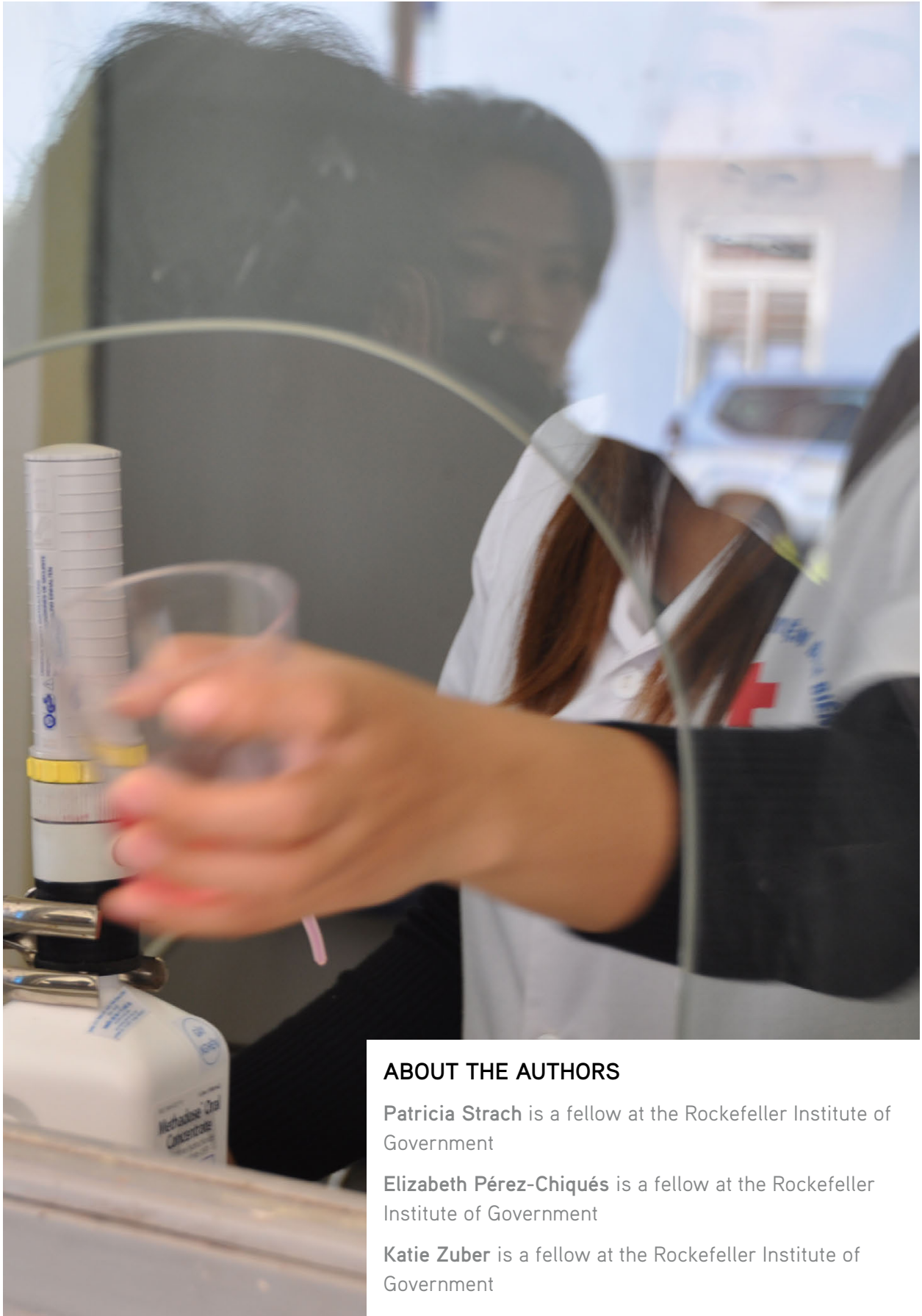# New York State's Substance-Use Disorder Services During COVID-19

Patricia Strach
Elizabeth Pérez-Chiqués
Katie Zuber

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Rockefeller
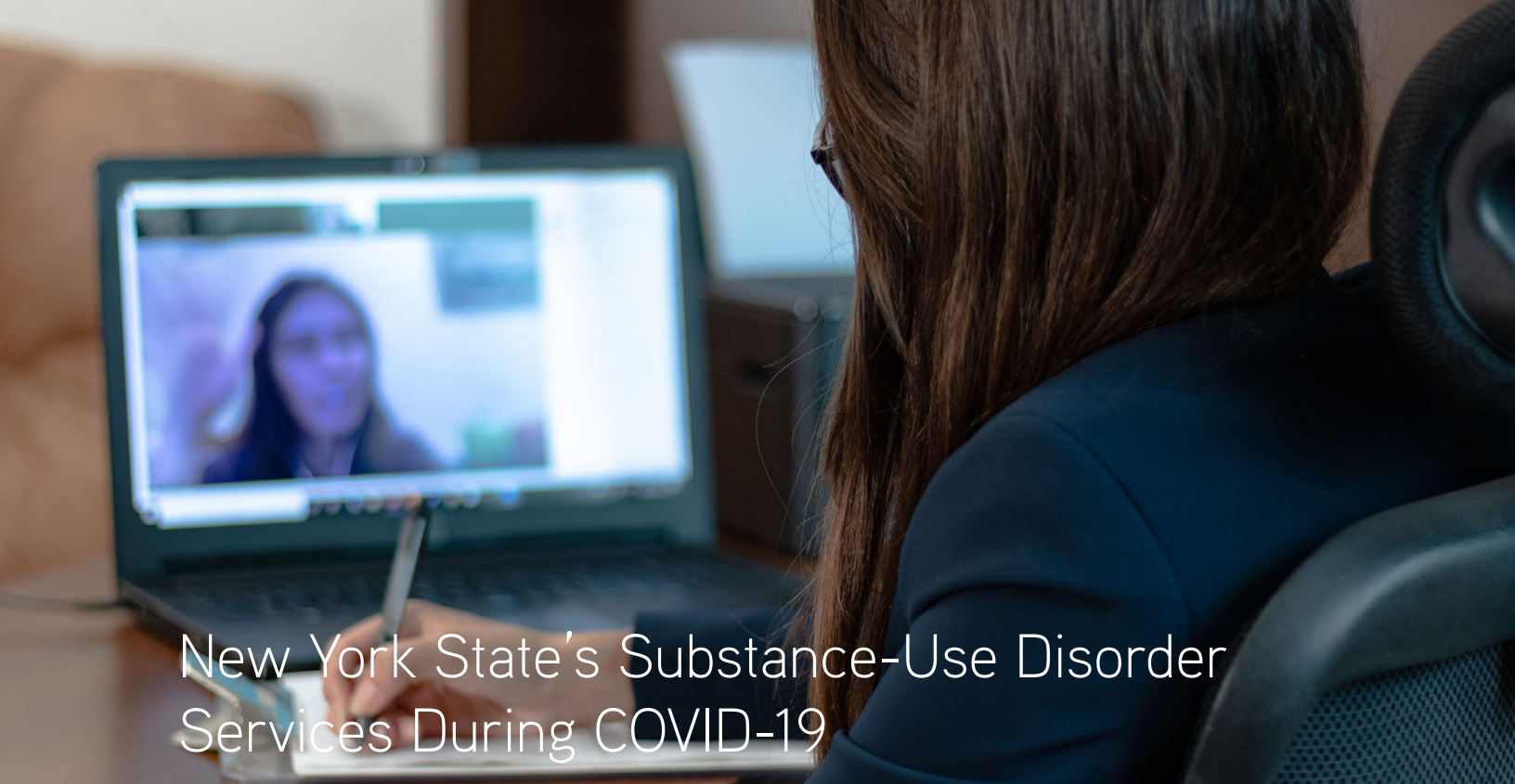Institute of Government

