

Good afternoon. I'm Commander Ibad Khan, and I'm representing the Clinician Outreach and Communication Activity COCA, with the Emergency Risk Communication Branch at the Centers for Disease Control and Prevention. I would like to welcome you to today's COCA Call, Leveraging Existing Resources to Meet the Challenges Faced by People Who Use Drugs or Who Have Substance Use Disorders During the COVID 19 Pandemic. Free continuing education is offered for this webinar. Instructions on how to earn continuing education will be announced at the end of the call.

In compliance with continuing education requirements, CDC, our planners, our presenters, and their spouse's partners wish to disclose they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. Planners are reviewed content to ensure there is no bias. This presentation will not include any discussion of the unlabeled use of product or product under investigational use. CDC did not accept commercial support for this continuing education activity. At the conclusion of this session, the participants will be able to accomplish the following; cite several flexible resources available to providers to ensure continuity of care during the COVID 19 pandemic, explain CDC strategies and activities to prevent opioid overdoses and related harms.

Including implemented solutions. Please note that all participants joining us today are in listen only mode. Upon the conclusion of this presentation, there will be a Q&A session. Using the webinar system, you may submit a question at any time by clicking the Q&A button at the bottom of your screen, typing your question in the Q&A box, and submitting your question. The video recording of this COCA Call will be posted on COCA's webpage and available to view on demand a few hours after the call ends.

If you are a patient, please refer your questions to your healthcare provider. For those who may have media questions, please contact CDC Media Relations at 404 639 3286, or send an e mail to media@cdc.gov. Now I would like to welcome our presenters for today's COCA Call. Our first presenter is Dr.

Neeraj Gandotra. Dr. Gandotra is the Chief Medical Officer for the Substance Abuse and Mental Health Services Administration, SAMHSA. Previously, Dr. Gandotra served as the Chief Medical Officer for one of the nation's largest addiction treatment networks, where he developed national strategies aimed at reducing risk and improving outcomes.

He is board certified in addiction psychiatry. Our second presenter is Dr. Cherie Peck. Dr. Peck is the Lead Health Scientist for the Applied Prevention Science Team in the Division of Overdose Prevention at CDC.

She has over a decade of experience leading projects in academia, government, and clinical settings, planning research activities and implementing evidence based programmatic strategies in various public health fields, including overdose prevention, mental health, adverse childhood experiences, HIV, AIDS, cardiovascular epidemiology, and obesity. Our third presenter is Dr. Shawn Ryan. Dr. Ryan is one of the founders of BrightView and is responsible for strategic development, alignment of operations and medical practice, clinical and outcomes research, and maintaining focus on the mission and vision of BrightView to pair a patient focused and evidence based approach to addiction treatment.

He is both a board certified addiction specialist and an emergency physician. I would now like to turn it over to Dr. Gandotra. Dr. Gandotra, please proceed.

Thank you very much. I appreciate the invitation from the CDC, and the time that everyone is spending to listen to what SAMHSA's been doing. And most importantly, hopefully gain some insights as to where we may move in the future. Certainly, I don't have any conflict of interest, and I will not be speaking of any medications or treatments that are off label. You can move to the next slide.

So, when COVID 19 first came out and into existence, we realized that the impact on operations for our behavioral health stakeholders really, really, really needed a lot of shoring up. We began a phase of rapid dissemination of guidance and support. Most importantly, we wanted to shore up our technical assistance, as well as provide these behavioral health organizations, the resources that quite frankly they may have understood that they needed, but didn't really know how to implement. The first thing we did was recognize that our outpatient mental health centers that see the majority of patients really did need guidance in how to triage the most severe patients versus those that perhaps could be checked in upon remotely. So, that was the first step that we placed in terms of guidance.

We did also widely disseminate our technical assistance publication, TAP 34. I will state that this was written I believe in the early 2000s. It did contain a chapter on the treatment of opioid use disorder during a pandemic, as well as several other sections that are certainly applicable. But we are in the midst of revising this, and we should have a new version out in 2021. Nevertheless, we did disseminate this as well.

We also found that our Opioid Treatment Programs, as well as our State Opioid Treatment Authorities, really needed guidance, and quite frankly, they needed someone to make a decision about what was clinically appropriate. And while in Rockville, we can't decide what may be clinically appropriate for our patient treated in any individual OTP. We did send out guidance that allowed for flexibilities. In particular, the take homes or take home medications that are typically given to patients as they earn more time in treatment being negative for illicit substances. We recognize that during the pandemic, special circumstances are certainly in play.

And we offer blanked take homes for any state or opioid treatment program that requested it. And I believe 42 states in the first month requested blanket take homes for their OTPs. It was still up to the individual OTP medical director to implement whichever flexibility they deemed appropriate for the patient. But many, many did utilize that. And while the state of the public health emergency is still in effect, we expect that flexibility to continue.

