COVID-19 OAT Guidance Implications for OAT Care

Jennifer Wyman, MD

January 12,2022

Context – March 2020

- People who use opioids are a priority population affected by COVID-19
- Opioid Agonist Therapy (OAT) is gold standard of care for Opioid Use Disorder treatment
- COVID-19 interrupts access to and delivery of treatment
- Ontario COVID-19 OAT Treatment Guidelines were developed to facilitate safe access to care and continuity of care during the pandemic, while supporting physical distancing

Context – March 2020

COVID-19 - Opioid Agonist Treatment Guidance

CAMH / META:PHI / OMA - This version March 22, 2020

This document will be reviewed and updated as the COVID-19 pandemic evolves. Please check for the most recent version on the CPSO and META:PHI websites.

Purpose and scope:

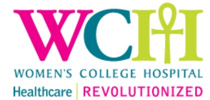
- This document provides a consensus interim guideline for management of opioid agonist therapy (OAT) with methadone and buprenorphine. It addresses office visits, remote visits, carry doses, and frequency of urine drug testing during the COVID-19 pandemic in light of the need for physical distancing, self-isolation, and quarantine while there is community transmission of COVID-19 in a prescriber's area of practice.

- This document supplements existing standards and guidelines and is a resource for practitioners who are clinically proficient in the prescription of OAT. It is not a general guide to prescribing OAT.

- Guidelines are to be used to provide guidance. They are not a standard, are not to supersede clinical experience/decision making skills, and are not intended to limit the scope of one's clinical practice.

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



Guiding Principles

- It is essential that patients have access to OAT during the pandemic
- Exceptional OAT carries can be considered as a way to provide ongoing care that balances the facilitation of physical distancing with considerations of individual and community safety
- Some patients who might not have been considered eligible for methadone carries under CPSO MMTG may receive carries
- Buprenorphine carries can be considered differently than methadone carries given the difference in safety profile
- UDS and contingency management can be de-emphasized
- In most instances patients can be assessed remotely; UDS can be collected at the time of a clinical visit and when relevant to care

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

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

Table 1: Methadone Carries

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.

- **COV-6 to COV-27:**
  - Patient should generally provide a UDS when each prescription ends; clear UDS are generally expected given the safety issues associated with 6 or more carries.
  - Positive UDS should prompt a discussion regarding safety, stability and harm reduction. Carries do not need to be reduced in light of a "slip" or isolated non-problematic use as long as the other parameters of stability remain intact. If the patient is less stable, carries can be reduced to COV-5 or less.
  - For some patients with long-term stability (including long-term clear UDS), it may be appropriate to prescribe up to 6 or more carries on an ongoing basis, with remote assessments without UDS.

Study: Evaluating the Impact of the Ontario COVID-19 Opioid Agonist Therapy Guidelines

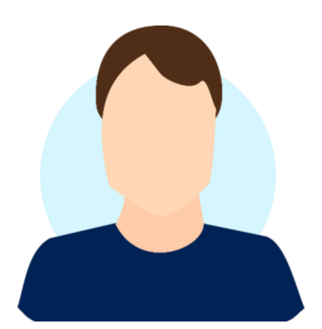
- Collaboration between:
  - The Royal Ottawa Mental Health Centre
  - Women's College Hospital
  - Canadian Centre on Substance Use and Addiction

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

METHOD: ONLINE SURVEY CO-DESIGNED WITH THOSE WITH LIVED AND LIVING EXPERTISE AND PRESCRIBERS

354

CLIENTS



76

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

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%

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%

Results: Prescribers' awareness, implementation, and opinions of the Interim Guidelines

- 93% of prescribers had read the Interim Guidelines
- Of the prescribers who read the Interim Guidelines:
  - 99% reported changes in prescribing carries as a result of the Interim Guidelines
  - Most supported the changes in Guidelines
    - 79% agreed that the Interim Guidelines were reasonable and balanced
    - 69% felt the Guidelines provided the right amount of structure for allowing prescribers to use clinical judgment for decision making

