Cambridge Health Alliance's Experience During COVID: Providing Care to Our OUD Patient Population

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Editor's note: *This op-ed was prepared by Randi Sokol, MD, MPH, MMedEd as part of our Special Series on Managing Addiction during COVID-19. Dr. Sokol is Director of Faculty Development and Pain/Addictions Curriculum within the Tufts Family Medicine Residency Program at Cambridge Health Alliance and an Instructor in Medicine at Harvard Medical School. Dr. Sokol and her colleagues recently published an article about the experiences she describes here. This Special Series is generously sponsored by the Greater Boston Council on Alcoholism.*

When the COVID-19 pandemic hit us in March 2020, providers at Cambridge Health Alliance (CHA) were confronted with a dilemma: how do we continue to help our patients with opioid use disorder (OUD) remain in recovery?

Across our health system, CHA provides the majority of our OUD care via group-based opioid treatment (GBOT). In this model, patients who struggle with OUD

come together for an hour-long shared medical appointment, in which they provide support to each other, discuss a topic of interest or participate in psychotherapeutic activity, and they receive their Buprenorphine-naloxone (B/N) prescriptions.

Our prior research conducting focus groups with this patient population has demonstrated that patients appreciate the GBOT model, as it fosters a sense of accountability, shared identity, and a supportive community. As one patient explained, "It's good to have, and to be in an atmosphere with those other people like you that understand you… you know, I feel like I'm not alone…. My sisters aren't addicts, so they don't understand it. My parents don't understand it. So it just feels good. I don't feel alone coming here."

Similarly, providers value this model, feeling supported in taking a team-based approach to providing care for this highly psychosocially complex patient population. And, the model has also proven to be sustainable and lucrative for our clinics.

While CHA had been providing GBOT as a treatment approach for our OUD patients for many years, the pandemic abruptly put a stop to this delivery model. Patients who had benefited from the social support of the group were now expected to socially isolate themselves. How would they get the support they needed? And, how would they get their B/N prescriptions? How would we do urine drug tests on them?

When CHA as an entire health system converted to televisits (i.e., conducting our visits exclusively via phone or video), we decided to do the same with our OUD patients. Fortunately, because of the pandemic, new federal and state regulations enabled us to treat our OUD patients virtually to mitigate the risks of in-person appointments. The Drug Enforcement Administration (DEA) issued new regulations allowing providers to write prescriptions for controlled substances, like B/N, without an in-person appointment; Medicare granted providers the ability to bill for telehealth delivered services; and Health and Human Services (HHS) issued a "Notification of Enforcement Discretion," waiving enforcement of Health Insurance Portability and Accountability Act (HIPAA) regulations, thus allowing providers to treat patients outside of the office without breaching privacy concerns. All this essentially meant that we could see a new patient, start them on B/N, and follow up with them (and bill for it) without ever having to see

them in person.

These new laws beautifully increased access to OUD treatment and ensured our OUD patients would not go without their life-saving medication. So it seemed like a win, right?

Unfortunately, as we converted to individual telehealth visits, we learned that this format could NOT replace our GBOT approach: rather than seeing 8-12 patients/group in two back-to-back sessions (i.e., about 20 patients per clinic session), we found ourselves spending an entire day or more calling patients individually. This was taxing for providers. And, we no longer utilized our robust interdisciplinary team-based approach that made OUD care fun and doable for providers and ensured patients got all their needs met. Finally, patients missed group. "When are we going back to group?" they kept asking us.

After about 6 months of providing OUD care via individual telehealth visits, we as a GBOT community finally said, "Enough is enough." We need to figure out a way to provide group-based opioid treatment via telemedicine– t-GBOT! But how do we get there?

