

## The Impact on Opiate Use and Covid-19 in a NYC Medication-Assisted Treatment Program

### **I. Acknowledging New York State's Leadership**

I am appreciative of the opportunity to provide you with my perspective of a New York State resident, who but for the grace of God, I might have suffered the combined consequences of opiate use and coronavirus infection. These are but two of the three concurrent pandemics suffered by many New Yorkers. The other, longer standing and contributing factor is racial discrimination, experienced by communities of color. Together, they serve as the trifecta of pandemic suffered by New Yorkers.

Through my roles on the NYS Public Health and Health Planning Council and the NYS Behavioral Health Services Advisory Council, I have been a witness to the leadership of our Governor and the Commissioners of the Department of Health (NYS DoH), the Office of Mental Health (NYS OMH), and the Office of Addiction Services and Supports (NYS OASAS).

I have benefited from years of collaboration with the Coalition of Medication-Assisted Treatment Providers and Advocates (COMPA), the American Society of Addiction Medicine (ASAM), and the Advanced Health Network (AHN) and Recovery Health Solutions (RHS). AHN-RHS is an independent practice association, comprised of 51 independent behavioral health and social determinants of health organizations providing integrated behavioral health services throughout New York City, Nassau and Suffolk counties, and upstate New York.

As Chief Executive Officer of START Treatment & Recovery Centers (START), I am affiliated with a phenomenally dedicated cadre of over 280 professionals, who deliver care to an economically disenfranchised and socially vulnerable population of over 3,000 adults and adolescents, more than 60% of whom experience co-occurring mental health disorders.

START has treated over 50,000 New Yorkers throughout Brooklyn and Manhattan, since it was founded in 1969. Its goal is to provide the highest quality of compassionate, comprehensive, evidence-based healthcare and social services; education of the public concerning maintenance of healthy lifestyles; and cutting-edge behavioral, biomedical, and healthcare services research.

Its community-based treatment programs for adults and adolescents use individual and group counseling with medical and behavioral health professionals to treat patients, offering short-term, outpatient medication-based detoxification and a drug-free chemical dependency program for non-opiate substance use disorders. Its outpatient services and programs for people seeking quality treatment for drug addiction and rehabilitation include comprehensive medical care and specialized HIV services; behavioral health and vocational services; and medical case management. For more information, visit [www.startny.org](http://www.startny.org).

## **II. Impact of the Coronavirus Pandemic**

Voluminous peer-review publications and increasing efforts of public and private healthcare agencies and foundations have examined the consequences of the continuing covid-19 pandemic from an array of perspectives. Unfortunately, the focus of the current public hearing is often underrepresented in most examinations.

Whether from the Centers for Disease Control and Prevention (CDC), or the Substance Abuse and Mental Health Services Administration (SAMHSA), common findings among most reports are that communities of color or persons with a substance use disorder experienced a disproportionately higher covid-19 infection rate, hospitalization rate, morbidity, and mortality. While extremely important, these reports have focused almost entirely on containing the virus with public health interventions such as social distancing and encouraging the wear of masks and face coverings.

This often singular focus does not include an examination of decades of social dislocations and racial discriminatory systems that place communities of color and vulnerable populations at greater risks for decades and thus it is not surprising that these same populations continue to suffer at a higher rate than the general population. This is largely due to a failure to focus and embrace the approach of examining the social determinants of health.

The interruptions in treatment related to the covid-19 pandemic, has placed these patients at a greater risk for relapse and at greater risk for engagement in behaviors that place them, their families, and their communities at risk for transmission for HIV and hepatitis C virus infection. To reduce covid-19 transmission, many programs paused or discontinued their treatment protocols of clinical drug testing and group counseling. Unfortunately, these changes have the potential of either adverse events (such as overdose or diversion).

Covid-19 also resulted in the establishment of other treatment protocols to include a greater emphasis on patient scheduling and reduced clinic attendance by providing more medication to take home or home (or in some cases, hotel) delivery of medication. There was also a modification of the program admission process and the implementation of teletherapy (although largely telephonic).

The impact on the workforce in substance use disorder treatment is often under-appreciated. Due to the nationwide deficiency in the supply line of personal protective equipment, treatment programs experienced inadequacies far worse than health care workers in hospitals or general health care. This further fueled the anxiety and fears, resulting in callouts and staffing deficiencies in an industry that has a longstanding history of difficulties in recruiting and retaining clinicians. This was worsened by their own risk of covid-19 infection and unfortunate acquisition of infection in some cases. These are just a few reasons why they deserve much more recognition than they have received.