And, of course, there were patients who actually developed COVID, COVID 19. And they needed, they needed, during their quarantine time, to have medications delivered to them. We developed guidance at that time how to safely deliver that medication. I will hat tip the CDC chief medical officer that assisted in the guidance development of that particular document. And then most importantly, telehealth.

What we found was that a lot of programs were really, really interested in implementing telehealth, but very few were poised to do so. And technical assistance was needed, as well as specific guidance with regard to the protections that could be implemented during this time. Given the difference between Methadone and Buprenorphine as the two main agonist treatments for opioid use disorder, in concert with the DEA, SAMHSA and the DEA issued guidance that allowed for telehealth, telehealth for the initiation of treatment for Buprenorphine. This allowed patients to still access treatment and allowed patients who were already established in treatment to continue via telehealth, irrespective of which medication they were on. The provisions most importantly we found to be asked where could patients who were already established on Methadone continue telehealth, could a provider start telehealth for a

patient who needed a Buprenorphine induction, and most importantly, could telehealth still be delivered for the counseling sessions.

All of those answers were in the affirmative. The training and technical assistance, I would ask anyone to look at our website. We have a variety of prerecorded and on point webinars, not just for the treatment of opioid use disorder, but also for substance use disorder in general, as well as resources for the providers. The one thing that we're most proud of is that we have disseminated over \$400 million worth of emergency grants during the COVID 19 crisis, 110 million of which we did over the course of the Easter weekend in the span of about seven days, we disseminated money, some of which was required to be earmarked for provider health as well. And then the 42 CFR Part 2 has been perplexing, even pre COVID, with regard to what is allowed to be disclosed and redisclosed.

We have issued guidance with regard to this, and in concert with the Office of Civil Rights. I've exercised discretion not to, not to penalize providers who are using commonly used platforms for telehealth. This would include Skype and FaceTime, as well as several of other platforms. Next slide. So, all of, well, not all of this, but most of the guidance came through our Division of Pharmacological Therapies.

I will say that our Division of Pharmacological Therapies has an acting director and myself right now. And we were very much interested in making sure that all of the providers could continue to see patients, and in cases, expand treatment capacity. DPT, as we like to call it, manages the oversight of the OTPs, the accreditation bodies that survey the OTPs, and the DATA 2000 Waiver Program, which certifies the Buprenorphine providers. In addition to that, we also provide education through the Provider Clinical Support System. Both the universities that we partner with, as well as the vendors that perform that training.

These numbers that I've stated now are probably much higher, but we've processed over now 5,000 OTP exception requests during this crisis. We've improved over 6,000 newly waived providers. I will also make a point that DPT has now brought all of the processing in house. For the past 19 years since the inception of the program, we had a contractor provide the Buprenorphine processing and maintain the database. As of September 1st, we brought all of those processes in house within SAMHSA.

We believe that we'll have more control over the processing, the data, and more oversight. In addition to those things, there is eligibility for any provider who has the DATA 2000 waiver to request a temporary increase to the 275 patient limit. We've also maintained biweekly called with the State Opioid Treatment Authorities to ensure that any questions they may have we will, we will address. We routinely correspond with grantees of the PCSS. We make sure that primary care providers, physician assistants, midlevels all are aware of the training that we have.

And we make sure that as this condition in this crisis develops, that we maintain the flexibilities as needed. Next slide. So, this is just a brief map of our technology transfer centers. I would encourage all of you to reach out. These technology transfer centers are available for any, any program, any provider.

There's a real person that's going to answer the phone and connect you with the information you may need when it comes to let's say telehealth readiness or questions regarding provider and patient eligibility for particular treatments. Lots of different resources are available. I would encourage you to look at our website, call the help line. Someone will be able to assist in helping a program provider, nonprofit, or anyone in general who might need more information. Next slide.

So, this is just a small sample of some of the technology transfer center activities. In particular, I focused on the Addiction Technology Transfer Center. Biggest things that we've done is help providers implement telehealth, help them get paid for telehealth, making sure that it is viable as a business opportunity, as well as the liabilities that may be incurred with that. And then, of course, the actual provider resources as they may feel fatigue and they may feel that their resources have been stretched. And then, of course, there are a host of other resources available on our webpage.

There are virtual rooms, sites to virtual rooms where patients can still stay connected. I want to comment that this is, this cannot be understated, that we know the treatment engagement is the key to maintaining and achieving the best outcomes. I understand that at times it may be difficult to remain, remain in a treatment during the COVID 19 crisis. Virtual rooms and virtual therapies are one of the things that we link to as well. Next slide.

So, of course, I would encourage you all to visit our webpage. Our mission remains true. We are undaunted. We do want to reduce the impact of substance use disorder and mental illness in American communities. I know that there have been a lot of, a lot of new developments that have come around even in the last month or so.