ABOUT THE AUTHORS

Patricia Strach is a fellow at the Rockefeller Institute of Government

Elizabeth Pérez-Chiqués is a fellow at the Rockefeller Institute of Government

Katie Zuber is a fellow at the Rockefeller Institute of Government

New York State's Substance-Use Disorder Services During COVID-19

Executive Summary

In early 2020, as COVID-19 spread to the United States, federal and state policymakers responded with extraordinary changes to policy, regulations, and guidelines. New York Governor Andrew Cuomo put the state on "pause," closing nonessential businesses to the public and sending nonessential employees home in March and laying out a series of guidelines for social distancing and personal protective equipment (PPE) shortly thereafter. At the same time, federal and state agencies overseeing substance-use disorder services relaxed stringent requirements for what could be provided (increased methadone take-home dosages), how services could be provided (allowing a wide range of telepractice services via video and audio), and shelving burdensome requirements (including in-person physical exams and frequent toxicology screenings).

In this report, we examine what happened to New York State's substance-use disorder services during the COVID-19 pandemic. How did COVID-19 affect the range of substance-use disorder services? What policy changes allowed for the safe and efficient provision of substance-use disorder services and which ones did not? And, what practices should be pursued moving forward?

To answer these questions, we partnered with the Alcoholism and Substance Abuse Providers of New York State (ASAP) to conduct a series of nine focus groups with providers and clients (81 total participants).

We found:

1. Substance-use disorder service providers faced a similar set of challenges with staffing, technology, fewer clients, and reduced revenues. Yet, what they did to adapt to the pandemic, the relative weight of the challenges, and the effect on services varied by type of service provider (residential, outpatient, opioid-treatment program (OTP), prevention, recovery, harm reduction).

2. Across the board, providers appreciated the flexibility of relaxed regulatory guidelines, allowing them to offer patient-centered care through telehealth, medication-assisted treatment (MAT), and fewer toxicology screenings. Providers noted frustration with aspects of policy and policy implementation, including lack of guidance, essential-worker status, and fiscal constraints.

3. COVID-19 offers policymakers and providers the opportunity to make changes to better provide substance-use disorder services in the future, including: flexibility of relaxed guidelines (telehealth, MAT, screenings, billing); better planning and preparation; more integrated services; fixing long-term staffing and finance issues; and including providers in the decision-making process.

COVID-19 captured public attention. But the onset of the pandemic did not lessen the burden of the overdose epidemic. Rather, access to substance-use disorder services has been more difficult and overdose deaths have increased. But the pandemic does offer lessons about the ability to provide substance-use disorder services in emergencies, the policy changes we can learn from, and productive avenues to pursue moving forward.

Introduction

After years of increases, opioid overdose deaths seemingly turned the corner in 2018. Before public health officials could respond to the good news, however, another deadlier crisis was at hand: COVID-19. On January 31, 2020, Secretary of Health Alex Azar declared a public health emergency. Six weeks later, on March 13, President Donald Trump declared a national emergency.[1] Federal agencies responded by loosening guidelines for substance-use disorder services provision, including allowing more telehealth (via video and audio), expanding take-home methadone doses, and waiving toxicology screening guidelines. At the same time, state and local officials responded with requirements for social distancing and personal protective equipment (PPE).

On March 20, 2020, New York Governor Andrew Cuomo announced the state would go on "pause" beginning March 22 (Executive Order 202.6). Nonessential businesses closed to the public and nonessential employees were sent home. In a matter of days, New York State's substance-use disorder service providers had to adapt to new federal guidelines and implement new procedures (social distancing, PPE, cleaning) to keep staff and clients safe. How did COVID-19 affect the range of substance-use disorder services? What policy changes allowed for the safe and efficient provision of substance-use disorder services and which ones did not? And, what practices should be pursued moving forward?

FOCUS GROUP PARTICIPANTS BY IDENTIFIER

R **Residential***
(Inpatient)

OP **Outpatient***
(Day medication-assisted treatment and counseling)

OTP **Opioid-Treatment Program***
(Focusing mainly on methadone)

P **Prevention***
(School or community based)

RY **Recovery***
(Continuing care and support services)

H **Harm Reduction***

FL **Frontline**

B **Business**

C **Consumer**

* Services chosen for this report to show range of substance-use disorder services.

Methods

To understand how substance-use disorder services were affected by COVID-19, we partnered with the Alcoholism and Substance Abuse Providers of New York State (ASAP) in June 2020. ASAP invited members to participate in a series of nine focus groups. We chose six groups to represent the range of substance-use disorder services offered: residential (inpatient), outpatient (day medication-assisted treatment and counseling), opioid treatment programs (focusing mainly on methadone), prevention (school or community based), recovery (continuing care and support services), and harm reduction. Additionally, ASAP convened two groups across the entire range of services on issues faced by frontline workers and issues related to business operations and fiscal constraints. We had one group dedicated to clients.[2] Invites were stratified by organization size, geographic location, and diversity to reflect the broader population of providers.

We had 87 participants across the focus groups representing 81 unique individuals (five people participated in more than one group).

Focus groups were conducted between July 14 and August 4, 2020 via Zoom and lasted 60 minutes. Each group included between seven and 13 participants. We had 87 participants across the focus groups representing 81 unique individuals (five people participated in more than one group). All interviews were recorded and transcribed using Otter.ai or Zoom software. The authors listened to all interviews and manually corrected the transcripts for accuracy.

We developed our focus group questions (see Appendix B) after conducting 14 interviews (May-June 2020) with state-level experts, substance-use disorder service providers, and healthcare experts.

Results

Our report is organized as follows: First, we summarize what happened to substance-use disorder services overall before turning to different types of service provision, asking how provision changed and what challenges each type faced. Second, we look at federal and state policy changes to see which ones made service provision more effective and which ones did not. Third, we look at the practices with the greatest potential for addressing substance-use disorder in the future.

How Substance-Use Disorder Services Changed

We asked all providers how COVID-19 affected them. The scope of change was enormous: how providers offered services (from in-person to telehealth); what they were able to provide (take-home doses for a longer timeframe); how they acclimated both staff and clients to new forms of technology; and how they balanced all of these internal changes against requirements from multiple external government oversight agencies and funders.

