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ECHO: LOW THRESHOLD BUPRENORPHINE

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12/20/2023

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[video transcript]

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Dr. Benjamin Hayes is an assistant professor in the division of general internal medicine at Montefiore Albert Einstein College of Medicine. Dr. Hayes, his clinical and research interests are in improving care for people who use, excuse me, people with opioid use disorder, including expanding access to deep and arcing and bridging primary care and harm reduction practices. Then I will hand things over to you. Thanks again for joining us today. Thank

00:32
you, Lauren. Hi, everybody. It's a pleasure to be here. Thank you for the invitation. So, presentation today will be best practices for low barrier buprenorphine. And I have no financial relationships to disclose learning objectives today. So hopefully, you'll feel comfortable listing barriers to starting buprenorphine treatment that patients face that you'll describe be able to describe sort of how formulation philosophy plays into that, although I've played down those sides, but I think people are pretty familiar with that. And then identify four components of low barrier buprenorphine treatment for opioid use disorder. And Alright, so I think, you know, EPI, I imagine everybody's pretty familiar with sort of the epi of overdose mortality in in the US and in New York City. This is the latest epi data brief from New York City showing that the overdose mortality from opioids continues to escalate and is not getting better. And that I think that this follows sort of trends of racial and ethnic and economic disparities. And you'll see here in New York City, that people who are black or Latin X or Latino, Latina, are more highly affected by overdose mortality in New York City than people who are white. So this is an issue of social and racial justice. And but we have, we have really good tools at our disposal to reduce this mortality risk. So medication treatment for opioid use disorder has amazing mortality benefit. You can see here from sort of compilation of data pulled data from 19 cohort studies showing that mortality rate for people who are in treatment for either methadone or buprenorphine is much lower than people who are out of treatment. But the issue is that most people in the US don't have access to treatment. A lot of some of this may be by choice. But I think we have a lot of data showing that a lot of people are really interested in engaging in treatment for opioid use disorder, and the issue is barriers to access. And we can see that these barriers to access, again, play along lines of racial and ethnic disparities. People who are more white have much higher access to buprenorphine than people who are black or other. So what are people doing in response to this, so people with opioid use disorder aren't just kind of sitting around waiting for us to come to them with treatment there. They know that buprenorphine is an effective treatment, they know that it helps reduce the risk of overdose mortality is protective against fentanyl, and helps prevent with symptoms of opioid withdrawal and cravings. So if they don't have access, people are using non prescribed views. And this is not infrequent. Imagine if anybody's practicing treating opioid use disorder, you know that most people come into the clinic for the first time

I've used non prescribed pupae. And there have been a lot of studies about people doing this document. This happens. And a lot of studies documenting around why are people doing this. And it's almost always because people are using it in ways that we would typically call consistent with therapeutic purposes. So people are using non prescribed buprenorphine as a solution to opioid withdrawal symptoms or opioid cravings when they when they can't get their drug of choice. Or people are, alternatively are using this as more long-term recovery strategies. So either as a gateway to enter treatment as sort of a temporary self-treatment until they can find a more long term prescriber, or as their own long term plan themselves to just treat their opioid dependence with buprenorphine. And so why are people doing this? You know, if we've expanded access in the US to clinically available buprenorphine and primary care treatment programs in opioid use disorder, treatment programs, other addiction settings, why are people still buying non prescribed people on the street? Well, if you talk with folks, there are so many barriers to getting into the clinic settings. So this was a qualitative study that I did several years ago around people using non prescribed buprenorphine when they had access to clinical settings. And people told us that it was a huge hassle. One person said, I thought I was going to fill out two or three papers. But now, I thought some here they sent me to another floor, I fill out some there, they sent me to another floor. People who want to get high are desperate, we just want to complete the paperwork and get out. So I ended up buying buprenorphine on my own. And then someone else said I was still doing heroin at the time, I didn't want to go find a doctor, I didn't want to sit down and wait hours, I didn't want to talk to anybody. You know, I think these are common experiences that we can all relate to. The another issue is people want to have autonomy and their treatment plan and how they treat their opioid use disorder. And I think there's a perception that you enter into a clinical space and you lose that autonomy over your drug use. I know another thing is that one of these days, something will happen that they will shut you off, and then you withdraw for four or five days until you get back onto it again. That's why I went to heroin because I could find it anytime I wanted with buprenorphine, you cannot do that once the doctor says you cannot have it. And I think we've heard this quite often, too, is that every almost everyone who's got addiction or opioid use disorder, who steps foot into a clinical setting has experienced stigma, and you only really need to experience stigma wants to sort of perceive and understand that it's going to be there every time you enter a clinic setting. I feel like anybody that has an addiction when they go to a doctor's office, they feel they're going to be judged. That's what I think makes a lot of difference. They don't even want to go there because somehow people give them looks. Oh, you're here. Yeah, I'm here for buprenorphine, whatever. There's a look to a drug user. I just feel like a lot of people get judged, so avoid having to do that. And even though people are avoiding clinical settings, finding autonomy, avoiding the hassle using non prescribed buprenorphine, it's not always producing good outcomes. Often people are having bad outcomes while they're doing this. And this often precludes their ability to engage in care down the road. When I shot it up, meaning buprenorphine and I thought I was gonna die. My heart was just bra bra, bra bra just in my chest, just sweating. I went into precipitated withdrawal. I thought I was gonna die. I was