The biggest one that's not mentioned on these slides, but is worth mentioning, is that there has been a revision to the 42 CFR Part 2 rulings. There is a very, very simple webpage that does explain what those are. And hopefully all of you will look into that as well. I will now turn it over to Dr. Peck.

Thank you, and good afternoon, everyone. It is a pleasure to be with you today. Thank you for the opportunity to brief you on the CDC's way to address the opioid overdose epidemic. I will focus my remarks on the Division of Opioid Prevention's current activities, with a slight focus on our work to support communities and industry care. I will also briefly highlight our ongoing effort to develop resources for clinical practice, implementing evidence based interest strategies, and linkage to care and public safety settings.

I will also highlight the CDC COVID resources that are available online pertaining to people who use drugs, perhaps substance use disorder for medical professionals. Next slide. I now want to move to CDC's response to the epidemic. We have activated an all hands on deck approach to addressing the crisis. And multiple parts of the agency are engaged in response efforts to address all aspects of the crisis.

There are five key strategies that guide our work. Conducting surveillance and research to improve data quality, and identifying new and emerging trends. These data can then be used to drive action with populations and in communities most affected by the epidemic. Next is building state, local, and tribal capacity to scale up evidence based programs. For instance, through our newest funding mechanism, overdose data to action, which I'll discuss in the upcoming slide.

We can target overdose prevention activities, as well as generate faster and higher quality data to rapidly respond to communities. Next is supporting providers, health systems, and payers to improve patient safety by giving providers data, tools, and resources that they need. We are in the process of updating our opioid prescribing guidelines to include new evidence on chronic and acute pain prescribing and developing additional tools for providers to best serve their patients. Next is partnering with public safety to identify threats and lead people to treatment. Our public health and public safety collaboration, the Overdose Response Strategy, promotes active engagement between multisectors and the community to prevent fatal overdoses.

Next is to increase public awareness through efforts by the Rx Awareness campaign to reach communities and provide education and awareness of the risks of opioids and other drugs. CDC has taken a multicollaborative approach to addressing the opioid overdose epidemic, and we are grateful for our partners with this endeavor. Next slide, please. I now want to talk briefly about our current funding opportunity, Overdose Data to Action, or as we refer to it, OD2A. OD2A is a three year cooperative agreement that focuses on the complex and changing nature of the overdose epidemic and highlights the need for an interdisciplinary, comprehensive, and cohesive public health approach.

We are currently in our second year of funding. OD2A supports state, territory, and select counties, city, or township health departments in obtaining high quality or comprehensive and timing our data on overdose morbidity and mortality, and use those data to inform prevention and response efforts. This married approach helps to seamlessly integrate the data and action components of this cooperative agreement. Sixty six jurisdictions were funded for OD2A, and included 47 states and 16 counties or cities. There are two components to OD2A, which include surveillance and prevention.

The surveillance component includes strategies for morbidity, mortality, and innovative projects. These are required strategies for state health departments, including the District of Columbia and Puerto Rico. The required prevention components include the following strategies; prescription drug monitoring programs to enhance utility of PDMPs as a form of public health surveillance and as a clinical decision making tool. The next strategy is state and local integration. For states, 20% of their prevention budget must go to local or other within state partners.

And I'll talk a little bit more about this in a moment. The next strategy is providers and health systems support to ensure that providers and health systems are equipped to contribute to prevention and response solutions and include activities, such as academic detail and guideline implementation support. Linkage to care is also a primary component of Overdose Data to Action. We at CDC are not engaging in provision of care or service delivery. That's not necessarily our lane.

But we do have a responsibility to ensure that there is a bridge from identification of risk to mitigation of risk. All recipients are required to implement programs around linkage to care that address three primary areas; enhanced programs and policies, which can include establishing protocols and policies in Emergency Departments to guide referrals and linkages to care for persons who have experienced overdose, or another example may be the development of a coordinated treatment access plan. The next area of linkage to care is to increase and improve coordination. So, one example of this is that in Emergency Departments with care navigators, or recipients can also implement case management systems to help individuals navigate the process. The last category of linkage to care is using technology to facilitate connections to care.

So, for example, a reservation system that allows referring clinicians to see what treatment options are available, and to reserve a spot for a patient in need of a fast connection to care. We integrated a series of optional prevention strategies within OD2A. These strategies include public safety partnerships, which may include activities like pre trial diversion, or naloxone training. Another optional strategy included empowering individuals by communicating awareness of risks, options, treatment of resources, and harm reduction strategies. And lastly, we included an innovative project strategy to allow recipients to implement innovative projects that may not have bid well under one of the previous prevention strategies.

Next slide, please. As I mentioned previously, 20% of the prevention budget must go to local or other within state partners. Our previous funding opportunities led to the recognition of the importance of

formally supporting an integration of state and local efforts. We recognize the many resources required for effective opioid prevention and response exist at the state level. However, effective expressions of prevention response efforts emerge also at the local level.

