Ensuring Access to Care in Opioid Treatment Programs

The ongoing COVID-19 pandemic is presenting significant challenges for opioid treatment programs as they seek to continue to provide quality addiction treatment while minimizing patient, staff, and community risk for COVID-19. This resource is intended to provide guidance on the issues that OTPs should consider as they navigate the COVID-19 crisis.

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Reopening Considerations

While many places across the country are starting to relax physical distancing restrictions, the COVID-19 pandemic is not over. Communities and treatment programs across the country remain at risk for increasing population prevalence over time. Providers and programs should continue to implement policies and procedures to reduce the risk for coronavirus transmission, based on national scientific guidance and informed by the available data and guidance in their state and local areas. In addition, clinicians and clinical programs should prepare for potential spikes in transmission in their community and program. Programs and providers should consider:

- Maintaining or implementing an incident command structure to prepare for and address any issues that arise due to COVID-19
- Reviewing current infection control processes, including the extent to which staff and patients are adhering to them.
- Assessing what worked well in your initial response and where there may be room for improvement, updating related policies and procedures as needed.
- Assessing your program or practices' potential needs related to:
    - Personal protective equipment and other supplies needed to control and mitigate the spread of the coronavirus.
    - Staff training
    - Staff support

- o Technology to support telehealth
- Addressing the evolving phases of the epidemic and how to prepare for the next stages in your community.

Remaining Open and Available to Patients

It is imperative that Opioid Treatment Programs (OTPs) remain stable sources of treatment for patients taking methadone or buprenorphine for opioid use disorders. The COVID-19 crisis has not diminished, and may have the effect of worsening the opioid crisis. OTPs are healthcare facilities providing vital healthcare services and have been deemed by SAMHSA as essential. Despite the challenges and limitations that COVID-19 places on OTPs, ASAM shares the mission of continuing to provide quality, life-saving treatment to all patients who need it.

Each patient should be reassured that their treatment program will remain open and that every effort will be made to continue their medication, peer support, case management, and counseling throughout this crisis, even if not in the traditional manner.

However, the unique nature of OTPs requires people to present in-person to a clinical site at a higher frequency than most other ambulatory treatments. Therefore, OTPs should actively develop protocols to safeguard their patients, staff, and community from spread of Covid-19. See ASAM's guidance on Infection Mitigation in Outpatient Settings.

In the process of planning for and implementing procedures to maintain ongoing operations, it may be useful to draw on emergency plans that all OTPs are required to have as part of federally mandated accreditation. However, even these plans may be lacking given the unprecedented nature of the COVID-19 crisis.

Continuing operations during the COVID crisis may require different processes based on several considerations:

- Clinic size and staffing resources
- County or city-level community resources
- Patient population characteristics

For example, larger OTPs with more staff may elect to stagger schedules for counseling, nursing, medical, and other staff to provide ongoing coverage of services but minimize the exposure of all staff at one time to possible work-related COVID-19 viral transmission. They may also need to stagger when patients present to clinic, either over the course of the day, week, or month. Smaller OTPs may not have the luxury of staggering staff and may need to consider alternatives. For example, the CDC recommends that "asymptomatic healthcare professionals who have had an exposure to a COVID-19 patient" may continue to work "after options to improve staffing have been exhausted". (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

With increasing community spread OTPs will need to consider how to continue serving patients at higher risk for infection. This may be particularly important for OTPs in areas without much in the way of community resources for isolating homeless patients with COVID-19 illness or providing alternative medication delivery systems. Strategies may involve establishing alternating days or separate times of day for patients who are considered at high risk for infectiousness, including those who are not able to physically isolate, those with respiratory symptoms, those recently released from incarcerated settings, and those who live in congregate shelter settings. The other days or time blocks would be reserved for visits by patients who are likely at lower risk of infectiousness. Alternatively, depending on the layout of the facility programs may provide separate physical spaces for patients at low vs. high risk of infection, including separate waiting spaces, separate areas for dosing, and separate rooms for clinical encounters.

With increasing use of telehealth and take-home dosing, OTPs may be able to stagger appointments such that they can space out patients six (6) feet apart across OTP waiting rooms, lobbies, and medication dispensing areas. These distances could be marked out with painters' tape on the floor and chairs should be placed 6 feet apart. Ensure that hand sanitizer is accessible in multiple points throughout the facility and clean frequently touched surfaces often, at least once a day.

Finally, no matter the processes any OTP puts in place to reduce the risk of COVID-19 transmission among patients and staff, the less time a patient spends in face-to-face contact with other persons inside and outside the facility, the lower the risk of COVID-19 viral transmission. This point should serve as a guiding principle for continuing OTP operations during the COVID-19 crisis.

Implementing Processes for Managing and Responding to COVID-19

Given the complexity of challenges associated with the COVID-19 response across the anticipated phases of this pandemic, all OTPs appoint and implement a dedicated management team with clearly defined roles and responsibilities to manage the planning and implementation of the program's preparations and response.

