number of carries upwards or downwards on the "Carry Ladder" as per their clinical judgment around safety.

Patients Not Suitable for Carries

- Intoxication or sedation when assessed
- Unstable psychiatric comorbidity (e.g. acutely suicidal or psychotic)
- Recent overdose
- Currently using illicit substances in high risk ways; particular caution to be exercised with methadone if patients are using alcohol or benzodiazepine in high-risk ways, or injecting high-dose opioids
- Unstable housing/unable to store carries safely

CLIENT & PRESCRIBER PERSPECTIVES ON THE IMPACT OF COVID-19 ON OPIOID USE DISORDER TREATMENT

- Collaboration between:
  - The Royal Ottawa Mental Health Centre
  - Women's College Hospital
  - Canadian Centre on Substance Use and Addiction

- **OBJECTIVE:** Assess how care delivery has been affected by the COVID-19 OAT guidelines from the client and prescriber perspectives

- Corace, Suschinsky, Wyman et al (2021). Evaluating how has care been affected by the Ontario COVID-19 Opioid Agonist Treatment Guidance: Patients' and prescribers' experiences with changes in unsupervised dosing. *The International Journal of Drug Policy.* https://doi.org/10.1016/j.drugpo.2021.103573

Canadian Centre on Substance Use and Addiction | Centre canadien sur les dépendances et l'usage de substances

WCHRI WOMEN'S COLLEGE HOSPITAL Healthcare REVOLUTIONIZED

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Method: Online survey co-designed with those with lived and living expertise and prescribers

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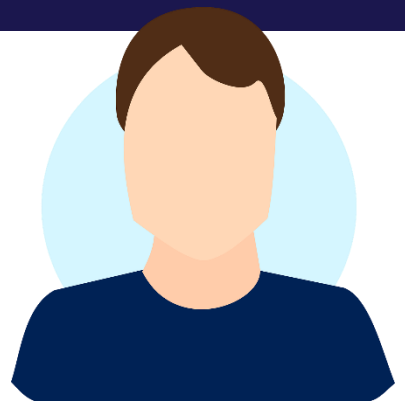
CLIENTS



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Prescribers

- Changes in the frequency of office visits and urine drug screens
- Changes in number of carries
- Perceptions of virtual care
- Awareness of the COVID OAT Guidelines
- Implementation of the COVID OAT Guidelines
- Experiences with care delivery under the COVID OAT guidelines

Background image: https://www.aislelabs.com/wp-content/uploads/2017/12/Online-survey-WiFi-login.png

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OAT Clients

Demographics and OAT Care		OAT clients
Age: % between 30 – 44 years		62%
Identify as: Male		53%
Ethnic/racial background: White		81%
Type of OAT care:	Methadone	34%
	Buprenorphine	25%
	SROM	23%
	Buprenorphine ER	18%
Started OAT:	0 – 6 months ago	31%
	6 – 12 months ago	31%

Recent Substance Use		OAT clients
Past 30 day use	Opioid use	39%
	Alcohol use	60%
	Cannabis use	29%
	Cocaine use	22%
Since March 2020, opioid use has:	Increased	49%
	Stayed the same	31%
	Decreased	20%
Past 90 day opioid injection use *(May – July/Aug, 2020)*		53%

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OAT Prescribers

Demographics		Prescribers
	Identify as: Female	62%
	What type of clinic do you work in? OAT clinic	42%
	Hospital-based clinic	34%
Professional identification	Addiction medicine physician	64%
	Family physician	46%
Extra training	Certificate of added competence	**64%**

OAT Care		Prescribers
Years in OAT practice	< 1 year	4%
	1 – 5 years	32%
	6 – 10 years	33%
	11+ years	32%
Prescribers reporting at least 50% of OAT clients are from	Urban setting	57%
	Rural setting	26%
	Remote setting	10%
	Reserve setting	8%

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	methadone prescribers *n* (%)	buprenorphine prescribers *n* (%)	SROM prescribers *n* (%)
I decreased the frequency of unsupervised doses for patients	26 (30%)	15 (18%)	5 (12%)
I prescribed unsupervised doses for patients who previously were not prescribed any unsupervised doses	58 (67%)	59 (71%)	21 (50%)
I increased the frequency of unsupervised doses prescribed in patients who had some weekly unsupervised doses	60 (70%)	67 (81%)	15 (36%)
I allowed unsupervised doses for patients where I was unsure about their social or housing stability	18 (21%)	21 (25%)	12 (29%)
I prescribed unsupervised doses only in situations where I felt their social and housing situations were stable	52 (61%)	51 (61%)	13 (31%)
Total # prescribers	86	83	42

Note: SROM = Slow release oral morphine; Prescribers were asked to note each type of OAT that they prescribe and to select each statement that applied to the type(s) of OAT they prescribe.