So, it's important that state and local integration is an appropriate area of focus for capacity building and technical assistance to ensure that our overdose prevention work is not only at the state level, but also reaches our local communities. Next slide, please. In addition to the work being done at the local and state level, CDC continues to develop resources for healthcare providers and organizations. In 2016, CDC released the CDC guidelines for prescribing opioids for chronic pain for primary care providers. The guidelines provides recommendations to primary care physicians about the appropriate prescribing of opioid pain medications to improve pain management and patient safety.

It is important to note that the guideline is not a regulation, but it is, instead, a set of recommendations. The first resource shown on the left is titled the quality improvement and care coordination, implementing the CDC guideline for prescribing opioids for chronic pain. And this document was published in September of 2018. This resource was developed to supplement the guideline, and is designed to encourage careful and selective use of long term opioid therapy and chronic pain management. Our next resource is the evidence based strategies for preventing opioid overdose.

This CDC reference document showcases 10 best practices to prevent opioid overdose. It includes harm reduction strategies, such as targeted Naloxone distribution, medication assisted treatment, such as MAT prior authorization, NED work initiation. And also despite strategies such as academic detailing and fentanyl toxicology screening. Lastly, our 2018 overdose response cornerstone report focused on public safety, linkage to care as shown on the right. The aim of this report was to describe existing public safety programs linking people with opioid use disorder to evidence based care.

This report examines five types of public safety led linkage to care programs, including pre-arrest diversion, drug courts, linkage to care upon release from incarceration, law enforcement led post overdose outreach, and safe stations. Next slide. Before I close, I wanted to point you to CDC's webpage that provides COVID resources on people who use drugs or have substance use disorder. The link to the page is shown below, and the page includes frequently asked questions for people who use drugs and for medical professionals. Questions address topics such as whether Naloxone can be given safely to patients that overdose without increasing risk of COVID, and what resources are available to medical professionals to help patients that may have lost access to their treatment program.

The COVID pandemic continues to be a rapidly evolving situation, and CDC will continue to provide updates pertaining to these topics as they become available. Next slide. And thank you for giving me the opportunity to discuss CDC's work in overdose prevention. As this was a high level overview, I'd also like to direct you to CDC's website for more information. Thank you, and I look forward to hearing the next presentation.

I will now pass the baton to Dr. Shawn Ryan.

Thank you very much. I'd like to actually start by thanking the two previous officials and their organizations with the CDC and the SAMHSA for all of the tools and things I'm going to talk about that we were able to provide, or to utilize over the past several months as a large treatment organization. I'm going to talk a little bit just about kind of where we're at and the COVID 19 impact. My framework as a clinician and a leader of a fairly large organization made up of OTPs and other treatment centers. And

then I'm going to talk just briefly about what it is that we've done tactically to implement these solutions in these trying times.

Next slide, please. The next slide. So, when this crisis first hit, and I'm sure many clinicians felt the same way about this issue, we were very, you know, I was very concerned right off the bat for a couple of reasons, if not many reasons. First and foremost, at our organization, we very commonly focus on a lot of the evidence basis around the challenges and barriers to our patients staying in treatment or doing well in treatment and outcomes that are related to those, those factors. And those are known issues that have been published for several years.

The reason that was important is because as one was, were to look at those factors, including something that you can see on the screen here from NIATx, it was quite evident that almost everything that we work against or to remove for our patients every day related to opioid use disorder and other substance use disorders, was going to be impacted or likely be impacted by COVID. So, in summary, you know, a week or two after the crisis hit, I received several calls from different state and national entities that I work with commonly as well as the press, and I said, hold on just a second, I don't, you know, we don't know exactly what's going to happen yet, but I would predict that it won't go particularly well, knowing the fact that things like housing, finance, depression, anxiety, access, and maintenance and treatment, all of the things that we know are positive factors, again, were going to be, were likely to be, and have proven to be negatively impacted by COVID unfortunately. Next slide, please. In the next slide, I'm going to talk a little bit about our organization, just so folks on the call have a frame of reference. So, BrightView Health is a network of over 25, at this point, wholistic outpatient addiction treatment centers across Ohio and Kentucky, many of which have OTP or opioid treatment program designation, allowing us to dispense the FDA approved medications from those sites.

This is important, I think, to relate to you all because we had to take action across several thousand patients in several treatment sites. And if there's a geographic, geographically disciplined area, and we had to do it really quickly. And I will say there were two primary factors that allowed us to implement the necessary changes, one of which were the, was the quick movement and information distribution by SAMHSA in particular, in coordination with the state SOTAs that we work with, or state opioid treatment authorities. So, it was, it was the latitudes and the information allowing us to make the changes to longstanding rules that we abide by very fervently. And then I'm very blessed to have a confident and capable team with a pretty robust information technology background, including our CEO, who, his name is Chad Smith, who has a master's in health informatics.

