Foundation *for* Opioid Response Efforts

April 2023
Issue Brief

How Have Covid-Era Flexibilities Affected OUD Treatment?

Reports from Providers and Patients

To sustain access to treatment for opioid use disorder (OUD) during the coronavirus pandemic, federal policymakers changed some of the regulations governing the prescribing and use of medications for OUD (MOUD). In particular, the flexibilities introduced in the spring of 2020 meant:

- Providers could give up to 28 days of methadone take-home doses to patients deemed stable and up to 14 days of doses to patients deemed less stable. Typically, methadone patients must visit opioid treatment programs for daily dosing, though federal guidelines in place before the pandemic allowed minimal numbers of take-home doses.
- Providers could use telehealth to initiate buprenorphine, eliminating the need for an in-person medical examination. In-person exams are still required for methadone induction.[1]
- Providers could use telehealth visits for medication management. The Centers for Medicare and Medicaid Services' approval of reimbursement for telehealth led many providers to adopt virtual visits for counseling and other services as well.

These policy changes — which are still in place as of March 2023 — are notable because before them, the federal regulations governing opioid use disorder treatment hadn't been substantially changed in decades.

FORE made a series of grants in 2020 and 2021 to track the impact of these new flexibilities on access to OUD treatment. In this issue brief, we report on what the grantees learned about how the changes affected patients and providers as well as variations in their implementation and adoption across states. Findings from these projects hold lessons for policymakers who are now considering whether to retain these flexibilities and what else may be needed to bring lifesaving treatment to more people.

1 In February 2023, the Drug Enforcement Agency proposed preserving this flexibility, though patients would need to be seen in person by a provider within the first 30 days of taking buprenorphine.

KEY TAKEAWAYS

1 FORE-funded researchers found that there were few negative, unintended consequences of loosening restrictions on opioid use disorder (OUD) treatment during the pandemic: providers did not report substantial increases in drug diversion, overdoses, or patients dropping out of treatment.

2 Because the treatment changes were voluntary, not all providers adopted them and not all patients benefitted. Two studies found racial disparities in access to take-home doses of medications for OUD.

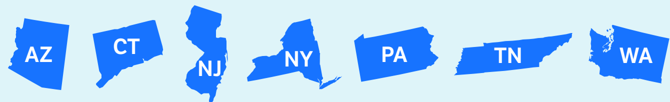
3 Making it easier to access medications can improve OUD patients' quality of life and help them stay in treatment. Regulatory changes are necessary but not sufficient to expand access.

How COVID-Era Treatment Flexibilities Affected OUD Patients and Providers

FORE grantees surveyed:

Nearly 500
patients taking medications for opioid use disorder

Nearly 400
providers serving MOUD patients



They heard from patients and providers in seven different states

TREATMENT CHANGES PRESERVED ACCESS, IMPROVED QUALITY OF LIFE

Overall, the researchers found that there were few negative, unintended consequences of loosening restrictions on OUD treatment: providers did not report substantial increases in drug diversion, overdoses, or patients dropping out of treatment.

Grantees at Rutgers University interviewed 21 MOUD providers in New Jersey during the fall of 2020 and later interviewed 22 providers in 2021 and 2022. During the first few months of the pandemic, most providers had shifted to telehealth, were dispensing more take-home doses of methadone, and had reduced the frequency of drug screens and counseling. Still, they were able to keep patients engaged in treatment. “The policy changes really did help ameliorate the negative effects and helped people stay in care,” says James Lloyd, JD, MPP, research specialist at Rutgers’ Center for Health Services Research.

During the summer of 2021 and then again in the fall of 2021, grantees at the University of Pittsburgh interviewed 175 staff members at 42 of Pennsylvania’s Opioid Use Disorder Centers of Excellence, specially designated providers that offer MOUD alongside other clinical services and social supports. As in New Jersey, Pennsylvania providers reported that seeing patients for fewer in-person visits hadn’t led to overdoses or relapses, as some had feared. Still, a few reported that having fewer toxicology screens led to breakdowns in trust with some patients and engendered concerns about illicit drug use; in some cases, staff went to patients’ homes to perform the screenings.