Policies and Procedures to consider:

For example, OTPs could consider implementing an incident command system to manage and coordinate the program's response. Whether a formalized incident command system is used or not, any

dedicated management team should include a hierarchy with clearly defined roles and responsibilities within specific areas including overall leadership, safety, communications, operations, and any other key function needed by the organization to effectively manage the response. For example, coordination with recovery/transitional housing providers may need a point person.

See example structure in appendix 1.

The dedicated management team should develop processes for regularly evaluating the impact of the crisis and developing updated policies and procedures to adapt to the evolving situation. Relevant information that may be helpful to track for planning staffing and other resources include:

- Number of patients with known or suspected infections
- COVID-19 related morbidity and mortality among the OTPs clinic population
- Staff and patients with potential exposure under isolation or quarantine
- Staff and patients in high risk categories for severe COVID-19 illness
- Changes in community spread
- Number of patients due in the next day.

Dedicated staff should be tasked with monitoring and managing supplies. The management team should define what supplies are essential to program functioning and implement processes for tracking and managing these supplies.

The management team should also work to rapidly develop updated policies and procedures needed to adapt to the COVID-19 crisis. For example:

- Infection control and mitigation procedures
- Transitioning to telehealth whenever possible
- Updated clinical procedures related to take home dosing, dosage changes via telehealth, drug testing, etc.
- Process for reviewing staffing daily and modifying schedules if needed to effectively provide care
- Communication with staff, patients, and caregivers
- Tracking patient hospitalizations and adjusting care as needed
    - Programs should be able to track patient emergency department visits and hospitalizations in their state or local health information exchange (HIE)
    - Programs may need processes in place to confirm hospital doses
    - Programs should also have processes in place to keep patients who have been hospitalized separate from other patients since the hospital poses a risk for COVID-19 exposure.

Unanticipated and unplanned for issues will arise as the crisis evolves. The dedicated management team should provide efficient ways for identifying and rapidly addressing challenges that arise in real time.

Overview of Federal Regulatory Changes

Federal agencies have been rapidly releasing guidance to provide flexibility to healthcare providers during the COVID-19 emergency. Guidance relevant to OTPs are listed below. Links to the relevant web sites and documents can be found by clicking on the section titles.

Enhanced Flexibility for Take Home Medication for OTPs (SAMHSA)

On March 19, SAMHSA issued updated OTP guidance indicating that states may request blanket exceptions for all stable patients in an OTP to receive 28 days of Take-Home doses of the patient's medication for opioid use disorder. That OTP guidance also notes that states 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.

Also, on March 19, SAMHSA issued a set of FAQs clarifying how telehealth can be used for patients being treated in OTPs. Specific questions that SAMHSA addressed in the FAQ are listed below. The detailed responses are provided in the FAQs under Resources at the end of this section.

- At this point, new patients being admitted to an OTP for OUD must receive a physical face–to–face evaluation if they are going to be treated with methadone.
- SAMHSA, however, has exempted OTPs from the requirement to perform a physical face-to-face evaluation for any new OTP patient who will be treated with buprenorphine (presumably when ordered and dispensed under OTP rules (see the caveat below regarding DEA guidance), if a program physician, primary care physician, or an authorized healthcare professional under the supervision of a program physician, determines that an adequate evaluation of the patient can be accomplished using telehealth (including use of telephone, if needed). This exemption will last for the duration of the declared COVID-19 national emergency.
    - **As of March 31, 2020, similar guidance with respect to the permissibility of initiating a new patient with buprenorphine under a DATA 2000 waiver, by use of telephone, has been provided by DEA (see Resources below).**
- Practitioners working in OTPs can continue treating existing patients with methadone and buprenorphine via telehealth (including use of telephone, if needed).
- An OTP can dispense medication (either methadone or buprenorphine products) to existing patients based on telehealth evaluation (including telephone, if needed).

Resources:

- Opioid Treatment Program (OTP) Guidance: https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf
- SAMHSA COVID main page: https://www.samhsa.gov/coronavirus
- FAQs: Provision of Methadone and Buprenorphine for the Treatment of OUD in the COVID-19 Emergency: https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf
- DEA Guidance: Exemption Allowing Alternate Delivery Methods for OTPs: https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-015)%20SAMHSA%20Exemption%20NTP%20Deliveries%20(CoronaVirus).pdf
- DEA Telemedicine Guidance (March 31, 2020): https://www.samhsa.gov/sites/default/files/dea-samhsa-buprenorphine-telemedicine.pdf

Alternative Home Delivery of Methadone Through This Emergency (DEA)

The DEA has authorized alternative methods for home delivery of methadone (and buprenorphine/naloxone if dispensed through the OTP) to patients isolating during the COVID-19 public health emergency. It allows for delivery through the OTPs established chain of custody protocol for take-home medications. In addition, it allows designated staff members, law enforcement officers, or National Guard personnel to make deliveries of methadone to quarantined patients, including "doorstep" delivery using an approved lockbox. See DEA guidance on alternative and home delivery of methadone: https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-015)%20SAMHSA%20Exemption%20NTP%20Deliveries%20(CoronaVirus).pdf

