Community Service Board – Substance Use Subcommittee Meeting
May 22, 2024, 3-4:30pm

Subcommittee Member Attendees:

- Adrienne Abbate, Debbie Pantin, Felecia Pullen, Soteri Polydorou, Sarah Church

Attendees:

- Brooke Gasdaska, Anika Kalra, Ellenie Tuazon, Janet Smith-Dobson, Julia DeWalt, MD Nass, Mike Selick, Nilova Saha, Rachel Vick, Roxana Hernandez, Shivani Mantha, Tejumade Ajaiyeoba, Winnie Ho

DOHMH Updates

- Recently published first-year report on OnPoint's operations that focuses more on quantitative data. Report can be found here.
- The 4th public health vending machine was launched in East New York with VOCAL-NY. This machine is the last machine to be launched as part of the public health vending machine pilot project.

Treatment Policy Updates

- Tina presents on a review of recent federal-level policy changes, made this year, for opioid use disorder (OUD) treatment, with a special focus on medications for opioid use disorder (MOUD)
- Methadone and buprenorphine (bupe) are the only treatments for OUD associated with reduced overdose risk but remain underutilized.

- **Updates to Federal Treatment Policies:**
    - The use of clearer and less stigmatizing language
    - Stricter accreditation standards for treatment programs
    - NPs and PAs can now order MOUD for dispensing at OTPS (depending on state-specific laws)
        - Intention is to expand access to care, particularly in underserved areas.
    - Easier access to treatment in terms of admission eligibility (1-year history of opioid use no longer required), electronic consent is allowed.
    - Take-home methadone doses (COVID-19 flexibilities now permanent) and allows for screening patients for buprenorphine via telehealth
        - Expanded take-home dose for methadone in OTPs, requires some level of state policy change to have full alignment with federal change.
    - Better patient care in terms of treatment plans (including collaborative decision making) and interim treatment (allowing access to care within first 180 days)
    - Allows practitioners to prescribe up to a 3-day supply at a time, which can be used for maintenance or detox treatments – helps minimize need for frequent visits during treatment initiation, streamlines initiations.

Discussion

Given federal and state policy changes, what are you excited/concerned about in terms of implementation?

What are possible opportunities or gaps do you see in terms of improving MOUD access, engagement, and quality of care?

- What kind of warm hand-off or practice can we create between ED and treatment providers to support initiation and more robust engagement with people who want to continue MOUD treatment?
  - Good question, implementation details are important. These changes can be overwhelming. Anyone have ideas about what that would look like?
- Changes are welcome and overdue, have been advocated for a long time. Concerns about implementation – how will this move the needle clinically? Hope that there's some clear guidance from OASAS to make sure regulations are all aligned, but also best clinical practices to support providers to change their clinical practice.
  - EDs might not be used to/comfortable with this. Let's see clear alignment from state and other agencies that need to weigh on and very clear best practice recommendations to support providers in lots of clinical environments (not addiction medicine providers specifically – the providers who will be more hesitant).
- Do we have mapping or locators of methadone and bupe providers?
  - Hard to map bupe providers because anyone can prescribe.
- Changes are great – will state integrate them? Some OTPs didn't follow COVID changes even at the beginning of it, individual clinics need to implement it. Also need to allow a higher dose to start at, 50mg isn't enough for many people.
- DSRIP (Delivery System Reform Incentive Payment) – were trying to do connection but fell apart without support at higher levels. Could some of this warm handoff be done via Relay to ensure people are connected to services?
- Hope this can help move the needle on stigma around MOUD. Misunderstanding by community at large is a problem, but so is misunderstanding of people who work in the field. Stigma is impacting access. People don't want to take MOUD because of the stigma.
  - OASAS and DOHMH have started an OTP learning collaborative.
  - Program directors may not hold these stigmas/misunderstandings but doesn't mean all the staff don't. Takes a village, everyone needs to be on the same page re: messaging.
- This has taken such a huge toll, have to do as much as we can to get these meds out to people. Bupe is a pretty safe medicine. Need to be getting this out through telehealth too so that location isn't a burden.
- Feels like addressing stigma is something we can all have a hand in. Stigma in this field but also among people who take MOUD. Comments about liquid handcuffs, replacing one addiction with another. People in Harlem think there are too many methadone programs, lots of NIMBYism (Not in My Backyard-ism). Need to help providers are in touch with patients enough about their experiences on methadone.

