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Low-Threshold Buprenorphine via Community Partnerships and Telemedicine—Case Reports of Expanding Access to Addiction Treatment During COVID-19

Ximena A. Levander, MD, Haven Wheelock, MPH, Justine Pope, MPH, Abby Lee, EMT, Kerith Hartmann, MPAS, PA-C, Sarah Abuelkhair, Jessica L. Gregg, MD, PhD, and Bradley M. Buchheit, MD, MS

Background: To reduce coronavirus disease 2019 (COVID-19) spread, federal agencies eased telemedicine restrictions including audio-only appointments. These changes permitted clinicians to prescribe buprenorphine to patients with opioid use disorder (OUD) without in-person or audio/video assessment. Our clinic utilized existing community collaborations to implement protocols and extend outreach. We describe 3 patients with OUD who engaged with treatment through outreach with trusted community partners and low-threshold telemedicine.

Case Presentations: Patient 1—a 40-year-old man with severe OUD who injected heroin and was living outside. A weekend harm reduction organization volunteer the patient previously knew used her mobile phone to facilitate an audio-only intake appointment during clinic hours. He completed outpatient buprenorphine initiation. Patient 2—a

48-year-old man with severe opioid and methamphetamine use disorders who injected both and was living in his recreational vehicle. He engaged regularly with syringe services program (SSP), but utilized no other healthcare services. Initially, an SSP worker connected him to our clinic for audio-only appointment using their landline to initiate buprenorphine; a harm reduction volunteer coordinated follow-up. Patient 3—a 66-year-old man with moderate OUD used non-prescribed pill opioids without prior buprenorphine experience. He lived over 5 hours away in a rural town. He underwent virtual appointment and completed home buprenorphine initiation.

Conclusion: These 3 cases illustrate examples of how policy changes allowing for telemedicine buprenorphine prescribing can expand availability of addiction services for patients with OUD who were previously disengaged for reasons including geography, lack of housing, transportation difficulties, and mistrust of traditional healthcare systems.

Key Words: buprenorphine, community outreach, COVID-19, homelessness, rural, telemedicine

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From the Department of Medicine, Division of General Internal Medicine and Geriatrics, Section of Addiction Medicine, Oregon Health and Science University, Portland, OR (XAL, AL, KH, JLG, BMB); Outside In's Injection Drug Users Health Services, Portland, OR (HW); Comagine Health, Portland, OR (JP); The People's Harm Reduction Alliance/Portland People's Outreach Project, Portland, OR (JP, SA) and Department of Family Medicine, Oregon Health and Science University, Portland, OR (BMB).

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Send correspondence to Ximena A. Levander, MD, Oregon Health and Science University - Division of General Internal Medicine, 3181 SW Sam Jackson Park Road, Mail Code: L475, Portland, OR 97239-3098. E-mail: levander@ohsu.edu.

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On January 19, 2020, the first known case of coronavirus disease 2019 (COVID-19) in the United States (US) presented to urgent care.¹ Less than 2 weeks later, Secretary Azar declared a nationwide public health emergency.² Since then, we have witnessed many policy changes attempting to slow COVID-19 spread, while also mitigating effects on vulnerable populations.

Early on, experts raised concerns around the synergistic consequences between a pandemic and the overdose crisis in those with substance use disorders (SUD).^{3–5} Physical distancing to reduce COVID-19 spread put those with SUD at increased risk of overdose, and also reduced availability of services. To improve health care access during the pandemic, the Centers for Medicare and Medicaid Services allowed for reimbursement of telemedicine services.⁶ To address concerns around access to medications for opioid use disorder (MOUD), the Substance Abuse and Mental Health Services Administration and the Drug Enforcement Administration announced patients could be initiated on buprenorphine for

opioid use disorder (OUD) via telemedicine, waiving the requirement for an in-person intake visit.⁷ Later these agencies announced additional flexibility allowing for initiation after telephone (audio-only) assessment.⁷