OTP Guidance for Patients Quarantined at Home with the Coronavirus (SAMHSA)

This guidance addresses the designation of someone who can pick up medications and complements that of the DEA above. See SAMHSA's OTP Guidance for Patients Quarantined at Home with the Coronavirus: https://www.samhsa.gov/sites/default/files/otp-covid-implementation-guidance.pdf

Compliance with Addiction Treatment Confidentiality Regulations – 42 CFR Part 2 (SAMHSA)

SAMHSA has issued guidance related to use and disclosure of confidential information in cases of a medical emergency. SAMHSA advises that (see link to full guidance in resources at the end of this section):

- "patient identifying information may be disclosed by a part 2 program or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained."
- "Information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed by such personnel for treatment purposes as needed."

SAMHSA's guidance emphasizes that under this medical emergency exception, "providers make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients."

See SAMHSA's COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance: https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf

Telehealth Related Guidance

ASAM is tracking federal guidance related to telehealth, including the following. For details please see ASAM's Telehealth Guidance page.

- Waiver of regulatory requirements related to HIPPA compliant telehealth platforms (HHS/Office of Civil Rights)
- Expansion of Medicare Coverage for Providing Services through Telehealth (CMS)
- Flexibility for Prescribing Controlled Substances via Telehealth (SAMHSA/DEA)
- DEA Exception to Separate Registration Requirements Across State Lines.

Resources:

Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency: https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf

CMS Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Medicare Telehealth FAQ: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

DEA guidance on Telemedicine: https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dea-information-telemedicine.pdf

DEA guidance on Use of Telemedicine While Providing MAT: https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/telemedicine-dea-guidance.pdf

Flow chart on How to Prescribe Controlled Substances to Patents During the COVID-19 Public Health Emergency (DEA) : https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-23)(DEA075)Decision_Tree_(Final)_33120_2007.pdf

DEA Policy: Exception to Separate Registration Requirements Across State Lines: https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-018)(DEA067)%20DEA%20state%20reciprocity%20(final)(Signed).pdf

Comprehensive resources can be found here: ASAM's Telehealth guidance

State Regulations

Each state may have their own requirements and regulations concerning OTPs. OTPs should work closely with their respective State Opioid Treatment Authorities (SOTA). In order to allow extended take-home doses, the OTP medical director may need authorization for "blanket" privileges from the state and the individual SOTA must have received permission from SAMHSA's Center for Substance Abuse Treatment (CSAT).

Resources:

Information on state policy changes related to Medicare and Licensing can be found ASAM's Telehealth guidance.

ASAM is working to compile relevant national and state guidance here: https://www.asam.org/Quality-Science/covid-19-coronavirus/national-and-state-guidance

The Center for Connected Health Policy is compiling COVID-19 related state actions here: https://www.cchpca.org/resources/covid-19-related-state-actions

Clinical Considerations

New patients

It is critical that OTPs maintain the capability to admit new patients to treatment during the COVID crisis. It is possible that a larger influx of new patients will present during the crisis. Under current regulations, this process will look different depending on whether the patient starts on buprenorphine, naltrexone, or methadone. As usual, the choice of medication should be made through consultation between the medical provider and the patient with full informed consent.

Buprenorphine or naltrexone

Under the updated federal regulatory guidance, buprenorphine and naltrexone may be initiated during this crisis using telemedicine or telephone-based appointments. An in-person physical examination is not required. The evaluation, treatment planning, and patient education processes should be maintained at the same level as would be performed during a face-to-face encounter. This includes a complete history of substance use, past treatments and responses, periods of recovery, prior episodes of overdose, a medical history, psychiatric history, social history, family history, and review of systems.

Methadone

A face-to-face examination is currently required by SAMHSA for patients starting on methadone. During this in-person encounter, the medical provider should take steps to minimize any exposures to themselves or the patient, including having the patient wear a face mask and the provider using appropriate PPE, if available. Based on CDC recommendations for healthcare providers and the extent of community spread of COVID-19 virus in the area, these precautions would include a face mask, face shield, gloves, and a gown.

Dosing titration is more complex with methadone than with buprenorphine, and during the initiation phase it may not be appropriate to give take home doses, even though this would be permitted under the emergency federal guidance. Close follow up and medical assessment is necessary during initiation in order to mitigate the increased risk of adverse events, including overdose, that patients are exposed to during this phase. Therefore, the OTP medical director, working in conjunction with other OTP clinicians, must thoroughly weigh the risks of COVID-19 illness and exposure with the risk of inadequately treated OUD and the risk of methadone-related harms.

Extended take-home doses

OTPs should consider giving extended take-home doses when clinically appropriate. SAMHSA's emergency guidance now allows for up to 14 to 28 days of take-home doses. Caution should be used in applying these allowances on a "blanket" basis. Rather decisions should be made on an individual patient basis with documentation of the rationale (risk/benefits). Providing more take home doses without requiring frequent in-person visits is likely to reduce risk of exposure to COVID-19. The benefit to the patient, peers, staff and the community of fewer clinic visits for dosing must be balanced against the risks of taking additional doses home in terms of adverse effects to patients and those around them.

