MITIGATING THE INTERSECTION OF COVID-19 AND OPIOID USE DISORDER

MAY 20, 2020
<table>
<thead>
<tr>
<th>WEBINAR SERIES PARTNERS</th>
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<tbody>
<tr>
<td>American Academy of Clinical Toxicology (AACT)</td>
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<tr>
<td>American Academy of Emergency Medicine (AAEM)</td>
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<td>American Association of Poison Control Centers (AAPCC)</td>
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<td>American College of Medical Toxicology (ACMT)</td>
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<td>Asia Pacific Association of Medical Toxicologists (APAMT)</td>
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<td>European Association of Poison Centers and Clinical Toxicologists (EAPCCT)</td>
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<td>Middle East &amp; North Africa Clinical Toxicology Association (MENATOX)</td>
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ON-DEMAND RESOURCES

All webinars are recorded and posted to the ACMT website

www.acmt.net/covid19web

Questions?
Write to: info@acmt.net
Q&A will be at end of the Webinar

Please type your questions into the Q&A or Chat function during the webinar and we will get to as many as we can

We monitor all platforms, including YouTube and Facebook, for questions
NONE OF OUR SPEAKERS HAVE ANY CONFLICTS OF INTEREST TO DISCLOSE
MODERATOR

Lewis Nelson, MD, FACMT, Chair of the Department of Emergency Medicine, Rutgers New Jersey Medical School, Newark, NJ
PANELISTS

Scott A. Brinks, Regulatory Drafting & Policy Support Section, Drug Enforcement Agency, U.S. Department of Justice, Arlington, VA

Regina LaBelle, JD, Director, Addiction & Public Policy Initiative; Distinguished Scholar, O'Neil Institute for National & Global Health Law, Georgetown University Law Center, Washington, DC

Loren T. Miller, Section Chief, Diversion Liaison & Policy Section, Drug Enforcement Agency, U.S. Department of Justice, Arlington, VA

Jeanmarie Perrone, MD, FACMT, Professor, Emergency Medicine and Medical Toxicology; Director, Center for Addiction Medicine and Policy, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA

Kimberly Sue, MD, PhD, Medical Director, Harm Reduction Coalition, New York, NY
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@DrKimSue
55M h/o HTN, DM2, obesity, anxiety/depression, arrives at syringe service program for help. Just released from prison 2 days ago in a decarceration policy effort. H/o OUD (intranasal 5-6 bags of heroin a day, x 10 years), now homeless. Had been on methadone in the past (80mg daily) but hasn’t been on it during prison (upstate NY - 2 year sentence). Smokes cigarettes daily (20 pack year history). He has not used any heroin but reports cravings. A program worker for the syringe exchange calls me: is he a candidate for buprenorphine?
# Chronic Disease Co-Morbidities and COVID19

<table>
<thead>
<tr>
<th>Demographics and clinical characteristics</th>
<th>Total (n=191)</th>
<th>Non-survivor (n=54)</th>
<th>Survivor (n=137)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>56.0 (46.0-67.0)</td>
<td>69.0 (63.0-76.0)</td>
<td>52.0 (45.0-58.0)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Sex</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>0.15</td>
</tr>
<tr>
<td>Female</td>
<td>72 (38%)</td>
<td>16 (30%)</td>
<td>56 (41%)</td>
<td>...</td>
</tr>
<tr>
<td>Male</td>
<td>119 (62%)</td>
<td>38 (70%)</td>
<td>81 (59%)</td>
<td>...</td>
</tr>
<tr>
<td>Exposure history</td>
<td>73 (38%)</td>
<td>14 (26%)</td>
<td>59 (43%)</td>
<td>0.028</td>
</tr>
<tr>
<td>Current smoker</td>
<td>11 (6%)</td>
<td>5 (9%)</td>
<td>6 (4%)</td>
<td>0.21</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>91 (48%)</td>
<td>36 (67%)</td>
<td>55 (40%)</td>
<td>0.0010</td>
</tr>
<tr>
<td>Hypertension</td>
<td>58 (30%)</td>
<td>26 (48%)</td>
<td>32 (23%)</td>
<td>0.0008</td>
</tr>
<tr>
<td>Diabetes</td>
<td>36 (19%)</td>
<td>17 (31%)</td>
<td>19 (14%)</td>
<td>0.0051</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>15 (8%)</td>
<td>13 (24%)</td>
<td>2 (1%)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Chronic obstructive lung disease</td>
<td>6 (3%)</td>
<td>4 (7%)</td>
<td>2 (1%)</td>
<td>0.047</td>
</tr>
<tr>
<td>Carcinoma</td>
<td>2 (1%)</td>
<td>0</td>
<td>2 (1%)</td>
<td>0.37</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>2 (1%)</td>
<td>2 (4%)</td>
<td>0</td>
<td>0.024</td>
</tr>
<tr>
<td>Other</td>
<td>22 (12%)</td>
<td>11 (20%)</td>
<td>11 (8%)</td>
<td>0.016</td>
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</table>