So, it was really those two factors that allowed us to not only maintain most of our patients, but actually thrive and deliver services in these very challenging times to a lot of our patients. Next slide, please. It may keep kicking on. I'm not sure if this is auto timing on the slide. This is just a little bit about the folks I discussed.

We, across our network, I think over 600, maybe almost 700 employees throughout the treatment network, and you can see there myself, our chief clinical officer, Dr. Nav Kang, who's a psychologist by background, and Chad Smith, our CEO, along with multiple other executives, all the way down to our front desk triage staff, who when we had to implement, you know, triage questioning before people entered the building, and a very robust kind of telephone triage and temperature, you know, evaluation, all the things that came out what felt like on an every 24 hour basis, I just want to make sure I let everyone know that the success and maintenance of patient care that we've had has been really, you know, possible because of competent executives. But, you know, everyone in the field was really towing the line. So, appreciated that. Next slide, please.

I'm going to let it roll over to the next slide. So, at BrightView Health, I just wanted to talk a few things, about a few things that we did do, and maybe even a little bit about some challenges that occur. So, we were very fortunate to be proactive in understanding what was likely occurring. I have a background in healthcare administration that includes some experience in infectious disease. Previous slide, please.

And happen to be married to an infection prevention specialist, which is something I never obviously could have predicted would have been helpful. But we really kind of solve, you know, what might be coming, and proactively and immediately started reaching out to all sorts of resources insofar as personal protective equipment, cleaning, thermometers, things that we didn't necessarily, you know, would have never necessarily predicted would be such critical tools in maintaining patient care, when we had to move to a primarily telehealth, but also still, in many cases, we're sorting patients in person daily in a limited fashion with very particular spacing and such and so on. So, you know, the entire organization moved, you know, from working fairly hard every day on a complex population, you know, increasing, increasing all of our workload by probably 25% to ensure that we instituted these issues as fast as they were pushed out into the public where we've even faster in some cases. We have actually increased our utilization of telehealth by tenfold, and really had to learn quickly around the most, you know, technologically and technically competent ways to do that, maintaining patient relationships, making it as easy as possible for folks to use technology when they may not have ever done that before. And, again, we're successful in doing that in delivering a very large increase in telehealth services and telephonic sources to our patients, again, through the latitudes provided by both the regulatory bodies of SAMHSA and all related, as well as the insurance companies, the payers, who align with those latitudes to allow us to lever these treatments.

What I will say about that particular piece, what I think is probably, you know, one of the most important to folks, is that, you know, there were still several challenges related to telehealth. We, we serve a primarily Medicaid and fairly large Medicare population across the network. And what's important about that is just the social economic challenges aligned with delivering, you know, high fidelity technology to those folks can be substantial. So, do they even have, you know, a data plan or access to Wi Fi? Do they have a device that will allow them to receive these services? And that's where the telephonic services also stepped in. So, we were able to kind of amalgamate all of these opportunities and really serve the patients quite well.

What I would say that our chief political officer, Dr. Nav Kang, talks about, and we were previously doing telehealth on a more limited basis, and we were limited by both the rules, as well as the reimbursement. So, you know, in simple terms, you obviously don't want to be violating rules and compliance is key to our, at least our organization's mission. But if you don't get reimbursed for the services, that can be non sustainable by definition. So, those two pieces are really the most important part I can relay to any official that we have to maintain in order to be able to continue to do these services.

Back to Dr. Kang's perspective, you know, we really feel like meeting patients where they're at, which is a key portion of our mission and vision, is now much more possible. And so although we were doing some of these things before in limited circumstances, we are now very happy to see that a hybrid or mixed services were able to deliver really do help folks. You know, and we have multiple stories around patients, and I'll talk about just a few here in a second, where, you know, they're better served either remotely, or there are folks who really do need that in person interaction, although it may be, you know, through a mask and distanced, et cetera. So, I think best case scenario, you know, is kind of where we're at as we continue to develop these services competently.

Next slide, please. And it may flip over. I do want to say that, you know, particularly in the states where we operate, but I also consult with several other entities across the country, I have seen sustained and even growth of efforts, despite the challenges, related to harm reduction in treatment. And so it's been this push and pull, or kind of give and take, where, you know, we had, as an example, BrightView Health and the University of Cincinnati where I trained in Hamplin County Public Health, which was part of OD2A, or is part of the OD2A grant, had, over the past couple of years, delivered the largest Naloxone distribution in the country. And we found that a lot of high impact areas, which you can see here, which were challenged by COVID.

So, many syringe exchanges did not continue to operate. The criminal justice settings were more shut down than ever. And emergency departments also of course had significant challenges in a myriad of ways. Despite that, you know, officials and funders, and, again, a lot of the grant funds that were discussed, were still being pushed out to promote these effort in whatever way they could be done. And it included innovative things like mailing Naloxone to, to individuals when it was appropriate and compliant with them.