Our clinic is a low-threshold⁸ buprenorphine bridge clinic in Portland, Oregon that opened in October 2019. Before COVID-19, visits occurred in-person in an office shared with the academic internal medicine clinic, weekdays from 4 to 8:00 PM. We had been working with 2 community partners, a syringe services program (SSP) and a harm reduction organization, to facilitate referrals to our clinic. However, requirement of an in-person assessment at our clinic remained a barrier to some patients. In response to changed regulations around telemedicine reimbursement and buprenorphine prescribing, our clinic rapidly converted to virtual (synchronous audio/visual through our electronic health record) or telephone visits and expanded hours of operation. Our clinic also reached out to our community partners, to collaboratively respond to these COVID-19-related telemedicine changes. The SSP is a component of a larger nonprofit organization providing healthcare and social support services to those experiencing homelessness. The SSP operates 3 fixed locations, and is one of the oldest programs of its kind in the US. The harm reduction organization is all-volunteer and provides direct outreach for need-based syringe and harm reduction services via bicycle, at a fixed outdoor location, or by foot outreach Fridays, Saturdays, and Sundays, respectively. Here we present 3 patient cases demonstrating how changes in telemedicine regulations and leveraging of addiction clinic and community organization partnerships allowed us to reach patients previously not engaged in addiction treatment. The patients described provided consent for publication.

CASE PRESENTATIONS

#1: A 40-year-old man experiencing homelessness and utilizing syringe services delivered by harm reduction organization on Saturdays. A volunteer helped connect him with our clinic for an intake appointment. At the time of his initial visit, patient had no personal phone so he used the volunteer's mobile device.

The patient had been injecting heroin off and on for 20 years, most recently returning to use in the year prior. When on MOUD, patient experienced intervals without heroin use. He had engaged with methadone maintenance and later did well taking buprenorphine/naloxone 24/6 mg daily before discontinuing the medication. Subsequently, he had overdosed when combining opioids with benzodiazepines. He had access to intranasal naloxone.

During the audio intake appointment, he was alert and oriented. He last used heroin approximately 12 hours prior. He underwent clinical assessment and was diagnosed with severe opioid and mild methamphetamine use disorders.

Patient consented to community initiation of buprenorphine/naloxone using our standard clinic protocol—day 1 up to 3 half-tabs of 8/2 mg (12/3 mg total) and on day 2 prescribed 16/4 mg daily. He received a 3-day prescription and our clinic coordinator and harm reduction volunteer arranged telephone follow-up.

Patient had 7 subsequent clinic visits in 2 months. His most recent appointments were virtual as he had used his

stimulus check to purchase a smartphone. He reported reduced anxiety as housing situation improved—he was accepted into city-sponsored outdoor COVID-19 shelter and had re-connected with his former case worker via his new phone to begin the supportive housing application process. Cravings and pain were controlled on buprenorphine/naloxone 16/4 mg daily. He continued intermittently using methamphetamine for energy to collect cans for income. Our clinic coordinator has connected him to previous primary care for ongoing MOUD and health care maintenance.

#2: A 48-year-old man, living in a recreational vehicle with his partner, who presented to SSP. At the SSP, he got connected to our clinic by an SSP staff member well known to him via an office telephone located in a private room.

He began injecting heroin 5 years ago after losing his house. At intake, he reported injecting 1-gram heroin daily and injecting methamphetamine most days. He had previously engaged with methadone treatment program for 6 months, but had disengaged, and wanted to try buprenorphine/naloxone. He had never overdosed, and had access to intramuscular naloxone.

During the telephone appointment, he remained alert and oriented. Last heroin use was 4 hours prior. He underwent clinical assessment which confirmed severe opioid and methamphetamine use disorders. He smoked a pack of cigarettes daily.

After a risk/benefit discussion, patient verbalized understanding, and consented to community initiation of buprenorphine/naloxone via the same standard clinic protocol as patient #1. He received 1-week prescription and was instructed to call for follow-up.