One provider summed up much of what we heard across the focus groups:

> [T]he world changed and spun on its head, really. And we felt it from the modalities that we provided to our clients. Whether it's medication dispensing that completely changed the way we did that, to telehealth, to the way we conducted groups and getting our clients accustomed to using telephonic or virtual care, and the whole culture of what we did changed, and then the requirements from bureaucrats and funders, and everyone else just compounded and just created chaos at some points. (FL5)

Providers faced similar challenges using technologies for new purposes, managing staff, and the uncertainty of reduced revenues. What providers faced and how they dealt with it, however, varied to some degree depending on the type of service provided.

Variation by Services Provided

Substance-use disorder services covers a broad spectrum, from prevention services that work to help people make healthy choices and to mitigate more severe outcomes to treatment services that work to help people stop using particular substances to recovery services that help people sustain their goals after treatment.

We held focus groups for the six different types of substance-use disorder services—residential (inpatient), outpatient, opioid-treatment, prevention, recovery, and harm reduction. We summarized the effects of COVID-19 public-health restrictions for each type of service, including how services changed and challenges that providers faced in offering them.

You talk about the proverbial rowing and bailing at the same time. I've never seen anything like this. We run… two outpatient clinics, 200 residential beds and multiple programs, housing programs. This is a real tightwire we're walking right now…. [I]t's hard to continually try to get the information, then to provide it to the staff, put it in a written form, and to balance it out with admitting people, not admitting people. It's very, very fragile. So, yeah, I would say utilization is a problem, staffing is a problem, the breakdown between the state agencies is a problem. It's just making things harder here. (R16)

Residential (inpatient) providers (R), who offer substance-use treatment to clients with overnight stays, had to slow admissions to their facility from 90 percent occupancy down to 70, 50, or even 30 percent to allow for cleaning of high-touch areas, social distancing, and limited PPE. Despite concerns that clients would be eager to leave to reduce the transmission of COVID-19, many providers found that patients preferred to stay because it was "the safest place for them" (R12).

Providers described walking a "tightwire" (R16), balancing demands for COVID-19 safety by slowing admissions against the demands of patients who need care. Residential facilities are built around "economies of scale," serving people in congregate care, and this type of "environment was rich for spread" (R18). Yet, slowing entry into facilities and keeping existing patients in them led to low levels of reported COVID-19 infections.

Despite social distancing precautions, staffing remained a significant challenge. Some staff contracted COVID-19, some staff had been exposed to sick family members, and some staff did not have the luxury of working from home. Providers also had challenges ramping up technology: purchasing, installing, and training staff to use new technologies. They had difficulty procuring PPE, at times competing with New York State to purchase products.

Residential providers described a lack of guidance about what to do when a patient was sick or how to deal with competing guidance among agencies. For example, the New York State Office of Addiction Services and Supports (OASAS) halted admissions to residential facilities while the New York State Office of Mental Health (OMH) continued admitting. Providers are frustrated about not being able to offer hazard pay to staff who came to work in difficult conditions. They worry with slowed admissions they are not "serving that group of people that we would normally serve" (R15). Reductions in the number of people in facilities also means a reduction in revenue. They followed state social distancing guidelines and they worry they may be "penalized for it" because the number of people in the facility is lower (R14).

[W]e have had quite a few clients not have robust enough Internet I guess you would say like they did not have the connectivity enough to sustain video connections. And so it's mostly been telephonic and again, that gets back to this, it's hard to know how people are really doing if you don't have eyes on them, at least with the video. (OP28)

Outpatient providers (OP), who offer substance-use treatment to clients without requiring an overnight stay, were able to switch from in-person to virtual services. The transition increased access for patients who may otherwise have a difficult time with appointments at a brick-and-mortar facility due to age, health conditions, work, or transportation barriers. Providers note that they have seen better documentation of client appointments by staff.

With greater reliance on technology, however, also comes challenges due to privacy (people who live in shelters, people who experience domestic violence), language barriers, and access to technology. In short, "not everybody has the ability to engage remotely" (OP26). Providers were not able to do toxicology tests and one provider described how staff "had a mixed reaction to not being able to test. I think that it's been more positive than negative" (OP30).

Although telehealth provides greater flexibility for patients, providers lack "the ability to observe body language" and "sense the emotions of a client," so "there's some give-and-take there" (OP21). Providers found it challenging to manage staff and programs through virtual means because it is "isolating" (OP22).

Outpatient providers, too, had difficulty with staffing. One provider noted that "almost 50 percent of our clinical team is on one form of leave or another," which has "really impacted the workload of everybody else and our ability to see people" (OP28). Like residential providers, they also are "not getting the volume of new people coming… into services" that they did prior to COVID-19 (OP29).

Outpatient providers worry about future funding due to state cuts, reduced reimbursements, and lack of fundraising (OP27). One noted, "I don't know how people are going to survive and maintain a program, you're going to have programs that are going to close," and the people who will suffer the most are "the ones that… already don't have a voice, that are already separated from connection to treatment" (OP20).

[W]e have a lot of shared experience. And it's very similar across the board, despite the fact that we may have services done in the parking lot because we have a large campus or it's just on a sidewalk because we just don't have the space. [T]here's a lot of overlap…. I think we need to get together, going forward, to try to figure out what's the best way to do it. And… because of this crisis, it's certainly showed us that we can adapt… very, very quickly. (OTP72)

Opioid treatment program providers (OTP), who prescribe and dispense medication-assisted treatments in person (including methadone) moved to longer take-home doses and more telehealth services. OTP providers had to quickly change each patient's medication schedule (between 200 and 1,600 patients per provider) between Friday when the state announced it was going on pause, and Monday when the pause started.

OTP providers faced challenges in creating new take-home schedules, including the logistics of preparing methadone take-home dosages and decisions about how many take-home dosages people could manage effectively. Because patients need to pick up methadone in person at the OTP facility, social distancing was also a challenge. Opioid treatment programs were creative in how they used their space: setting up drive-through dispensing, repurposing parking lots and empty rooms, and creating telehealth appointments between two offices in the same building to maintain social distancing. Providers—especially those in urban areas with little or no flex space—strategically scheduled patient appointments. Patients, for the most part, have cooperated with social distancing and PPE. They appreciate "all the efforts that we are making to keep them safe and continue to have services here" (OTP75).

Like other services, OTP providers had challenges with technology. Telehealth had "a big learning curve" for staff (OTP75) and it does not work for all patients, some "have dropped off the map" (OTP80). Telehealth makes individual counseling more accessible. But it has been hard to do group sessions through this medium. As one provider explained, "Our clients are telling us they miss the groups; they want to come. And so we're really trying to figure out a way to do that" (OTP76). Providers are looking for a way to do a "hybrid" model with some people in person and others online moving forward to meet continuing challenges (including the onset of colder weather during winter months and rural transportation).

Like outpatient providers, OTP providers believe that pre-COVID-19 toxicology requirements for number of screenings are expensive, excessive, and used as a punitive tool rather than a clinical one. They appreciate the COVID-19 flexibility in screening guidelines, which allows them to apply clinical judgement when treating patients.