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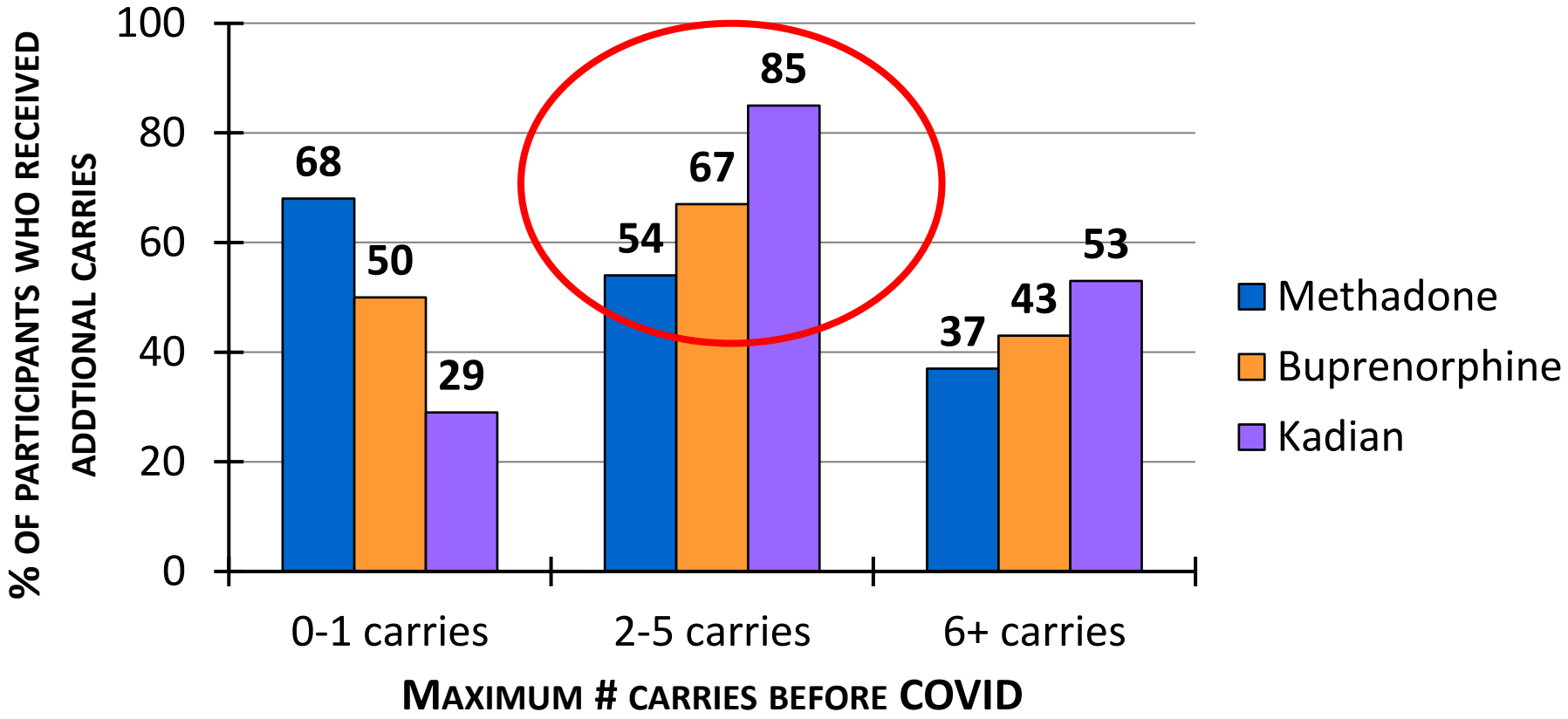
Results: Client-reported increases in carries during COVID



