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INNOVATIVE MODELS OF PRIMARY CARE FOR PEOPLE WHO USE DRUGS

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REACH Medical

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Innovative Models of Primary Care for People who Use Drugs
[video transcript]

(00:00:09):

Hi everyone. And welcome to the Innovative Models of Primary Care for People who Use Drugs webinar. I'm Emily Scognamiglio, I'm the program coordinator for the Hepatitis C and Drug User Health center here at CEI. I'd like to take a moment to thank our funders, the New York State Department of Health AIDS Institute for allowing us to offer a CE credit for this webinar, as well as I'd like to thank REACH Medical for being here today and introducing and then presenting for the webinar. I'm going to start with a few housekeeping points. So if you have any questions during the webinar, feel free to type them into the chat box that's on the bottom. And everybody is moved over as a panelist, so feel free to share your screen so we can see you because I am going to ask that everyone briefly introduce themselves as well after I introduce our two presenters today. Also for evaluating and claiming CE after the training, look out for an email from I believe it will be CEI for further instructions on how to evaluate the program and then claim your CE. That should be coming no later than tomorrow morning. And if you have any problems with that, feel free to contact me at my email below or give me a call. You can move to the next slide.

(00:01:26):

This is just the accreditation statement stating that we are offering CME as well as CNE for today's webinar. This is just stating that the Planning Committee has no disclosures to disclose. And now I will introduce briefly our two presenters, Dr. Justine Waldman and Dr. Judy Griffin. And then after that, I'm going to turn it over to all of you to quickly introduce yourselves. So Judy Griffin is board certified in Internal Medicine and works as a Primary Care Physician and buprenorphine provider at REACH in Ithaca New York. She serves as the Director of Research at REACH Medical and is the Director of the Rural Health Equity Training Collaborative. Dr. Griffin also holds an appointment as a Clinical Instructor in Medicine at Weill Cornell Medical College and is a member of the Criminal Justice Alternatives to Incarceration Advisory Board for Tompkins County. So welcome Dr. Griffin.

(00:02:26):

And then Dr. Justine Waldman is board certified in Addiction Medicine, Emergency Medicine, and a fellow of the American College of Emergency Physicians. For 15 years, she practiced Emergency Medicine, primarily in Ithaca, New York. Her interest in medicine has always been driven by access to care and health equity issues. In 2005, she spearheaded the opening of Ithaca Free Clinic, a volunteer, multidisciplinary clinic open to the uninsured. In 2014, she was part of the Harm Reduction Team that gave recommendations for the Ithaca Plan, a public health and safety approach to drugs and drug policy. Since her involvement on that team, she has focused most of her work on health equity. In December of 2016, she began providing medical services at the first HealthHUB at a syringe exchange program in New York State at the Southern Tier AIDS program in Ithaca. At the HealthHUB, Dr. Waldman provides a low threshold medication assisted therapy, hepatitis C treatment, and acute care to people who use drugs. She is currently the CEO of REACH Medical in Ithaca, New York, a medical practice offering integrated

primary care and low threshold harm reduction services for people who tend to face stigma in the current medical system. So welcome both. And thank you for being here today.

(00:03:50):

And now we'll turn it over to all of you to briefly introduce yourself. Can we start with Vivian Gerard? Oh, we can't hear you. I think you might be muted Or maybe your audio is not connected. You can feel free to type it in the chat box as well because we still can't hear you.

(00:04:26):

I think she's muted. Gail, is there any way to unmute the panelist?

(00:04:33):

So in zoom she is un-muted. Her computer may need to be un-muted.

(00:04:38):

Got it.

(00:04:43):

Maybe there's an audio issue. It's okay. You can type into the chat box if you want to introduce yourself.

(00:04:51):

And I see Deborah Norris also just introduced herself. She has no microphone on her computer.

(00:05:04):

Alright. Let's see, Karen Wall. Do you have microphone on your computer or you can also just put it into the chat function?

(00:05:21):

Alright. Well, at any point, if you guys want to put it into the chat box, feel free to introduce yourself. State where you work, your organization, all of that. And I will turn it over to Dr. Waldman and Dr. Griffin to do the webinar.

(00:05:38):

Just making sure I'm on. I un-muted myself. Hi, I'm Justine. Can everyone hear me? Can you guys hear me? Okay. Okay, great. I'm probably one of the most informal physicians around, and I'm a little less formal now that I'm living with my parents during COVID and now in my daughter's room. So it's like the only place I can find that is somewhat quiet, so bear with me. So the title of our talk is Innovative Models of Primary Care for People who Use Drugs. I think what's great about us at REACH is that the

whole practice is really built on the idea that when we look at people who use drugs we are looking at people who face health inequities, and I think once the mindset sort of turns around that then everything sort of changes in how you deliver care. So as of right now you're the slide person, I guess next slide. I have no financial disclosures and I don't think Judy does either.

(00:06:50):

So our learning objectives are to identify different models of care when working with people who use drugs. And it's important herh to kind of pick up on the wording, right? We're using it as people who use drugs, another word would be people with opiate use disorder. We're not really identifying the person with the disorder, which is really, really important as you move forward. Describe the integration of Medication Assisted Treatment for primary care, behavioral health, and hepatitis C care for people who use drugs. Discuss best practices in developing welcoming clinic sites for people who use drugs. And describe barriers and ways to overcome the things that you have to overcome when delivering care to people who use drugs. That's really something that's always in the forefront of our mind, which is I think one of the things that really helps us be innovative and sort of ahead of the curve. Okay. Next slide.

