OTP COVID-19 FAQ

Personal Protective Equipment (PPE)

1. **Q: What does AATOD recommend OTPs do in the absence of equipment-- hand sanitizer, masks, face protectors—we would typically use?**

A: In the current situation of a worldwide shortage of personal protective equipment, staff in OTPs will have to use the best possible options available, the most important of which is frequent hand washing and the second of which is keeping good physical distance from other staff and patients when possible. Obviously, it is not possible to do so when giving patients medication. Wearing a cloth mask or bandana over nose and mouth probably reduces possible transmission by the person wearing the bandana. It would be reasonable to ask all patients coming in to wear a lower face covering until such time as they have to ingest their medication.

2. **Q: How do we get N95 masks? How can we obtain proper PPE rapidly?**

A: There will not be any way to do so ethically until the supply is vastly increased. For now this equipment is much more desperately needed by health care providers working in emergency rooms and inpatient hospitals. OTPs are having difficulty in getting access to personal protective equipment. AATOD is working with key suppliers to get this equipment to the programs. We obtained a letter from the Assistant Secretary of Health and Human Services, which has been sent to suppliers.

3. **Q: I read that the virus droplets are between 0.06 microns and 0.14 microns. The n95 mask article says it will not stop the virus. Is this true?**

A: The N-95 mask will filter out 95% of 0.3 micron particles. Thus, even N-95 masks are not perfect and will not prevent penetration of all virus particles, but likelihood of infection depends on the amount of virus transmitted, so these masks will prevent most infections from aerosolized droplets.

4. **Q: Does each state determine how OTPs will operate during a pandemic? Who regulates OTPs during a pandemic?**

A: The OTPs continue to be regulated by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) at the federal level. This oversight was mandated by Congress in the early 1970s and this oversight has not changed during this epidemic.

The OTPs are also regulated at the state level by State Opioid Treatment Authorities (SOTAs). Illustratively, OTPs file take-home exemption requests with these SOTAs. The SOTAs then file such blanket take-home exemption requests with SAMHSA.

5. **Q: How can I prepare for caring for patients during this pandemic?**

A: OTPs should determine their medication management needs in order to ensure they have the proper inventory needed to treat patients effectively as more take-home medication will be required, especially if the program falls within a quarantine zone. Inventory also includes medical supplies and equipment that the programs will need to function and effectively treat patients. Please keep in mind that this is a rapidly changing event and programs need to be as prepared as possible to deal with such ongoing challenges.

Please see this document from the Ohio Mental Health and Addiction Services for a number of other great suggestions to consider.

6. **Q: Do we need to increase infectious disease control standards?**

A: You are advised to increase maintenance standards throughout all public access points of the OTP as well as all other facilities and programs under your auspices. This includes making sure that clean water is used when mopping floors based on typical maintenance standards, in addition to being sure that supplies e.g., soap, water and towels/proper drying equipment are available in all staff and patient bathrooms. In addition to posted handwashing protocols, there should be adequate availability of hand sanitizer throughout the facility, as well as federal, state and local advisories.

7. **Q: How will the United States handle a methadone shortage?**

A: We do not have a methadone shortage in the United States. AATOD has been in contact with the major suppliers of methadone hydrochloride products. They have sufficient inventory to meet demands.

Below From the Ohio Mental Health & Addiction Services FAQs

8. **Q: How do we reduce transmission in our program facility?**

A:

- The Centers for Disease Control and Prevention has provided interim infection prevention and control recommendations in health care settings.
- Anyone with a respiratory illness (e.g., cough, runny nose) should be given a mask before entering the space.
- Provide hand sanitizer at the front desk and at each dosing window.
- Clean all surfaces and knobs several times each day with EPA-approved sanitizers.
- Provide educational pamphlets to patients and staff on how patients can respond to COVID-19.

9. **Q: Can we dose someone in a separate room if they present with a fever or cough?**

A: Yes. Please develop procedures for OTP staff to take patients who present at the OTP with respiratory illness symptoms such as fever and cough to a location other than the general dispensary and/or lobby, to dose patients in closed rooms as needed. OTP staff should use interim infection prevention and control recommendations in health care settings published by the Centers for Disease Control and Prevention.

Telehealth

10. **Q: What are best practices to obtain informed consent and releases of information in a telehealth setting?**

A: If the clinic has a secure portal, documents can be moved between patient and clinic via such a portal. In most instances this approach is probably not practical. Thus, the best practice is to provide informed consent orally over telephone or video link and document in the chart notes that this process was conducted. SAMSHA has temporarily removed some 42 CFR Part 2 restrictions so that providers can communicate without a release for anything considered a medical emergency during this national

emergency. If communication is important for the patient's health or well-being, it is reasonable to consider that an "emergency" under the current circumstances. It is wise to document the reasoning behind the communication that occurs without a release.