Providers are worried about the increased costs in making facilities compliant with state regulations when revenue is down. OTPs were grateful for a chance to allow weekly rates rather than rates by visit; the latter, if kept, would have been "devastating" (OP72).

[H]ow does one report and still get to some level of outcomes in a world where you haven't a clue, so proposing three different scenarios, whether live, virtual, or hybrid, shifting intervention strategies, depending on the ability to meet EBPs [Evidence-Based Practices], and a relaxation…. But in terms of meeting the 60 percent EBP, we're looking for a waiver and a relaxation around that understanding the challenges that we're going to face, the uncertainty we're going to face, and just kind of a respect and a camaraderie that we're all in this together and we're all figuring this out together and you may be our regulators but you also are our colleagues and partners and we hope we can help you work together collectively not punitively. (P40)

Prevention providers (P), who offer services through schools and community-based organizations, continued providing services "without missing a beat" (P33). Providers transitioned from mostly in-person to virtual services, with an emphasis on overall healthy living. Prevention providers incorporated pandemic-related issues into traditional services, for example encouraging mask wearing as a "booster" to traditional Too Good for Drugs programs or opening an avenue to "talk about health and wellness and taking care of yourself" (P35). Prevention providers found themselves making sure that families' immediate needs for food, shelter, and safety (including masks and sanitizer) were being met.

During the pandemic, providers found greater engagement and participation from rural participants and from parents "because they were home" and able to schedule meetings (P35). Online Narcan trainings have also been popular, attracting large crowds. Video sessions allowed staff the "opportunity to see how people live, it's a very different experience than working with someone primarily at school" (P41). Some providers noted that community-partner relations improved because "we're all really trying to take care of the community and working together to do that" (P34).

Yet, providers faced a number of challenges. Most importantly for prevention services, school-based programs rely on schools for ready access to students. Prevention providers had to adapt to each school's "different abilities, different platforms" (P40). Some providers found it "very, very difficult" to engage students online and providers had to keep group meetings small (P38). Others had to pause community outreach

because "people were refusing to wear their masks" and they "weren't listening to social distancing" (P37). Like the challenges that other types of providers experienced with technology, prevention providers experienced issues with access to technology and internet connection, whether "due to economic reasons or just the locale" (P37).

Finally, fiscal uncertainty "presents its own challenges" (P38). Providers are concerned about what their budgets will be and what services they will be able to provide in the future.

[T]his isn't a political thing, this is a human being thing…. I get there's going to be differences across party lines, but, I challenged [policymakers] to work together to find a way to make this work to save lives. So that's the bottom line…. [W]e come to work every day… to save lives. (RY44)

Recovery service providers (RY), who offer support and resources for individuals to continue managing substance-use disorder, immediately transitioned from in-person to online services. Recovery centers are often (pre-COVID-19) drop-in and flexible places, unlike medical facilities with structured appointments. Transitioning to online services changed the culture of service provision.

Although personal connection is important, especially early in recovery or in long-term recovery "when things get chaotic" (RY44), new technologies allow recovery centers to provide "person-centered" services, a true "continuum" (RY45). Telehealth services worked for client wellness checks, for people without transportation, and for clients who had already established connection through face-to-face settings. Online trainings—particularly for recovery coaches—have been "thriving" (R46).

Technology presented challenges to recovery providers, too. Clients view recovery centers as "a real hub of activity" and recovery as "social connectedness" and, for some providers, those two components did not transfer to a virtual format (RY46). And, like other providers, technology requires an investment of computers, phones, software, as well as access to internet. Although access via teleservices may be easier for some people, providers found it harder to engage people in group sessions and, as one provider noted, people are "getting burnt out with technology.… Zoomed out" (R49).

Like other services, recovery service providers are planning to bring clients back into facilities in person, which requires further investment in safety measures. Yet, "as money is being taken out, we're needing to spend more money on PPE and technology and… it doesn't make sense" (RY44). They worry that the people who need their services the most will be the least able and likely to take advantage of them electronically.

[S]ubstance abuse, as long as it's been around and has impacted the lives of the communities that we serve, is not just going to magically go away…. [P]eople are suffering, they are looking for ways to resolve many of their problems and… drug addiction has been a part of an escape. It's a part of our communities. And it's not like it's an invisible issue that we've been grappling with. And it's something that's been a part of the communities for a very long time. And if we're going to get the help, people need to put aside the politics and really begin to fund the services that we know work based on proven data that helps to save lives. (H59)

Harm reduction service providers (H), who are committed to meeting people where they are at, provide a range of services from prevention to outreach to MAT. As a result, harm reduction saw significant changes across the range of services.

Although some harm reduction providers have been able to do curbside Narcan distribution and others have retrofitted vans to be able to go into communities and pick people up, without the hands-on work in the community and peers at substance-use disorder treatment facilities, harm reduction "looks completely different" (H63). Providers were not able to "offer a warm meal, a bag of food, some clothing, whatever it was… to establish a relationship with someone before they were ready to seek treatment" and that was "a huge loss for us" (H64) and has "been extremely difficult" (H62). Providers have also not been able to get out in local communities to distribute clean equipment (e.g., sterile needles), and they worry "what hepatitis C and HIV rates are going to look like after… COVID-19" (H60).

In prescribing and dispensing MAT, "reducing a lot of those restrictions has been in many ways beneficial to the patients and to us across the board" (H61). They like not having to rely on toxicology tests. But some providers have not been able to take full advantage of induction via telehealth because they "just haven't been able to reach" people who need help (H62).

Like other providers, telehealth has its advantages. Some populations are easier to engage via telehealth, and providers have been able to attract people who "were resistant to treatment before" (H64) because of comorbid health conditions like "depression, anxiety, or physical health," which make coming into the office in person difficult (H62). Telehealth allows providers to hold group sessions, but it lacks "humanness" and "connection" (H61) and is not the answer for harm reduction's "holistic approach" (H6).

Because client engagement is down, harm reduction providers are having difficulty retaining and paying peers, who are "feeling the financial impact because if there's no clients at the office, if everything is telehealth, there's not really much peer support that can go on" (H62).

Policy Changes

Treatment for substance-use disorder has long been tightly regulated: strict licensing requirements, extensive reporting, and conflicting guidelines. Prescribing and dispensing medication for opioid treatment operates under extensive federal rules. Two of the most common medications to treat opioid-use disorder, methadone (a Schedule II drug) and buprenorphine (a Schedule III drug), fall under the federal Controlled Substances Act (USC Title 21).[3] Only federally certified opioid-treatment programs may dispense methadone (42 CFR 8.12) and only DEA-waivered practitioners may prescribe buprenorphine and only to a limited number of patients (21 USC 823(g)(2)), up to 275 under an emergency waiver (42 CFR 8.655).

Federal guidelines regulate who may prescribe and dispense medication to treat opioid-use disorder, but they also regulate the circumstances under which patients are eligible to receive them. Patients must have an in-person physical exam, an initial toxicology test, and frequent screenings to ensure they are adhering to their treatment plan (42 CFR 8.12). Patients receiving methadone must come in to the facility six days a week at the start of their treatment and, gradually, earn longer take-home doses based on their compliance, participation, and screening.