(00:07:58):

So we sort of see ourselves as the new standard of healthcare all the way around. And it's important to me that we're relatively clear on the idea that as an organization, our aim is to be a health equity organization for all people who tend to face stigma within medicine. And I'm sure many of you can imagine that there are other groups, so people of color, people who have been recently incarcerated, we've all been sort of told messaging around how we're supposed to deliver care. And we've also been told very clearly that, at least I was told throughout residency and medical school, that some people really don't deserve the care. And it's important for us to really get at the idea that we've been delivered sort of spoonful after spoonful of implicit bias that not only our peers, but really our mentors and our teachers were telling us were true. And at the same time that really gets into your brain, because they're also telling you that certain diseases you're supposed to be learning from these people. And it's important that we really start to evaluate what we've been told.

(00:09:12):

So probably the most important thing that we do, which is really interesting, is we're just nice we are super nice. We do our best to engage people. We do our best to have no stigma, and we do our absolute best to decrease barriers to access. That's really all we do. We really look at social determinants of health. And we really do a lot of reflection. I think Judy and I talk all the time, like right now I'm whining a lot because I'm living in a gigantic, beautiful house that I'm renting from my parents. Most people wouldn't have that kind of ability to do that. And so I'm whining, but I really come with a lot of privilege. And Judy and I have talked about care for her kids and realizing that we're in this privileged state where most of our patients have no access to any sort of care for their kids during this. And a lot of people are more stressed than we are during these times. And it's important to kind of do a lot of self reflection around what's happening, how much chaos is happening in your life versus what might be happening in someone else's life, especially now. We do medication assisted therapy and we do primary care. We do

PrEP, which is not an easy sell for our population who don't necessarily always want to identify as needing it. Especially we like to bring up things like sexual transactions, which might be a reason that someone needs PrEP, and we really try to kind of normalize discussions around that. We offer full harm reduction and we deliver hepatitis C care. And whenever I say hepatitis C, I always cheer because I really like delivering hepatitis C care because it's the one thing we can cure for our patients. And I'm pretty clear on that with patients, I can't cure opiate use disorder. This is something that is likely to plague them, maybe their whole lives, maybe just a portion of their lives, but really it's a really difficult disorder. And I think having empathy for how difficult that disorder is, is important. I'm changing the slides myself right now.

(00:11:32):

So the organization mission and history, so the word REACH is Respectful Equitable Access to Compassionate Health. It exists to serve individuals who typically face stigma in the healthcare setting, and it serves all individuals without their regard for their ability to pay for services. It's actually two organizations in one, there's the REACH Project which is a 501c3. And under it, we have basically a tax exempt captured medical practice called REACH Medical, and REACH Medical was opened in February 26, 2018. The very funny thing about this is we have an amazing director of finance and strategy and before we opened she was so concerned that we wouldn't have anybody coming. And I was the opposite because I had already delivered care at the syringe exchange. And I knew that basically and said if people know you're nice, then word gets out on the street. And very quickly we were serving 23 counties and we were inundated.

(00:12:43):

So why do we need innovative models? As you know, there's an ongoing overdose crisis throughout New York state. I imagine things are going to get worse or are already getting worse because of COVID. Access to MAT, to Medication Assisted Therapy is severely inadequate, especially in upstate where being in a rural area without access to a car makes it really hard. And when we're really thinking about this, when I was first introduced to this topic in 2014, it really sort of mirrored for me exactly what happened with HIV and AIDS. You know, 'people shouldn't be gay. People shouldn't be engaging in unprotected sex.' These were no-nos in society, and we decided then to basically move this population over and not offer compassionate care for them. And these are the sorts of things that happen once we tell patients what they can and cannot do instead of really looking at what they are doing and helping them stay safe with whatever they're doing. And of course the big problem is that not only is access to MAT severely inadequate, there's regulations as everyone knows on and limits on how many patients a provider can see. And in addition, in my mind, the traditional form of service isn't actually adequate. So even if patients have access to care, it may not be competent care.

(00:14:19):

So basically 20 to 40% of people with OUD have access. So that leaves 60 to 80%. New York state is not bad. I really wouldn't want to live in a state like Texas. And often MAT is not offered at all. Or it's still at some places is offered as something that should be weaned down on, or it's offered at a very low dose

despite the fact that studies show that really a person needs to be on 16 to 20 milligrams to decrease illicit drug use. But most places are really uncomfortable giving the higher doses, thinking that it's contributing to addiction. And that's really not the way that we think. Social determinants of health really are problematic. Transportation, insurance, housing, childcare. There are so many issues for a lot of our patients and we do our best to sort of try to figure out ways to help people get there. And now with COVID, which I'll explain later, it's actually better for us. And stigma and discrimination. So it's been shown that providers actually feel a lot of stigma or display a lot of stigma towards patients who have substance use disorder. And I think being aware of that is important. It's important to be aware of our own feelings in how we're treating patients.