11. Q: Can we do intakes over the telephone?

A: The history taking part of the intake can be entirely conducted by phone. To begin methadone maintenance, an in person visit with physical exam is still required. See 42 C.F.R. § 8.12(f)(2) below. Under the current circumstances, a physical exam that addresses areas of concern detected in the history should be sufficient, which could reasonably include checking to see that the patient appears generally healthy and does not have any obvious neurological impairment. It would be reasonable, under these circumstances, to ask the patient to wear a nose and mouth covering during the exam, unless an exam of the oral cavity is required. Following the exam, the provider needs to thoroughly wash hands and disinfect all surfaces if disinfectant wipes are available. Certainly, this situation is an anxiety provoking one, but currently unavoidable. We have to keep in mind that just like the front line providers putting themselves at risk to care for COVID-19 patients, OTP staff are putting themselves at some risk to provide life-saving treatment afforded by methadone maintenance.

Federal law requires a complete physical evaluation before admission to an OTP.
Under 42 C.F.R. § 8.12(f)(2):
(f) Required services— . . . (2) Initial medical examination services. OTPs shall require each patient to undergo a complete, fully documented physical evaluation by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician, before admission to the OTP. The full medical examination, including the results of serology and other tests, must be completed within 14 days following admission.

However, with respect to new patients treated with **buprenorphine**, SAMHSA has made the decision to pre-emptively exercise its authority to exempt OTPs from the requirement to perform an in-person physical evaluation (under 42 C.F.R. § 8.12(f)(2)) for any patient who will be treated by the OTP with buprenorphine 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 via telehealth. This exemption will continue for the period of the national emergency declared in response to the COVID-19 pandemic, and applies exclusively to OTP patients treated with buprenorphine. **This exemption does not apply to new OTP patients treated with methadone.** In addition, treatment of OTP buprenorphine patients must be done in accordance with SAMHSA's OTP guidance issued on March 16, 2020.

The OTP provider caring for the buprenorphine patient under these circumstances must be a licensed healthcare practitioner who can, in his or her scope of practice, prescribe or dispense medications and have a current, valid DEA registration permitting prescribing or dispensing of medications in the appropriate Controlled Substances Schedule.

For **new** OTP patients that are treated with **methadone**, the requirements of an in-person medical evaluation will remain in force. SAMHSA has made this determination on the basis that eliminating the in-person physical examination requirement for new methadone patients could present significant issues for a patient with OUD. Patients with OUD starting methadone are not permitted to receive escalating doses for induction as take home medication. This means that a person starting methadone for OUD would get a maximum dose of 30 mg/d and may be on this dose, which for most people with OUD would be a low dose that will potentially be inadequate, for extended periods (up to 14 days if the

clinic is using a blanket exception during the current medical emergency). The methadone dose could only be increased by a small amount (e.g., 5 mg/d) meaning that the person would be on what are considered to be subtherapeutic doses of methadone to treat OUD for an extended period. An initial in-person physical evaluation is needed in order for OTP providers to address such risks in each ***newly*** admitted methadone patient.

12. Q: Can a practitioner working in an Opioid Treatment Program continue to treat an *existing* OTP patient using *methadone* via telehealth (including use of telephone, if needed)?

A: Yes, a practitioner may continue treating an existing patient of the OTP with methadone via telehealth and in accordance with SAMHSA's OTP guidance issued on March 16, 2020, assuming applicable standards of care are met. See the DEA's document, "Use of Telemedicine While Providing Medication Assisted Treatment (MAT)."

The OTP provider caring for the methadone patient under these circumstances must be a licensed healthcare practitioner who can, in his or her scope of practice, prescribe or dispense medications and have a current, valid DEA registration permitting prescribing or dispensing of medications in the appropriate Controlled Substances Schedule.

13. Q: Can a practitioner working in an Opioid Treatment Program, continue to treat an existing OTP patient using buprenorphine via telehealth (including use of telephone, if needed)?

A: Yes, a practitioner may continue treating an existing patient of the OTP with buprenorphine via telehealth assuming applicable standards of care are met, and the patient's buprenorphine treatment is in accordance with SAMHSA's OTP guidance issued on March 16, 2020. See the DEA's document, "Use of Telemedicine While Providing Medication Assisted Treatment (MAT)."