In response to COVID-19, federal agencies relaxed regulations and guidelines. Notably, federal agencies permitted telehealth (including video and telephone) services; allowed patients to start buprenorphine (but not methadone) without an in-person physical exam; authorized longer take-home dosages for methadone; and shelved toxicology screening guidelines. All of these changes made services easier to provide and more accessible for patients.

However, at the same time, providers had to adapt—in a matter of days—to very different social distancing and PPE regulations.

What Policy Changes Worked? Which Ones Did Not?

Providers stressed that increased flexibility was essential for their ability to maintain services. They found telehealth, increased take-home methadone dosages, and reduced toxicology screening requirements allowed them to provide better patient-centered services. Not every patient has the same needs and faces the same barriers and these policies allowed providers to tailor services to what works best for patients.

Yet, not every change was successful. Providers found the lack of or shifting guidance, essential work status designation without hazard pay or protection, and fiscal constraints to be problematic.

Telehealth

Substance-use disorder service providers turned to telehealth to offer counseling sessions, medical appointments, and group therapy with their clients. Although telehealth is not perfect—it comes with myriad technical issues and a lack of "human connection"—the consensus in each and every group was positive. Telehealth is, in the words of one harm-reduction provider, "a godsend" (H62).

Telehealth increased access for people who previously had a hard time making appointments because of work or other scheduling conflicts, comorbid health conditions, lack of childcare, or no transportation. It opened up options for populations that were once difficult to get into treatment, such as women with young children or people who had to take time off work. Further, some people prefer telehealth to in-person engagement. One provider was able to attract "a group of people that were resistant to treatment with us before," who "did not want to come into the office and demonstrated lack of interest in participating in that kind of way but powerfully engaged with us through telehealth" (H64). Telehealth can also reduce awkwardness of in-person meetings, especially group sessions (C70).

Through a waiver, medical personnel can induct people on buprenorphine without being seen in-person first. Providers "want to get people the help they need when they need it" (OTP74). The waiver encourages providers to get people inducted "on addiction medication much faster, because it's allowed our prescribers more flexibility in their schedules to be able to schedule something with our clients" (OP30). Although individual clients responded better or worse to telehealth in general, engagement with programs went up while no-show rates went down.

But telehealth is not a blanket solution. Technology is not perfect and residents across the state face difficulties. They need access to a computer with internet or cell phones with data plans and minutes. Some areas of the state do not have access to high-speed internet (B55). Urban communities—where broadband is better but not more affordable—are not necessarily better off. Privacy was also a concern, especially for adolescents who share the house with their parents (OP27), people experiencing domestic violence (OP21), and people who live in shelters (OP26). Children were hard to engage on Zoom (P38). The effect was, as one provider explained, that some people "have dropped off the map and then lost the follow-up" (OTP80).

As much as telehealth can engage people who at times have difficulty making it to in-person sessions, teleservices are not a replacement for in-person sessions because "the ability to engage and establish rapport with a client happens best in a face-to-face environment" (OP26). Many providers noted that human connection is important for successful prevention, treatment, and recovery. One client who relapsed during the pandemic explained it was hard to find meetings, hard to talk in crowded online meetings, and hard to build trust: "when you take away the social aspect of it, the connection that you have with other people, I just found it very difficult" (C67).

Medication-Assisted Treatment

In addition to permitting services via telehealth, federal flexibility for increased methadone take-home dosages meant that patients would not have to come into the facilities as frequently. Prior to COVID-19 guideline changes, some patients on methadone would have to show up at the facility up to six days a week to receive medication. But, as one state-level expert explained in an interview, "some people don't want to go to a brick-and-mortar place because they can't get there. They don't have transportation" (#183[4]). Additionally, relaxed guidelines allowed providers to deliver methadone to patients. During COVID-19, these rules were essential for getting medication to people who were sick (OTP74).

One OTP explained how patients with symptoms came into the facility because they were worried about not getting their medication. Providers had to "get creative" and bring methadone out to their cars "or, if they were driven here by a cab, we went to the cab and dosed them at the cab…. [I]n one instance, we even had two nurses deliver methadone to one of the patients who had COVID" (OTP75). Relaxation of federal guidelines for telehealth and medication-assisted treatment allowed providers to continue offering services to people who would have suffered greatly with a disruption.

Although opioid treatment providers liked the flexibility that increased take-home dosing gave them for stable patients, they did not think that blanket increases in doses were a good idea for all patients. "[P]rescribing for a 28-day stretch" made the doctors at one facility "very, very nervous" and "very uncomfortable" (OTP76). Providers, who may have increased the number of take-home dosages, brought some patients back to daily dosing and moved others back to weekly from biweekly (OTP76). Yet, opioid treatment providers were in favor of keeping some form of relaxed guidelines and allowing medical personnel to use clinical judgement. One explained:

> I think patients deserve to be on a less rigid schedule. This is the only healthcare issue that we have people coming in six days a week. If you're a diabetic, if you're hypertensive, any other medical condition, we wouldn't subject you to come into the program at six o'clock in the morning. But on the flip side of that… the reality is patients are going to be out there, they're going to be selling the medication. We've seen it firsthand. We've seen the overdose increases because they've had a larger supply of medication on hand. So it's a delicate balance… but it can be done. (OTP 72)