(00:15:43):

So our mission is we're very low threshold. So basically it's our job to get our patients what they need. And most often the same sort of factors come up over and over again. So I think that in a traditional practice, someone would say something like, 'well, they missed three visits, we're kicking them out.' We try to figure out what's going on that all of our patients can't make it in. Do we need to figure out ways to order the Medicaid cabs for them? Do we need to figure out ways to look at whether their insurance is in place before they come for the visit? Do we need to get them in touch with insurance? With, I can't think of the name, someone who can help them get insurance. We're very stigma lowering. And in fact, the thing I've always said about our practices, I think almost anyone would love to come to our practice because when you walk in the front desk person is like, 'Hey, you look great. You know what, there's some donuts over there. Or we had some new donations in.' And patients come in and have never experienced that in a physician's office. It's usually what's your name, have a seat. And we do the opposite. We're offering care, we're offering friendliness right at the front desk. And we have a very strong harm reduction framework. So we do whatever we can to make sure our patients have their buprenorphine. And we make sure that they feel safe on the dose that they're on with buprenorphine. And we've actually become pretty comfortable sort of arguing things out. Especially I think for a good year and a half, actually two years, we were trying to figure out what's our role with benzodiazepines. And it took us a long time to sort of get somewhere. And we are comfortable sort of figuring out as a group, what is our comfort level here? And I would say that some providers have more comfort than others, and we try to match patients with providers to make sure everyone's comfortable. We don't kick patients out of the practice. We have had some patients that we have asked to leave, and that is actually always said to be because of behaviors towards staff, and we always find them somewhere else to go. But if the behavior towards staff is really, really out of control and we can't contract with them, then we'll ask them to leave. We've had a few patients that we weren't able to give buprenorphine, because of reported selling by a licensed individual, not by a friend, but by someone who was licensed. Otherwise we tend to just read over the agreement with patients and say, 'you know, someone's calling about this. We need to make sure you don't sell your Suboxone.' And we provide very rapid access to care. So we have open access. I think we probably have open access every day of the week, but I know that I do it on Fridays. And it's known in the community that Friday's the day to just call and say that you want to see someone about getting on buprenorphine and we do it same day.

(00:18:54):

And basically the REACH Model is based on the New York State Health Hub model. So we've been surprised at how much people are attracted to working with us. And I think it's because we attract providers who are sick of just clicking off that box and being a part of the system. We attract providers who really want to deliver care and went into medicine for that reason, but can't find a place that offers that kind of work. We try to be very low threshold for both patients and providers, and we have a very nursing intensive model. We're independent and community based and we integrate our care. So we don't really have the same, I guess you would call them bean. Well, we do have our bean, instead of bean counter, we do have one, but we push back a little bit when we need to. And we try to figure out ways to make sure that we stay viable.

(00:19:49):

We have medication assisted treatment. We have primary care, Hep C treatment. We do medical cannabis. We actually talk openly about the use of cannabis and about the studies that are out there, which is not so much studies, but the statistics. So in the States that legalized marijuana, they had a 25% decrease in overdose deaths. So there's something there. And if patients are telling us that they're using marijuana with their Suboxone and it's working for them, we're happy for them that that's working. We treat PrEP. We utilize PrEP, HIV care. We have psychiatric and psychological services. We do opiate overdose prevention training. So we give Narcan at our visits and we also prescribe it. We have case management embedded and we offer Medicaid enrollment with a Medicaid enroller.

(00:20:46):

So one thing that we did when putting this together was to try to have providers from different portals. So two of us came from the emergency department. We have one person who is a hospitalist at our local hospital. We're a college town, so we have two college health providers. We have a psychiatric NP, we have three community providers. And basically the breakdown is at this point, we're four full time and five contracted. We started two years ago with one full time and everyone else contracted, but over time more people have come on board full time.

(00:21:23):

And basically we offer service at several sites. So we offer services at two syringe exchanges, one in Johnson City and one in Ithaca. And we basically either contract for services or embed a nurse and offer our own services at these two sites. And at both of those sites, I think one thing that's different about us is our biggest thing that we do is offer MAT and sort of acute primary care. And then we also offer primary care, so not all of our patients are getting primary care. And what I've noticed is not all patients are ready for primary care yet. They sort of have to feel out how getting care from us feels and then often they want to get primary care. Oh, but we do offer Hep C to all, and behavioral health to all, just to let you know that.

(00:22:16):

So for us, the idea of telemedicine has really advanced our practice and changed our business model almost completely. And as everyone knows, March was a very hectic time. The DEA at that point really

let loose on a lot of the regulations. So at this point, you can put someone on Suboxone by a phone call. It used to have to be face to face or by telemedicine with one provider on one end and one on the other. Now you can do it face to face. And also in a difference though, there's lower reimbursement for telemedicine in New York State. So basically they made the managed care organizations reimburse for telemedicine and all of this, what we found is it's lowered our barriers for patients and providers. It allows us to do on the spot medical treatment, and basically we've wanted to do outreach forever but haven't been able to figure it out. And now what we do is have one caseworker going out to our homeless encampment in town and offering care, and it's been spectacular. We get them right on to telemed and we're able to offer induction onto buprenorphine. And now we're in the process of hiring a second outreach worker to do the same. Our goal is to be at multiple sites with a outreach worker offering healthcare to people at the homeless shelter, at community housing, and at basically more of the lower income housing sites so that we can really give out great care.