The OTP provider caring for the methadone patient under these circumstances must be a licensed healthcare practitioner who can, in his or her scope of practice, prescribe or dispense medications and have a current, valid DEA registration permitting prescribing or dispensing of medications in the appropriate Controlled Substances Schedule.

14. Q: Can a practitioner with a DATA 2000 waiver, and working outside the context of an OTP, treat new and existing patients with buprenorphine via telehealth (including use of telephone, if needed)?

A: Yes, if a practitioner has a DATA 2000 waiver, the practitioner may prescribe buprenorphine under the practitioner's DATA 2000 waiver while complying with all applicable standards of care. In such a case, the patient will count against the practitioner's patient limit and must treat the patient in accordance with any rules that apply to practicing with a waiver under 21 U.S.C. § 823(g)(2), and 42 C.F.R. Part 8, as applicable.

15. Q: Can an OTP dispense medication (either methadone or buprenorphine products) based on telehealth (including telephone, if needed) evaluation?

A: Yes. Under the current national health emergency, OTPs can provide medication under blanket exception: up to 14 doses for clinically less stable patients and 28 doses for clinically stable patients (clinical stability and ability to safely manage medication must be determined by the clinical team and documented in the patient's medical record) in accordance with SAMHSA's OTP guidance issued on

March 16, 2020. See the DEA's document, "Use of Telemedicine While Providing Medication Assisted Treatment (MAT)."

16. Q: Can OTP mid-level practitioners continue to dispense and administer MAT medications at an OTP in the event that their supervising provider can no longer provide supervision regarding the administration or dispensing of MAT medications?

A: Yes. A mid-level practitioner can administer and dispense MAT medication within an OTP, absent the direct supervision of an OTP physician, if the mid-level practitioner is "licensed under the appropriate State law and registered under the appropriate State and Federal laws to administer or dispense opioid drugs." Please note, however, that this flexibility does not negate the OTP medical director's obligation to "assume responsibility for administering all medical services performed by the OTP." See 42 C.F.R. § 8.12(b).

17. Q: How do we handle paperwork from intakes if it is done remotely?

A: Options include patient portals, various standalone eSign applications and good old fashioned snail mail. At least one OTP in Minnesota has this plan: Patients will come into the clinic and will be placed in an interview room with all the required paperwork. A counselor will be in another interview room and via a HIPAA compliant video system the counselor will do the intake evaluation and the patient will be able to complete the required paperwork and interview.

18. Q: Should we delay lab testing?

A: A number of OTPs have stopped testing for now, but plan to re-evaluate how to best continue testing moving forward.

19. Q: How do we convince the facility to convert to telemedicine?

A: Lack of telemedicine will place patients and staff at risk.

20. Q. Are required urine drug screens waived for out-patient MAT programs if telehealth is done?

A: A number of OTPs have suspended urine drug screens for now, but plan to re-evaluate moving forward.

Employees

21. Q: How do I provide staff support from home?

A: Remote supervision can be provided in much the same way as counseling services are provided remotely (phone, zoom, google hangouts, facetime, microsoft teams, skype, etc.). Schedule time for supervision either individually or in a group setting. Group supervision is also an excellent opportunity for staff to share experiences and creative solutions. Some programs may have trouble with adjustment if there is typically a lot of collaboration across the clinic and supervisors have an open door policy. This can be addressed by providing additional opportunities for staff to meet (i.e., all staff meeting through zoom, only clinical staff meeting, group supervision, etc.). This ensures continuity of care amongst providers and gives clinicians an opportunity to connect about clients that interface with multiple providers and need more support at this time. Communication about what is to be expected in terms of 1) documentation in progress notes for teleservices, 2) following up with clients that have disengaged,

and 3) guidance for providing additional support to clients should be given to all staff, preferably at the same time, so everyone is on the same page about logistical changes.

22. Q: How can I protect my workforce?

A:

• Screen patients and visitors for symptoms of acute respiratory illness (e.g., fever, cough, difficulty breathing) before entering your healthcare facility. Keep up to date on the recommendations for preventing spread of COVID-19 on CDC's website.
• Ensure proper use of personal protection equipment (PPE). Healthcare personnel who come in close contact with confirmed or possible patients with COVID-19 should wear the appropriate personal protective equipment.
• Conduct an inventory of available PPE. Consider conducting an inventory of available PPE supplies. Explore strategies to optimize PPE supplies.
• Encourage sick employees to stay home. Personnel who develop respiratory symptoms (e.g., cough, shortness of breath) should be instructed not to report to work. Ensure that your sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Continue to remind staff that their primary role is to support their clients in making the best decisions for themselves and their families. With OTPs, some essential staff functions will remain and services will need to be provided onsite. Those staff and clients need to be protected as best as possible from potential exposure to COVID-19. For staff that continue to interface with clients in-person on-site, they should follow CDC guidelines. If clients are presenting with symptoms and are asking for testing, assuming that OTPs do not have full primary care services and are not able to test, you should direct them to your local non-emergency hotline for more information about where they can go for testing.