The risk for coronavirus has forced many programs to make substantial changes to their facilities. These have included establishment of isolation rooms and establishing and maintaining processes/procedures for social distancing within and outside their facilities. One of the greatest challenges for most programs has been the establishment of technical infrastructure to support teletherapy. At our agency, this has meant repurposing rooms so that patients can be connected virtual with clinicians working remotely.

All the foregoing changes occurred during an atmosphere of a rapidly changing regulatory environment involving the federal agencies (CDC, SAMHSA, DEA, etc.) and state agencies (NYS DoH, NYS OASAS, etc.). On some occasions, the guidance was not harmonious between these regulatory bodies. There were a few occasions where they added additional burden to providers. Still, because of the regulatory relief provided by NYS, many providers were able to shift their operations using telehealth services. However, the transition was not smooth due to the inadequacy of internet services in many areas, the limited minutes of telephone providers used by some patients, and/or the capacity of some patients to use the technology. Despite the implementation of these technologies, it did not adequately address the social isolation experienced by many persons served.

The covid-19 pandemic also revealed longstanding limitations in the health care delivery systems, including the limitations in public health, primary care, and mental health infrastructure. From the standpoint of behavioral health providers, this meant dedication of resources in the purchase of laptops for clinicians to work remotely and the purchase of personal protective equipment. These expenses had not been previously anticipated or budgeted. This is especially significant, given that revenues were reduced to limit in person interaction among clinicians and between clinicians and the persons they serve.

In summary, the almost singular focus on the virus, the inadequate attention to the social dislocations, and not adequately focusing upon the impact on other co-occurring medical and mental health disorders has placed communities of color and persons with mental health disorders at greater risks. The covid-19 pandemic also revealed longstanding weaknesses (workforce, reimbursement, etc.) in the delivery system.

### **III. Recommendations**

As we have recently celebrated the Labor Day holiday, this hearing represents another opportunity to recognize our behavioral health workforce. The significance this year is unlike its relevance in past years. This represents one of the recommendations I would like to offer for consideration by the committees if we are to sustain some of the positive experiences and learn from the undesirable experiences.

Related to this recommendation is a need to focus upon efforts to expand this workforce using traditional and non-traditional vehicles such as loan forgiveness for counselors. Telehealth needs to be expanded across the state, especially for those incapacitated by illness or those unable to access services in person. We cannot continue to have travel to be a barrier for access to care. Even so, telehealth should not be viewed as a replacement for in-person treatment.

Clearly, the embrace of telehealth was stimulated by covid-19. The state should consider investing in other innovations that will either enhance the access to care or the impact of services delivered. Additionally, this may be an appropriate time to review the framework of credentials of clinicians providing care to persons with behavioral health disorders.

From an access to care and an ability of providers to deliver these services, it is critical that the waiver for telephone services continue and that reimbursement of brief services continue. For the fiscal viability in behavioral health, it is imperative that rates for providers reflect the actual work being performed and account for adjustments made including length of client interaction and the use of technology to replace face to face appointments. It is also important that the state establish an inventory of personal protective equipment and consider establishing a state payroll protection plan to reduce the potential for lay-offs that will only add New Yorkers at greater risk to covid-19.

I recommend that the state encourage and support research to develop clinical tools for decision making in a virtual environment. The research agenda should also include assessments of the impact of the virtual environment to achieve optimal outcomes in substance use disorder treatment as well as patient and clinician satisfaction.

These recommendations are especially critical given the concern that reductions in services are on the horizon due to covid-19 related deficits in the state revenues. This could not happen at a worse time for New Yorkers and especially communities of color who suffered prior to the pandemic and disproportionately greater during the pandemic.

In closing, I truly hope that at the close of this public hearing that there are some undeniable take home messages. One is that there is a sustained focus on the social determinants of health to inform the development of effective interventions. Second is that behavioral health services are viewed and treated as essential health services and have access to the same resources and support that other sectors of the health care field are afforded. In my professional opinion these are critical ingredients in addressing this pandemic and those down the road, especially for communities of color and New Yorkers with opiate use and other substance use disorders.