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Tales from the front lines: An alarming rise in hospitalizations related to opioid use disorder in the era of COVID-19

Panelists:
(In order of presentation)

Richard C. Dart, MD, PhD
Dana Clifton, MD
Noel Ivey, MD
Shavone Hamilton, LCSW

Moderator:
Richard A. DeVito, Jr.

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Webinar Overview

Opening Remarks/Welcome
Richard DeVito, Jr. (moderator)

OVERVIEW: This webinar will explore an alarming rise in hospitalizations related to opioid use disorder and provide behavioral health resources to assist medical professionals in disaster response.

The COVID-19 pandemic has had harmful effects on the opioid epidemic. While a negative effect was predicted, the presenters will report on this reality in the hospital setting. They have seen a sharp rise in hospitalized patients with opioid use disorder (OUD). their data should encourage ongoing efforts to reduce barriers in accessing medications for treatment, harm reduction interventions and additional education for trainees, primary care providers, and hospitalists alike. In the current climate, these interventions are critical to save the lives of patients with OUD.

Speaker Presentations
Richard C. Dart, MD, PhD; Dana Clifton, MD; Noel Ivey, MD; Shavone Hamilton, LCSW

Curated Q&A via Chat & Closing Remarks
Richard DeVito, Jr. (moderator)

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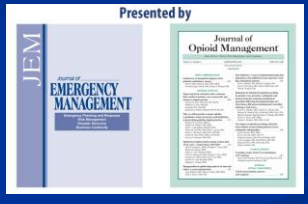

JEM - Celebrating our 19th year supporting emergency management across the globe!
JOM – Celebrating our 17th year as the only journal focused exclusively on opioids!

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Funding for this training/webinar has been provided by The National Institute of Environmental Health Sciences (NIEHS) of the National Institutes of Health (NIH) under award number U45ES019350.

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Details and recording links to this webinar are located on the *Journal of Emergency Management* Webinar Page located here:
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By attending this webinar you confirm your acceptance to being recorded in voice or image.
Please send all questions through ZOOM Q&A for moderation and to be asked.
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Richard C. Dart, MD, PhD

Dr. Dart is certified by the American Board of Emergency Medicine and the American Board of Medical Toxicology. Since 1992 he has served as the Director of the Rocky Mountain Poison and Drug Center. He is the Executive Director of Researched Abuse, Diversion, and Addiction-Related Surveillance (RADARS®) System. He has published more than 250 papers and chapters as well as served as editor for the book The 5-Minute Toxicology Consult and the 3rd edition of Medical Toxicology. In 2002 he was recognized with a special citation from the Commissioner of the US Food and Drug Administration. He was the 2004 recipient of the American College of Medical Toxicology Matthew J. Ellenhorn Award for Excellence in Medical Toxicology. He also serves as a Deputy Editor of the medical journal Annals of Emergency Medicine and is past-president of the American Association of Poison Control Centers.

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Dana Clifton, MD

Dr. Clifton is an Assistant Professor in Medicine and Pediatrics at Duke University. Dr. Clifton attended the University of North Carolina at Chapel Hill for undergraduate studies. She attended Duke University for her medical degree and was inducted into AOA. She is board-certified in Internal Medicine and Pediatrics. Dr. Clifton works clinically as a Medicine/Pediatrics hospitalist, rounding on both General Medicine and Pediatrics services. Dr. Clifton is the Co-Medical Director of Project COMET, a program designed to improve the care of hospitalized patients with opioid use disorder and withdrawal at Duke University Hospital. She is the Associate Medical Director for Quality Improvement within the Duke Hospital Medicine Program. Dr. Clifton is also the Associate Director for Pediatric Undergraduate Medical Education and Pediatric Sub-Internship Director.

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Noel Ivey, MD

Dr. Ivey attended the University of North Carolina School of Medicine and completed her training in Internal Medicine at the Oregon Health & Sciences University Hospital in Portland, Oregon in 2010. From 2010-2017, she worked as a hospitalist at the Charles George Veterans Affairs Medical Center in Asheville, North Carolina. She joined the faculty at Duke University Hospital in 2017. She currently serves as co-director of Project COMET – Caring for patients with Opioid Misuse through Evidence-based Treatment, a quality improvement project seeking to improve care for hospitalized patients with opioid use disorder. Additionally, she is actively involved in clinical trial work for hospitalized patients with COVID-19, and she has a special interest in physician wellness.

