

Countering the Opioid Crisis: Time to Act Podcast

Episode 1: An Epidemic Within a Pandemic

Guests: Dr. Kelly Clark and Daniel Sledge

Host: Ruth Katz

Narrator: Welcome to Countering the Opioid Crisis: Time to Act, from the National Academy of Medicine and the Aspen Institute. This podcast explores the most critical drivers of the opioid epidemic and key strategies to stem the crisis. Host Ruth Katz leads the Aspen Institute's Health Medicine and Society Program and co-chairs the National Academy of Medicine's Action Collaborative on Countering the U.S. Opioid Epidemic. Here's Ruth.



Ruth Katz: COVID-19 is making the opioid epidemic worse, and the opioid epidemic makes COVID-19 more deadly. The American Society of Addiction Medicine's past president, Dr. Kelly Clark, says the pandemic makes it difficult, and sometimes impossible for people with substance use disorders, or SUDs, to get treatment.

Kelly Clark: People who have opiate use disorder who get COVID have a higher risk of dying than people who get COVID who don't have opiate use disorder. This is a population that is at risk for succumbing to serious side effects or death from COVID.

Ruth Katz: The number of new and worsening SUDs is rising as people look for ways to cope with the pandemic. Daniel Sledge works with the Williamson County mobile outreach team in Georgetown, Texas. He responds to opioid-related mental health crises.

Daniel Sledge: When you're talking to some of these folks, it's like yeah, the stress of everything – I lost my job, I lost my healthcare, I'm losing my housing, I don't know how I'm going to pay for food or where I'm going to sleep tonight. All of this sort of came crashing down at once.

Ruth Katz: People are trying to deal with this unprecedented situation and the extreme levels of stress that come with it. More than 40 states have reported increases in fatal overdoses since the pandemic began. It's time to take a close look at what's going on and what needs to change. Kelly, Daniel, welcome. Great to have you here.

Kelly Clark: Thanks. It's great to be here.

Ruth Katz: Let's start by really beginning to set the stage. You've both been involved in responding to the opioid epidemic for years, actually, way, way, way before the emergence of COVID-19.

Daniel, let me start with you. Describe for us what it's been like for you since the emergence of the pandemic.

Daniel Sledge: Sure. So, I'll answer this in terms of our response on the outreach team and doing peri- and post-overdose follow up. Before COVID, the biggest thing is that, you know, we had a much larger menu of options for somebody who wanted to engage in treatment to choose from. That was the biggest difference. Afterward, several places, at first, just closed down. Or you know, some of the inpatient detox centers or respite centers were not able to logistically make enough space to have, you know, single-person rooms or anything like that. So a lot of places closed in that menu, kind of shrunk down to almost nothing. So we had to get really creative in terms of connecting people to services.

The other thing that was a stark difference is that our call volume as part of the crisis team, our call volume went way, way up post-COVID, and on top of that our staff went down, because some of them were reassigned to COVID-specific roles. So, we kind of had this double challenge, and I feel like for a while there we were just running around doing damage control just trying to put out fires. You know, a lot of people were accessing social services for the first time ever, and had become you know food insecure and housing unstable or unhoused for the first time, and kind of all at the

same time. So those are some of the biggest challenges that we've seen. A lot of people fell down kind of to the bottom level of Maslow's pyramid and were just trying to get access to food and shelter, much less medications that they may have been on for a while.

Ruth Katz: So what were some of the options they had before COVID that they lost out on once COVID emerged?

Daniel Sledge: There was an office-based opioid treatment that stopped taking new patients. One of the inpatient detoxes closed. Another one eventually went out of business, post the onset of COVID. And then I think there were fewer options for new patients to access office-based care, especially at first, when you know, so much was unknown.

So, thankfully, with some of the new provisions by SAMHSA and DEA, we were able to get people access to care, just by telemed visits.

Ruth Katz: SAMHSA is the Substance Abuse and Mental Health Services Administration and DEA is the Drug Enforcement Administration. Both are federal agencies. So, basically, people have fewer places to go.