(00:24:03):

Great. And I think that's where we decided to transition. Thanks Justine. And I'll just follow that up by saying I think there's been a lot of concern, understandably so, about access to telemedicine services and thinking about access, especially in rural areas with limited broadband, et cetera, but we've really found tremendous uptake in continuity of care and engagement through telemedicine from our patients. And then using outreach workers that go out with a smartphone to actually expand access to care. So we're super excited about it. So I'm just going go over some of our numbers. Over the last two plus years since we've been open, as Justine said at the beginning, we had no idea what the level of demand would be. Justine I think had a sense of it already working in the syringe exchange, but essentially through no advertisement other than word of mouth from our patients in two years we've had over 10,000 visits and 1700 unique patients. So it's really remarkable. We have over a thousand people on MAT currently. We've seen about almost 1300. So our two year level of retention approaches right around 80% of our patients remain engaged in MAT. So it's really tremendous. And what we've seen with the transition to telemedicine is that number has remained the same. So we haven't seen a drop off in retention rates, which is fantastic. And then if you look at the unique patients column that they don't add up, so each type of patient. One patient could be receiving both primary care and MAT and that would be the same person. So, but what this shows us is as Justine said, not all patients are receiving primary care but about 700 of the patients are receiving primary care. So more than half. In terms of behavioral health, it's about a quarter of our patients receiving behavioral health. So that includes seeing our psychologist or seeing the psychiatric nurse practitioner for medication management. And we've treated in terms of Hep C, that includes treatment for hepatitis C. Screening for hepatitis C, we aim for universal screening. And other types of visits I think would include our medical cannabis visits, HIV visits, and any other category.

(00:26:47):

Judy, can I just say one brief thing about behavioral health, which is we started our behavioral health program last September. And I think this is a great way to sort of highlight the idea that it hasn't been a smooth road. And what we've really noticed is we thought that patients, we kind of based it on the college model, which was patients would probably want to come for six visits, but they wouldn't want to

engage more than that. And what we've really noticed is patients want the therapy when they want it at that particular time, and it's usually crisis management that they want at that particular time. But unless it's tied to getting medication, maybe only 10% of our patients will engage in a more longterm therapy. So we just keep having to make adjustments and more adjustments to our model to figure out what really works for the patient. So when the patients are telling us something, we listen to it and we try to figure out what is it that they're really wanting. And I think it's that their lives are very chaotic and they want sort of help right then and there. But after that, it's harder for them to engage in more longterm care.

(00:28:06):

And then just to follow that up to say that the model is making things low threshold for patients, but also providers. So what does every primary care provider need? They need support for patients that are outside of their comfort zone in terms of medication management. So that may not be starting someone on SSRI. You may be comfortable doing that, but if someone has more complex psychiatric conditions, needs bipolar management or mood stabilization, that person could be seen by our psychiatrist. And it's challenging, but we know that's what our patients need, so that's what we're going to do.

(00:28:43):

In terms of the counties we've served, these are just the most common county of origin in New York state. We have served patients from over 26 New York state counties and Pennsylvania as well. But about half of our patients are from Tompkins County, which is our local county. And 20% coming from Broome County, which is just to our south where Binghamton is located. Cortland. And then Tioga, Cayuga, Chenango, these counties are much more rural and we have people coming from hours away and that is kind of a testament to the care that we offer, which is to say that in some places there's no MAT available for people whatsoever. In other instances, there is MAT available but not in a way that's accessible or preferable for patients and they choose to come see us, even if it means a two hour drive. And through telemedicine, that need to travel so far has been lifted, which is amazing. And really we'll just continue to extend our reach. We're currently seeing patients in the Plattsburgh area who have lost access to an MAT provider. So we've been providing care in that region, which is new for us.

(00:30:06):

We face challenges, of course. But I think because we're independent, community-based, resilient, mission driven, we see challenges as an opportunity to improve what we're doing. One big challenge of course, is financial and the payment models. Around 70 to 80% of our patients at any given time are enrolled in Medicaid, New York State Medicaid primarily through managed care organizations, Fidelis, Molina, what have you. And we have to strive to be reimbursed for the care that we provide. We have to work constantly on advocating to lower barriers around prior authorizations for the different buprenorphine products that our patients need. And some of you have experienced and as you gain experience, you'll see that different people do well on different types of buprenorphine products and you need to have the ability as a provider to offer and work with a patient to find the formulation, dose, and brand that works for them. And this isn't a fee for service model that we still exist in rather than a

value based payment system, so that is inherently challenging for primary care practices, for addiction medicine practices. And so we do see a good volume of patients, mostly through demand because people want to come, but we want to give each patient the time they need. And so we're really committed to that. But we have to be pragmatic. So we're constantly trying to think of effective solutions to overcome these barriers. In terms of challenges outside of the existing healthcare system, we interface very closely with other systems, including the criminal justice system, the community, and other treatment models. Based on sort of the more traditional addiction medicine treatment model, which is outside the realm of medicine, interfacing with those systems in a way that's proactive and productive for our patients, but really focused viewing ourselves as advocates for patients in this milieu which can be very damaging. I'll just give an example and many of you probably are familiar with this, but the stigma itself that surrounds treatment with buprenorphine. And so many people view buprenorphine as "trading one addiction for another," which of course is not true. And I always engage in conversations around stigma of treatment. Of course there's stigma for drug use, but actual stigma for being on medication. And I think it's really important. And if people are interested in getting off buprenorphine, I always wonder why. Is it a side effect? Can we figure that out? Is it stigma or pressure they're facing, either internally self-imposed or by family or pressure from the criminal justice system? And I think we need to be clear on the fact that we are medical providers. We have the medical expertise and medical decisions never should be made by people who aren't trained in medicine. They shouldn't be made by jail administrator or by judges, or people working in the criminal justice system. And not that we're in confrontation with those systems, but that we're advocates for our patients. And we have to be committed to promoting the utilization of evidence based medicine and treatment for opioid use disorder in all of these domains.