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Shavone Hamilton, LCSW

Shavone Hamilton, is a licensed clinical social worker with a Master of Social Work from Fordham University and a Bachelor of Social Work from Iona College. She has worked in the behavioral health field since 1999 and has experience in community behavioral health administration. Shavone joined Duke University Hospital in 2019. Shavone is currently an adult inpatient clinical social worker, where she is a member of the Opioid Use Disorder and Withdrawal consult team, also known as Project COMET (Caring for Patients with Opioid Misuse through Evidence-based Treatment).

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Richard C. Dart, MD, PhD

Presentation:

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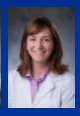
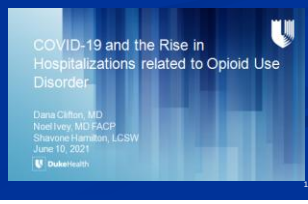



Dana Clifton, MD
Noel Ivey, MD
Shavone Hamilton, LCSW

Presentation:



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Questions & Answers via Zoom Q&A & Closing Remarks
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Moderator:
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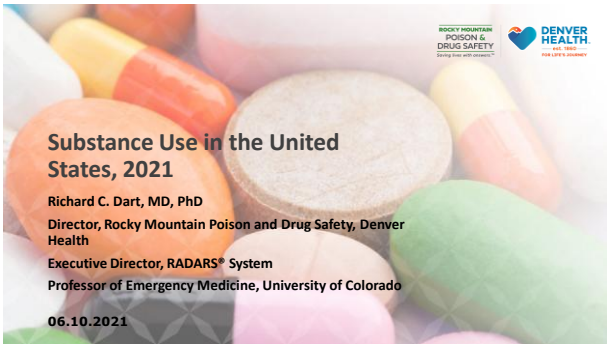

Competing Interests

RADARS® System is supported by subscriptions from pharmaceutical manufacturers, government and nongovernment agencies for surveillance, research, and reporting services.

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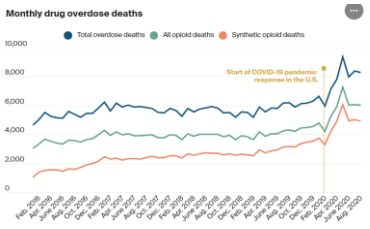
Mortality Caused by Drug Use



https://www.commonwealthfund.org/blog/2021/spike-drug-overdose-deaths-during-covid-19-pandemic-and-policy-options-move-forward#:~:text=Our%20estimates%20show%20that%20total,had%20never%20risen%20above%206%2C300.

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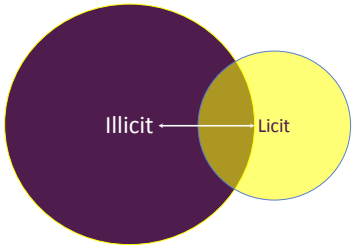
Interaction of Licit and Illicit Pharmaceuticals



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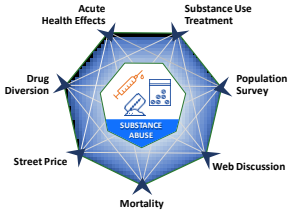
Real World Evidence and Triangulation

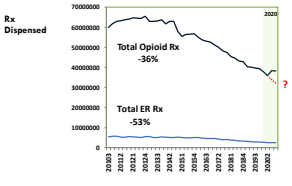
Triangulation

- More reliable answers
- Integrating results from several different approaches
- Each with different and unrelated key sources of bias



Lawlor DA, et al. Int J Epidemiology, 2016, 1866–1886 doi: 10.1093/ije/dyw314

Trends in Annual Opioid Prescribing Rates



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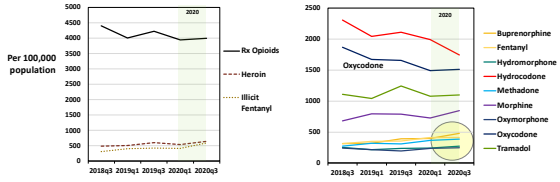
Source: IQVIA™ US-Based Longitudinal Prescription Data