Using the 8 decision criteria for dispending methadone for unsupervised use under 42 CFR Part 8.12 (h)(4)(i)2, the patient's stability should be assessed. Patients still using other CNS depressants such as other opioids (particularly fentanyl), benzodiazepines, or alcohol may be at higher risk and may not be ideal candidates for extended take-home doses. Other considerations may include:

- The patient's ability to safely secure and store medication.
- Home environment and availability of a responsible adult in the home who can help the patient appropriately manage take home medication.
- The presence of concerning symptoms consistent with COVID or recent potential exposures.
- The risk to the patient associated with an-in person visit
  - Are they at high risk for severe COVID-19 illness?
  - Are they living with or caring for someone at high risk?
  - Would they need to take mass transit to the visit?
  - What is their level of anxiety around coming to an in person visit?

Based on this risk benefit analysis, the provider should determine if additional take-home doses are appropriate, and how many. This plan can range from having the patient come in every other day instead of daily, to giving the full 28 or 14 days (depending on whether the patient is considered stable or less stable), or anything in between. Programs should also work to structure patient visits such that they spend the least amount of time possible in the facility. See the *Waiting Room Precautions* section below.

Managing extended take-home doses

Patients should be educated concerning the importance of maintaining their medication securely and away from children and pets. They should be given clear dosing instructions and they should be counseled on the risk of overdose if they take more than their prescribed dose, or if they combine opioids and other CNS depressants, especially benzodiazepines and alcohol. They should also be reminded that the program cannot replace lost or stolen doses.

Some patients may be able to work with other trusted family members or a significant other to help monitor their doses, although it is important to be vigilant for dysfunctional or abusive family situations. If appropriate and the patient consents, the program should provide guidance and education to a responsible adult in the home who can help the patient appropriately manage take home medication. This guidance should include education on safe storage, overdose risk, appropriate dosing, chain of custody procedures, and use of rescue naloxone.

Consistent with ASAM's public policy recommendations, all patients should be given access to naloxone rescue kits and instructions on how to use them. Preferably, the naloxone would be dispensed at the OTP, but if this is not possible then it may be accessed through local pharmacies. However, many pharmacies do not stock naloxone. The program should consider working with a local pharmacy or local naloxone distribution programs to ensure that their patients have the ability to fill the prescriptions they are given. Lack of insurance or co-pay requirements can also hinder access to naloxone, and the program should follow up with patients to see if they were able to access naloxone.

All patients granted extended take-home doses should have their contact and emergency contact information reviewed and updated.

Assessing patients who have extended take-home doses

Some patients given extended doses at home will do well and others will struggle. It is important that counselors and OTP medical staff keep in contact with the patient on a regular basis, via phone or telemedicine (including video connection to the patient's own device). During these contacts the counselor should assess whether the patient has been able to store and take his/her medication

correctly, assess the patient for triggers or cravings, assess for any new major stressors, and reinforce social distancing measures. Medical providers should contact patients regularly to assess for responses to medication, review medication lists, and identify any potential side effects such as sedation or constipation. If a patient is not doing well, it is important that she or he be brought back into the clinic and a new treatment plan developed, with potentially fewer take-home doses and/or more intensive home monitoring.

Considerations for In-Person Visits

Patients who are relatively stable can be managed by telemedicine. Those who are unstable may be better served by a face-to-face visit, again balancing the risk of COVID-19 exposure with the benefit of in-person compared to telemedicine contact. Examples of instability that would warrant an urgent in-person visit might include suicidal thoughts, new homelessness, interpersonal violence, difficulty dealing with the pandemic, or involvement of child protective services. For stable patients, the risk of in-person visits is likely to outweigh the benefits of such visits. OTP personnel must use their clinical judgment in determining when an in-person visit may be beneficial.

Managing Clinic Visits

Measures should be taken to help patients maintain 6+ foot social distancing when coming to the clinic to pick up their doses and/or for follow up visits:

- Limit the number of patients who can enter the waiting room at a given time (see *Waiting Room Precautions* section below).
- Consider using larger rooms to facilitate social distancing as available.
- Place furniture and/or markings on the floor to manage patient flow and maintain 6+ feet of distance.
- Consider having patients wait outside (6+ feet apart) until it is their time to dose. Using online sign in and queue management, such as 'take a number' protocols, may help with this process.
- Consider assigning dosing blocks and expanding dosing hours in order to spread out traffic.
- Consider alternate dosing areas, such as dosing patients in their cars when appropriate, especially for high-risk patients or those with symptoms or known COVID-19 illness who are unable to isolate or for whom alternate medication delivery is unavailable.
- Consider scheduling appointments to minimize interactions between patients at high risk for COVID infection and those with lower risk. For example, patients at high risk of infection may be seen on different days, or at alternate times, than patients at lower risk. If such strategies are used, thoroughly cleaning patient areas and clinic facilities often and between patient days or time blocks is critical.
- Mobile dispensing units may be used for prescribing buprenorphine (new mobile dispensing units for methadone are not currently being approved by the DEA).
- Home deliveries may be made in selected circumstances. Resources:
    - See DEA guidance on alternative and home delivery of methadone: https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-015)%20SAMHSA%20Exemption%20NTP%20Deliveries%20(CoronaVirus).pdf
    - See SAMHSA's OTP Guidance for Patients Quarantined at Home with the Coronavirus: https://www.samhsa.gov/sites/default/files/otp-covid-implementation-guidance.pdf

For in-person encounters within 6 feet, current public health guidance is that patients and clinicians should both wear a mask. After the visit, both patient and clinician should wash their hands and the room should be cleaned between uses.