COVID-19 and OUD: Risks of increased morbidity and mortality

- Post-incarceration: increased risk of morbidity and mortality, 12x higher than general population, overdose death 129x (Binswanger et al. 2007, 2013)
- Untreated chronic medical and mental health conditions can be risks factors for COVID acquisition and severity
- Congregate shelter/homelessness: COVID risks, risks of violence, assault, OD
- Lack of access to harm reduction supplies (syringes, naloxone, fentanyl test strips, people not using together), uncertain drug supply
- Lack of access/ability to enact COVID-19 prevention measures
- Racism, stigma, distrust of patients with the formal healthcare system
- Racial disparities and COVID19: Black ppl 3.5x relative risk of death, Latinx 2x (Gross, Essien, et al/unpublished pre-print, 2020)
Case Continued: OUD and telemedicine

- Able to use phone, Facetime or use doxy.me platform to see patient for initial visit
- Able to take history and establish patient has OUD and high OD risk
- Not able to have toxicology performed at this time, since bathroom at syringe exchange is closed
- Able to check PMP, no issues, counseled on home initiation of buprenorphine
- Able to prescribe 1 week rx, to local pharmacy 2 blocks from SSP and schedule f/u within 1 week
- Peer hands patient naloxone or rx naloxone, establishes OUD/harm reduction safety plan, counseled on risks of fentanyl
- Pt has no phone: how to continue our visits during this time?
PANELIST

Loren T. Miller, Section Chief, Diversion Liaison & Policy Section, Drug Enforcement Agency, U.S. Department of Justice, Arlington, VA
Closed System of Distribution

- Foreign Mfr
- Importer
- Manufacturer
- Distributor
- Disposal
- Patient
- Practitioner
  - Pharmacy
  - Hospital
  - Clinic
  - OTP
Tools the Division Uses

- Scheduled Investigations
- Established Schedules
- Recordkeeping Requirements
- Registration
- Security Requirements
- Established Quotas
- ARCOS
PANELIST

Scott A. Brinks, Regulatory Drafting & Policy Support Section, Drug Enforcement Agency, U.S. Department of Justice, Arlington, VA
DRUG ENFORCEMENT ADMINISTRATION
REGULATORY DRAFTING AND POLICY SUPPORT SECTION

- Responsible for the drafting and publishing regulations for the DEA.
- Responsible for the DEA COVID-19 Website.
- EO13891
  - Went into effect November 1, 2019
  - Requires DEA to obtain permission from the Department of Justice and the Office of Management Budget (White House) prior to publishing any public guidance document.
  - Prior to this Executive Order DEA could publish guidance documents on their own.
Triggering Event – Secretary of HHS declares a public health emergency January 27, 2019.

DEA had to obtain further guidance from HHS.

EO13891 Approval of Guidance Documents.

Between March 15, 2020 and April 20, 2020, DEA issued 24 emergency guidance documents to assist practitioners in the treatment of patients.
COVID-19 GUIDANCE

- Telemedicine Questions and answers.
- Supporting responsible use of telemedicine while providing medication assisted treatment.
- Working with registrants to facilitate satellite hospitals and clinic locations.
- Temporarily raising aggregate production quotas for certain medications.
- Providing clear guidance on electronic prescribing of controlled substances.
- Not requiring doctors to obtain a DEA registration number in every state where they practice.
- Allowing Narcotic Treatment Programs (NTPs) to sign invoices post delivery.
- Ensuring Narcotic Treatment Programs (NTPs) can get medication to their patients.
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Jeanmarie Perrone, MD, FACMT, Professor, Emergency Medicine and Medical Toxicology; Director, Center for Addiction Medicine and Policy, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA
A patient struggling

A 64 y.o. M h/o heroin use seeking treatment

ED Buprenorphine program visit— warm bridge

• “feared” the ED due to COVID19

• public transportation

• had phone but not a “smart” phone
Rapid implementation

Phone access

• Peer led model of recovery access
• Connection to new “virtual clinic”
• Phone dispensing via new grant
  • returning citizens
  • homeless with COVID19 in quarantine
  • PCP’s not taking new patients
Benefits
--patient centered
--less stigma
--no travel/exposure
--more trust

Disadvantages
--naloxone access
--phones/telehealth
--pts of health systems
--less structured—UDS
--diversion risk
QUESTIONS WITH PANELISTS
What interventions and harm reduction strategies should cities and states be considering or ramping up to reduce the risk of transmission of COVID among these groups?
Policies like social distancing and avoiding non-emergency medical visits – while necessary for flattening the curve – may increase the risk of recurrence for patients in recovery because they increase social isolation and eliminate in-person social support. What are the potential long-term implications of these policies for people with substance use disorder; what data do we need to evaluate their risk and benefit?
Do these solutions have the potential to transform how we deliver addiction medicine in the future, and if so, how?
What will happen with the COVID-19 emergency regulations once the Health Emergency is over?
There seems to be a misunderstanding by practitioners of what telemedicine really is and how it works. Could you please fill us in?
What data do we need locally and nationally to demonstrate the value and risk benefit of the new emergency regulations to lend evidence to support this low barrier access strategy that we have now?
Final question, with one sentence answer:
What is the single most important policy or practice you would implement to meet the needs of people with opioid use disorders during this pandemic?
THANK YOU TO ALL OUR PANELISTS

Scott A. Brinks, Regulatory Drafting & Policy Support Section, Drug Enforcement Agency, U.S. Department of Justice, Arlington, VA

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NEXT IN OUR COVID19 WEBINAR SERIES

Pulmonary Manifestations of COVID19

Wednesday, May 27, 2020
3:00 PM EDT

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