Nonmedical Use of Rx Opioids, NMURx, 2018 - 2020



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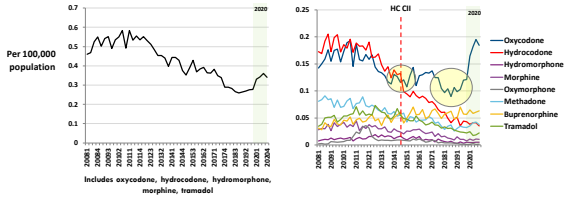
Poison Center Program, Intentional Abuse, 2006 - 2020



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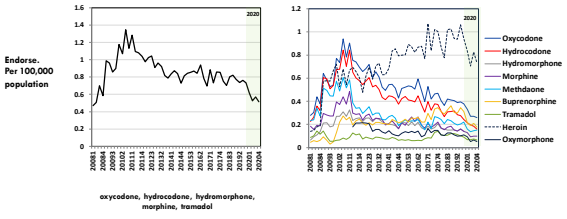
Treatment Center Programs Combined, 2008 - 2020



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Changes in Treatment Center Operations

Operation Change	March1, 2020 through May 31, 2020	June 1, 2020 through September31, 2020	October 1, 2020 through December 31, 2020
Suspended patients from entering treatment	15.3%	3.1%	11.9%
Temporarily Closed and Reopened	6.9%	3.1%	5.1%
No closure/suspensions	76.4%	93.8%	83.1%

Open Ended Text Response Examples

- "A decrease in the number of patients seeking MAT services"
- "Moved to very generous take homes, two week or monthly take homes."
- "Telehealth counseling; car dosing"
- "Staffing shortages have led to decreases in counseling services in recent months."
- "Due to court and legal offices not meeting regularly, demand for treatment has decreased."
- "Some clients who are positive for Covid or experience symptoms have been dosed in their cars."
- Several noted increased use of telemedicine for treatment and counseling

Summary

- Opioid deaths are still rising
  - Mainly due to synthetic opioid analog
  - Counterfeit drugs rising.
- Most patients misuse more than one drug
- Most deaths involve more than one drug
- Many treatment centers affected

Questions?

- RADARS.org
- Richard.Dart@rmpds.org

COVID-19 and the Rise in Hospitalizations related to Opioid Use Disorder

Dana Clifton, MD
Noel Ivey, MD FACP
Shavone Hamilton, LCSW
June 10, 2021

DukeHealth

Disclosures/Conflicts of Interest

- None

Outline

- Review of the opioid epidemic and medication for opioid use disorder (OUD)
- Intersection between COVID-19 and the opioid epidemic
- Experience at Duke
- Social Work Perspective: Impact of COVID-19 on the surrounding communities in managing OUD
- Conclusion - call to action
- Questions

Objectives

- Explain the changing landscape of the ongoing opioid epidemic
- Recognize the importance of medication for OUD
- Understand the impact of COVID-19 on the opioid epidemic broadly and at our institution
- Identify best practices for successfully transitioning care for those hospitalized with OUD to the outpatient community setting
- Apply and disseminate harm reduction strategies for patients who inject drugs

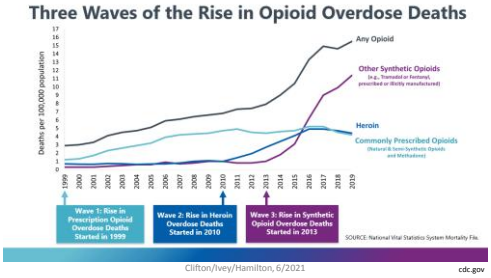
BACKGROUND

Opioid Epidemic: Epidemiology

- ~ **12 million** Americans **misused opioids** in 2016
- Opioids serve as a **gateway to heroin**
- Opioid-related **overdose deaths** have increased **200%** since 2000 (data from 2016)
- **Death rates for drug overdose are on the rise**, while death rates for leading causes of death, cancer and heart disease, are trending down (2018-2019 CDC)
- Concerning impact of COVID-19 on opioid epidemic

SAMHSA, 2017.
Rudd, et al. 2016.
Compton, et al. 2016.
Muhuri, et al. 2013.

