PCSS Providers Clinical Support System

Buprenorphine Treatment in Non-Traditional Settings

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Disclosures

- **No financial disclosures**

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

Target Audience

- The overarching goal of PCSS is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.

- The Fundamentals of Addiction Medicine ECHO (FAME) series is for physicians, physician assistants, nurse practitioners, nurses, and behavioral health specialists. It is designed for those new to treating patients with addiction and for individuals who have had little or no addiction training.

Educational Objectives

- At the conclusion of this activity participants should be able to:
  - List effects of War on Drugs on health inequities for people who use drugs
  - Describe how Drug War Logic might inhibit participation in traditional healthcare settings for people who use drugs
  - Compare strategies to provide harm reduction and low barrier access to buprenorphine outside of traditional medical or treatment settings

Harm Reduction: Low Barrier Buprenorphine

1) How do failed War on Drug policies prevent access to Harm Reduction and Evidence-Base Treatment?
2) What barriers prevent access to buprenorphine for opioid overdose prevention and treatment of opioid use disorder?
3) What strategies to lower barriers to access have worked?
4) What does success look like?

Undoing Drug War Logic

- ***Drug War Logic***
  - Prioritizes and justifies drug prohibition, criminalization, and punishment
  - Fuels the expansion of drug surveillance and control mechanisms, negatively impacting key social determinants of health, including housing, education, income, and employment
- To improve individual and collective health, ***healthcare providers should resist drug war logic*** and work to transform these systems so they can truly promote health and safety.
- When has drug war logic shaped your practice in ways that you regret?

Cohen (2022)

Failed Policy and the Overdose Crisis

Self Reinforcing Processes:

- Trauma/ACES predispose to SUD, MH and Suicide
- Criminalized drug use frequently leads to incarceration, which impedes future employment and housing
- Unemployment, eviction and homeless associated with increased overdose deaths
- Accumulation of trauma
- Social and Health care services available at each node?
- Less likely to access traditional care voluntarily due to stigma and control

Buprenorphine: Preventing Overdose Deaths

- Disability Medicare recipients (age 18-64) who received treatment for non-fatal opioid overdose in ED
  - N=81,616
  - **62% reduction in risk of overdose death if treated with buprenorphine after non-fatal overdose**
- BUT
- Few are treated: 4.6% received buprenorphine in following year
- Fewer are treated soon enough – not initiated at time of overdose
- Fewer are treated consistently – gaps in treatment frequent and dangerous

- Similar results in Medicaid populations
  - Massachusetts study: buprenorphine 37% reduction in risk for all cause mortality and 38% reduction in risk of opioid related death
  - Only 17% treated buprenorphine

Samples (2023), Larochelle (2018)

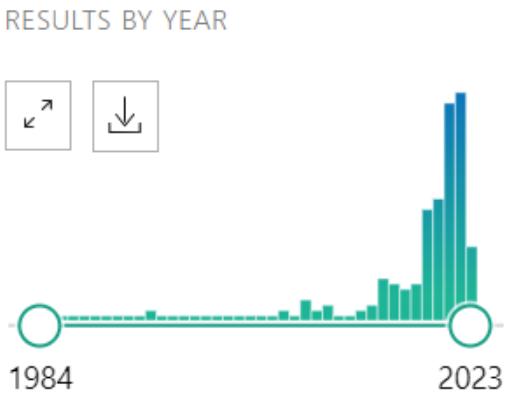
Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: a Rapid Review

Barriers	Patients	Clinicians/Administrators
Stigma	Social Stigma Self stigma Buprenorphine Stigma	Social Stigma Stigma of patients with OUD Buprenorphine Stigma
Treatment Experiences and Beliefs	Willpower more important than treatment Treated poorly by staff in past Rigid treatment structure	Lack of patient need/desire Lack of interest/motivation to rx *Perception unwillingness among clinicians
Knowledge Gaps	Lack of education OUD treatment Uncertainty where to find care	Lack of training on OUD Lack of confidence tx OUD Perception OUD medications not effective *Lack provider awareness
Logistical Issues	High out of pocket costs Long wait times “First fail” policies	Time constraints Low reimbursement Inability refer to pscychosocial supports Diversion concerns Lack institutional supports Prior authorizations Requirement concurrent counseling

Mackey (2020)

What does “Low Barrier” mean?