throwing up so hard. I burst the capillaries in my eyes. I was so sick. It scared me from doing buprenorphine again for a few years period even touching it. Okay, so we'll talk about next like what is the next step? I think the next step based on the title of the presentation is going to be how do we do low barrier, buprenorphine. But let's start with a case to sort of ease ourselves into this. So it's a Friday afternoon. 35 year old male drops into your clinic for the first time requesting a prescription for buprenorphine saying it's an emergency. He only speaks Spanish, he's in a hurry because he needs to get to another appointment. But he tells you that he uses heroin and fentanyl and pills every day. He also can't give urine today, he moved to New York City from Puerto Rico six months ago, has no family in the area. And it's currently living street homeless. So as the clinician seeing this patient would love to get thoughts from people, someone wants to raise their hand and jump in here about what you would do in this situation, I sort of put a few options there. Which you could take up or choose a different option.

08:28
Any brave volunteers in the audience today? I guess I would probably pick a different option. Can you guys hear me? Okay? Yeah, similar to like option one. I mean, depending on how much info I could get from him that day, and if I had a translator or a way to communicate with him, and are one of the clinics amount where we try to do well threshold buprenorphine, like, a lot of times, I'll do phone appointments with patients who don't have a lot of time to talk or we're just trying to get them into the next visit. So I always try and keep those prescriptions, three or five days try to at least review like if they're familiar with buprenorphine and how to take it, what they're using talk about precipitated withdrawal, if it's going to be an issue, you know, and get as much as I can kind of like, the pertinent stuff, where medications are on, make sure there's no red flags, why they can't start or have you been morphine. And then I try to see them again. Sooner than a week, I would say, you know, five, five days probably the most, if I can, if I had to go longer, probably would maybe just start like low dose, just give them something to start trying to, you know, depending on what information I can get from them.

09:40
Great. Yeah, I think that there's no one single answer. And I, I think that that sounds appropriate. I sort of hear the points that you're hitting on, which is, you know, the patient's told you his priorities. You know, you kind of get what you can but you prioritize the clinic visit to make sure that he's going to be safe on the buprenorphine. And the idea that he can walk out of that that clinic appointment with the same day prescription. And some sort of close follow up. Yeah. And then Linda says, as the patient that can come back to you and seven days, what works for them if not considered given a little more than seven days. So yeah, you know, and this is going to sort of be based on what your clinical comfort is and what your clinic setting is like. Great, alright, so we'll move on here. And nobody chose B, which is informed that you need to do a full medical assessment get your and toxin treatment for before you can start to in for opioid use disorder or turn them away. Although scheduling and telehealth visit, may be considered low