National perspective



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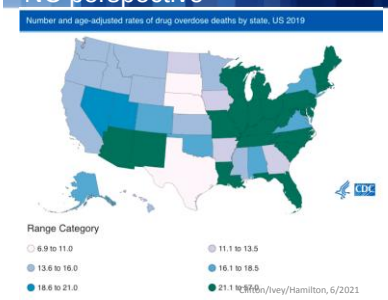
cdc.gov

NC perspective



Opioids involved in ~70-80% of all drug overdose deaths

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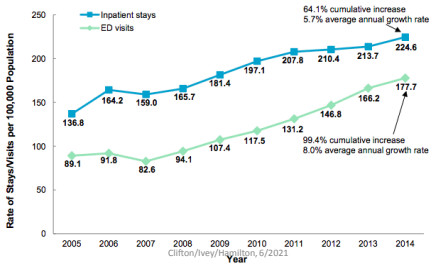
cdc.gov

Hospital/ED national perspective

National rate of opioid-related inpatient stays and emergency department visits, 2005-2014



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Weiss, et al. 2016.

A couple of truths on treatment…

Medication for OUD (MOUD) saves lives

+

MOUD is cost-effective

Schwartz, et al. 2013.
Degenhardt, et al. 2009.
Sordo, et al. 2017.
Larochelle, et al. 2018.
Fairley, et al. 2021.

Medication for OUD saves lives

Earlier studies (1980s/90s to 2000s)

- Average annual heroin overdose **deaths reduced by 37%** after introduction of buprenorphine
- **Reduced mortality (29%)** for those on methadone or buprenorphine

More recent data…

- Systematic review and meta-analysis of literature, up to 2016
  - **Reduced all cause and overdose mortality** if on methadone or buprenorphine
  - *Increased mortality risk with induction phase for methadone and time right after leaving treatment
- Retrospective cohort of nonfatal opioid overdose, 2012-2014
  - **Reduced all cause and opioid-related mortality** for both methadone and buprenorphine, NOT naltrexone
  - *Overall low proportions of patients enrolled in treatment

Schwartz, et al. 2013.
Degenhardt, et al. 2009.
Sordo, et al. 2017.
Larochelle, et al. 2018.

Medication for OUD saves lives

- Number needed to treat with opioid agonist to avoid one additional relapse = 2.9
- Number needed to treat with buprenorphine to prevent one death from OUD = less than 3
- Number needed to treat with higher dose buprenorphine (16mg) to prevent illicit drug use or stay in treatment = 2

To compare…

- Number needed to treat with aspirin after STEMI to prevent 1 death = 43
- Number needed to treat with warfarin to prevent 1 stroke = 25

Chou, et al. 2020.
Poorman. 2021.
Raleigh. 2017.
ISIS Collaborative Group. 1988.
Aguilar, et al. 2005

Medication for OUD saves lives

- Number needed to treat with opioid agonist to avoid one additional relapse = 2.8
- Number needed to treat for retention in treatment = 2

To compare…

- Number needed to treat with aspirin after MI to prevent 1 stroke = 30
- Number needed to treat with warfarin to prevent 1 stroke = 25

Bottom line: Medication for OUD has been shown to be safe, cost effective, and with clear mortality benefit yet use of MOUD remains low

Chou, et al. 2020; Fiellin, 2021; Raleigh, 2017; ISIS Collaborative Group, 1988; Aguilar, et al. 2005

Treatment terminology for OUD

Photo: cvs.com

+

Photo: nclplpc.org

- MAT = medication-assisted treatment
  - Medication + counseling
- MOUD = medication for OUD

COVID-19 PANDEMIC AND THE OPIOID EPIDEMIC

COVID-19 and opioid epidemic

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Englander, et al. 2020.
Becker, et al. 2020.

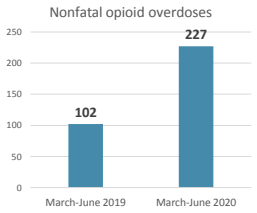
COVID-19 and opioid epidemic

- Experts predicted worsening of the opioid crisis due to COVID-19
  - Social isolation
  - Volatile drug trade
  - Disruptions in care
  - Financial stressors/job loss/loss of insurance
  - Public health efforts to allow early release from jail or prison

Englander, et al. 2020.
Becker, et al. 2020.
Wakeman, et al. 2020.
Alexander, et al. 2020.
Slavova, et al. 2020.

COVID-19 + opioid epidemic

- At one urban ED in Virginia, total number of nonfatal opioid overdoses increased dramatically at start of COVID-19 pandemic in the US



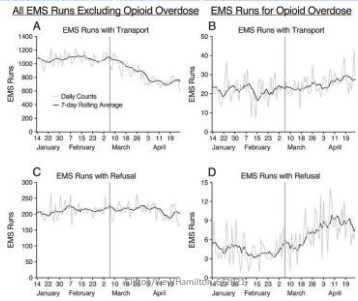
Ochalek, et al. 2020.