So, I'm just happy to report that we, you know, we're continuing to expand these important things, including evidence based treatment, which I'll touch on more in just a second. And that despite the challenges of COVID, people have been very innovative in their solution delivery on how to get, you know, how to know what we were doing directly, it was beginning to extend the tide of the opioid epidemic. And then also, you know, translate that into a delivery model that was necessary in the COVID crisis. In regards to evidence based treatment, we still do have a fairly long way to go. Most data demonstrates that only approximately 20% of patients with an opioid use disorder actually receive evidence based treatment, including MOUD, or medications for opioid use disorder.

That's a very unfortunate factor when there's a huge discrepancy between folks getting evidence based therapy for OUD, and many other well defined chronic diseases, which are commonly quoted in the 60 to 80% range in regards to evidence based treatment being delivered. And this is well demonstrated in multiple studies. And, again, growing. It was much worse, you know, 10 years ago when I really dove into the field full time. But, you know, we are still at a, we still have a pretty significant gap between where we're at and where we need to go.

And I think that COVID compounding that highlights the need to continue developing, and, again, the previous two officials that presented really laying out a lot of the roadmap and continued funding to allow us to grow necessary services in this crisis. Next slide, please. I just want to touch for a minute on what we consider, and most of the literature considers to be wholistic and evidence based treatment. And you can read this slide. I'm not going to detail that out for you.

But it really, it really does often take the wholistic three components of treatment to promote long term recovery for patients with substance use disorder. And that is the medical, including MOUD and MAT, or, because there are obviously other MATs, or other medications for other substance use disorder, including alcoholism. So, making sure that medical is part of any evidence based substance use disorder treatment plan, then there's the therapeutic interventions and the psychological category. And also just as important as the first two in those cases for many folks are the social components, and, again, everyone I'm sure has seen more and more literature, which has become even clearer in the face of the COVID crisis around the social determinants of health affecting mental health and addiction and other chronic disease states. So, I just wanted for a moment to make sure I pointed out that these things were cleared before in the evidence have become much more clearer during this crisis as things have been stretched to their limit.

Next slide, please. I believe this is my last one. I just want to give a couple of patient examples that are actually my patients. I still see patients every week as the chief medical officer of an organization, or stay grounded and really understand what's affecting people on a day to day basis, what the top patient was a longstanding patient of mine a couple years who was a 44 year old African American female who drove a fair distance to see me approximately once a month. Despite all of our locations and other certified providers, there was really nothing around where she lived, so she would see me approximately once a month after these years, and it has been tapering from her MOUD slowly and doing quite well.

Her husband had a head injury, and she was unable to leave the house for a multitude of reasons, including COVID concern. And so we were able to see her and be reimbursed, so both compliantly and financially able to see the patient and deliver the necessary medical and psychological services to her during a trying time related to COVID. The patient does have cooccurring mental health issues, not surprisingly. And, you know, also related to the trying time to her, because of her husband's illness. So, she's, you know, continuing to be maintained, and is doing well.

And I remember the first teleconference call I had with her, she was so excited and happy that we were able to continue services because of the technology that we were utilizing. Other cases included things that were a little more focused on COVID, to be honest, wherein, you know, the give and take or the risk and benefit, of course we know that patients that discontinue their MOUD that are in an opioid treatment program really have a high chance of relapse and can struggle significantly. We had to weigh that against seeing an immunosuppressed patient in person despite all the cleaning and personal protective equipment we were deploying. And we were able to, through many rules that were modified, were able to see this particular patient through telehealth platform, and also deliver their medications in a distanced manner, and even obtain toxicology testing in that same manner. So, you know, we took what I would describe as full advantage, appropriately so, of the latitudes that the regulators were able to rule out, and it did result in ground level impact to individual patients.

And I just wanted to make sure that everyone understood that. I believe that is about it for me. Maybe one more slide of summary. Yeah. In summary, unfortunately, my first two weeks of COVID prediction have definitely come to fruition in regards to the challenges and factors that would affect patients with opioid use disorder particularly.

Rapid action, by state and federal officials, made it not easy, but possible for us to continue to manage patients. You know, many providers, including us, took immediate action. Some providers couldn't, you know, the technological or operational challenges were too much. And so we really did benefit from a lot of these things coming together. And I think our patients have done so as well.

Thank you.

Thank you very much to our presenters for providing our audience with such useful information. We will now going into our Q&A session where I would like to welcome Ms. Linda Christensen. Ms. Christensen is a health scientist in the Division of Overdose Prevention at CDC's National Center for Injury Prevention and Control.

And she will be joining Dr. Gandotra, Dr. Peck and Dr. Ryan for the Q&A session. And for our audience, please remember, you may submit questions through Zoom by clicking the Q&A button at the bottom of your screen, and then typing your question.