barrier, but I think you want to make sure that he's able to walk out of there on a Friday afternoon with a prescription for buprenorphine since, you know, some to like Saturday, Sunday could be an overdose incident. So great. So I think a lot of a lot of practitioners have been using low barrier low threshold models for access to buprenorphine and opioid use disorder for several years now. SAMSA just came out with this advisory this year. In fact, this month, for how to do low barrier models of care for substance use disorder, which is really helpful kind of brings together a lot of what the evidence base has been out there. And I think Lauren is going to make this available, she's going to send this out after the meeting. So what we'll walk through some of the key principles and components here. So principles of the low barrier model, which I think we've been, we've sort of been advocating for person centered, flexible, making sure that there's access to comprehensive services, culturally responsive and inclusive, acknowledging trauma, the impact of trauma with our patients, and then implementing sort of harm reduction approach and meeting people where they're at. And then the specific components is that you want care to be accessible and available. So flexible, responsive, collaborative, and then implement in your in your setting, learning and quality improvement as you move along. And we'll go through some of these details through the case. So the same case, he's now I've been receiving buprenorphine treatment from you for several weeks. He's had one year and toxicology without buprenorphine when he had his bag stolen. But otherwise, he reports taking his beaut most days, he's reduced his heroin and fentanyl use from four bags per day to just one bag every couple of weeks. And at your last visit, you both decided to extend his buprenorphine prescription from weekly to every two weeks. He misses his next appointment and his phone is disconnected when you try to call him. A week later, he calls the clinic requesting another two week refill. So yeah, we'd love to open this up again to get people's thoughts about how they might approach this situation and proceed.

13:33
As can also put your answers in the chat box. Like we're a quiet group today.

13:40
I don't mind speaking again, because we encounter this a lot at one of our clinics. And it's always a little tricky. I think I've over the last couple years, I've definitely become a lot more my practice has changed, obviously with guidelines and become much more lenient, I try to I definitely try to see them if I can, even if you know, like we have a lot of flexibility. And I will do phone appointments from home kind of randomly if I can, or at least like I always asked the staff who they reached out to the K are they doing okay? Is their dose working, trying to get some info so I can make changes if needed. And we always try to gently encourage like, hey, just make sure you make your next appointment. And that's kind of the big things we stress on when they first start like, Hey, if you as long as you're at your appointments, you'll get your Suboxone. If something comes up, let us know and just try to keep that line of communication open. That's usually how we approach in some in some other clinics I work at, you know, there's certainly

some staff who think that it should be more strict and you know, always trying to balance out best approach. Yeah.

14:52
Great. No, thanks for sharing that Brett. And I think yeah, this has sort of been an evolution for a lot of us from How we were trained to sort of what is the reality with helping people in the moment? See, Dan chose B. And then Emma, Emma agrees that this scenario is so common these days. And yeah, we see this a lot. So right, I think that some of the points that maybe people are getting at is that, again, being responsive to what the patient's needs are that trying to be somewhat flexible in where he's at, and what he needs to prioritize keeping him within your sort of treatment envelope. But also, you know, maintaining some parameters where you feel like you can maintain some patient safety is a real balance. But I think we're sort of erring on the side that it's safer for a patient to remain on buprenorphine if, if they're taking the medication than to have treatment disruptions. And so how can we adapt to a person's, you know, sort of barriers in their life and competing priorities to, to meet people where they're at, in those circumstances. And you know, right here, again, this is somebody we don't really know all the stuff going on in his life, his first visit, he wasn't able to tell us too much. Sounds like we've gotten a little more history from him, maybe know him a little bit better, but you know, then his phone is disconnected. We can't really talk with him in a whole lot of detail. So it's hard to really know, like, what happened there? What happened? Why did he miss his appointment? Why is he calling a week late? And so I think it'd be important to try to figure out what are the barriers to his treatment at this time? And how can we help them resolve those? So accessible and available? Oh, sorry. Yeah.