COVID-19 + opioid epidemic

- Similarly, one Kentucky study evaluated EMS data
- Researchers found that EMS runs for opioid overdoses increased by 17% after stay-at-home orders were instituted in KY, while overall EMS runs for other causes declined by 20%.

Slavova, et al. 2020.

COVID-19 + opioid epidemic



Slavova, et al. 2020.

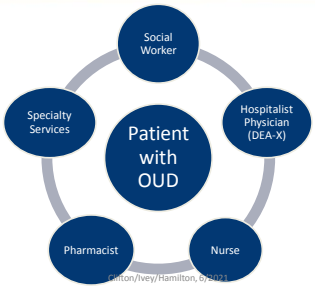
THE DUKE EXPERIENCE

Project COMET: Overview

- **C**aring for patients with **O**pioid **M**isuse through **E**vidence-based **T**reatment (COMET)
- Hybrid model: Primary team + Consultation services
  - Evaluate for opioid use disorder (OUD) and/or acute opioid withdrawal
  - Full-time hospitalist and social worker

Clifton/Ivey/Hamilton, 6/2021

Multidisciplinary Collaboration



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Project COMET: Program Goals

- Start medication for OUD/withdrawal
- Increase number of earlier, safe discharges for patients with hx intravenous drug use
- Promote harm reduction
- Connect patients to the community for ongoing treatment for OUD post-discharge

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Project COMET: Impact of COVID-19

- Increase in overdose-related 911 calls in Durham County (where Duke University Hospital is located)
- Increase use of local harm reduction organizations
- Increase in COMET consult volume by 77% (Jan-April 2020 compared to May-August 2020)

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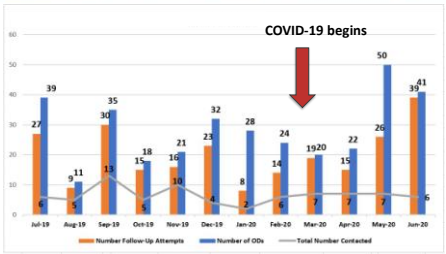
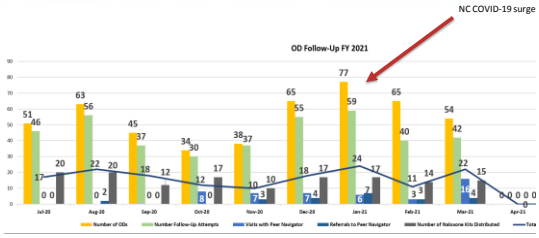
Durham County EMS Overdose Data – FY 2020



Clifton/Ivey/Hamilton, 6/2021. Durham County CP Opioid OD Data FY 2020 [data file]. Retrieved from Durham County Office of Emergency Services: EMS Division

Durham County EMS Overdose Data – FY 2021



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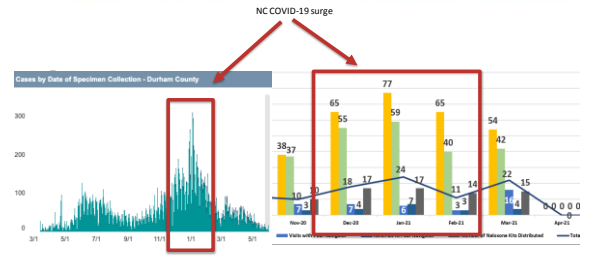
DCEMS. 2021.

Durham Co. Overdose data + COVID-19 surge



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DCEMS. 2021.
NCDHHS. 2021.

Duke ED challenges in COVID-19

- Anecdotal reports
  - Longer waiting times and overfull capacity makes it harder to get OUD patients seen and treated (some have to stay in the waiting room till they leave)
  - Less time to give resources during ED encounter
  - Lower priority due to pressing COVID-19 issues
    - Staff may not be thinking about intervening on OUD while in ED
  - Peer supports not able to come in person

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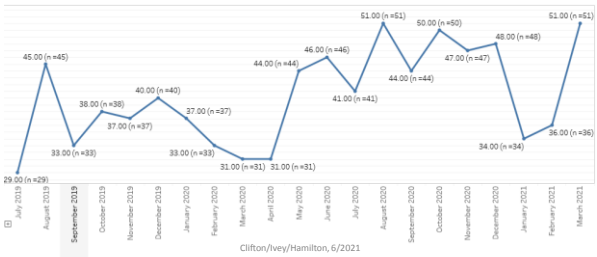
Project COMET: Impact of COVID-19