(00:33:40):

Just want to add one more thing there. I think it was a big thing for all of us and Judy, you were in on that meeting, and it comes up a lot at the state level, just so that people know like as a physician, I always thought, 'Oh, if a judge sends me something, then I need to comply.' But many of these court systems are actually acting outside of the law. So when they send your patient a blank release that they've made them sign and you're supposed to report back everything on it, usually the patient has been coerced to sign that release and they're making judgements based on what you say. Or even if you don't say anything. And so in general, a patient could be doing really great, and great by our standards. Maybe they used one time and now everything's going to slip away from them. And so we're very careful about what we report to the system. We are very clear about that we will report their engagement and making sure that they have buprenorphine in their urine, but we don't necessarily talk about other drug use. And our job is for the patient again, as Judy said not for the judicial system. And we're very clear about the rules around HIPAA and CFR 42. So just keep that in mind when you're being asked to get to give up information.

(00:35:10):

Absolutely. Early on in the organization, we wanted to be an amazing medical practice, meaning we provide high quality primary care that really anyone would want to get. Cause it's just a friendly, welcoming environment and we provide great medical services, but we realized that what we were

doing was innovative and also new. And so we wanted to be able to evaluate what we were doing and also link what we were doing to broader issues within health equity. So, you know we're located in Ithaca, New York, it's where Cornell University is located. So very early on, we linked up with the Cornell Center for Health Equity and we collaborate with some health service researchers that are based at Weill Cornell, an infectious disease and Hep C specialis, epidemiologists specialized in harm reduction. And we receive funding from the Cornell Center for Health Equity to study our model and are moving that forward. So we're trying to push the envelope in terms of what outcomes are considered success, because we're not an abstinence based organization. And because we don't view addiction treatment as having sort of a beginning intake middle, you know, do all those things for a certain amount of time and then end your discharge. The plug that this is a chronic disease medical model that we need to think about how are we, what are the benchmarks of success we're looking at? And so we're engaged in that very proactively and recently started continuing that work through the funding with Pew Charitable Trust. At the state level advocacy, because as medical providers with on the ground experience, we carry a lot of leverage and we should use that power to advocate for our patients around things like prior authorizations. Fidelis or different, I don't mean to single them out at all, any insurance company really creating false barriers. We need to push back against those. Focusing on efforts to expand diversity and inclusion of our healthcare workforce, of our staff, who is working in our office, and what message does that send about who we are and who is welcome here. So that's something we're aware of in terms of all communities that normally face stigma or discrimination in our healthcare system, which we all know is embedded within the racist institutions that make up our healthcare system. So we want input from peers. We have a peer advisory board that is not abstinence based. So it's people who use drugs in all spectrums of sort of use and recovery and soliciting feedback from them about the program we're offering and getting their ideas, because really our patients are experts. I mean, I'm sure some of you have that experience as well, seeing how much you can learn from your patients at each and every visit, and as an organization. So that's critical. And then the social determinants of health is just continually infused in all our work. And so we have found that offering things like, it's not listed here, but we had a little library of donated books in our waiting room. And I have a patient that had meant so much to her. And during COVID, she's reading the books that she got from our free library and you know, those things matter to people, and so we offer that.

(00:38:57):

In terms of grants and other programming. Several of our providers were or are National Health Service Corps scholarship recipients. So we became a designated site, meaning that providers who need to work in a designated location as part of their loan forgiveness arrangement can do so at our office. The Rural Health Equity Training Collaborative is a HERSA funded medical education program with our local internal medicine residency program and community college nursing program to have trainees rotate through REACH and a clinical elective, as well as a didactic that's infused with health equity and harm reduction. I mentioned the Pew Charitable Trust to continue our research efforts. We're submitting additional funding through HERSA, through CCN which is our Care Compass network, our local DSRIP entity, we're involved in different cohorts studies at the local and state level. I don't know if you want to speak to any more of these, Justine?

(00:40:08):

So that Behavioral Access to Rural Health Grant was put in place that was through DSRIP, and then the multiple cohorts there are some that we have with our local hospital looking at primary care for patients who identify as having opiate use disorder in the emergency room. The Transformation Grant we received early on and we're sort of actively looking at article 28, although that sort of waxes and wanes. And at this time, we are right now in the process of our OASAS application to be a pilot for OASAS. I'll let you go ahead. I'm sorry.

(00:40:53):

I think you could speak to these.

(00:40:55):

Okay. So most of our grants have either come through OASAS or the AIDS Institute. We also have some private donors. Our newest initiatives, our LEAD, which is Law Enforcement Assisted Diversion, which has been sort of actively pursued in Ithaca since about 2015 or 16. And they finally found another grant to support that. And so we helped write that grant, which has got submitted in May. And right now we just submitted a rural, it is an RCORP. I can never remember what the letters stand for, but another initiative with several counties in the Southern tier to sort of increase access, provide education for people who use drugs.

(00:41:49):

And then we're going to go through two vignettes. And then definitely open up for discussion. And these are really simple, but just to raise the kind of typical cases. This is a 34 year old man coming to the clinic, no known history as an abscess, he's afebrile, vital signs are stable. He's irritable, maybe seems anxious or restless on exam. You hear rhinorrhea, he's yawning, you're treating the abscess but what other information do you want to find out and what services do you want to offer? And so the purpose of this is really just being able to recognize someone who may benefit from either harm reduction services or a treatment for opioid use disorder or another substance use disorder. So of course you want to treat the abscess in a way that's compassionate and approach the patient with curiosity about what's going on and what that patient might be interested in. And I actually offer this case because it reminds me of when I was a resident at Montefiore in New York City, I had the great opportunity to train there where they have harm reduction education for their residents, which is pretty unique. And through OSCEs, which are these sort of like observed cases. And I was a third year resident and familiar with these things, but I just kinda choked up in the moment. And the patient had signs of opiate withdrawal, had some acute infectious concerns, but was not interested in methadone or buprenorphine induction. Wasn't interested in any form of treatment at that time, and I just didn't know what else to do. So it's just a reminder that even if a person isn't ready to engage in care, I think it's really critical to let them know that at any time if they are, they should contact you. And that you're always there no matter what, you know, within reason. And that you can also offer harm reduction services at that time as a medical provider, including inquiring about access to a syringe exchange program or syringe exchange services, or just prescribing syringes, alcohol pads and things of that nature and ensuring that the person