16:52
Yeah, just real quick, then I think that's a good, I've really appreciate you choosing a really relevant case, to just walk us through. For me, my background is in social work, I'm not a medical prescriber. But as I'll talk about later, today, I've helped teams multidisciplinary teams set up low threshold buprenorphine programs and implement them. And I think in this case, it's really important to me that we have kind of frequent informal and formal case conferences, so that the whole team knows, you know, this is a list of people that if they call, try to, you know, do everything you can, to, you know, don't just take a message and then tell them, we're going to call back, like, any touch with this person is going to be one that we really want to build trust and rapport, but also try to get them in here for a visit. So sometimes we just really try to flag that for our staff, and like build teams, where people are on board with a low threshold approach, because it doesn't feel good for our patients, or our providers, when staff say like, Well, they didn't, I don't, I can't believe we're gonna continue to prescribe to them, even though they hadn't come in, like three weeks or something. It's like, you know, that has no role in addiction medicine these days, I think, because the risk of fatal overdose is so severe. Just

naming you know, as an administrator, my role has to be to try to build an environment where prescribers can do this, this work.

18:25
Yeah, no, I think that that, that point is, like, really well received. And it's been an evolution, right, I think physicians are necessarily in the practice of having to work in that sort of, like, necessarily team setting, we're so often feeling so individualized or isolated within our medical practice. And sort of the expectation that patients will meet us where we're at that, you know, we set these parameters for how treatments supposed to be, but that doesn't really work. And, and, and you do that in the setting of addiction, and dependence upon opioids, and there's a real risk that somebody's gonna have a fatal overdose and die. And then you don't get a second chance. So then, given the safety of buprenorphine, I think that it seems like a little more flexibility can go a long way there. And that's where I think our social work teams and our peer counselor teams and our sort of clinical staff teams and our nursing teams can really be a huge help for us. And, and so part of that, I think, is how do we collaborate with our colleagues in those settings? Some of that is like how do we do some, some training with our colleagues about addiction, you know, people who may not be as familiar like nursing staff or front desk staff who may not be as familiar around sort of the cycle of addiction and what it means to treat somebody with opioid use disorder, how to do some anti stigma training In have some good outreach sort of protocols. And I think I love the case conferencing, we do that as well. It can really make a big difference, because it's so easy for people to kind of like, fall through the cracks, cracks and fall into care. Alright, I'll move on here. So accessible and available, I think we're sort of talking about same day appointments, extended hours. And then telehealth, if you can, has really made a huge difference, you know, maybe if there was a silver lining and COVID it was that we really learned how to do telehealth and find greater comfort and in remote prescribing for people with opioid use disorder, at least in our clinic. And then being flexible. So you know, people patients have a lot of competing priorities. And we don't solve them in our medical clinic, to be honest, so we want people to come and see us but we're not always the top priority, but maintain some sense of continuity is going to be important with the buprenorphine prescription. Having other things other services available, it's gonna be really helpful for folks, different ways, different formulations of medications, you know, we're really pushing our clinic to sort of be a little more adaptable with injectable buprenorphine, which is going to suit some people's life a little bit better, which is really great. Counseling available, but optional, not mandatory is another big one for us in our clinic. Alright, so continuing our case, that is next visit, he tells you that his anxiety and seizures, primary problems, he feels unsafe on the street, he has been assaulted and robbed. As a result, he's had to spend time in a different part of the city and it's harder for him to reach your clinic. He's buying what do you what do you think so Xanax and Klonopin is on the street to deal with his anxiety. And in the time, between his prescriptions with you that that time that week that he didn't have one, he overdosed after taking only pills and needed to be revived with naloxone. He also tells you that he doesn't go to any other organization because he only

speaks Spanish and he feels uncomfortable and uncertain that they're going to be able to meet his needs. So now that we know a little bit better, we have a little bit of history. What would someone do now?