- Inpatient volume by month



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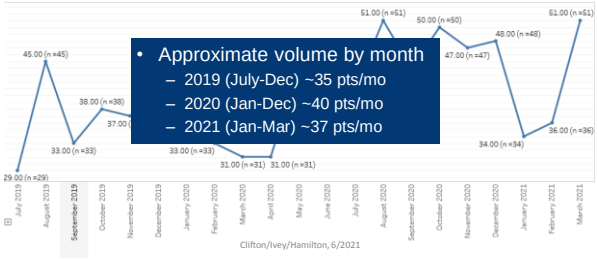

Clifton/Ivey/Hamilton, 6/2021

Why is this concerning trend happening?

- We do not have a full answer as the situation continues to evolve. It is complex…
- In talking to patients, we learn that a lot of factors are at play
  - Joblessness, increased stress, homelessness
  - Isolation, boredom
  - Change in the cost and quality of drugs
  - Experiences of racism/fear of police brutality
  - Purchasing higher quantities at a time for fear of losing access to supply
  - Reduced access to MOUD in the community
  - Reduced interaction with providers in person, peer support specialists, counselors

Clifton/Ivey/Hamilton, 6/2021

Concerning Trends: volatility in drug market

- Legal trading camouflages drug trafficking
- Worldwide stay-at-home orders have disrupted trafficking
  - Supply: demand dynamics result in higher prices
  - Declining purity of drugs
  - Some may move from using heroin to fentanyl
  - Turn to substances that are easier to access (alcohol), increasing risk of fatal overdose

Clifton/Ivey/Hamilton, 6/2021

UN Office on Drugs and Crime. 2020.

Accessing community care for those with OUD in the era of COVID-19

SOCIAL WORK PERSPECTIVE

OUD Treatment in the Community

Under normal circumstances, accessing treatment for OUD can be challenging.

- People who are uninsured or underinsured have limited access to affordable treatment
  - While some NC clinics receive grant funding to cover the cost of treatment for OUD, funding does not always include the cost of medication.
- Not all substance use treatment clinics offer MOUD.
- Stigma is a barrier to accessing care.
  - Some people avoid medical treatment out of fear of being treated differently because of their substance use.
  - Addiction still seen as a moral failing or the result of lack of willpower instead of a chronic, relapsing and treatable brain disease
  - Language reinforces stigma and influences clinicians' perceptions of people with substance use disorders.

Broyles et al, 2014
Zwick, et al 2020
NIDA, 2020
National Academies of Science, Engineering and Medicine, 2019

Impact of COVID-19 on Treatment in the Community

In the setting of the pandemic, we encountered additional challenges:

Outpatient Treatment

- Early efforts to adjust resulted in delayed access to treatment.
  - Adjusted hours of operation
  - Suspension of new referrals
  - Fewer onsite groups
  - Limited providers and staff to deliver care, which resulted in long waits to get into treatment.

Impact of COVID-19 on Treatment in the Community

- Community agencies adapted their practices based on CDC guidance.
  - Increased access to telemedicine visits to include two-way audio-visual *and* audio-only appointments for new buprenorphine patients.
    - Telemedicine increased access to care for several patients, especially those in rural areas or those who lacked reliable transportations.
    - For others, gaps in technology were clear barriers to participating in telemedicine visits.
  - Methadone clinics still required in person appointments for new patients.
    - Very few patients received 14 or 28 days of take home medications at methadone clinics.
    - Many patients attended daily or received take homes every other day or on weekends only.

Impact of COVID-19 on Treatment in the Community

Inpatient/Residential Treatment
- Reduced capacity to create room for quarantined residents or admissions

Self-Help Groups
- In-person meetings were temporarily suspended.

Peer Support Services
- Hospital visitation restrictions prevented onsite engagement with peers.
- Social distancing impacted peers' abilities to pick people up for appointments (in Durham).