Also see ASAM's guidance on [Infection Mitigation in Outpatient Settings](#)

Managing Telehealth Visits

It is very important to maintain close contact with patients during this time of stress, anxiety, and social isolation. Telehealth, including both telephone based and audio-visual based check-ins and visits, are an important way of staying connected with and managing patients. Federal regulations have been relaxed during the COVID-19 pandemic to facilitate the use of telehealth, including allowing providers to use non-HIPAA compliant technologies such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype. These changes should make it easier to rapidly transition to telehealth.

Communication with patients is key during any transition to telehealth services. Programs should work with patients to make sure they understand how to join a telehealth visit and should be prepared to adapt to any technical issues that arise. See guidance from the National Council on Best Practices for Telehealth During COVID-19 Public Health Emergency: https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Telehealth_Best_Practices.pdf?daf=375ateTbd56 and the APA's Telepsychiatry Toolkit: https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit

During a telemedicine encounter, face masks should be discouraged unless there is a specific need. This can facilitate a more satisfactory connection between the patient and provider, even though they are not in the same location and are connected via video rather than in person.

In addition to the typical assessments and treatment modalities, during this crisis [telehealth](#) counseling sessions should address how the patient is responding to the COVID-19 crisis, and should focus on reinforcing social distancing and hygiene practices. Counselors should help patients to problem solve around these issues. Counselors should also talk to patients about what they should do if they develop symptoms.

If the patient is receiving additional take-home doses the counselor and medical provider should check in with the patient regularly to determine how they are managing. Counselors and medical staff should reinforce the risk of overdose and the importance of safe medication storage.

Patients should also be encouraged to participate in virtual support groups if appropriate for the individual. See ASAM's COVID-19 guidance for [Support Group](#) Access.

Providing services through telehealth does require clinicians to adapt their practices. Programs should encourage staff to participate in virtual trainings on how to effectively provide services through telehealth.

Resources:

National Council's Best Practices for Telehealth During COVID-19 Public Health Emergency: https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Telehealth_Best_Practices.pdf?daf=375ateTbd56

APA's Telepsychiatry Toolkit: https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit

ASAM Telehealth Guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-telehealth

Considerations for Annual Assessments

Federal regulations do not require an annual medical exam for patients in OTPs, however it may be required in some states, and is considered a best practice. OTPs in states that require an annual medical exam should reach out to their State Opioid Treatment Authority if they have questions related to flexibility around this requirement during the COVID-19 crisis. ASAM members are also encouraged to reach out to their state chapter if state level advocacy is needed.

In making determinations about whether a patient's annual medical exam can be delayed or can be provided through telemedicine, OTPs should consider the risks and benefits for the individual patient. Much of the exam can be conducted through audio-visual telehealth. The provider should determine whether there are risks to the patient associated with either delaying the exam or conducting it through telehealth that outweigh the risks to the patient posed by an in-person visit and potential exposure to COVID-19.

Considerations for dosage changes

The stress, anxiety, and social isolation associated with the pandemic response may exacerbate mental health and addiction symptoms in some patients. OTPs should be prepared to assess these needs on an individual patient basis. Programs should develop policies and procedures for making changes to medication dosages based on phone consultations.

Drug testing

OTPs are still required to provide a minimum of 8 drug tests per year for each patient. See ASAM's guidance on Adjusting Drug Testing Protocols.

Coordination with Recovery Homes or Caregivers

During this crisis many factors may increase the need for coordination with patient support systems including recovery homes and other caregivers. Programs should establish clear lines of communication with the appropriate caregivers/support systems for each patient. The program should consider assigning a main point of contact to manage these communications. These coordination channels should be used to:

- Coordinate take-home doses
- Develop shared protocols for safe storage/access
- Ensure timely communication about any suspected COVID-19 in the residence
- Provide a clear point of contact if there are any cases of COVID-19 among the program's staff or patients
- Ask for caregiver/support system's help observing take-home dosing.

Reimbursement issues

__Medicaid__: Many OTP patients are covered by Medicaid, although this may vary from state to state and among clinics. Medicaid reimbursement rules for OTPs are determined by each state's Medicaid office.

OTPs will need to work with their state Medicaid office in order to maintain reimbursement and clinic income stream during the crisis.