We have received quite a few questions. Some were answered electronically, but I might repeat some of them because I think it would be for the greater good. And some of our audience that were not able to see the answer might also benefit. Our first question is regarding residential centers. Can you please share any reasons you think residential centers might not be able to admit patients that would otherwise be eligible or qualify?

This is Dr. Gandotra. I'll take a stab at that question first. First of all, residential treatment facilities may have had to limit capacity with regard to keeping one patient per room, perhaps modifying patient flow, perhaps they've also had some staffing issues that might have limited intake. But in general, because of COVID 19 and the number of screenings that may have to occur with staff and with patients, more frequently, all of those factors may play a role.

But I think the biggest one is making sure that they have a segregated area in the event that a patient does test COVID positive, that they don't completely have to close their program, may limit some of their capacity by keeping patients in individual rooms rather than sharing rooms. That's just off the top of my head from what I've heard.

Thank you very much. Our next question asks, regarding OAT and evidence based care, what is, in your opinion, the importance of, what is your opinion on the importance or evidence on better outcomes where counseling support accompanies OAT?

This is Shawn Ryan. I'll take a stab at that one. It's a little bit of a complicated question because several studies have looked at the comprehensive model that I described. And several of the published kind of references, tip manuals and stuff, and others, talk about ensuring that patients have access to those therapeutic or counseling based interventions in conjunction with their medication. But there are, that, I guess, you know, needs to be taken in context of not all patients are the same.

And so when looking at the evidence more specifically, you know, it really does talk about, you know, several of the more severe, which is a lot of the patients at least where we operate, you know, kind of monitor severe injection heroin use as an example. Several of those patients, if not, you know, almost all of those patients definitely benefit from the counseling or therapeutic interventions, that is primarily because they, a lot of them have such significant history of psychosocial trauma, in which case they would need other therapy anyways, and they do better with it in conjunction with medications, if that makes sense. That is not to say that two things I'll finish with, that we should never withhold medications in the absence of therapy, that is an issue that has been well discussed, because of the stabilizing and mortality reducing nature of the MOUD. So, we should never withhold. But we should always make sure that the patient is evaluated for the necessary counseling component of a holistic treatment plan.

Thank you very much. Our next question asks, in our local community, we experience an immediate surge in fatal ODs. At its peak, we saw an unimaginable 51% increase in deaths in the third quarter of 2020. And the inquirer is wondering if these trends were observed elsewhere in your knowledge with and if there's a similarly strong correlation with the timing of mitigation efforts.

Hi, this is Cherie Peck. I can take this. We are watching this, using the best of view data that we have at the federal level. The data we have for overdoses is disproportionately slow. So, don't use surveillance coming from states directly.

It is an important tool to track trends and direct resources. We are, unfortunately, also seeing early signs of high numbers of overdoses during the COVID pandemic.

Dr. Peck, I think you broke off a little bit towards the end. Would you like to repeat just the last part of your answer again? I don't think we caught all of it.

I'm sorry. I'll move a little closer. Can you hear me now?

Yes, that's a lot better.

Okay, I was just saying that we are, unfortunately, also seeing early signs of high numbers of overdoses during the COVID pandemic. So, but we are tracking this, as I stated previously. And it is something that we are collecting data from our states during, who are syndromic surveillance system.

Thank you very much. Would any of our other presenters like to add anything before we move to the next question?

I would just say that we've seen, you know, again, as unfortunately predicted, we've seen these increases in a lot of areas where we are located as well as other areas that I'm involved in. And I think the answer to some extent in my mind is to double down on the two core functions that we know are having an impact, or have an impact where we've seen reductions in the years of 18 and 19, which are harm reduction and evidence based treatment delivery.

Yes, we at SAMHSA have also seen a similar unfortunately trend. It appears that this is not just true for drug overdose, but also for suicide, that patients are unfortunately delayed care and presented in much more serious states for both substance use disorder overdose, as well as suicide attempts. Both of those have seen a dramatic increase during, during this crisis.

Thank you very much. Our next question is regarding telemedicine. Can you please share how you were able to implement toxicology testing with patients that were given telesessions and medication delivery?

Absolutely. So, a couple points there. You know, people have tried to deploy different methodologies, including oral fluid testing, which is unfortunately not as scientifically accurate as, as urine toxicology for a multitude of reasons. And so it was, you know, medication delivery with, well, of course, depositing the toxicology cup with the patient, and then having them deliver it back to, this, unfortunately, as I'm sure the person asking the question could understand, limits the ability to observe urines, unless entering the house was a possibility. And so we would manage these issues.

And if we were very concerned about a patient, depending on the risk and benefit of pros and cons of their particular case, they actually have been calm in a very controlled fashion to the treatment centers for an observed urine toxicology if we had concerns about diversion or toxicology tampering. So, a little bit of a mixed strategy of a little bit more patient trust, as well as managing the challenges related to in person observed toxicology, if necessary.