Another grantee, Ayana Jordan, MD, PhD, associate professor of psychiatry at the New York University Grossman School of Medicine, worked with a team of researchers to interview 358 patients being treated with methadone at six opioid treatment programs of differing types (e.g., for-profit, nonprofit, part of the Veterans Administration, independent, and part of a large academic health system) in different parts of the country. The majority (63%) of patients reported they were able to keep their methadone safe in locked cases. Among those who had a preference between taking home some methadone doses or visiting the clinic each day, a majority (69%) said they preferred take-home doses. In rural areas in particular, people said that having take-home doses made it easier to work, meet family responsibilities, and keep themselves safe from COVID-19. They also appreciated not having to travel as often or as far to their opioid treatment providers.

NOT ALL PATIENTS BENEFITTED EQUALLY

Because the treatment changes were voluntary, not all providers adopted them at all, or in the same ways, and not all patients benefitted. Some patients struggled to take part in telehealth visits because they didn't have reliable Internet connections. In Pennsylvania, some providers gave patients phones with prepaid minutes or other devices to make it easier for them to take part in telehealth visits. Still, in Pennsylvania and elsewhere, providers expressed concerns that not all patients were able to participate in virtual visits.

For another FORE grant, field researchers with drug use experience interviewed 131 people taking MOUD in Arizona about their experience of treatment during COVID-19. Most of them (71%) said they took part in telehealth visits, but the majority had to come into clinics for video visits with their providers, who were themselves off site. Before the pandemic, the state shifted to payment parity for in-person and virtual visits for Medicaid patients.

The researchers also found that 40 percent of MOUD patients had health conditions that put them at high risk should they develop COVID-19. And for methadone patients, the situation was even more grave: "Over half of methadone patients who were at high risk for severe outcomes of COVID were required to come to the clinic daily to receive their medication," says Beth Meyerson, MDiv, PhD, one of the principal investigators on the FORE grant and professor and director of the Harm Reduction Research Lab in the Department of Family and Community Medicine at University of Arizona's College of Medicine.

About half of the methadone patients were offered some take-home doses, but none were offered the full 14 or 28 days' worth. Over time, some patients reported that their clinics stopped offering any take-home doses at all.

Other FORE grantees looked at racial disparities among MOUD patients served at OUD treatment providers at the onset of the pandemic. Thomas D'Aunno, PhD, a professor of management at New York University's (NYU) Wagner Graduate School of Public Service, and Charles J. Neighbors, MBA, PhD, associate professor of population health at the NYU Grossman School of Medicine, found white patients across New York State used telehealth counseling more than Black and Hispanic patients. They also found opioid treatment programs in New York that had relatively more Black patients were less likely to allow patients to take their medication home for self-administration.

> There's an assumption of parity in opioid treatment programs (OTP) because OTP patients are disproportionately racial and ethnic minoritized individuals. But the results of our study indicate there's inequity in who receives take-home doses."
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> – **Ayana Jordan, MD, PhD, associate professor of psychiatry at the New York University Grossman School of Medicine**

In five of the six opioid treatment programs Jordan and her colleagues investigated, more white patients than patients of color had access to take-home methadone doses. With no evidence that programs were using nationally standardized protocols to decide which patients were clinically stable, Jordan theorizes that these differences may have been mediated by interpersonal racism, with providers more likely to view white patients as reliable: "My hypothesis is that our ideas about who is going to be a good steward of the medication is very much influenced by our own racialized biases."

EARLY ADAPTATIONS WERE NOT SUSTAINED

As the pandemic wore on, many OUD providers reverted to business as usual.

Some OUD providers stopped offering as many, or any, telehealth visits. Some staff reported fatigue with virtual visits, saying they disrupted their bonds with patients. Others worried that the growing lethality of the drug supply made it more important to see patients in person. In New Jersey, some patients said they missed the routine and structure of having in-person visits, including group counseling.