Although the DEA, SAMHSA, and CMS have all allowed delivery of the majority of OTP services via telemedicine, it is still up to each state Medicaid program to determine how these services will be reimbursed. Some states have implemented COVID-19 specific codes for certain services, while others are using a bundled billing model.

Medicare: For those patients who have Medicare, audio-video telemedicine services are reimbursable. However, audio only telehealth services are not.

Private Payors: While some private insurers do not reimburse for OTP services, many do provide coverage. In some states, health plans have announced that they will pay for services rendered either through audio-visual and/or telephonic only means at the same rate as in-person visits. Programs and clinicians should consult they plans with which they participate for further information.

Some patients who are paying out of pocket may lose their employment due to COVID-19. It is advised that OTPs work with patients on payment deferrals or schedules to maintain their treatment until they can get back to employment and/or obtain health care coverage.

See the AMA guidance on Policy, Coding, and Payment for telehealth services: https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice

See ACP's Telehealth Billing and Coding Tips: https://www.acponline.org/practice-resources/business-resources/covid-19-telehealth-coding-and-billing-practice-management-tips

Considerations for Documentation

Telehealth

Verbal or written consent should be obtained from the patient before each telehealth visit. If the OTP is not using a HIPAA compliant telehealth platform, the patient should be informed about this and about the potential security limitation, and their verbal or written consent to continue should be obtained.

All documentation should note the patient's consent for treatment via telehealth (acknowledging the potential HIPAA violation if appropriate). It should also document the time of the beginning and end of the call, the location of the patient and the provider at the time of the visit, and the technology used for the connection. It is important to verify the patient's identity, especially for phone contacts. Each note should describe how the patient's identity was verified. As with all services the note should document the discussion during the call, including information regarding assessment of the patient's mental status, mood, quality of speech, etc., and it should outline the plan for the next contact. The note should also indicate that the encounter is in the context of the COVID-19 crisis, and describe how this was addressed during the visit (e.g. reinforcing the importance of social distancing, assessing how the patient is coping with the stress, anxiety and social isolation during this crisis, etc.).

Documenting a physical examination via telemedicine

Some OTPs will be able to use internet-connected equipment such as stethoscopes, otoscopes, and high-definition cameras. These devices, when manipulated by an assistant who is with the patient, may allow for a full multi-system examination to be performed via telemedicine. Using such equipment, however, does not avoid the issue of having someone in close proximity to the patient, and will not meet the SAMHSA requirement for a face-to-face examination before initiation of methadone treatment.

Much information can be obtained through an audio-visual telemedicine visit. Areas that can be documented include:

- General appearance, nutritional status, diaphoresis
- Eye movement, lids, presence of scleral icterus, facial skin lesions, neck masses or asymmetry
- Level of respiratory effort, use of accessory muscles, audible wheezing
- Neurological – can observe gait, asymmetry or focal weakness, facial asymmetry, presence of normal hearing, tremor
- Mental status examination
  - Appearance
    - Hygiene: clean, shaven, grooming
    - Dress: clean, dirty, neat, ragged, climate appropriate, unusual findings
    - Jewelry: rings, earrings, facial piercings
    - Makeup: lipstick, nail polish, eye makeup
    - Other: prominent scars, tattoos
  - Speech
    - Slurred or clear
    - Rate: fast, slow, latency
    - Volume: soft, normal, loud
    - Intonations: decreased (monotone), normal
  - Behavior
    - General: increased activity (restlessness, agitation), decreased activity
    - Eye Contact: normal for video wandering gaze, staring
    - Mannerisms
    - Engagement: cooperative, reluctant, hostile, suspicious
  - Thinking
    - Thought Processes
    - Associations (tight, loosened, circumstantial, tangential, word salad, etc.)
    - Thought Content - (delusions, suicidal or homicidal ideation)
    - Hallucinations (auditory, visual, olfactory, tactile)
  - Mood – stated mood
  - Affect – depressed, sad, anxious, euphoric, angry
    - Range and stability: full range, labile, restricted, blunted/flattened
    - Appropriateness to content and congruence with stated mood
  - Memory – ability to recall recent life events
  - Insight/Judgment, - understanding of illness and situation, weighing potential actions

- Informed consent: ability to comprehend and verbalize risks, benefits and alternatives of treatment, information and instructions

Take home doses

When programs provide patients with increased take home doses of medication, they should clearly document the rationale for the individual patient. This should include a discussion of the risks and benefits with regards to both their opioid use disorder and COVID-19. The OTP should also regularly document how the patient is responding to increased take home doses and how problems are addressed.

Suspension of drug testing

As discussed in ASAM's guidance on Adjusting Drug Testing Protocols, programs may need to suspend drug testing for some patients during the COVID-19 crisis. If the OTP's regular protocol for drug testing is suspended for a patient, the program should document the rationale for why this was deemed appropriate for the given patient.