Daniel Sledge: Fewer places to go. So, if somebody said hey, you know what, I do want XYZ service. Then it was like, all right, normally they would be taking people, and we would be able to get you in in a reasonable amount of time. But that's not an option right now.

Ruth Katz: Fewer places to go and longer waits to get in.

Kelly, what about you, how would you compare your pre- and post-COVID experiences?

Kelly Clark: I think that Daniel did a really great job of doing that sort of bottom-up approach to what's happened. Before COVID-19 we still had a problem with an adequate number of evidence-based treatment providers in every community in the country, really. But what happened with COVID is a number of things: people who are providing care can get COVID, and the understanding of what needed to happen for staff and employees to be able to function in the healthcare environment without sufficient PPE was rapid and somewhat devastating.

A lot of organizations that do treatment for addiction don't really come from a medical standpoint, and they didn't know how to do infection mitigation, etc. And large numbers of them, as Daniel said, treatment providers did in fact close down or were repurposed in a general medical area to be general medical beds.

One of the things that was really impressive, I think, about the initial response was how quickly some parts of the federal government relaxed some rules. The rules about doing telemedicine to get started on medication, basically everything but methadone, were relaxed at a federal level. In my state, which is Kentucky, they worked very quickly to relax the requirements as well at a state level for providing treatment for people with pain as well as people with addiction. The payers moved very quickly to pay for telemedicine, so that was a really rapid and important shift to some of the telemedicine.

Ruth Katz: Now that you're both in the middle of this, what would you describe as your biggest and most difficult challenges that you and those with whom you work are now facing in trying to do the jobs you do, and do so well?

Kelly, what would you say are the two or three biggest challenges that you face?

Kelly Clark: Well, our biggest challenges are always around regulation and payment. Those have been in place before, but they're also in place during COVID, because what I mentioned before, about the changes that have been allowed, those could change back in a heartbeat. Literally with the stroke of a pen, and all of that's being allowed with telemedicine could go away. So that is a huge issue for us.

Another one of the big issues is around how we're dealing with people, as Daniel said before, who now struggling at a more basic level – being unemployed, not knowing how they're going to make their rent, how to get their food, people who are at home with their children, without childcare, trying to work. The resources that are available for them, just given the entire changing society, are inadequate and are going to stay that way.

So, the other thing that that's really important for us is to try to keep people connected. That goes back to telemedicine, but things around support groups and mutual help groups and groups that aren't just for people who have been diagnosed with a substance use disorder but people with lots of different kinds of stressful issues. One of the things that's been really impactful for us as addiction doctors is trying to get information out to people on how to gather safely. How to do it in support groups and how some of this treatment can proceed.

One of the things that I would say is if any treatment providers or people who are trying to figure out how to do mutual help groups, they can google ASAM, like the American Society of Addiction Medicine and COVID. We've put up, I don't know, 15 or 18 pieces of guidance around this. That material is available for people. So just google that for some more information. Hopefully, that'll help.

Ruth Katz: Daniel, what would you say that one or two of the biggest challenges that you and the folks you work with are now facing in addressing this problem?

Daniel Sledge: You know, the biggest challenge has been the stark uptake in call volume. We need more staff.

So, right after COVID came into our area, I might be on outreach at an extended stay motel or something, I'll be in the parking lot with someone, and then 3, 4, 5 other people might come up and say, hey, I don't have food. I don't have XYZ medication, or I need help paying for another week at the motel. So, we just need we need more staff, more access to resources.

Health care resources are finite. And I think that's been one of the biggest challenges. Overall, just in general, responding to this overdose and drug poisoning crisis in the context of the pandemic.

Ruth Katz: You've both spoken to the issues that you face doing your own jobs. Let me turn to the challenges faced by patients - those individuals with substance use disorders.

Kelly, you and your team provide treatment to those with SUDs. What specific challenges has the pandemic created for these people, and how are they navigating throughout the pandemic?