After gathering as a network of GBOT providers for monthly video meetings and sharing ideas and best practices, we soon evolved a t-GBOT model to help meet both patient and provider needs during the COVID-19 era. Below, I share with you a few lessons we all learned along the way in making the transition from individual telehealth visits to telehealth group-based treatment (t-GBOT):

1. We required a t-GBOT champion, i.e. someone who was VERY versed in telehealth technology AND enjoyed working with our OUD population. A medical assistant emerged with this expertise and took on this role. She would call each patient individually and set them up with our Google Meet format. This was no easy task. As one provider reflected, "Many of our patients still have flip phones without video technology. And, many of our patients have quite low technology literacy… they barely even know if they have an e-mail address or how to use it." Thus, our t-GBOT champion had to have a lot of patience, literally hand-holding patients and calling them back to do practice run-throughs in preparation for their telehealth experience.
2. We needed to implement NEW ground rules to govern our group. When patients logged onto the virtual format, we soon found them "talking over

each other" rather than listening and building off what each other was saying. To reduce frustration among patients and encourage more collaborative dialogue, we asked patients to MUTE themselves when they were not "checking in" about their week. They could unmute themselves to support a patient after that patient checked in. We created other new ground rules as the groups evolved: (As you can probably imagine, many of these new rules emerged AFTER our patients had committed an act that disturbed the trust and confidentiality and appropriateness of sharing in a group-based setting.)
    - "Please be in a quiet and confidential space, no riding on public transportation or shopping while in group."
    - "No vaping"
    - "Shirts on"
    - "No driving while in group–it's dangerous and illegal!"
    - "Cameras on at all time unless your phone does not have a camera"
3. We adjusted to new activities during group. While we previously were able to delve into rich back-and-forth dialogue by introducing topics around mindfulness or cognitive behavioral therapy (CBT), we had to provide activities with less discussion. Thus, we began our groups with an activity everyone could easily participate in (such as breathing exercises or progressive muscle relaxation) or read a prompt that each person could respond to during their check-in without back-and-forth conversation.
4. Surprisingly, we learned to challenge the utility of the urine drug screen. While we had previously used this mostly for accountability purposes (and studies also confirm that offering UDS helps prevent relapse) and never for punitive purposes (in other words, we never discharged patients for "failing" a urine test), we soon saw that patients continued to discuss relapses and close calls despite not having to submit a urine test. As the pandemic evolved and our labs re-opened, we did bring select patients back to the lab for urine toxicology testing, but we realized that we could still keep patients on their B/N while expecting and promoting honesty without mandating regular toxicology testing.
5. Finally, as intensive outpatient programs (IOPs) and 12-step meetings became less available, we continued to operate around a harm reduction model. We provided electronically signed prescriptions and extended their duration with the goal of keeping patients in group and on B/N, even

> when they were struggling and might need a higher level of care. Not prescribing and not offering groups would simply further isolate them and promote relapse, and that was not acceptable.

After 6 months of doing individual televisit appointments with their providers only, our patients were *stoked* to see each other again. They appreciated reconnecting with each other and finding out how everyone was doing during the COVID pandemic. For many folks, this one-hour of t-GBOT time was the only time they saw anyone outside of their "COVID-bubble." For a patient population that thrives off social connections and support from others with similar experiences, t-GBOT proved to be a breath of fresh air.

Over the past year, we have continued our t-GBOT model with our previous group patients and brought in new patients. Now, as the pandemic continues to shift and it is becoming increasingly safer to see patients in PERSON, we are transitioning back to our in-person GBOT model. Our t-GOBT patients have been asking for this at every session: "When are we going to actually see each other again?"

Because we know that the informal socializing and the accountability associated with showing up in person to a group each week is irreplaceable and supports patients in their recovery, we are working on shifting back to this format and figuring out how to do it safely.

The pandemic journey has taken us full circle. We, as a recovery community, have learned so much: about technology and how we all can adapt to a virtual world, about the need to reduce social isolation, the value of having communities of support for patients and providers, and how many of the roles and rules we previously adhered to were not even necessary. We also now feel blessed to be able to return to IN-PERSON GBOT. As we say at the beginning of each GBOT group visit: "The purpose of our group is to support each other in our common goal of recovery by respectfully sharing our experiences, strengths, and hopes." We will likely now enter this new phase with renewed gratitude and true appreciation for being together again!

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Conflict of Interest Statement

Dr. Sokol has no conflicts of interest to disclose of personal, financial, or other benefits that could be seen as influencing the content of this editorial.

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