Providers criticized existing regulations as "archaic" and they need to be more "patient centered" to work with physicians and counselors to manage patients better and to allow "more take-homes at an earlier time, depending on how somebody's doing in care" (OTP 74).
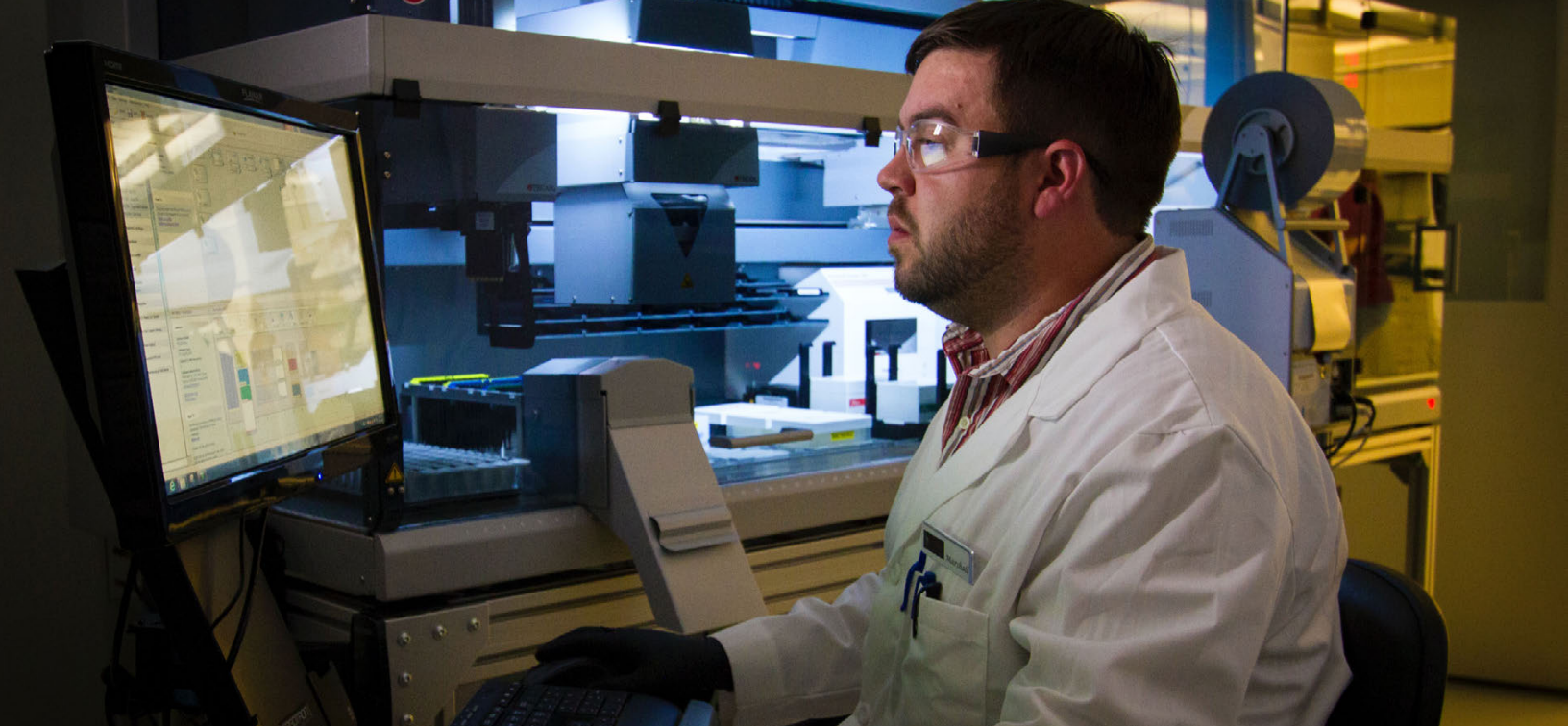
Toxicology Screenings

A final issue that came up in three of the provider focus groups, as well as the client focus group, was toxicology screenings, which are used to see whether patients have been using substances other than what has been prescribed and dispensed to them. Some providers see screenings as necessary for accountability but many object to the punitive nature in which they are administered. Providers note that toxicology screenings are useful for doctors before starting treatment and helpful early on to assess a patient's progress. Reducing or suspending toxicology tests during COVID-19 has generally been seen as more positive than negative because "we've built different relationships with our clients." Yet, some clients "struggled" without the screens because "they really liked that accountability piece and they like seeing their results" (OP 30), and screenings can be the confirmation they need "to stay on this path" to recovery (C67).

Most providers criticized the value of toxicology screens as they are currently used, noting "there's actually very little difference" between self-reporting and toxicology screens, but "we spend more on toxicology then we do on treatment. It's really absurd" (OTP74). Too often, toxicology tests are used as a substitute for clinical judgement. Providers believe toxicology should be "a clinical tool, not a punitive tool. And I think we've been using it as a punitive tool" (OTP72). Reducing toxicology screenings, or letting clinicians decide when they are needed, could "really keep clients engaged" as some providers found during COVID-19 (H59).

Remaining Challenges

Unlike the consensus around the flexibility that telehealth and extended dosing (and even toxicology screening) affords, there was not a singular policy change that providers found unhelpful. Rather they were frustrated with the uneven process of regulatory and guideline changes; they wanted clear and consistent treatment for essential works; and they are fearful of what might happen with budgetary cuts moving forward.

Lack of Guidance, Shifting Guidance

The problem of guidance came up in nearly every provider focus group we conducted. Providers felt frustration: "there was no protocol, no guidance" (FL6); "it was difficult to comprehend, and it was changing all the time" (FL 5); "interim guidance" were "more challenging than they were helpful" (FL9). Because guidance was delayed, providers "were creating our own guidance… [and] backpedaling to make sure it complied with what the state put out" (FL8). "There was so much confusion, too, that started at the top at the federal level… and then it trickled down to New York" (FL5).

Providers had to navigate rapidly changing requirements of multiple federal, state, and local oversight agencies as well as funders, all of whom could be at odds with one another. Although, even prior to COVID-19, providers noted the challenges of multiple agency oversight, they found it especially difficult during a crisis. It was challenging, one provider explained, "to follow the various different guidelines from… OASAS from the state health department" as well as "five different county health departments that we were dealing with. To say that the guidance was not always identical, or even sometimes always helpful, I think would be an accurate statement" (R15).

Even now, providers hope for longer-term guidance to help with planning. They want "continuity" and to understand the state's plan "going forward for the addiction field," noting "[w]e all do [that] individually in our own programs, in our own counties, in our own communities" (B15).

Essential Workers

Providers noted that although their staff members were technically essential workers, they were not given hazard pay or provided with PPE. In a chronically understaffed and stigmatized field, providers described frontline workers as "heroes," noting how "virtually all of them came in day after day after day, [with] no promise of incentive pay" (B52). But many of these workers stood to make more money from unemployment than in jobs that put them at greater risk for COVID-19, especially in residential settings. Although they had to come to work, providers had to scramble to find PPE "because we couldn't get on New York's list" (R10). One provider summarized the experience: "from the get go, we were told we were essential workers. But at the end of the day… I don't think our field was treated as an essential workforce" (R12).

Fiscal Constraints

Like many industries, substance-use disorder service providers are very concerned about the state of fiscal health of the field. Providers noted that policy changes during COVID-19 were helpful to keep their doors open, not only seeing clients but being able to bill for telehealth services, weekly rates for patients receiving methadone (rather than by the visit), and billing for outreach. Many also applied for federal Paycheck Protection Program (PPP) funding, to help maintain payroll and cover overhead. These financial changes have been a "lifeline," but providers worry "how long those will be in existence" (B52).

"…we were told we were essential workers. But at the end of the day… I don't think our field was treated as an essential workforce."

Providers have increased expenses and reduced revenues. They did not budget for technology (purchasing computers, cell phones, minutes) and protective equipment (masks, plexiglass barriers). They are experiencing lower numbers of patients in residential settings, fewer appointments at methadone facilities, and less traffic in office-based environments. With looming budget cuts to state and local government, they do not know how they will meet expenses. One provider noted they have "just 30-days worth of payroll" (B54). It's not just lack of resources that's a problem, it's a lack of information about what will happen in the future. Another provider explained: "The biggest challenge is… the uncertainty of everything, right, and so managing. Everything is so uncertain from what cuts are coming… will regulatory relief continue or not, how will things like the PPP loan be applied?" (B53).

Potential budget cuts threaten the state's ability to address substance-use disorder. Providers wondered, "how do we sustain our staff, our programs, so that when this whole thing does finally resolve, the system isn't wiped out?" (R18). And, without a financial cushion to fall back on, providers do not have room for cuts. At the time of the focus groups, it was unclear how New York State would treat federal PPP funds, which many cited as beneficial. One provider explained PPP money "just kept us solvent for those eight to 10 weeks. I'm sure everybody thought things were going to get better. Well, they're not." And, further, if the state wants the PPP money, "swing by, I'll drop the keys off. You can have everything because… we're done" (R16).