23. Q: How can I support staff who still need to interface directly with clients?

A: Remind your staff of the ways they can protect themselves: Keep six feet of distance when possible, constant hand washing and disinfecting of surfaces. Remind them that 80% of COVID cases are mild so most of us are not at high risk of serious complications. Remind them that every one of us have to pitch in at this time of national emergency and as health care workers their contributions are saving the lives of our patients with a potentially lethal illness, opioid use disorder. It is understandable that these nostrums may not be very comforting to many staff. We are all in a tough situation. Consult the CDC guidelines for detailed information.

24. Q: What is the federal definition of essential employees?

A: There is no specific federal definition, however the Department of Homeland Security has issued guidelines that you can learn about here. The definition is determined by localities or states. However, most health care workers, which would include OTP staff, would be considered essential. OTPs have unique considerations regarding medication dispensation. This resource developed by SAMHSA is an example regarding options and practices for OTPs. All behavioral health providers should view the designation of essential employees as an inverted pyramid, and take into account the guidance offered by each entity. Federal guidelines are the broadest, and at the top of the inverted pyramid, and additional designation information will be offered as you move down the levels from federal, to state and local government, to individual practice sites/organizations.

25. Q: To gauge staff stress and emotional state, should we conduct mental health screenings?

A: That is a determination that is probably unique to each agency. It certainly would be good to provide resources helpful to staff to avail themselves if they wish such as mindfulness exercises or debriefing times done over conference call or video connection. If staff members need mental health care, help them to arrange it.

Professional boundaries in most helping professions suggest avoiding dual relationships when possible. For this reason, it may not be advisable to conduct mental health screenings. However, there is much to be gained by making sure employees have access to the tools and resources they need to manage their stress and emotional state. Providing self-assessment tools, information on accessing the organization's EAP, sharing contacts related to organizational healthcare plan resources for behavioral health and highlighting local or virtual tools can provide much-needed support to your employees who may be struggling. An emerging best practice is to offer staff self-screening tools and/or information about signs of mental health problems, with concrete strategies and tips for managing stress and promoting self-care. Similarly to the clients that they serve, they may be experiencing a lot of associated hardship, stress, anxiety, etc. Providing resources to staff about coping with stress or different resources that are free and open to healthcare providers right now (such as the headspace app) is a great way to encourage self-care for staff at this time. Staff may be currently (or in the near future) dealing with friends, family members, or clients that are in the hospital due to COVID-19, or they may be experiencing grief due to death of someone close to them. If your clinic does not have a protocol in place for any of these situations (such as providing personal leave for death of loved one or for alerting participants of a group that one of their group members has died) then now would be the time to get those in order and distribute to all staff.

26. Q: What are the best ways to promote resiliency and reduce fear and anxiety for our frontline direct care workers?

A: It helps if leadership can model these behaviors. It also is reasonable to acknowledge that everyone is afraid right now and everyone has worries. Let's remember that we are in this crisis together, and solidarity probably helps. Frequent virtual debriefings may help.

Reinforce the concept of autonomy. Client's have autonomy over their own lives. Remind staff to talk about choice with the clients. No single person is in charge of the change in another person. Workers who are using evidence-based practices to the best of their ability can be reassured that they are doing the best thing for their clients. Promoting autonomy and emphasizing what is in the healthcare worker's control. Having regular check-ins with staff, keeping them up to date about what the organization is doing to address this and giving them space to discuss their fears and stress can help with coping. Research also suggests that in a pandemic situation, program management should not minimize the threat in these discussions. Encourage staff to follow all CDC guidelines for households to increase feelings of preparedness. Per the SAMHSA TAPS guide on emergency planning, staff competencies and attitudes need to be assessed to ensure that all employees are prepared, and feel prepared, for the duties they will be expected to perform under pandemic conditions. Workers who are not confident in their abilities may need more resources/information in their designated disaster roles and education about how their contributions make a difference.