Kelly Clark: Actually, people who have opioid use disorder and who get COVID have a higher risk of dying than people who get COVID that don't have opiate use disorder. We're really seeing that this is a population that is at risk for succumbing to serious side effects or death due to COVID. The problems that have been facing people with addictive diseases now are just more acute than they have been.

Our basic issue is that we have never had, in this country, any kind of coherent or cohesive or comprehensive construct of a treatment system. We need to build directly to Daniel's point, and build actual treatment infrastructure that's based

on evidence-based care. Because right now, if a patient says hey, I want help, there's no way for that patient to know or their family to know, or even their primary care doctor to know if a treatment program boundary or in the next city over that is providing appropriate evidence-based care or care that could even be harmful. So, the very baseline pieces are difficult for folks.

So, just getting into the appropriate kinds of treatment, knowing what to expect, getting the appropriate follow up, every piece of the way is problematic – it's just now also more acute with COVID.

Ruth Katz: You mentioned earlier, about stress levels going up, in addition to the things you've just talked about. I assume the pandemic has created lots of stress among those you treat, higher than normal, I suspect. Can you give us some examples of the role stress is playing in all of this?

Kelly Clark: Let me give you just one thing to think about. As a culture, we've taken a lot of things like Valium, benzodiazepines, Xanax, Klonopin, over time, those are sedative drugs that we use for anxiety. But for the last 10 years, in the U.S., there's been less and less and less prescriptions for Valium and those kinds of drugs, for 10 years, going down. From March [2020] on, our rates of prescribing for those, across the country, for those kinds of drugs, are up over 30%, for those types of sedative drugs that we use for anxiety.

Ruth Katz: And you're talking about it across the board now.

Kelly Clark: Across the board. Just that kind of sedative. The amount that people are drinking right now has been astonishing. I hear from colleagues all around the country that they can't even grasp that 20-something-year-olds are coming in with liver failure from drinking at rates that we just have not ever seen before.

People are isolating. They're without their social structure of having to get up and go to work. Structure is really important for people, to have an external structure. And they're not out interacting with their clergy, going to their doctor, just taking care of routine health things. All of those pieces have kind of fallen down and so, you know, gosh, what I would say to people, is make those connections back again.

You can see your doctor, even on your telephone in a lot of areas. You can go to a support group and reach out to your clergy by telephone, get those connections going because the more connections we all have, the better we all do as individuals and communities.

Ruth Katz: What about the stress level stress levels among health providers, including paramedics? Daniel, what's happened in terms of the stress levels with those with whom you work?

Daniel Sledge: I mean, obviously, it's shot sky-high. When COVID first came into our area, there were vacation callbacks and a moratorium on taking time off.

And so much at first was unknown. And so you're unsure what you're walking into when you make contact with somebody in direct care. And there's this level of anxiety, like, okay, is this next scene or this next call the one where somebody is going to be pre-symptomatic for COVID.

There's a hyper-vigilance, I think, among providers, like I can't get lax about anything, about masks, goggles, hand cleaning, anything like that, because the one time you do will be the time that something will get past the barrier. So, yeah, I just think a lot of heightened anxiety among providers, and the other anxiety among providers is not wanting to bring something home to our families. So, yeah, stress levels are definitely way up.

Ruth Katz: I mean, what about some examples among physicians and nurses and others you work with?

Kelly Clark: So, let's just be really, really clear. Medical personnel are dying of COVID and are also seeing that large numbers of the general population refusing to wear masks. This has been beyond demoralizing to doctors and nurses and EMTs and paramedics and respiratory therapists and the wide variety of medical providers that I work with. There's now a feeling that they are front-line cannon fodder and are no longer being respected. The burnout that has been occurring in medical professions for several years now, with increasing suicide rates, particularly among physicians - there is no sign that that's going down with COVID, but rather that is going up. General thoughts about suicide have gone up in the general population, and we're hearing lots of reports from colleagues about this across the country.