22:32
I mean, you know, these answers that I really like see, I think this gets into a really like difficult area, I think sometimes with prescribing of benzos to sort of reduce the harm and potential overdoses coming from all the you know, fentanyl mixed in with the press. I don't think I know we're sort of working through and into planning soon to sort of discuss more of a unified approach to this, but we've you know, we've been we've been doing this in Psych patients and sort of giving them the option of getting benefits from us with the hope long term of coming off of them and tapering, maybe starting on the medications to help with some of the symptoms that were driving the benzo we use but knowing that that's not you know, always possible for some patients. So I feel like this is a whole nother facet of the addiction treatment is coming up with the opiates and benzos out there now and all the fentanyl Yeah,

23:34
yeah, thanks for Thanks for pointing that out. Because I think that there's been a lot of, you know, for good reason, concern around kind of been taking benzodiazepines with other opioids concern of increased risk for overdose. But with buprenorphine, the risk seems really small. So buprenorphine does provide some protective effect, but there's also some maybe indication here that he may not like his pills may not be simply just straight up benzodiazepines, too, right. Like there's been a lot of fentanyl that's pressed into pills sold as Xanax or Klonopin, and which has been really scary and contributed to sort of the overdose mortality rate. So in fact, that's kind of what we did with this patient is I sold I told him like, let's get you on a long-acting benzo taper. Got him into our clinic. He started following up we started doing that he could he stopped buying his benzodiazepines on the street. We were fortunate I was working. This was in the clinic that we have in onpoint. NYC in the Harm Reduction Program. So we had a lot of wraparound services, I was able to connect and right away with a Spanish speaking social worker who had a lot of knowledge of community resources. He got connected with a housing program. Just here, there's a peer navigator connected to spoke Spanish. And that, to be honest, that was probably the biggest difference maker was like somebody who could sit down and just have a comfortable conversation with who got a lot more history than I got about everything going on. And for him, I think became like his biggest social support. And then there was just a safe space for him to spend the day. So he didn't have to spend all day on the street trying to figure out where he was going to set his stuff down. And then we could do some harm reduction counseling about, you know, the risk of fentanyl within the pills that he could be buying and, and the real risk of death, overdose and death from combining street pills with other opioids and sort of the safety feature of staying on buprenorphine. And then, yeah,

25:48
yeah, I think it's such a great case is it just like, illustrates, when you have the resources to address, you know, the rest of life that is really driving so much of a substance use? It goes such a long way and being able to engage somebody, in this case with a counselor who speaks Spanish and can meet them in a better sort of better rapport is huge. Yeah, totally. Zero felt very heard and like respected and not stigmatized, and that's why he kept coming back and was able to open up with you guys.

26:22
No, I yeah, thank you for saying that. Because I think that was the key is that he felt like he could belong in that clinic that that was a space that was comfortable for him and safe. You know, and I was just like, one small piece. It was really, I think the other things and it is a bit of a shift. I you know, I don't know, within internal medicine, clinical practice. You know, we're trying to expand the access to buprenorphine, you know, saying, you know, primary care doctors and anyone else, she want to prescribe buprenorphine expand access. But a lot of our primary care clinics aren't built with this sort of support features, right, like, and so it's like, how do we re envision those spaces? And how do we re envision our collaboration with other support services to you know, in that may mean reaching out of the clinical space to the organizations in our community in ways that can really support people making phone calls with like caseworkers, social workers, peer to peer navigators at other agencies, building relationships outside of our own our own clinic space, that can really help sort of build a safety net around somebody. Finding a good way to warm handoff to folks. And you know, I think this is sort of talking about how we're going to be responsive to people's needs, in the moment as they come up. Peer support is a huge component of that, I think, if they have other social support family, that's really nice to tap into. But I'll be honest, most of my patients don't have that support available to them. So our kind of harm reduction staff ends up being that for them. And outreach is a huge part, as soon as somebody leaves the clinic, there's a lot of other forces that come into play. So having a phone number or a frequent hangout is a big advantage. And then also, I want to highlight that sort of support clients in determining their treatment goals. And what treatments they want is that don't assume that they want the treatment that you want to offer them, I think you really want to sort of highlight like, what is their priority in that moment for what they want from you. Because they're more likely to accept that and I think there'll be a little more trust in what advice you have to offer as you move forward. And then being collaborative, in what we're talking about is like finding, finding, what are the other support services that that we can provide, you know, where, what our deficits and where our strengths and it can be highly effective. So it's been, there's a lot of there's a lot of different papers out there showing really good retention and engagement in a variety of different settings, syringe service programs, homeless shelters, mobile units, bridge clinics, pharmacies now. And if you work in a traditional medical setting, like many of us have trained in, or to find ways that you can integrate sort of drug user friendly services. So can you find a space to have some walk-in hours? Can you do more telehealth