27. Q: Can you explain Families First?

A: On March 19, the President signed into law, H.R. 6201, the Families First Coronavirus Response Act. The bill includes a complex set of temporary paid leave mandates and employer reimbursement provisions, as well as funding for free coronavirus testing, food nutrition security and Unemployment extension. You can find information on Families First here.

Patients

28. Q: What is the protocol to inform clients their clinician tested positive for COVID-19?

A: There is no specific protocol. Honestly inform the patient and encourage the patient to get tested herself or himself if any symptoms develop. As more testing becomes available, even asymptomatic individuals will likely be able to get tested, although the value of testing asymptomatic individuals is uncertain since a single test only means they do not have the virus right now, and they could still contract it later.

29. Q: Should we continue oral and urine drug screening?

A: It is recommended that oral fluid toxicology testing be suspended.

30. Q: Is curbside dosing be considered?

A: Curbside dosing should be considered if you are concerned about a symptomatic patient coming to the clinic. This should be in accordance with instruction per your SOTA. Suggestions for curbside dosing include:

- The nurse can prepare the dose, put it in a locked box, and with the escort of security, dose the patient outside of the clinic area.
- Prepare take-home doses consistent with your clinic protocols and provide them to patients in this same way with appropriate ID verification.
- For patients who you deem ineligible to manage take home doses safely, consider identifying a patient's family member or stable support and, with the patient's informed consent, provide education about safe storage, chain of custody procedures, and dosing instructions for them to administer the patient's dose.

31. Q: Are there risks to giving our patients take-home medication?

A: As is always the case, the consideration of providing take-home medication is based on individual risk/benefit assessments. Clearly, there are a number of patients in treatment who are not clinically stable, which is why so many are attending the program 6 or 7 days a week, depending on the program's operating schedule. Programs may consider staggered dosing days (organized by alphabet, patient ID, etc.) to manage increased distribution of medication. Consider limiting the number of patients in the waiting areas and practicing safe social distancing whenever possible. In addition, as states and cities impose curfews, programs will need to operate in such guidance.

32. Q: Should I supply my patients with Narcan®?

A: Providing significant take-home medications to unstable patients should be considered very judiciously. As a reminder, we are still in the midst of a changing opioid epidemic with many opioid

related overdoses each day. If unstable patients are being given take-home medication, they should also be given access to Narcan® kits. This may be a challenge for some OTPs depending on the state or county's regulations governing the utilization of Narcan® kits in or through an OTP.

33. Q: Should I give all our patients take-home medications?

A: It is not recommended that programs use blanket exceptions to provide take-home medications to unstable patients unless the OTP is in a quarantined region. Although we do not want infected patients to come to the program and pose increased risk for the spread of this virus even further, there are liability related issues as well as risks for OTPs to be implicated in contributing to increasing opioid related overdoses. Keep in mind that no matter what the issue, we still exist in a litigious environment. This is why clinical personnel need to balance risk against need/benefit.

34. Q: How can I protect our patients?

• Stay up-to-date on the best ways to manage patients with COVID-19.
• Separate patients with respiratory symptoms so they are not waiting among other patients seeking care and have them wear a mask. Arrange for symptomatic patients to get COVID-19 testing.
• Consider the strategies to prevent patients who can be cared for at home from coming to your facility potentially exposing themselves or others to germs, like:

    o Using your telephone system to deliver messages to incoming callers about when to seek medical care at your facility, when to seek emergency care, and where to go for information about caring for a person with COVID at home.
    o Adjusting your hours of operation to include telephone triage and follow-up of patients during a community outbreak.
    o Leveraging telemedicine technologies and self-assessment tools.

35. Q: What are the increased risks and vulnerabilities for people with SUDs related to the coronavirus?

A: We know that individuals with SUDs are also likely to be tobacco smokers. That seems like the biggest increased risk. They may also be cannabis smokers which may increase risk, although this point remains an open question. Many individuals with SUDs have underlying serious health conditions which may make them more vulnerable both to get the virus and to have a more severe infection. We know that alcohol impairs the immune system so that might also make individuals with SUDs more susceptible and prone to a more severe infection.

36. Q: Will disaster relief funds be available in states that do not have Medicaid for methadone and do not use block grant money to pay for MOUD and depend 100% on patient payments.

A: This question is one that your agency should pose to its local and federal elected representatives. Don't shy away from contacting them. They should be there to serve you.

37. Q: Will disaster relief funds be available for unemployed patients so they can receive extended take homes?

A: This question is one that your agency should pose to its local and federal elected representatives. Don't shy away from contacting them. They should be there to serve you.

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