Ruth Katz: So let me ask you both this. Looking at both the impact on providers, the impact on patients with SUDs – can you speak to the impact that all of this has had, overall, in confronting the country's opioid crisis? What I mean by is are we somehow just holding on? Has progress that we might have been making slowed, or have we really lost ground in combating this national epidemic?

Kelly Clark: We've lost ground.

Daniel Sledge: Absolutely. We've lost ground. I think that pre-COVID, the status quo left a lot of room for improvement. We've got a long way to go.

Kelly Clark: We've got this epidemic of overdose deaths that's been overshadowed by our pandemic of COVID, which we rightly need to focus on. But overdoses have gone up substantially since COVID, and by the way, they hadn't been trending down, even immediately before COVID. So they've gone up since COVID, and that's superimposed on our endemic. We have drug use and misuse at very high levels in our society, even before the overdose rates, but our overdoses are going up and we are not going to be able to get a handle on COVID, we're not going to be able to get a handle on our society until we deal with our opioid and other addiction problems in this country.

Ruth Katz: Despite all the challenges you have just discussed, and even setbacks – when I said have we lost progress, have we lost ground, you both immediately said yes.

Despite the setbacks, it does seem the pandemic has brought about at least some unintended benefits, if you will, such as Kelly suggested, the relaxation of rules and regulations that have allowed easier access to addiction treatment.

Daniel, do you agree, first of all, with that some of the relaxation of rules and regulations have made a difference in easier access and, if so, can you give us some examples.

Daniel Sledge: I absolutely agree. I know there were a lot of advocacy folks who worked incredibly hard to get those changes and especially in as timely a manner as they were for DEA and SAMHSA to relax some of the restrictions on methadone or buprenorphine. For example, going out and making contact with participants who say hey, I heard about this program from someone who wanted to get started on buprenorphine, we want to start Suboxone. Suboxone is a branded version of buprenorphine, and then there's methadone, these are medications used to treat opioid use disorder.

And so, you know, looking at that menu that's now shrunk. And we're having to say okay, well, this place is not accepting new patients. This place is closed, this place went out of business, you know, and on and on. The provision for telemedicine opened up kind of a whole new item on the menu, if you will.

We partnered with this awesome addiction medicine doctor in Austin. I met these folks, the participants, in a park, at a picnic table, two meters away, of course. And I set up a hotspot on my phone, set up the laptop, made sure there was a good connection, and the doctor was able to have a face-to-face via technology with these folks, and then was able to prescribe the medication. I picked it up from the pharmacy, delivered it to them, and they were able to be on this medicine that otherwise they probably would not be able to access.

Ruth Katz: What about Narcan or naloxone, the nasal spray that can help reverse an opioid overdose – have we made that easier for people to get access to?

Daniel Sledge: We give out a ton of Narcan, and one of the difficulties is just that people are scared to engage with healthcare for several reasons. One of them, though, having to do with COVID, is that they don't want to get sick. I've seen abscesses or cellulitis, skin infections, that might have gone on longer unattended or longer without someone having gone to the emergency department because they're worried about, okay, if I go to the ER, I'm going to get COVID there, so I'm just going to not go or I'm going to try and ride this out as long as I can.

Anyone that we make contact with, we get them naloxone, and as much as they can get out into the community as well, so that's the one thing that we've continued to push, especially in our area after we've seen a huge spike in overdoses related to press pills or counterfeit pills containing fentanyl.

Ruth Katz: Kelly, you mentioned earlier telemedicine. That seems to be an unintended benefit, if you will, of the pandemic. And again, as you mentioned, the use of this technology has just skyrocketed across the board.

It has been helpful, I think, in dealing with the treatment of people with SUDs. Can you tell us a little more about it, are there other benefits or improvements, with other technologies dealing with ongoing treatment options that have really had this unintended benefit as well – can you give us some other examples?