appointments? And can you take some time to do some training with staff on harm reduction, Drug User Health, and the benefits are huge so facilitates engagement with people who face barriers to healthcare. So there's an article by Wakeman showing that the MGH low threshold bridge clinic in Boston showed an 80 to 94% engagement for people receiving buprenorphine which is higher than national average. And that engagement was actually higher among people who were on housed. So you know, this is really finding the right service for the right the right group of people, helps people initiate treatment and remaining care So, another study showed that low threshold Bubut, syringe service programs showed an increase in pupil initiation from 33 to 96%. That's the hood paper out of Seattle. And it can be cost effective. So there's evidence that reduces IDI visits. And then in our own clinic, and at onpoint, NYC, when we first started off the 3090, and 180, day retention was 6243, and 31, which is pretty good for that setting and relatively comparable to what national averages are for, for people often retention with population that's, you know, a lot of barriers to care, homeless or marginally housed and a lot of competing priorities. So I'll just talk about this is the place where I practice now I'm the clinical director of the Montefiore onpoint collaborative Drug User Health clinic, it we have two clinical locations that are embedded within the harm reduction programs, one in East Harlem, and one in Washington Heights. And the goal is really to establish supportive, healthy, non-stigmatizing clinical relationships with people who use drugs and who have had bad experiences that help the healthcare system in the past, you can see like a nice drop in center where people can watch TV, listen to music at food, there's hot showers and laundry there, which is amazing. There's now the overdose prevention center, you can see in the bottom left where people can, there's a safe space for people to use drugs in a supervised sort of situation. And then on the bottom right, you can see that's where our clinic is, it's really attractive, you know, sort of like kind of it hand in hand with the with the Harm Reduction Program, the idea is to provide a sense of dignity and respect and that you belong here, you own this space. And you can see, we sort of act as a sort of spoke upon the hub of the onpoint drop-in center that does all sorts of great stuff, holistic health, case management, showers, laundry, peer led counseling and support groups, the overdose prevention center. And then, you know, we, we just do a lot of really great basic Drug User Health clinic stuff. And sort of thinking about how to expand this model to the future generations of people who are going to treat addiction is that we now have a lot of opportunities for residents and fellows to train with us. All right, so in the last few minutes, urine drug testing, I know this is always like a big issue now. What answer would people choose here with urine drug testing?

33:02
Any thoughts? You can't We can't have Brad answer everything for us. All

33:07
right, let's see somebody put D required by law and compliance, the USDA, somebody else put Sean put. Linda put E Sean put a A or E. Okay, great. So the actual answer is just a that's

recommended by ASAM. But it's not required by law. And, you know, there's really no evidence that it improves buprenorphine adherence or reduces nonprescription opioid use. So it can be useful, just as you know, I think. Right, there we go. So it's a balance, right. So how do we pay patients centered in harm reduction versus prevent diversion and safety? You know, there's a lot of I think there's a lot of sense among our patients that urine drug testing has a history of being very punitive, about who can stay on MOTD medication ropey, just to sort of who, who gets kicked off sort of monitoring people's drug use and being very punitive about that. Are Cindy says per MTP, I thought the patient has to attend your talks per year. I actually don't know about that. You know, OTP might be different than you know, in our outpatient clinical settings.