has access to Narcan. Naloxone for opioid overdose reversal. And then coaching around safer use, like not using alone, things like this. So these clinical encounters in the primary care setting can be an opportunity to form a compassionate alliance with the patient and also provide harm reduction based medical care.

(00:44:45):

But if the patient was interested in treatment, this is our polling question, what is the best treatment option for this patient? The choices are referral to inpatient rehab, referral to detox program, home induction onto buprenorphine, referral to outpatient counseling and self-help program. Like I said, these are pretty straightforward, but the idea is to really just highlight that the evidence indicates that medication assisted treatment for opioid use disorder is the gold standard. It's the only form of treatment that has been shown to reduce mortality and morbidity associated with opioid use disorder, reduce overdose. And I would point people to a JAMA Internal Medicine article published by Sarah Wakeman in January of this year, showing that in a review of over 40,000 patients with opioid use disorder that referral to inpatient rehab, detox, or outpatient counseling, didn't seem to have any impact on reducing the three month overdose or accessing acute care services when they analyze that data. And home induction onto buprenorphine has been shown to be safe and effective. And so it's the gold standard.

(00:46:14):

Can I add just one thing on that? Sorry that I took everyone on a little circle. I think I must be fidgety.The other thing that I like about that case also is the idea that when you look at, and I'm sure people have heard of it, but I like really looking at opiate use disorder as similar to a diagnosis of cancer in sort of when people are really extremely ill with it and diabetes otherwise. And we don't really expect our diabetics not to eat any sweets, we want them to as far as I know, I'm not an internist, but I guess that's what you would want Judy, right? You want them not to eat any sweets. You want their insulin levels to be 100. And when their insulin levels aren't 100, do you shame them? So in other words, like insulin reduces sugars, right? Buprenorphine reduces, and I say in some cases eliminates use, but it doesn't eliminate use in a hundred percent of patients. It often reduces. And so when I'm talking with patients, I feel like it's very comfortable and I'll say, 'how much are you having to use heroin with your buprenorphine?' I don't ask how's the buprenorphine going? Cause they'll all say good. And I won't say 'you're not using are you?' I'll make it the opposite question, which is, I'm assuming that they are still using. And I say it in a nice way. And then the patients who aren't using get pretty offended with me but in a fun way, like I haven't used in three years and I'm like, okay, cool, cool. Just in case though if you ever were to use, I would want to make sure that you had that you had access to clean needles, and I don't want you to think that I would feel shame or I would feel anything bad towards you if something did happen. I want you to know that this is a safe place to come back to if something does happen. So sort of the expectation is more like just a more realistic expectation that people might use. And one other thing is and we'll probably teach this during all this is a lot of our patients already have had exposure to buprenorphine and sort of asking them if they have, mostly people are buying it off the street, asking them what dose works for them. It's really a way of getting trust from them.

(00:48:53):

Great. Okay. So the second case, and then we'll wrap it up for questions is a 57 year old woman. History of hypertension, allergies, opioid use disorder, here for MAT followup. She's interested in tapering off buprenorphine treatment. So what questions do you have about this and what other services would you want to offer this patient? And you know, I alluded to this previously, I don't know about all of you, but it's a question that comes up in my practice pretty regularly. When can I get off this? How soon do you want to taper me off? Right? Absolutely want to get off this medication. I would never make someone feel bad about that. I would be curious about what's motivating that issue. And for some patients, I have patients on two milligrams of buprenorphine and they have found themselves that when they've gotten off of it, they had cravings and they decided to go back on. So it's not that no one can taper off ever, but that it should be motivated by the patient's wishes, but also informed by your medical expertise. And just telling the patient that most people do better on chronic maintenance therapy and if we do taper, we should go slowly and check in frequently. And we can always go back on or go back up on your dose. And this is where I got to the point about stigma. So reinforcing the chronic disease model that we use, which is akin to diabetes, as Justine said. Some of my diabetic patients make radical lifestyle changes and are able to control their diabetes with no medication, but that's the minority of cases. And some patients are able to do that for a period of time, but very, very rarely are they able to sustain that level of change forever. And so they may need medication at some point and not at others. And so that's how I view it. And that's what I tell patients. I always say I'm happy to speak with anyone who has more questions about this type of medical care, because again, leveraging your role as the physician or provider to advocate for the patient. And then I would just say, one thing we found is because patients are really motivated to get their buprenorphine, it's an opportunity to provide additional medical services. So like they want their Suboxone, you provide buprenorphine, but you inquire about what about vaccinations, preventative health services that we could offer. General preventative health services, like flu vaccination that all our patients would benefit. People in particular who may benefit from vaccination for hepatitis B and A. And then also other preventive health services that our patients who may never have accessed previously, this is a 57 year old woman, what has she done in terms of breast cancer screening or colon cancer screening, or cervical cancer screening? Because you know, these types of services, maybe an opportunity to advocate for them to engage, maybe there's things around access or fear that you can talk about and help the person access. So I would say that's a great opportunity in this case. And then empowerment, you know, saying in terms of hypertension, maybe not so much seasonal allergies, but managing their own hypertension or in partnership with you as their provider. So it really is infused in all forms of care. And I'll leave it at that.