Practices to Pursue Moving Forward

We can learn many lessons from COVID-19 about what kinds of policies and practices the state and the state's substance-use disorder service providers can pursue in the future to prepare not only for the next major crisis but also to offer services more effectively even during noncrisis times. This section summarizes what policies providers would like to pursue moving forward to better provide safe and effective services, both those policies that were put in place during COVID-19 to address substance-use disorder, and those weaknesses that COVID-19 highlighted that ought to be addressed.

COVID-19 Policies to Keep

Providers like the flexibility that accompanied new guidelines for telehealth, medication-assisted treatment, toxicology screenings, and flexible financial rules. They believe that flexibility will allow them to provide tailored, patient-centered care. Not every facility took full advantage of federal relaxation: some providers still offered in-person sessions, especially for patients at risk (e.g., domestic violence); medical directors at some opioid-treatment programs capped take-home doses at 14 days; and some providers continued—or even increased—toxicology screenings. Yet, they all appreciated the ability to use their expert, clinical judgement to meet individual needs.

Providers want the temporary regulations around telehealth (including video and audio-only options) to continue. They want to be able to offer a "continuum" of services (RY45), including in-person, telehealth, and a hybrid of the two. They want to continue

to allow buprenorphine induction via telehealth "to get people to help they need when they need it" (OTP74). These services are helpful during the pandemic, but they would be beneficial for New Yorkers in the long-run, too. As one provider noted, "I can't tell you how many times in the winter time… patients don't come in because of weather" and it would be a real benefit to have telepractice (OTP75).

Providers also want increased flexibility around methadone take-home dosages to continue. Some providers were ready to go back to shorter time frames. They emphasized the proper take-home dosages were patient specific. One provider summed up, "we actually think that having the flexibility to dose people differently has worked in our favor, clinically. We just want to now be able to make a better clinical judgment as to who gets what" (OTP 76).

Providers were mixed, though generally favorable, with allowing more flexibility for the number of toxicology screens (often set by other state or city agencies). Courts and other agencies request a "toxicology once a week, and I can do a toxicology five times a week. It's not going to change what I do" (OTP72). Toxicology needs to be a clinical—not merely punitive—tool.

Providers were grateful for changes in financial rules, which allowed them to continue to provide services. For example, Medicaid reimbursement for follow-up after residential discharge helps patients with continuity of care (R13); bundled rates for OTP providers allowed flexibility for stable patients to increase their take-home dosages (OTP74); and better telehealth rates made it a viable option to help clients (OTP75). Providers suggested that allowing them to bill for time that clients need rather than in set increments would give patients the care they need: "if a patient needs to be there for an hour and a half, patient needs to be there an hour and a half. If you can provide a service in 15 minutes and the patient gets what they need then so be it" (OTP72).

In sum, flexibility is key but providers also want to know what works. "Flexibility and options are critical as we move forward and if we're going to build it better" but, one provider noted, they also want "guidance and feedback in terms of… best practices" (OP26).

Policies to Build It Back Better

COVID-19 shone the light on weaknesses in the current system, too. Looking forward, providers suggest areas of improvement, including: better planning, more integrated services, and a seat at the table in future decisions.

Better Planning: COVID-19 offers providers and governments more generally an opportunity to think about preparedness for the next major crisis. New York State may continue to face COVID-19, but it will also need to prepare for hurricanes, tornadoes, floods, and fires (FL3). The goal should be a committee or group that focuses on a "state of readiness" (FL3).

To the greatest extent possible, providers want longer-term (more stable) guidance, rather than shifting rules. They note with everything up in the air there's "anxiety that

permeates" both staff and clients (P36) and having some stability "would take a lot of stress off of programs" (R15). With the likely event that COVID-19 will last long past the time of the focus groups, "give us at least, 18 months, two years of emergency regulation that really expires it sometime in 2023. Then we will have data" to make good decisions (B51).

Integrated services: Providers believe that the best care is integrated because it lessens the likelihood that people with substance-use disorder will fall through the cracks. One client explained what it was like navigating siloed services: "I had to go to a detox. And then I had a wait. Wait for an opening for a rehab… you want to definitely go from detox straight to rehab. You don't want to be left on the street" (C67).

Many times, conflicting rules and policies make integration difficult. One provider explained, "when we begin to understand that prevention… and recovery are more alike than they are at separate ends of the spectrum, then we really could do some good work" (P39).

Staffing and finances: Although providers did not have a singular policy solution to staffing and finance issues, these long-term problems (which were issues prior to COVID-19) need long-term solutions and should be a priority in building it back better.

COVID-19 shone light on financial weaknesses like the inability to have a cushion or rainy-day fund in case of crisis. The state's last dollar contribution , which assesses the state's contribution only after all other financial aid is calculated, is a "design flaw" that makes providers "incredibly vulnerable to any type of interruption of revenue, any type of take up, any type of unplanned costs" (R10). Although providers are well aware of the reality of budget cuts, these cuts are taking place at the same time that there is growing awareness that underserved communities—especially communities of color—bear a disproportionate impact.

> You are talking about the effects of COVID on minority communities. And the first thing you do is you hold, you withhold, or you cut funding to resources that are supposed to address the same issues that cause some of the problems that happened, right. So mental health, substance use, physical health conditions, poor transportation, poor economics, joblessness, I mean, education, all those combined to cause the problems in minority communities. You don't really have to… spend too much money to study it, it's there. It's blatant. The structures have been built and they're loaded with racism. (FL5)

Staff shortages in substance-use disorder services were common before the pandemic and across the country. They do not get easier during COVID-19, especially when they are essential workers but not given priority as such. Workforce issues "bubbling under the service" include lack of diversity (B51), need for training, and inadequate payment and benefits (B12). One provider summarized the difficulty retaining staff: "I'm not losing those staff to another provider. I'm losing them to Best Buy, or someplace where they say, 'I'm not going to do this anymore. I'm not going to get paid. I can get paid the same money and not get spit on or told I'm a 'terrible person' and then not even get recognized during" COVID-19 (B57).

Although every provider recognized the difficult financial situation they—along with local and state governments—are in, they also recognize that workforce issues are only going to become more challenging. As one provider explained "[W]e can build it better, but we can't continue to do it on the backs of those that we have walked on and pulled from and begged from and who have done it willingly for many years. We can't continue to go to that well and not replenish it" (P33).

A seat at the table: Whatever alternatives are on the table, providers want to be included in the decision-making process. When considering new policies, "have the people that actually have to implement them at the table so that we can share with you the realities of what they're going to mean and the expenses" (B57). Rather than be presented with rules already created that need to be implemented, they want to hear about ideas that agencies are considering, that other states are doing, or that the federal government is taking up. "It would make a huge difference if those were the kinds of conversations that could precede any changes" (R15).