Ensure up to date contacts for staff and patients

During this pandemic, programs will need to have clear channels of communication with both their staff and their patients. Programs should ensure that they have up-to-date information on:

- **Emergency contacts for staff and patients**: This is important if a patient or staff member exhibit severe symptoms of COVID-19 and need to be sent to the hospital. It is also important if supervisors or OTP management are unable to reach the staff member or patient to be able to check on them as needed.https://www.asam.org/Quality-Science/covid-19-coronavirus/infection-mitigation-in-outpatient-settings
- **The established chain of custody protocol for each patient:** This is important in case a patient needs to be quarantined for any period of time and the program needs to quickly ensure processes are in place for delivering the patient's medications to them.
- **The best ways to reach each patient:** The COVID-19 epidemic is rapidly evolving. Programs need to be able to reach patients to alert them to changes in the schedule, cancelled or moved appointments, changes to procedures when they arrive, or confirmed or suspected cased of COVID-19 to which they may have been exposed.

Staffing Challenges

See ASAM's guidance on Infection Mitigation in Outpatient Settings for guidance on protecting and monitoring staff during the COVID-19 crisis.

Essential personnel

The program should clearly define the minimum essential personnel necessary to safely provide patient care. At least one staff member must be on site who can dispense medication doses to patients. According to DEA regulations, this must be a licensed medical provider, or a nurse, LPN, or pharmacist acting under the orders of a licensed medical provider. OTPs should develop a list of authorized dosing personnel and make sure that each of them is adequately trained in dosing procedures. In certain

situations, dosing staff may be shared among OTPs – this should be arranged beforehand with inter-operational agreements to assure adequate credentials and training.

In addition to dosing personnel, at least one other staff member must be in the clinic to manage patient flow. Depending on the size and location of the OTP, multiple patient flow and/or dosing staff members may need to be on site.

Medical providers will need to be on site in order to perform intakes for methadone patients. They could also be on call to come in in a timely manner if a patient asking for methadone presents, depending on how far away the medical provider lives from the clinic and the expected number of new patients.

Most other essential OTP functions can be performed via telemedicine. This includes counseling and case management visits, peer specialist contacts, medical follow up visits and buprenorphine initiation for new patients, and the initial exam for initiation of naltrexone.

The program should closely monitor staff availability and have established procedures to address situations in which the minimum coverage cannot be provided.

Staff working from home

In some cases, clinic personnel may be assigned to work from home and at other times the telemedicine connections can be performed from one room to another within the clinic.

All on-site personnel should use PPE to the extent necessary to protect themselves. Those dosing should wear full PPE, as available, especially when performing curbside or car dosing. Based on CDC recommendations for healthcare providers and the extent of community spread of COVID-19 virus in the area, this would include a face mask, face shield, gloves, and a gown.

Drug supply issues

OTPs should notify their distributors that initially they may be ordering larger amounts of medication than usual – this will help prevent triggering an alert to the DEA for excessive orders. It is prudent to keep on hand additional stocks of medication to last at least 28 days.

In selected cases for patients receiving 14 or 28 days of take-home methadone doses, programs may use dissolvable tablets instead of liquid medication. In this case, the program should work with their distributor to ensure availability.

There have been some reports of pharmacies not stocking enough buprenorphine to accommodate the increase in doses being prescribed. In addition, this crisis could increase the need for naloxone distribution. The program should consider coordinating with local pharmacies and state opioid treatment authority to encourage pharmacies to keep additional buprenorphine and naloxone on hand.

Waiting room precautions

The unique nature of OTPs requires patients and staff to have face-to-face interactions at a higher frequency than many other treatments. Therefore, OTPs should actively develop protocols to safeguard their patients, staff, and community from spread of Covid-19. See ASAM's guidance on Infection Mitigation in Outpatient Settings.

Minimizing risk for COVID-19 transmission may require different processes based on several considerations:

- Clinic size and staffing resources
- County or city-level community resources
- Patient population characteristics.

For example, larger OTPs with more staff may elect to stagger schedules for counseling, nursing, medical, and other staff to provide ongoing coverage of services but minimize the exposure of all staff at one time to possible work-related COVID-19 viral transmission. They may also need to stagger when patients present to clinic, either over the course of the day, week, or month. Smaller OTPs may not have the luxury of staggering staff and may need to consider alternatives. For example, the CDC recommends that "asymptomatic healthcare professionals who have had an exposure to a COVID-19 patient" may continue to work "after options to improve staffing have been exhausted" (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

With increasing community spread OTPs will need to consider how to continue serving patients at higher risk for infection. This may be particularly important for OTPs in areas without much in the way of community resources for isolating homeless patients with COVID-19 illness or providing alternative medication delivery systems. Strategies may involve establishing alternating days or separate times of day for patients who are considered at high risk for infectiousness, including those who are not able to physically isolate, those with respiratory symptoms, those recently released from incarcerated settings, and those who live in congregate shelter settings. The other days or time blocks would be reserved for visits by patients who are likely at lower risk of infectiousness. Alternatively, depending on the layout of the facility programs may provide separate physical spaces for patients at low vs. high risk of infection, including separate waiting spaces, separate areas for dosing, and separate rooms for clinical encounters.