(00:52:43):

Thank you both. That was great. Alright. We'll open the floor up to any questions. Now, anyone can feel free to unmute themselves and ask the questions or type it into the chat box either, and I can always read them off. We'll give them a minute in case anybody wants to type something in, alright. It doesn't look like there's any questions.

(00:53:18):

Can I ask a question?

(00:53:19):

You can.

(00:53:20):

I would love to ask a question of the participants. I don't know if we have any ability to have folks chime in better than we did at the beginning, but I'd be curious to hear from folks their response to anything that was said or how that compares to their own practice currently.

(00:53:53):

Just chime in?

(00:53:54):

Yeah, we hear you.

(00:53:55):

Okay. It's Dr. Bonate, about six months, maybe eight months ago I was asked to come to help out a practice. It's a social service organization in Bushwick, Brooklyn, and they lost their medical practitioner. She just left. So they asked if I would come in in the interim and they have a lot of patients who have mental issues, drug abuse issues, a lot of social service issues. And that's why I got interested. They asked me about Suboxone treatment and if I would be able to do it because there was a clinic maybe about 10 minutes down the road that the local officials weren't happy with, they had lines around the corner in the morning, and it was just an unsightly thing early in the morning to late in the evening. So I really knew nothing about offering substance abuse treatment. And I took the course and I just want to become better and more adept at helping them to get a program going. So my first step was to do the course, and then I signed up for this. So I'm just learning slowly what to do to make their social service program better. Any tips that you can give me? They want to get a buprenorphine program started there.

(00:55:36):

That's amazing. It sounds like you're such a dedicated clinician and that's wonderful that you stepped up to the plate for them and actually took the course. I mean, there's so much, there's so many barriers for providers to getting certified and then going on to be a prescriber. But what I would say is it sounds like there's a huge demand for Suboxone, because you said this other place 10 minutes down the road has a huge line. So I think it speaks to an unmet need. That's really crucial and critical and life saving. Buprenorphine reduces mortality by 50%. If we had any drug comparable for other leading causes of death in our country, like buprenorphine, you know, for cancer, heart disease, this would be the biggest blockbuster medication. And they wouldn't have all these barriers in place for doctors being able to prescribe this. So I would say it's critical, and it sounds like really important. I would seek to provide that

in a way that maybe you already do in all forms of your medical practice, which is taking to account the patient's situation and trying to be pragmatic and compassionate in how you prescribe it. Prescribing buprenorphine in and of itself is pretty straight forward. There's a few formulations and part of it is how you do it, which is to say that this is a chronic disease. There are ups and downs, normalizing things. It's not saying that 'I think you're going to go back to using heroin', it is saying, 'but sometimes people do. And if you do, I always say, I want my voice in your head, which is I want you to be safe as you can be. I want you to have Narcan. I don't want you to use alone. I want you to test things out and see what your tolerance is, and but I want you to try to take your Suboxone. It's helpful. It really helps.' And so if you can be really open about these really stigmatized topics like drug use, setbacks, relapse. Being curious, asking the patient like Justine said about 'what's your experience with buprenorphine so far? Many people have tried this many people's friends have helped them out.' And what the evidence shows in the literature is that the diverted buprenorphine is used for purposes of self management of withdrawal. It's not generally used in any way to get high in that sense. So if you talk to patients about how they've taken buprenorphine in the past, what dose works for them.

(00:58:24):

And they have a great harm reduction program at that facility also.

(00:58:29):

So I would see yourself as part of that team, buprenorphine is part of harm reduction. It's not separate from. That's our take, right? Justine, would you say that?

(00:58:41):

I would say that for me, I mean Judy got trained at Montefiore where she learned harm reduction, for me I really learned the morality style around use disorder until well, mostly because especially like in emergency medicine, we were just told that people go to rehab and either they're strong enough to stop using, or they're not. And I never really saw anyone stop using so that didn't really seem to fit, which was why it was easy for me to realize there's something else going on here than what I'm being told. And so I potentially would not trust necessarily what other providers are telling you. And I would trust a little bit more and really go in depth into what sort of your harm reduction specialists are telling you, because they're going to be the ones. Once you start to understand that, you really get to have compassion for what people are going through and then are able to sort of offer services from that light. I try hard also to focus on my own wording of, you know I try hard not to use like clean or dirty. It is fine for you to use that term for yourself. But for me, I don't see you as an addict. I see you as a person who has opiate use disorder, and I don't see you as dirty or clean. I see maybe your urine has some substances in it that's it.

(01:00:27):

I see that Dr. Norris has a quick follow up question too. 'Thanks to you for providing treatment. This is wonderful until they are discharged and everything sort of falls apart, despite appointments being made, any advice?' And then she had another one saying 'our local hospitals also have a very biased

view/stigma to all of our patients who use substances. I would like to reach out to them to try to get better nicer care for our patients. Any again, any advice or guidance?'.