Harm Reduction
- Limited in person contacts
- Increased risk of use in isolation

Impact of COVID-19 on Treatment in the Community

Transitions to Skilled Nursing Facilities
- Pre-COVID 19, completing IV antibiotics in a skilled nursing facility offered patients an opportunity to leave the hospital early

- During COVID-19, referring patients to SNFs to complete IV antibiotics became a challenge:
  - Focus on caring for patients with COVID-19
  - Staff shortages and efforts to maintain appropriate staffing ratios
  - Reduced census to allow space for quarantine.
  - Requests for longer buprenorphine bridge prescriptions
  - Patient fears of transition to SNF due to COVID-19

A CALL TO ACTION CONCLUSIONS

Opportunities for lasting improvements

- Federal agencies have made some important changes
  - Relaxed restrictions for take-home methadone
  - Increasing ability for tele-visits for OBOT
- Early in 2021, HHS removed of some barriers to prescribing buprenorphine in the community

Haley, et al. 2020.
Wakeman, et al. 2020.
SAMHSA. 2021

More to do

- Increase the use of medication for OUD
- Ease regulations on SNFs to allow dispensation of methadone/buprenorphine
- Make naloxone more affordable and accessible
  - Available without a prescription in NC pharmacies
  - Still usually ~$90.00 for patients without insurance
- Advocate for Harm Reduction Coalitions and promote harm reduction practices in your settings
  - Example – Recent NC bill to undermine Syringe Services Programs

Harm Reduction

- Addiction is a life-long, chronic illness→ not uncommon to return to use
- Clean needles/syringe exchange
- Discuss environment of use
- Naloxone training for patient/family
  - Patients treated for OUD and their families **should get RX for naloxone and be trained in how to use it**
- Fentanyl test strips

Photo: usnews.com

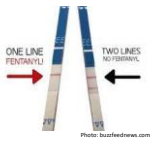

Photo: buzzfeednews.com

Kampman, et al. 2015.

What can we do as providers?

- More judicious opioid prescribing practices
- Recognize and diagnose OUD and withdrawal
- Manage withdrawal symptoms with buprenorphine/naloxone (preferred) or methadone
- Promote safety while hospitalized and following discharge
- Encourage harm reduction
- Reduce use of stigmatizing language
- Educate learners/trainees
- Engage SW, address social determinants of health
- Connect to community resources for ongoing treatment post-discharge

Discussion or Questions

Thank you for your attention!

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BRIEF COMMUNICATION

Tales from the frontlines: An alarming rise in hospitalizations related to opioid use disorder in the era of COVID-19

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ABSTRACT

The coronavirus disease 2019 (COVID-19) pandemic has had harmful effects on the opioid epidemic. While a negative effect was predicted, we report on this reality in the hospital setting. We have seen a sharp rise in hospitalized patients with opioid use disorder (OUD). Our data should encourage ongoing efforts to reduce barriers in accessing medications for treatment, harm reduction interventions and additional education for trainees, primary care providers, and hospitalists alike. In the current climate, these interventions are critical to save the lives of patients with OUD.

The opioid epidemic in the United States has entered a tumultuous period thanks to the coronavirus disease 2019 (COVID-19) pandemic. Disruptions in outpatient care, increased isolation due to social distancing, and rising cases of nonfatal overdoses in patients with opioid use disorder (OUD) have been described in the outpatient and emergency department settings,[1,2] and recognition of these "converging crises" is growing.[3] In an effort to address the challenges facing patients with OUD in the current climate, federal agencies have relaxed some of the restrictions surrounding prescribing and dispensing medications, allowing for telemedicine visits and for more flexibility with take-home methadone.[4] Despite these important interventions, however, we have seen hospitalizations for patients with OUD increase substantially. The worrisome reality that has been predicted is already here.

In July 2019, we launched a hospitalist-run service to improve care for inpatients with OUD. Our team offers initiation of medications for OUD and links patients with community clinics for continuation of treatment after discharge. Since the spring of 2020, we have also been at the frontlines of caring for those with COVID-19. At the beginning of the COVID-19 pandemic, our hospital saw a noticeable drop-off in inpatient volumes across the board. Indeed, our hospital census decreased by 30 percent and nadired in mid-April 2020. Hospital leaders and medical experts provided public service announcements urging patients not to delay medical assessments for emergencies, concerned that serious illnesses would go untreated.