The patient completed 4 subsequent clinic telephone visits in 2 months, stabilized at his first follow-up visit on buprenorphine/naloxone 16/4 mg. Harm reduction outreach volunteers facilitated follow-up visits using their phones, as he lacked one. At his most recent visit, the patient expressed smoking cessation interest and received nicotine replacement therapy. We provided one-month prescriptions to reduce risk of running out. Plan remains continued telemedicine follow-up at our clinic.

#3: A 66-year-old man presented for intake at our clinic via virtual visit. Patient lived over 5 hours away, in a rural community with limited buprenorphine prescribers, who heard about our services via community referral. Last year, he underwent hip replacement and was prescribed hydrocodone-acetaminophen for 2 weeks. When the prescription ended, he started taking non-prescribed pills. He reported using 3 to 4 non-prescribed hydrocodone-acetaminophen 10 mg tablets daily, with concern regarding counterfeit pressed pills. He had never taken buprenorphine, but knew about it. He denied intranasal or intravenous use, and had never overdosed.

On video, he appeared alert and without distress. Last use was 3 days prior and he reported feeling “crummy.” He underwent clinical assessment and was diagnosed with moderate OUD. He reported consuming 3–4 whiskey drinks per night, and smoked half pack of cigarettes daily.

After risk/benefit discussion, he verbalized understanding, and consented to community buprenorphine initiation. We prescribed buprenorphine 2 mg twice per day for one-week and arranged follow-up. The local pharmacy did not

carry buprenorphine/naloxone. We prescribed him intranasal naloxone.

In the 2 months after his intake, he completed 6 clinic visits. Improved pain control with buprenorphine 2 mg twice daily led to reduction in alcohol, by one drink daily. Given limited buprenorphine prescribers nearby, current plan remains ongoing follow-up in our clinic.

#1–3: The prescription drug monitoring program was reviewed and consistent with reported history for all 3 patients. No patients had urine drug testing (UDT) available, but COVID-19 related risks to acquire UDT outweighed benefits of initiating buprenorphine. We provided guidance on how to reduce exposure to COVID-19⁹ and recommended screening for HIV and HCV.

DISCUSSION

These cases illustrate the possibilities of buprenorphine initiation without first conducting an in-person clinical assessment, including via telephone only, to reach vulnerable patient populations previously not engaged with addiction treatment.

Barriers exist to accessing buprenorphine treatment, especially in rural areas.^{10,11} Our rural patient experienced limitations in buprenorphine formulation available at his local pharmacy and has no available long-term non-telemedicine addiction follow-up. Policy makers and clinicians had postulated pre-COVID that telemedicine services would expand availability to these communities.^{12,13} However, gaps in addiction services remain, possibly due to prior telemedicine reimbursement rates,^{6,14} requirement for in-person assessment, and technological challenges such as limited high-speed Internet. Two of our patients engaged with our clinic via personal connection with members of the harm reduction organization and SSP, respectively. Initial engagement via telephone allowed them to stay in familiar environments, while also getting needed addiction treatment, something unavailable before telemedicine policy changes.

We acknowledge concerns around initiating buprenorphine via telemedicine, particularly via phone. Clinicians may lack UDT results, as with our 3 patients, and must rely on patients providing accurate drug use histories. However, not having confirmation about concurrent use of other substances, like benzodiazepines, should not preclude initiating buprenorphine.¹⁵ Additionally, clinicians using telemedicine may struggle to provide screening for infections associated with drug use. Although it may delay screening, prescribing MOUD has been shown to effectively reduce HIV and HCV-related infections.^{16,17}

COVID-19-related telemedicine policy changes have led to rapid development of innovative programs¹⁸ and creative outreach efforts.¹⁹ We must remember, though, that the overdose crisis existed before COVID-19 and will continue post-pandemic. Previous policies and regulations restricted access to MOUD and harm reduction services.²⁰ More research is needed to explore changes in addiction medicine clinician decision making via telemedicine and to determine the efficacy of telemedicine initiated buprenorphine compared to more traditional approaches. These cases demonstrate the feasibility of buprenorphine initiation without an initial in-person assessment, the utility of audio-only intake

for buprenorphine, and the role of utilizing trusted community organizations to connect with patients not previously engaged in traditional healthcare systems.

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