(01:01:04):

I think it's like, it's that we all have our hands full, you know? OASAS, and wwhen we talk more during the preceptorship, OASAS is really changing or has changed completely at the upper levels, but it hasn't changed at the lower levels yet. And so that right there what you're describing is really against OASAS rules. Naltrexone has been seen as being inferior to buprenorphine. And so it really isn't the right medical choice to put someone on naltrexone. I'm right about that, right Judy? It's inferior, so just because the person isn't doing well on Bup they should try again, or maybe they might do better on methadone. But the idea that I would say the product isn't working for them as opposed to the person is having an issue. But you can sort of talk with OASAS about this and potentially try to do some changing of your organization that you work in, but these are slow changes that have to happen. And maybe if you're able to go back with some studies or some data to show them. Also there's a lot of rulings around that OASAS has come out with that changes everything, and so they're not really acting with the law. And we do a lot of work with our local hospital. I think it's a big effort. And we can get you in touch with people who do work with emergency rooms. There's a lot of data coming out of Yale. A lot of stuff coming out of even Rochester, New York. So there's stuff coming out. It's just a matter of getting the change to occur and being an advocate for the change.

(01:02:57):

And I would just say also being, we as providers can be stigmatized by the system with this type of care. And it sometimes, not to generalize but it's often women who are doing this type of work, which is actually evidence based medicine, the gold standard of care in the face of a culture in medicine, which is hierarchical and shaming of patients and providers. And so I would advocate us being courageous and also supporting each other in this work because we're on the right side of history and more and more data is coming out. I mean, just that what I would say is that what is shown is that the best outcomes in terms of reducing overdose, reducing mortality, and morbidity are with either methadone or buprenorphine. Those are the only treatments that are as effective. So that OASAS is changing, that we need to be champions for our patients, but also just evidence based medicine and talking openly. Like that's something I admire about Justine too, is that just talking openly, this is tough. You know, this is tough stuff. These are tough cases. It's not black and white all the time, or it's not crystal clear what to do, but erring on the side of compassion also benefit of the doubt. I had a patient who's been struggling with using heroin off and on. He had been doing very well. He told me, 'Oh, I didn't get the last prescription.' I'm thinking, okay. I checked, I stop of course he hadn't filled it, on my end it said it had sent. So I was peeved and I was a little bit like what's going on? But I didn't say that. And then I looked through the EMR more carefully and it said that there had been an error through Surescripts. So he was telling me the absolute truth. I did give him the benefit of the doubt and I did it and I verified, you know, I had to look into it. But I think it's this approach of like he was irritable and annoyed at me. He was mad at me because he had been doing well. And then there was an error. And from what I could tell, I hadn't made the error, but I was like, look, let me look into this. Let me get you a prescription right away. I was seeing his girlfriend through telemedicine and he got on. He trusted me enough even though he was

irritable, to advocate for himself. And I thanked him for that. What's my point here? My point here is it's tough, but the medicine is the easy part and I would say we view ourselves as patient advocates.

(01:05:35):

And I wonder whether or not the buprenorphine dose was high enough in the past. So there really seems to be, in traditional programs, a need to keep people definitely below 16. Although the studies actually do show that it's 16 to 24, 16 to 32. We really try to limit our patients to 24 because we receive so much stigma locally, but that 16 to 24 range is where patients are going to be comfortable. And I really advocate like, 'Oh, it's not working is that why you're having to use, do you want to try, like, are you having withdrawal? Do we need to increase the dose?' So a lot of advocacy and I think there's a feeling on the part of providers that they're so worried they're being lied to. And I don't find that patients really lie that often. I think some of them do, but I think it's about the same rate of patients that lie in any practice. And I think it's about the same rate of patients that are difficult in any practice. But I do notice that potentially the coping skills might be a little bit less. But patients are typically easy to talk down in their excitement, if you sort of are able to do it with them. And so they're so used to sort of I would say being screwed over that as long as you can recognize that that's why they're getting so irritable, because they're so used to being cut off or like they arrive and they're like, 'well, your last urine was dirty. You're not getting this anymore.' So really being trustworthy on our part, it's super important to us.

(01:07:18):

I want to thank you Judy and Justine for the presentation, but more so for just even being able to share that you were able to empower a patient to advocate for themselves that takes a lot of trust and comfortability in the practice. And I definitely want to just send the message to our preceptorship participants that harm reduction is not easy. Harm reduction is not welcomed in many spaces. If you look at the history of harm reduction, it was something that was done at a local level by folks before it was passed as a law. So I want definitely to create the environment and communicate that you are change agents and you will be catalyst of change in any organization or clinic or practice. And that's okay as long as you have the research to back it up and the support networks to work with other peer clinicians that can support you along the way. And I think that's how we see change little by little. So just my 2 cents. And thank you. This was great.

(01:08:18):

Thank you. I do want to be mindful of time because I know we were supposed to end at 12. But I know that in your clinical shadowing portion, all of everyone who is participating in that, there's going to be a lot more time for followup questions. And I know some people chatted me privately asking to connect to you guys about just issues that they need more advice on. So I can be sure to connect everyone after this webinar and just keep an eye out for that email and just how to evaluate and claim your CE. Anything else?

(01:08:51):

Before we end, I definitely want to let folks know everyone is confirmed for their clinical shadowing experience. If you needed a different date, we're working on that and we'll get you that confirmation before the end of the day. And we will also be able to have the opportunity when you conduct the clinical shadowing, to be able to debrief after those sort of sessions with the clinician you have. So definitely take on that opportunity. Following the clinical shadowing experience possibly in July, we'll hope to bring together this cohort again so that possibly Judy and Justine can talk a little bit more about implementation, how this is actually looking in practice for you. So just wanted to give you those highlights. Yes, definitely. So thank you everyone for coming and I hope you have a great day. Thank you. Thanks guys. Looking forward to the same year. Thank you.

[End]