The lull in volumes was transient. In a matter of a few weeks, the hospital census was back to normal, but our OUD consult service was much busier than in previous months. As the COVID-19 crisis raged on, we saw a sharp rise in admissions related to OUD. Moreover, patients with OUD seemed to be staying in the hospital longer. Our partnerships with community skilled nursing facilities were on pause as the nursing facilities dealt with COVID-19 response plans and outbreaks of their own. Homelessness and financial strain continued to make discharges home difficult. With fewer options for discharge, more patients were completing prolonged courses of intravenous antibiotics in the hospital. Delayed discharges held up bed space for other patients, as we anticipated ongoing increases in volumes related to COVID-19. Furthermore, the length of time between hospital discharge and outpatient follow-up for medication-assisted treatment (MAT) was longer, offering additional opportunities for relapse once discharge was achieved. These distressing trends have continued.

What felt, anecdotally, like high volumes of inpatients with OUD has been borne out in our data. Joblessness, homelessness, financial uncertainties,

social isolation, and an unpredictable drug trade as a result of the COVID-19 pandemic have converged on a vulnerable population, leading to the highest consult numbers we have seen since our service launched. Compared with the previous 4 months (January-April 2020), our consult volume has increased by an incredible 77 percent in the subsequent 4 months (May-August 2020). And we know this is not just at our hospital; our surrounding county of Durham saw a similar increase in overdose-related 911 calls. (Amy O'Regan, MPH, email communication, September 9, 2020).[5] Additionally, Richmond, VA, saw a rise in patients with nonfatal opioid overdoses presenting to the emergency department.[2] Harm reduction organizations across the state of North Carolina were seeing more participants than they did before the COVID-19 pandemic and at times were unable to meet the full demand.

Why is this happening? There is no simple explanation, but the individual stories of our patients hospitalized with OUD offer insight into the impact of the COVID-19 pandemic on the opioid epidemic. One patient, hospitalized after being found unresponsive, explained that his employer continued to pay him, but his job site was temporarily closed. He stated he relapsed in the face of boredom and isolation. Another patient reported she and her boyfriend had spent their government-issued stimulus money on heroin. One patient said that the pandemic made heroin harder to come by; fentanyl was much more readily available, and her substance use pivoted toward the use of a dangerous synthetic opioid. Another patient stated that he worried about losing access to his dealer, explaining that he began purchasing larger and larger amounts of heroin at each encounter. Multiple patients mentioned the higher costs of heroin and the declining quality of heroin as the drug trade faced increasing barriers. These are complex issues, but these individual stories exemplify some general problems.

There is a clear concern that reductions in access to MAT, isolation, stress, unstable drug supply, financial uncertainties, and reduced interactions with peer support specialists and counselors may be negatively impacting patients and contributing to an increase in opioid misuse and overdoses. More frequent use of intravenous drugs increases the risk of infectious disease transmission and associated complications. Additionally, concerns over a more volatile drug supply may further contribute to complications and the subsequent rise in hospitalizations we have seen.

Despite some of the deregulations for buprenorphine and methadone instituted by federal agencies early in the pandemic, we clearly have more work to do. We know that surveyed general internists, including hospitalists, have stated they feel ill-prepared in caring for patients with substance use disorders (SUDs).[6] Yet, support for inpatient treatment of SUD has existed for some time. Prior studies have shown that initiation of medication for OUD in the hospital can lead to less illicit drug use post-discharge, but continuation of care following hospital discharge remains problematic.[7]

While the COVID-19 pandemic and the opioid epidemic continue, we are called upon to think about how best to support those in our community with OUD who are at risk of overdose, serious infectious complications, and death. Suggestions for management of hospitalized patients with SUD have been outlined recently.[3] These recommendations were based on the possibility that the COVID-19 pandemic would have substantial negative effects on those with SUD. Our experiences and data demonstrate that this feared scenario has already happened; the number of hospitalized patients with complications from OUD massively increased during this time. Because we have experienced the brutal reality of this situation, we are in a position to further elucidate the necessary interventions. While recommendations like initiating medications for OUD in the hospital and promoting harm reduction strategies are critical, other crucial components are needed as well. We must develop systems that improve access to low-barrier MAT for all patients with OUD, both in the hospital and in the community. We must evaluate more hospitalized patients with OUD for outpatient parenteral antimicrobial therapy. We must increase funding for harm reduction organizations. Moreover, we should place a larger emphasis on education. We must continue to encourage training for hospitalists and primary care physicians to prescribe medications for OUD. We must teach our resident trainees about judicious opioid prescribing as well as how to recognize and treat opioid withdrawal and OUD. Much has been accomplished in the past year, but we must continue to work harder to save the lives of our patients struggling with OUD, as their challenges have surely been made tougher by the other ubiquitous pandemic.

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