Thank you very much. Our next question is in a similar vein, asking about patients that establish care virtually. What are your recommendations for writing opioid prescriptions for new patients that establish care virtually.

I can, I'm sorry, make sure I understood the question. Is this about medication specific treatment or MOUD or about pain medications?

There is not a lot of information in the question delineating the two. So, if you would take a crack at it.

Sure. In particular to MOUD, again, per, I would say, you know, almost every medical professional's career is a risk and benefit analysis. And in this case, modifying that risk and benefit, particularly for MOUD. So, in cases where you're determining the differential between, or the potential between, you know, Buprenorphine and Methadone as an example, knowing that Buprenorphine is a physiologically safer medication, you may choose to do that instead of Methadone and less risk and benefit demonstrate that Methadone is actually better for that particular patient. So, that's one of many considerations we would make.

Also, understanding duration of prescription or dispensed medications. So, that was something, again, that latitudes were given by regulatory agencies to allow us to make a little bit more of an individual clinical determination. But it had to be based on the risk and benefit analysis. And in some cases, those were challenging. The last thing I'll say about it is, you know, the evidence is very clear that both agonist therapies have a significant mortality reduction, and it's not really up for debate.

So, the choice to allow a patient to continue to use illegal opioids, in particular, in this part of the country where Fentanyl is so prevalent, versus starting either agonist MOUD, that really wasn't too terribly tough, knowing the evidence. I think I probably should pain medication is a whole different, you know, kind of situation. But you could generally be viewed through the same lens.

Thank you very much. Our next question asks, nationally, there is an increasing trend, at least anecdotally, of people switching from opioid use to methamphetamine use, in order to avoid the increasingly volatile and predictable opioid market. What can providers of programs know or do to better serve people presenting with chaotic polysubstance use, even if they're not specifically equipped to treat amphetamine use disorder?

That's a great question. I'll take a little bit of a stab at it, and my colleagues maybe have some thoughts. In particular, that actually speaks to the need for the more holistic program and individualized treatment plans that organizations like ours focus on delivering. What I mean by that is with drug switching, one often finds is that there were some core issues the patient might have that were not being addressed, only by the medication or the MOUD. Myself, as well as many others, are actually working on different panels to develop or certify medications since the treatment for stimulant use disorder.

But as everyone knows, we're not there yet from FDA approval status. But folks are definitely focusing on that. And there are some, you know, some research around different medications that have been effective. And there are folks using those when indicated and working through the risk and benefit of that for each individual patient. Lastly I'll say is part of a holistic program, recognizing our evidence based interventions for stimulating use disorder, or methamphetamine use, like continuously management.

So, as opposed to throwing up one's hands, if you're operating in in a holistic program, and you have a capability of delivering some of these evidence based interventions like a contingency management for stimulant use disorder, then it's not that you have a full suite of tools, including medications, necessarily, but you do have evidence based interventions to be delivered through, through a comprehensive program. Lastly, I'll say, of course, addressing someone's kind of cooccurring mental illness, or other

issues that actually may be underpinning their stimulant use, can be a, can sort of be part of the medical part of the program. Hope that made sense to folks.

Thank you very much. We have time for one more question. And this question asks about specific to their area, we're finding a higher number of overdoses among older women in our region. Are treatment providers able to offer opioid treatment, or do you have any specific recommendations that would be beneficial specific to older adults and older women?

Let me start this one. And certainly the other docs can chime in too. I'll make a quick plug that SAMHSA is frequently, has just completed a revision for the treatment of substance use disorder in older adults, treatment improvement protocol now available, specifically addressing some of the concerns that treatment providers may face when treating substance use disorder in older adults. Specifically, the question of anyone who is asking for care who has opioid use disorder should not be denied care. That is the other aspect.

All of our treatment providers should have either the training or the availability to obtain the resources to treat this population. You can look at our treatment locator site to see if there's a particular provider in the area that may, that may be able to deliver that care. And certainly reach out to us for the technical assistance if there's anything that that provider may need questions answered about. I'll just make one quick comment, which is early in the development of our programming, and because of background from which I came to the field and recognizing how long the opioid crisis has basically been festering, you know, since the 80s and 90s, I think that on face, several folks might have thought that older individuals would not have demonstrated such significant opioid dependence and opioid use disorder. But for me, looking at it from an epidemiologic and historical level, it really was quite clear that was going to be the case, so we've actually focused on the Medicare population, participated in the development of the Medicare OTP and OBOT bundles, which we appreciate CMS moving on.

So, I think that just recognizing that that is a population and potentially tailoring programming to meet the needs of those individuals is something that the programs really should have been doing, but if they're just now realizing it, it's a necessary component and a large part of the population in my opinion.

Thank you very much. I want to thank all our presenters today, as well as our audience, for joining us for this COCA Call. All continuing education for COCA Calls is issued online through the CDC training and continuing education online system at <https://tceols.cdc.gov>.

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