	N	Patients without additional unsupervised doses during the pandemic *n* (%)	Patients with additional unsupervised doses during the pandemic *n* (%)	χ^2	*p* value
Able to take unsupervised doses as prescribed	268	75 (70%)	80 (50%)	10.97	<.001
Lost or misplaced unsupervised doses	269	16 (15%)	38 (24%)	3.11	.08
Unsupervised doses were stolen	268	14 (13%)	30 (19%)	1.57	.21
Requested early refills	269	26 (24%)	50 (31%)	1.55	.21
Shared unsupervised doses with others	268	18 (17%)	104 (65%)	59.16	< .001
Traded unsupervised doses for food or other goods	268	11 (10%)	41 (26%)	9.48	.002
Experienced opioid overdose(s) with or without emergency department visit	268	14 (13%)	25 (16%)	0.37	.54
Visited the emergency department because of substance use	268	10 (9%)	15 (9%)	0.00	.98
Admitted to hospital because of substance use	265	7 (7%)	19 (12%)	2.05	.15

	Patients Without Additional Unsupervised Doses				Patients With Additional Unsupervised Doses			
	n	Disagree *n* (%)	Neutral *n* (%)	Agree *n* (%)	*n*	Disagree *n* (%)	Neutral *n* (%)	Agree *n* (%)
Changes to my OAT care have helped me to be more open with my prescriber(s)	138	13 (9%)	36 (26%)	89 (65%)	170	2 (1%)	41 (25%)	135 (74%)
I appreciated my prescriber(s) trying to protect me from COVID-19	138	11 (8%)	19 (14%)	108 (78%)	170	6 (4%)	29 (17%)	135 (79%)
Changes to my OAT care during COVID-19 made sense to me	137	11 (8%)	34 (25%)	92 (67%)	166	4 (2%)	26 (16%)	136 (82%)
I would have liked more information about the changes to my OAT treatment	137	10 (7%)	32 (23%)	92 (67%)	166	4 (2%)	54 (33%)	108 (65%)

Gomes et al. Association between Increased Dispensing of Opioid Agonist Therapy Take-Home Doses and Opioid Overdose and Treatment Interruption and Discontinuation (in press)

- During the week of March 17,2020 there was an immediate and significant increase in the percentage of Ontarians dispensed 7-13 and ≥14 methadone carries
- There was a non-significant decrease in the number of people receiving daily dispensed methadone and a significant decrease in the number of people receiving daily dispensed buprenorphine
- Dispensing of increased take-home doses was significantly associated with lower rates of treatment interruption and discontinuation
- No statistically significant increases in opioid-related overdoses

What about post-pandemic carries?

Flexibility:

- Patient-centered care
- Opportunity to increase engagement and retention
- Destigmatizing methadone and OUD

Regulation:

- Safety – individual and community
- Legal and emotional liability for prescribers
- Increased reliance on clinical judgement
- Structure
- Contingency Management

Clinical Assessment of Suitability for Carries

- Primarily a clinical assessment that relates to social stability and an individual's ability to manage carries safely rather than a clear UDS
- Patients who continue to use substances, including opioids, can receive carries unless they are at high risk/not suitable based on the following criteria
- Patients require safe storage for carries (i.e. a locked box) and safe housing

Carry Assessment: First Principles

- Safe Storage (housing + ability to store and manage medications)
- Clinical stability:
  - Receiving a majority of doses
  - Attending appointments regularly
  - No recent overdoses
  - Not presenting with sedation or intoxication
  - No unstable psychiatric comorbidity (not acutely suicidal or psychotic)
  - Not using substances in high-risk ways; e.g. not injecting fentanyl, not using alcohol or BZDs in high-risk ways
- Minimum duration on OAT? Progression?

Questions and Considerations:

- How much structure do prescribers want?
- How much structure do patients want?
- Is there still a role for contingency management?
- How does this fit/prompt "reform" of MMT more broadly?
- How do you see buprenorphine and SROM fitting this model?
- How can we evaluate the impact of changes in carry prescribing?

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