Conclusion

The pandemic has put stress on Americans, and many Americans with substance-use disorder have been struggling. Healthy habits—like gyms and movies—and even some Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings shut down. But unhealthy habits were easy to find. According to one client: "There's plenty of liquor stores open…. I find myself out in the real world wondering 'well what am I going to do for the next couple hours?'" This person asked how is it that meetings are not open when "the liquor stores never closed?" (C69).

As the need for services has grown, access has shrunk. Providers balance "having space to be able to help people" against "not being able to actually bring people in," which is "difficult because we still have people who are struggling in our community" (R13). Providers "have

> "…how is it that meetings are not open when 'the liquor stores never closed?'"

seen a significant increase in overdoses" and while "[w]e're trying to figure out what the risk of COVID is," "the risk of the overdose is still very much present at our door" (R13).

Providers are well aware that the risk is not shared equally. COVID-19 added a layer of stress on communities that were already underserved on a number of dimensions. One provider explained that the disproportionate impact was neither surprising nor new "because those communities were so stressed to begin with. There was so much underserved. Everything: health care, economic opportunity, employment, quality housing, there really has been a crisis in these communities for a very long time. And COVID really just exacerbates, it exploits… the systemic problem that's already there" (FL10).

For clients, it has been difficult to access services. Yet, it is crucial to provide help when people with substance-use disorder are ready for it. One client explained: "there was a waiting list for almost every inpatient place, which is unbelievable. I was in active use and I'm calling, begging, for help and they're saying 'oh well call back in a week or two.' That week or two I might not have made it…. [I]f you're telling an addict that's pleading and begging for help to just call back or wait… in a day, he might not want that same service" (C67).

If there is a "silver lining" (RY45) in substance-use disorder service providers' experience, it is the opportunity to reassess services: the "archaic" (OTP74) regulations that remove professionals' discretion and the "punitive" guidelines toward patients (OTP72). It is an opportunity to wrap "services around the individual" and offer a "continuum" (RY45).

Although COVID-19 dominated public attention, the opioid epidemic did not go away. Evidence from individual counties suggests that substance-use and drug-overdose deaths increased. This report suggests that there are lessons we can learn in the short-term about what worked and what didn't and opportunities that we can take to strengthen the state's ability to meet the needs of some of the most vulnerable New Yorkers.

Appendix A. Variation by Geography

One notable feature of the focus groups was how federal and state rules and regulations had an unintended differential impact based on geography. Notably, rural providers, who had long struggled with transportation difficulties, benefitted from teleservices even though access to technology was a problem across the state. Rural and suburban providers also had better access to space to meet social distancing requirements. We summarize below the geographic differences in transportation, technology, and space.

Transportation: One of the most common problems rural communities have long faced addressing the opioid epidemic is transportation. Rural communities have few (if any) substance-use disorder services and with large geographic areas and little or no public transportation, it is hard for residents to access services.[5] One provider explained: "I can get somebody from [point A] to [point B], which is over an hour drive on public transportation, but they have to leave their house at six fifteen in the morning to get here by nine in the morning, and then they're here until five o'clock at night" (RY44). With telehealth, however, rural transportation problems were alleviated. One Buffalo-area provider, who serves the city and surrounding rural communities, described how participation increased and no-show rates decreased because "the further out of the city center you get, the more challenging transportation becomes. So having virtual services, both individually and groups, has really helped us overall" (OP19).

Technology: Technology is not perfect, and residents across the state faced difficulties. They needed access to a computer with internet or cell phones with data plans and minutes. Some rural areas of the state do not have access to high-speed internet (B55). Urban communities—where broadband is better but not more affordable—are not necessarily better off. One provider explained, "a lot of times people think that the suburbs are the areas that have internet issues or rural areas and we experienced that in the city, that we had a lot of internet issues" (FL4). Privacy was also a concern, especially for adolescents who share a home with their parents (OP27), people experiencing domestic violence (OP21), and people who live in shelters (OP26).

Space: Rural and suburban communities also had greater access to space, which became crucial in implementing the state's social distancing guidelines. Upstate rural and suburban providers had access to parking lots, outdoor space, and vacant rooms and buildings. They rented tents and retrofitted current office space to be able to meet the social distancing requirements. One rural methadone provider turned the facility's parking lot into an innovative drive-thru dispensary:

> We're fortunate enough to have almost four acres on our campus here… our parking lot is the queue. And so patients either come into the parking lot or if they're by, you know, public transportation there the security just kind of holds them in a queue and our mobile van is our dispensing unit now…. It's quick and easy and so it leaves our building more open to see patients inside we have less patients coming in than we used to. (OTP74)

New York City's providers, though, had a much more difficult time both because they faced COVID outbreaks among their staff and clients and because they had little room to expand. Unlike rural providers with large campuses and parking lots, one New

York City provider explained, "We obviously have zero outdoor space in the middle of Manhattan" (OTP76).

Residential facilities across the state had to decrease their census from occupancy rates of 80 to 90 percent, in many cases, to 50 percent to meet social distancing requirements. As one provider explained, "much of residential treatment is built on economies of scales that do not work" (R18). Clients literally are "on top of each" other in bunk beds in shared rooms, which is particularly tight in urban areas with small spaces (FL3). Many facilities have only one elevator and that can be an extra challenge with social distancing. State guidelines mandate a minimum of 80 square feet of space in a single room, 60 square feet per person in shared rooms, and 40 square feet for facilities operating in 2002, which were grandfathered into the regulations.[6]

Appendix B: Focus Group Questions (General)

1. What has changed since the state officially went on pause, March 22, 2020?

2. So, there were a number of regulatory changes at the federal and state level. What were the key regulatory changes for you and how has this changed what you do?

3. Do you see any benefits from these policy changes? Any pleasant surprises? What modifications should continue after the pandemic ends?

4. Did anything harmful result from these changes? Are there policies you would like to see discontinued once the pandemic subsides?

5. Is there anything that we didn't cover that we ought to know?

Endnotes

1   Jennifer K. Elsea, et. al, *Emergency Authorities Under the National Emergencies Act, Stafford Act, and Public Health Services Act* (Washington: Congressional Research Service, July 14, 2020), https://crsreports.congress.gov/product/pdf/R/R46379.

2   Participants are identified by focus group and number identifier: residential (R), outpatient (OP), opioid-treatment programs (OTP), prevention (P), recovery (RY), harm reduction (H), frontline (FL), business (B), and consumers (C).

3   For a list of controlled substances see: https://www.deadiversion.usdoj.gov/schedules/orangebook/c_cs_alpha.pdf.

4   This is from one of the 14 interviews that were done to develop questions for the focus groups.

5   Stacey C. Sigmon, "Access to Treatment of Opioid Dependence in Rural America: Challenges and Future Directions," *JAMA Psychiatry*, 71, 4 (April 2014): 359-60, https://jamanetwork.com/journals/jamapsychiatry/article-abstract/1819581.

6   New York State Office of Addiction Services and Supports, "Part 814: General Facility Requirements," https://oasas.ny.gov/system/files/documents/2019/05/814.pdf.

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