Jordan found that some of the opioid treatment programs stopped offering take-home doses of methadone for reasons related more to finances than patients' clinical stability; one program had lost revenue because of having fewer in-person visits and procedures.

LESSONS FROM THE COVID ERA FOR POLICY AND PRACTICE

Several lessons emerged from this rich body of research.

Federal regulatory changes are necessary but not sufficient to expand access to treatment.

Many of the clinics surveyed only partially or temporarily implemented treatment changes during the pandemic, for reasons related to inertia, risk aversion, financial incentives, bias, and the belief that the therapeutic bond requires frequent, in-person visits, among other factors. Particularly at methadone programs that have functioned in the same manner for decades, providers were reluctant to change their approach during what some saw as a temporary situation.

In addition, states had discretion regarding whether and how to support the federal regulatory changes. Some states including New Jersey and Pennsylvania put resources behind the COVID-era policy changes. For example, through New Jersey's two Medication-Assisted Treatment Centers of Excellence, providers could access training and technical assistance about MOUD and COVID-related policy changes. State officials also offered detailed guidance and communicated regularly about the new flexibilities. Other states placed less attention on the new regulations, which appeared to affect providers' behavior. "If there's regulation without any enforcement, then we will continue to have this bifurcated system where people who are from minoritized backgrounds are not given parity," Jordan says.

To improve outcomes and address disparities, we need better data.

Monitoring the effectiveness of changes in OUD treatment policy and practice requires timely and actionable data. Stephen Crystal, PhD, distinguished research professor at Rutgers' Center for Health Services Research, noted that much of the data on drug use and access to treatment are out of date by the time they're acted on: "We are always the generals fighting the last battle," he says. And it's not clear we're measuring the right things, for example how patients do over the long term and what mediates racial and ethnic disparities.

Jordan found some of the opioid treatment programs lacked electronic medical records and had varying systems for collecting data. More standardized and public reporting of treatment processes and outcomes could be used to hold providers accountable, Crystal says — an approach used by campaigns that successfully changed longstanding clinical practices, such as one that reduced prescribing of antipsychotics among nursing home residents. At the very least, we need to remove disincentives and stigma that discourage too many providers from treating OUD patients. “Right now, there is more risk in treating MOUD patients than not,” Crystal says. “There is no risk in abandoning your pain patient.”

Regulations should be flexible.

Making it easier to access MOUD during the pandemic improved the quality of life for many patients and helped them stay in treatment. And most providers appreciated having greater autonomy to decide how and when they needed to see patients, just as some patients felt empowered by having more responsibility to manage their treatment. But researchers also heard from providers that they wanted to retain the ability to customize treatment to patients’ needs. “With 25 years’ experience as an addiction psychiatrist, it’s clear one size doesn’t fit all in substance use treatment,” says Antoine Douaihy, MD, professor of psychiatry and medicine at the University of Pittsburgh.

Patients, too, wanted flexibility. When asked what they would like to change about their opioid treatment provider if they had a “magic wand,” many patients in Arizona said they’d like to have multiday doses of methadone, since having to visit the clinic for daily dosing interrupted their work and home lives. Some advocated for pharmacy dispensing of methadone, or home-delivery options. Meyerson and her colleagues are now partnering with people with lived experience of drug use and harm reduction organizations as well as MOUD providers and patients to pilot a new approach to treatment that is grounded in shared decision-making among patients and providers.

Culture change and leadership are needed.

Ultimately, changes in providers’ behavior are likely to be driven from within their organizations, says D’Aunno. “To change providers’ behavior, you need to change their beliefs and values, rather than focus on financial incentives or regulations you can change. None of that works in comparison to having a leader on the ground who is a believer, who knows how to bring change.”

FORE is a national, private, grantmaking foundation focused on inspiring and accelerating action to end the opioid crisis.

We are committed to convening and supporting partners advancing patient-centered, innovative, and evidence-based solutions to make the greatest impact on the crisis.

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