RESULTS: REPORTED CHANGES IN FREQUENCY OF CLIENT OFFICE VISITS AND URINE DRUG SCREENS

% OF PARTICIPANTS	Office visit: Clients' self-report	Office visit: Prescribers' self-report	Urine drug screen: Clients' self-report	Urine drug screen: Prescribers' self-report
Decreased	24.8	50	19.3	59.2
No Change	51.6	40	51.4	23.7
Increased	23.6	9	21.6	14.5

RESULTS: CLIENT-REPORTED INCREASES IN CARRIES DURING COVID

58% of clients received additional carries during COVID

RESULTS: CLIENT-REPORTED INCREASES IN CARRIES DURING COVID

% OF PARTICIPANTS WHO RECEIVED ADDTIONAL CARRIES

MAXIMUM # CARRIES BEFORE COVID	Methadone	Buprenorphine	Kadian
0-1 carries	68	50	29
2-5 carries	54	67	85
6+ carries	37	43	53

Results: Prescriber-reported changes in carries

- Most prescribers (66-76%) prescribed carries to patients who previously were not prescribed any carries.
- Most prescribers (49-91%) prescribed additional carries to patients who already had carries prior to COVID.
- Fewer prescribers (14-33%) decreased the frequency of carries for their patients.

Max # Consecutive Carries	Pre-COVID *(median; range)*	During COVID *(median; range)*
Methadone	**10** *(range = 2 – 35)*	**13** *(range = 1 – 56)*
Buprenorphine	**13** *(range = 0 – 46)*	**15** *(range = 0 – 60)*
SROM	**5** *(range = 0 – 29)*	**6** *(range = 0 – 30)*

RESULTS: RESPONSES TO CHANGES IN CARE DELIVERY

- Most client… …nges in care
- Most clie… …e, but there is r…
- Clients repo… …additional carries

Additional carries

were not associated with self-reported adverse health outcomes:

- No ↑ in opioid overdose
- No ↑ in emergency department visits
- No ↑ in hospitalizations

Conclusions and Implications

- Ontario COVID-19 OAT Treatment Guidelines allowed for balance between protection and safety in maintaining continuity of care
- Changes in care delivery not associated with self-reported adverse health outcomes
- Most clients and prescribers responded positively to changes in care delivery
- Study limitations impact generalizability of findings
- Policies and supports to reduce barriers to OAT care post-pandemic should be implemented
- Results support the need for equitable access to quality virtual care for all

Where do we go from here?

- August/21 update – essentially suggested that patients could expect carry and practice protocols to return towards pre-pandemic approaches
- -”may” reintroduce elements of contingency management
- For patients who have achieved or are maintaining stability on extended or “exceptional” carries, prescribers should consider maintaining this approach. It may also be appropriate to continue this practice for patients who have remained stable without regularly providing urine samples.

- Jan/22 – pandemic, publications supporting no increase risk with take home dosing
- ->reinstate COVID guidance (see Jan 22 updated COVID OAT guidance)
- >move towards more permanent flexibility

Suggested criteria

- 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

References

- Corace K, Suschinsky K, Wyman J, Leece P, Cragg S, Konefal S, Pana P, Barrass S, Porath A & Hutton B. (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*, 103573–. https://doi.org/10.1016/j.drugpo.2021.103573
- 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.* 2021:1-8.
- 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 Dec;131:108449. doi: 10.1016/j.jsat.2021.108449. Epub 2021 Apr 29. PMID: 34098303.

- College of Physicians and Surgeons of Ontario. Methadone maintenance treatment program standards and clinical guidelines. Toronto, ON: College of Physicians and Surgeons of Ontario; 2011.
- COVID19 OAT Guidance Update January 2022
- http://www.metaphi.ca/wp-content/uploads/COVID19_OpioidAgonistTreatmentGuidance_Jan2022Update.pdf