34:29
I think there are different regulation programs. I just had a, this is very relevant. I just had an interesting conversation with a front office staff member of our work in a methadone OTP program, and it kind of enveloped a lot of what we talked about today in different views of the front office, and myself and talking about urine screens. And I mean, I couldn't really go down a rabbit hole here. But yeah, you know, in the low threshold access program, I work out where he was syringe exchange. We rarely do urine screens. In my personal opinion, I've never found them. I feel like it just creates more drama. I'm we've had multiple times where I know patients didn't come back because we like asked for a urine screening, we always even tried to be very open about it like, hey, not punitive. And there's still some people at the methadone program I met where they're kind of upset, we're not doing observed urine screens. And I even in that, I just never found that. It never really never was like an open like, Oh, I'm going to admit to something because it's observed, it just created more drama and people weren't ready to talk about it. They can be positive time and time again, and they'll still deny it, you know, and so what's the point? I've never felt that changed treatment. And it's interesting, like I said, this is with the front office staff member who is gonna like, why aren't we doing that anymore? And it just kind of enveloped a lot of this conversation today. So this is this is a great topic to bring up.

35:55
Yeah, you know, and it's sort of like, what, what is the real utility? Right? And so, what does that information actually tell you? So, to be honest, I don't really, you know, I, if the patient's goals are to, to manage certain drugs, then maybe we can have conversations about what drugs are in their urine based on that or what their risk factor is, if they're, if they still have fentanyl in their urine, you know, they're using cocaine, and they're, they still affect on their urine. So, you know, those are cocaine fentanyl in that, and you know that that's a helpful conversation to have with somebody, you know, how do we do drug testing? How do we reduce your exposure to these deadly drugs? You know, if we're monitoring their adherence to buprenorphine, you know, that's an incomplete assessment in a way you can order a GCMs to sort of double check. But even that isn't, you know, it's having a long conversation, Linda, that is not fully accurate all the time. It's hard to really judge so. Yeah, like what Cindy says here. It's some people are shocked

to find out that there's, there's they're just getting fat on that it's not even cocaine. So yeah, so there can be some harm reduction conversations there. But you know, you I think you are sort of balancing like, what are the patient's priorities? Who does this patient? What do they really want other treatment? And how do you engage them best? Yeah, right. PEP sort of agrees. Okay.

37:16
I do have a random question that to like, kind of hijack this. But in just in terms of urine screens, we do them at this methadone program, our other scene, we do send out confirmation testing. And we're finding that the fentanyl that's out there these days, is not just sticking around in urine for three to five days. I mean, initially, patients were passing away, I haven't used that in two weeks for like Yasher. But now it's pretty consistent that we're seeing fentanyl being urines up two to three weeks post use, and I know heavy use it's lipophilic. There's a lot of properties that are explaining that. But and even sometimes, like cocaine, we're seeing, you know, you look at the standard drug chart from the company we use and say, Oh, three to five days, metabolites will be seen, but we're seeing way longer. And I didn't know if that's consistent with others that do the send out confirmation testing for anybody.

38:05
You know, I'm only seeing I've seen that because I can just follow. We happen to get them in our clinic. And the urine drug screens with fentanyl included in it. And you can just see that it just last for a long, long time.

38:19
Yeah, yeah. Yeah.

38:21
Yeah. All right. I know, we're sort of out of time. So I'm going to move through to the end here. And just that, you know, I would advocate that there's probably a middle ground approach. And don't I feel like the point is that they're not mandatory and they shouldn't be punitive. They should be about how do you improve a patient, patient care in that moment? And then just to put a plug in that, you know, the guidance around benzodiazepines has changed in that, although there is an increased risk with taking non prescribed benzos with any opioid for respiratory depression that the effect of untreated opioid use disorder is much greater than that. So please don't stop prescribing buprenorphine just because somebody is also co taking benzodiazepines. All right, low barrier treatment, so that I think increased access embraces flexible harm reduction approach and challenges as providers to shift our thinking. So thank you so much, everybody. I really appreciate your participation.

39:29
And we are lucky to have you with us.

[End Transcript]