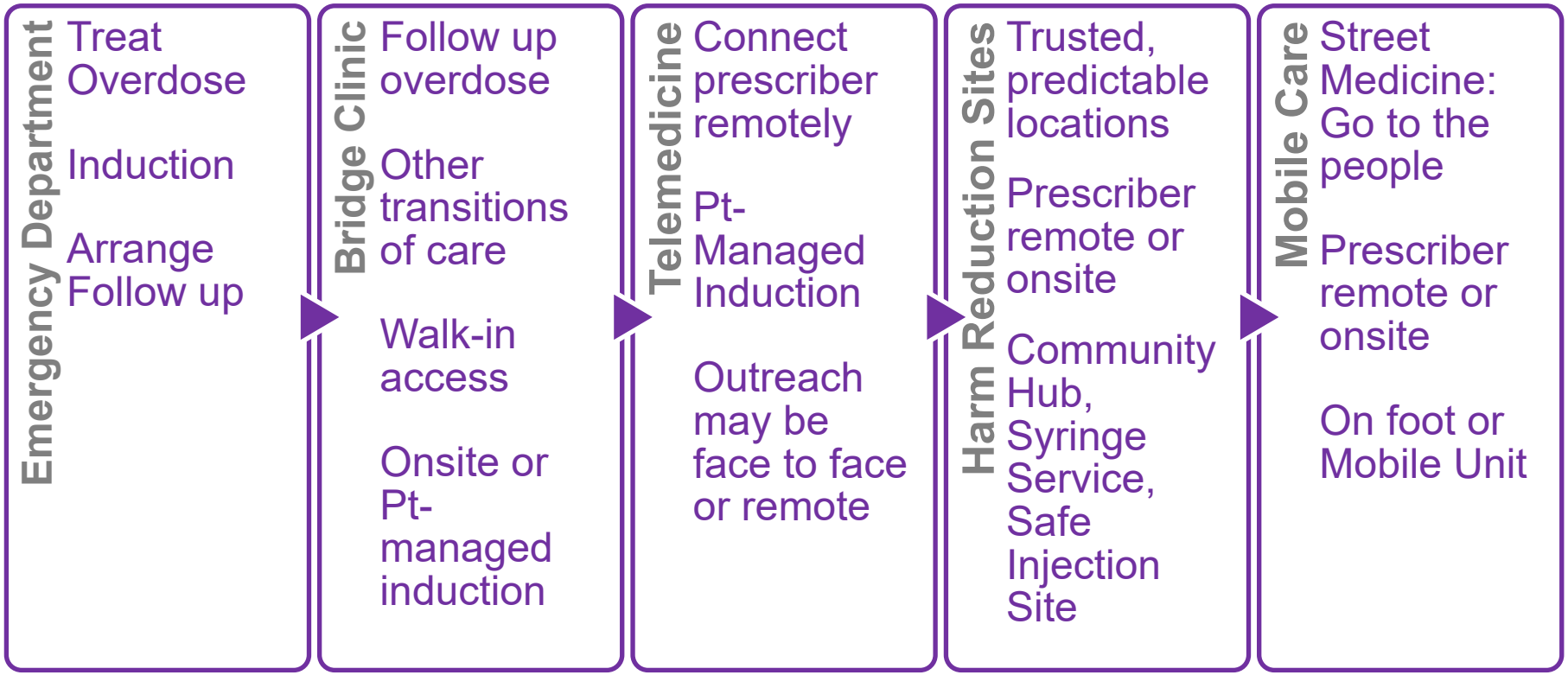
- PubMed: Growing interest!
- Act of resistance to Drug War Logic
- But what does it mean?



- “Remove as many barriers as possible”
  - Same day treatment
  - Harm Reduction Approach
  - Flexibility
  - Wide availability in places where PWD go

Jakubowski (2020)

Low Barrier Buprenorphine Strategies



Common Features

- Peer support
- Interdisciplinary teams
- Flexible access
- Focus on Harm Reduction
- Multiple pathways
- Improve quality of life
- Reach people with low trust in health care
- Co-creation and Shared Power

Our Mobile Harm Reduction Team

Radical Welcome

- Everyone has a story
- Everyone has the capacity within themselves to heal
- Healing happens in relationships
- Relationships happen in community

Peer Support

- Lived experience that is Hyperlocal
- Team support with Case Management
- Harm Reduction approach
  - Multiple pathways, consistent visibility. Trustworthy follow through