With increasing use of telehealth and take-home dosing, OTPs may be able to stagger appointments such that they can space out patients 6 feet apart across OTP waiting rooms, lobbies, and medication dispensing areas. These distances could be marked out with painters' tape on the floor and chairs should be placed 6 feet apart. Ensure that hand sanitizer is accessible in multiple points throughout the facility and clean frequently touched surfaces often, at least once a day.

Finally, no matter the processes any OTP puts in place to reduce the risk of COVID-19 transmission among patients and staff, the less time a patient spends in face-to-face contact with other persons inside and outside the facility, the lower the risk of COVID-19 viral transmission. This should serve as a guiding principle for continuing OTP operations during the COVID-19 crisis.

Resources

SAMHSA's TAP 34: Disaster Planning Handbook for Behavioral Health Treatment Program.
https://store.samhsa.gov/product/TAP-34-Disaster-Planning-Handbook-for-Behavioral-Health-Treatment-Programs/SMA13-4779

SAMHSA's COVID-19 guidance for OTPs: https://www.samhsa.gov/coronavirus

AATOD Guidance to OTPs in Response to the Coronavirus (COVID-19)
http://www.aatod.org/advocacy/policy-statements/covid-19-aatods-guidance-for-otps/

ASAM's COVID-19:

- Infection mitigation guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/infection-mitigation-in-outpatient-settings
- Telehealth guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-telehealth
- Drug testing guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/adjusting-drug-testing-protocols
- Virtual support group guidance: https://www.asam.org/Quality-Science/covid-19-coronavirus/support-group

Appendix 1 - Incident Command Structure

To help manage the response to the COVID-19 pandemic, we have adapted the Incident Command System (ICS) to fit our organization. This will help us achieve several objectives: 1) effectively communicate and update staff and patients regarding clinic operations; 2) continue providing the services that patients rely on to treat and manage their substance use and other health conditions; and 3) ensure that we protect the safety and health of staff and patients.

The flow chart and the brief descriptions below outline the critical areas within an ICS that are essential to creating a cohesive and well informed environment that is responsive to a rapidly changing situation. It also identifies the specific individuals responsible for completing related tasks within each area.
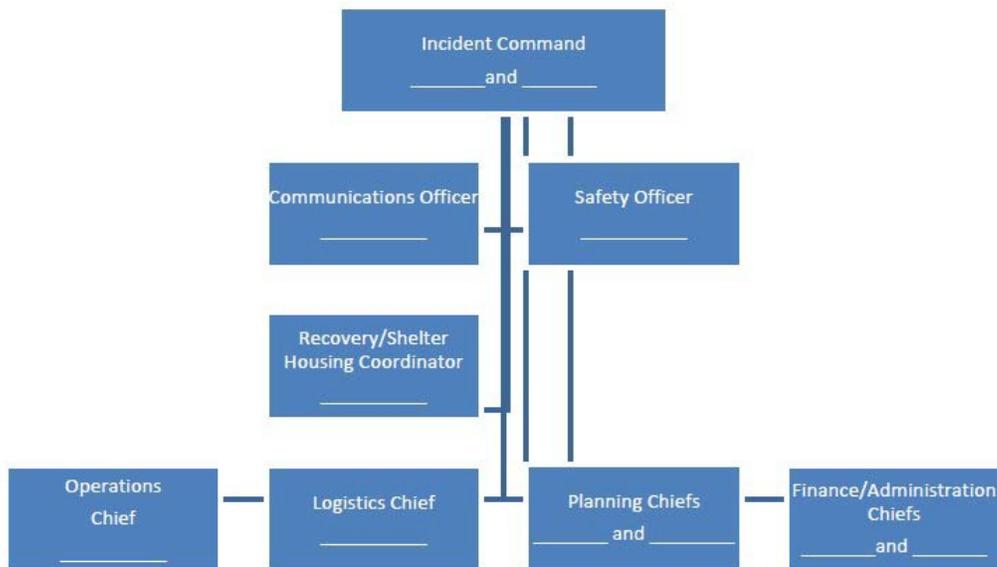
Incident Command: The Incident Command has overall responsibility for management of the incident. Communications Officers: Communications Officers are responsible for drafting internal communications to staff and external communications to patients about the incident as operations/processes and information changes.
Safety Officer: The Safety Officer monitors incident operations and provides feedback and advice to the Incident Commanders on all matters related to operational safety.
Recovery Housing/Shelter Coordinator: The Recovery Housing/Shelter Coordinator serves as the initial point person for communication and coordination between recovery/transitional houses and our program.
Operations Chief: The Operations Chief is responsible for implementing the procedures and plans established by the Incident Commanders to achieve the incident objectives. Works particularly in close contact with the Logistics Chief and Incident Commanders.
Logistics Chief: The logistics chief is responsible for resource management.
Planning Chiefs: The Planning Chiefs develop and update brief, written reports outlining options and plans for continuing services and operations during the incident.
Finance/Administration Chiefs: The Finance/Administration Chiefs are responsible for tracking and managing financial and administrative activities related to the event.