Kelly Clark: Sure. So what telemedicine used to be before COVID is that a patient would go into a medical center? They would see somebody as staff there, they would go into a room with their telemedicine equipment, their audio and visual, they would get their blood pressure taken or whatever, the person would sit in the room with them and they would dial up basically the doctor who would be at a different location and then they would have their session there, and the person would leave their healthcare situation and go back home.

But what's happened now, the relaxation that happened with COVID is that the patient doesn't have to go into that health care center anymore. They can literally, from their home, engage in a telehealth and telemedicine interaction with their doctor or other health care provider, and that's a big change. But let me be clear - that is a temporary change that is a federal change and is around particularly Medicare payments. There's some states that still have problems with this and when the public health emergency runs out, we are not at all sure that we are going to be able to continue to do exactly what Daniel said because it requires changing a law or regulation in DC to continue to do this.

So this has been incredibly helpful and moved things much faster than they had been moving for several years, but we need to stand back and solidify those gains in order to make sure we don't lose those going forward.

Ruth Katz: That's a perfect segue to my next question and that's about lessons learned and lessons that we're still learning, both about what has gone wrong and what has gone at least somewhat right and addressing this opioid epidemic within the COVID pandemic.

Going forward, because I think we'd all agree the opioid epidemic will continue long past the time we hope the COVID pandemic is under control. Going forward, are there are things we should do differently than the way we've been doing them in the past in terms of both practice and policy?

What would you like to see being done Kelly, what would you recommend. Actually, let me put it this way. What would you tell the administration?

Kelly Clark: Oh, this is not a hard one. I would tell the administration that we will not be able to meet any of their policy goals unless we look very clearly at our drug misuse and addiction problem in the US. We cannot get people employed if they can't pass a drug test. And I will tell you that's a problem in my community where an employer repatriated 2,000 jobs and then immediately had to think about sending those jobs back overseas because literally, people couldn't pass a drug test.

If we don't help employers know how to deal with people when they get an addictive disease and how to get them back to work and keep them back at work; if we don't have appropriate childcare for people and understand that drug use and addiction is also a women's issue because we've got a lot of single parents out there – this is an issue beyond public health and public safety. This is an issue of our justice system and our social service system.

You know there was a school in Eastern Kentucky with 300 kids and 30 dead parents. I mean, we don't have parent-child days, we have caregiver-child days because so many parents are dead, in rehab, or incarcerated. Our foster care, our social services are totally overwhelmed.

What we need to do is to look at our drug problem from an issue of building an actual treatment system, that's evidence-based. Stop paying for what doesn't work, pay for what does work. Engage all of these different stakeholder groups, including the people that are in charge of insurance and the department of labor, all together to look at this from a comprehensive three-dimensional approach and then we can pull the right levers to get done what we must get done.

Ruth Katz: Let me press you a little bit. All those things are important and I think many people would agree, need to be addressed to take on this problem. But they also take a long time to implement. They're not going to happen overnight. Are there some things based upon the experience that we've had that you have seen that have really made a difference. Like the example, you've given with telemedicine that you said we want to make that permanent, or some other examples that you would say immediately we should put those into effect, and that could make a difference. Daniel jump in here, if you've got some ideas as well.

Daniel Sledge: I think that continuing the provisions for telemedicine and continuing the provisions for take homes for methadone would be a good start. I feel that we should deregulate buprenorphine and methadone as well. These need to be medicines that are left between a patient and a prescriber to decide what is best for him or her.

Other changes I'd like to see - harm reduction workers are essential health care workers. They should be treated as such. There needs to be more funding. If we could tap into some of the lawsuit money from some of the makers of some of these opioid medications and then route that funding toward harm reduction coalitions, I think that's a change I would like to see as well.

In terms of deregulating these medicines. I know that it's controversial, but the DEA should not be in health care. I would not ask my doctor for legal advice, we should not be going to law enforcement agents for medical advice.

Kelly Clark: Daniel, I think what you mean is to take away the regulations that methadone to treat addiction must only be used in a licensed methadone clinic and buprenorphine has to have training, by the clinician has to have. There's a certain cap - we can't treat more than 275 patients, even when we're experts, at a time. Is that what you meant by deregulate?