Community Engagement

- Community Harm Reduction Guides
- Mutual education and information
- Collaboration with informal and formal networks of care

Low Barrier Access Buprenorphine

- Limited hours due to resources
- Mobile in neighborhood of high impact
- Low dose or high dose initiation
- De-emphasize urine tests

Mobile Care in Action: Meet DB

- DB gave me permission to share his story
- DB describes himself as a heavy fentanyl user, 3-4 bundles daily when he can afford it. He has used heavily for about 20 years, sometimes interrupted by incarceration, and once with successful inpatient stay.
- He met his wife in treatment, and they vowed to do well by each other, but within 3 months they were both homeless and using heavily. She developed terrible skin infections and her mental health deteriorated.
- I met DB about 3 months after he engaged with the Street Medicine team, when I went with team to their tent to check on wife. She declined to go to hospital due to her past experiences being treated with hostility and not feeling her needs were met.
- He said he felt hopeless and could not seek solutions for himself if his wife was not safe in treatment. He also described himself as a hopeless case that no amount of treatment could help.

Team Approach for DB

- **Radical Welcome:** Frequent contact, sometimes only social, build trust by showing up, following through and no judgement
- **Peer Support:** Any positive change - wherever he needs us, whenever, even if he sometimes avoids one of us
- **Community engagement:** multiple community partners, our role is to support positive approach
- **Low barrier buprenorphine:**
  - We tried low dose initiation
    - unable to tolerate precipitated withdrawal even at tiny doses
    - Another attempt interrupted by incarceration
    - Another attempt interrupted by partner wanting to use
  - Street Medicine team asks: Is he diverting? Does he really want help?

Diversion and Non-prescribed buprenorphine

- **Low barrier care as diversion prevention**
- Most diverted buprenorphine used for self-initiated treatment or withdrawal management
- Those who are self-treating when admitted to treatment show
  - Improved retention in treatment
  - Improved attitude toward MOUD
  - Lower opioid use
- Prevent diversion by offering evaluation and treatment of patient network of associates

Williams (2022) Rubel (2023)

Patient Safety and Low Barrier Access to Buprenorphine in Non-traditional Settings

Relationships!!!	Assessment for OUD diagnosis and comorbidities	Agreements and safety education
Patient Prescription Monitoring Database	Easy access for partners/associates	Overdose prevention education • Naloxone for friends • Never use alone • Avoid sedatives (benzodiazepine, alcohol)
Anticipate some continued use: Harm Reduction not punishment	Intermittent treatment is better than no treatment	Flexible scheduling with goal of increasing stability

Access to Treatment

- DB and his partner decided that they needed a different setting for help:
  - Admission to 4 different withdrawal management programs
  - DB left early each time (wife finally stayed at one!)
  - Unable to tolerate anxiety and overcome his negative self image
  - Unable to return to high quality evidence-based center : “banned” after leaving twice
- Team continues to “hover” and build relationship, treat cellulitis, abscess and hypertension
- Finally receives word from wife and a gift
- Successful macro-induction (3x12/3mg)
  - Currently 2 weeks with reduced use
  - No cravings/withdrawal 12/3mg BID
  - Starting to think about goals

What has our team learned?

- Relationships are everything – It's all about love
- There may be a thousand pathways, and most of them are not straight lines
- The impact of criminalization and institutional stigma is profound
- People have good reasons not to trust healthcare
- We have to earn trust by doing things differently
- Low Barrier Buprenorphine based on shared decision making is possible in non-traditional settings

Partnerships for Buprenorphine in non-traditional settings

Challenge Drug War Logic by talking to people with a different perspective	Nothing about us without us	Strengthen relationships with people most affected by stigma and disparities
Support peer recovery specialists	Bring resources to the table: Prescribers, telehealth technology	Invest in communities impacted by war on drugs
Share power equitably	Practice Harm Reduction	"It's all about love"

References

Bradford AC, Bradford WD. (2020) The effect of evictions on accidental drug and alcohol mortality. Health Serv Res. 55(1):9–17.

Batts, H., Joseph, R., & Stoeffler, S. W. (2021). Addressing Engagement Suppression in Black and Brown Racialized Communities. Social Development Issues (Social Development Issues), 43(3).

Carter J, Zevin B, Lum PJ. Low barrier buprenorphine treatment for persons experiencing homelessness and injecting heroin in San Francisco. (2021) Addict Sci Clin Pract. 14(1):20.