Daniel Sledge: Yes.

Ruth Katz: And that's all, that's all current law?

Kelly Clark: Yes, that's current law.

Ruth Katz: And all of those are still in place?

Kelly Clark: The things that Daniel just said, those are still in place.

But the other things that you mentioned we could do very quickly. We could do Medicaid reentry. This is incredibly important because where we see people are at most risk for dying is when they're coming out of incarceration, a jail setting, prison setting. Or coming out of rehab, where they have not been given appropriate medication to take as they leave, which would be you know methadone or buprenorphine, potentially naltrexone. And when they're leaving they are at very high risk of dying. And we know that if we give people their choice when they're leaving a jail, two-thirds of them will take methadone, a third will take buprenorphine. Their rates of dying go down so low.

I mean, they did this in Rhode Island and it decreased the entire state's overdose death rate. So something that you could do fast, and it would be incredibly impactful, would be to do that - get people into their medication treatment and turn on their Medicaid as they are leaving incarceration as well.

Ruth Katz: Kelly, Daniel, any parting thoughts?

Daniel Sledge: We talk about stigma and countering stigma. This is one of the chief barriers to accessing care for our folks. I feel that sometimes we use the word stigma when we are actually talking about discrimination, and the fact that it took this respiratory virus for there to be changes so that people with opioid use disorder could easier access proven treatment to save lives. The fact that it took this respiratory virus and not the ongoing crisis of people we have lost to overdose - to me that is the epitome of discrimination.

Kelly Clark: As we focus on COVID, which we need to focus on COVID, we cannot take our eye off the increasing number of deaths we are experiencing due to our drug problem in the U.S. The problem isn't just opioids - its opioids and stimulants, and opioids and stimulants and sedatives, like those Valium types of drugs, and it's alcohol mixed in with opioids and sedatives. We are really hurting in communities by this problem. Before COVID, during COVID it's worse, and after COVID we are going to have to pick up these pieces, and it's going to be worse if we don't start doing it now.

Ruth Katz: Kelly, Daniel, you've given us an awful lot to think about as a nation continues to confront this epidemic within the pandemic. Thank you both so much.

Dr. Kelly Clark specializes in addictive disease medicine, evidence-informed behavioral health care and payment reform. She founded Addiction Crisis Solutions and has provided expertise about the opioid crisis to many federal agencies. She's also the immediate past president of the American Society of Addiction Medicine.

Daniel Sledge is a community paramedic with the Williamson County mobile outreach team responding to mental health crisis calls. He provides follow-up after opioid overdoses to train patients and their loved ones on administering naloxone and connect them to treatment and recovery resources.

Upcoming episodes of *Countering the Opioid Crisis: Time to Act* we'll explore the role of racism and the opioid epidemic, the stigma of addiction, and the changing nature of pain management. So, don't forget to subscribe and make it easier for others to find this podcast by giving us a rating on Apple Podcasts.

I'm your host, Ruth Katz. Thanks for joining us. I hope you're staying safe and healthy.

Narrator: Ruth Katz is Vice President and the Executive Director of the Aspen Institute's Health Medicine and Society Program. She Co-Chairs the National Academy of Medicine's Action Collaborative Countering the U.S. Opioid Epidemic.

The conversations in this podcast build on the ongoing work of the NAM Action Collaborative. The Action Collaborative is committed to developing, curating, and disseminating multi-sector solutions designed to reduce opioid misuse and improve outcomes for all who are impacted by the opioid crisis.

To learn more about the Action Collaborative, please visit nam.edu/opioidcollaborative.

Our theme song was composed by Benjamin Learner and Joshua Sherman and recorded at Old Mill Road Recording in East Arlington, Vermont. The Aspen Institute's Pearl Mak created our logo. Our podcast editor and producer is Shanna Lewis. Special thanks to the Aspen Institute and The National Academy of Medicine.