Cohen A, Vakharia SP, Netherland J, Frederique K. (2022). How the war on drugs impacts social determinants of health beyond the criminal legal system. Ann Med, 54(1):2024-2038

D'Onofrio G, O'Connor PG, Pantalon MV, et al. (2015) Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial. *JAMA.* 313(16):1636–1644.

Jakubowski A, Fox A. (2020) Defining Low-threshold Buprenorphine Treatment. J Addict Med. 14(2):95-98.

Jakubowski A, Norton BL, Hayes BT, Gibson BE, Fitzsimmons C, Stern LS, Ramirez F, Guzman M, Spratt S, Marcus P, Fox AD. (2022) Low-threshold Buprenorphine Treatment in a Syringe Services Program: Program Description and Outcomes. J Addict Med. 01;16(4):447-453.

Leo P, Gastala N, Fleurimont J, Messmer S, Maes P, Richardson J, Neeb C, Stackhouse N, Koruba S, Watson DP. (2021) A Community Partnership to Improve Access to Buprenorphine in a Homeless Population. Ann Fam Med.19(1):85.

References

- Larochelle MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, Bagley SM, Liebschutz JM, Walley AY. (2018) Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. Ann Intern Med. 169(3):137-145.
- Mackey K, Veazie S, Anderson J, Bourne D, Peterson K. (2020) Barriers and Facilitators to the Use of Medications for Opioid Use Disorder: a Rapid Review. J Gen Intern Med. 35(Suppl 3):954-963.
- Rubel SK, Eisenstat M, Wolff J, Calevski M, Mital S. (2023) Scope of, Motivations for, and Outcomes Associated with Buprenorphine Diversion in the United States: A Scoping Review. Subst Use Misuse. 58(5):685-697.
- Samples H, Nowels MA, Williams AR, Olfson M, Crystal S.(2023) Buprenorphine After Nonfatal Opioid Overdose: Reduced Mortality Risk in Medicare Disability Beneficiaries. Am J Prev Med. 9:S0749-3797(23)00052-1.
- Suarez E , Jr, Bartholomew TS, Plesons M, Ciraldo K, Ostrer L, Serota DP, Chueng TA, Frederick M, Onugha J, Tookes HE. (2023) Adaptation of the Tele-Harm Reduction intervention to promote initiation and retention in buprenorphine treatment among people who inject drugs: a retrospective cohort study. Ann Med. 55(1):733-743.
- Williams AR, Mauro CM, Feng T, Wilson A, Cruz A, Olfson M, Crystal S, Samples H, Chiodo L. (2022) Non-prescribed buprenorphine preceding treatment intake and clinical outcomes for opioid use disorder. J Subst Abuse Treat. 139:108770.
- Yamamoto A, Needleman J, Gelberg L, et al. (2019) Association between homelessness and opioid overdose and opioid-related hospital admissions/emergency department visits. Soc Sci Med. 242:112585

CME questions

- Which of the following increases risk of overdose death?
  - Incarceration
  - Eviction
  - Homelessness
  - All of the above
- Buprenorphine after non-fatal overdose
  - Is contraindicated because it will cause precipitated withdrawal
  - Increases all cause mortality
  - Enables further drug use
  - Decreases risk of death from overdose
- Barriers to buprenorphine treatment include
  - Having a primary care clinician
  - Telemedicine appointments
  - Flexible scheduling
  - Stigma against people who use drugs

CME questions

- A patient who self-initiated buprenorphine approaches the Mobile Harm Reduction Team seeking a “legitimate prescription.” The team should
  - refuse to see the patient because she has taken non-prescribed buprenorphine
  - refer the patient to a more controlled setting for buprenorphine induction where the patient can be monitored more closely
  - Require a urine test with no illicit buprenorphine before scheduling an evaluation
  - Connect the patient to prescriber for evaluation the same day and assist with other immediate needs
- The prescriber can enhance safety by
  - Checking prescription drug monitoring program
  - Educate about safe use and storage of medication
  - Coordinate support for primary care, mental health and social needs
  - Maintain flexible scheduling to facilitate treatment retention
  - All of the above

CME questions

- Partnerships for low barrier access to buprenorphine include:
  - A community drop-in center for people with food and housing insecurity, a telemedicine provider and a Peer Support organization
  - A syringe service program and a medical toxicology service
  - Street medicine team and a Harm Reduction advocacy organization
  - A neighborhood center and a community health center
  - All of the above