- **DOHMH:** Planning patient-facing materials around MOUD, will share with this group when they're ready.
- Methadone – most Black and Brown folks have been directed to methadone treatment. Highly stigmatized, but if we're looking to expand and increase, are we consciously making sure that we're doing thing stop destigmatize the medication.
    - Black and Brown families don't have good associations with methadone programs, and that's what they think of when someone mentions MOUD, the don't normally think of bupe. What have we done to address this?

DOHMH: What's the potential for actual low-threshold, compassionate approaches to reducing stigma? How to concretize and use that to reduce overdose death among Black New Yorkers? As a Health Department, what can we do to really move the needle on stigma?

- Runs an outpatient 822 program. Have been thinking about how to serve folks who only want medicine and don't want other services – OASAS issue – how to slim down regulations. Right now, programs must do a lot of things to get someone into treatment and otherwise aren't in compliance, the regulations don't allow for low-threshold, quick initiation into treatment.
    - OASAS put out guidance earlier during COVID-19 quarantine about being able to provide MOUD without counseling etc. In general, OASAS has also shifted since opioid epidemic and COVID-19 because stakes are high.
- Drugs are the treatment, should be okay if people don't want the therapy or counseling. All the intake paperwork is a barrier – can get around giving case management or very minimal therapy.
- Meeting people where they are is important, but are there unintentional consequences of not requiring counseling if there's not adequate support and care? Does that apply when a patient expresses that they're not interested in proceeding with medication, or do they have to be checked at multiple points to see if they've changed their mind. If patient doesn't want counseling, short counseling could be worse.
- Education is important, but there are not many other examples with high mortality risk where you're expected to do education, preliminary counseling, motivation building. When patients are in other urgent, critically important scenarios, they get the treatment.
    - Expectation shouldn't be that counseling was offered. Medication should be started unless there's a clear contraindication or refusal. Important to just get people on the medication first, rather than everything else before medication is started.
- Agreed, also the education of community at large is important. If neighbor knows I'm in treatment. What other medication do people have to stand in a line that goes around the building?
- Not surprising that there's this stigma based on the way the methadone system was all set up – basically designed to be difficult and restricting.
- Talking about recent data, but in the '50s-'70s when Black and Brown communities were dying and prescribed methadone. Also battling a long history of community stigma against methadone

- Don't want us to use money for subway ads, want us to use it to open more clinics or mobile methadone vans, things that will put medication into people's mouths
- **DOHMH:** We've been discussing utility of ads. It's a way to get citywide conversations going, but citywide campaigns create negative attention too. Education is important for providers and patients who have been historically hesitant to engage in treatment and harm reduction.
- A lot of stigma comes from the recovery programs that emphasize abstinence only (no MOUD)
- How to educate providers, clinical education – use the term low-threshold but don't always talk about what that means on a day-to-day basis in a program. Historically have managed risk by pushing people away, now are asking patients to handle risk with patients – this is a shift in the way we're asking clinicians to do this work.
- Good point. Education of staff is important. Some staff have been in field for a while who have bias, younger people who don't understand it. Did a lot of training for MICA (mentally ill chemically addicted) treatment, that level of educational investment to educate people about MOUD hasn't happened.
    - What would that look like?
    - Building out curriculum, training entities that state and City use, integration trainings.
    - We provide training on MOUD to NYC programs. Have completed contracts with NYC for the year and don't have resources until new contract.
    - Could do some of this in TPII (Training and Practice Implementation Institute)
- Real structural change across systems is necessary. The way hospitals get measured impact care. Measures around infections etc. If we could tie MOUD into this type of benchmark, that gets systems to move. Would need teeth, though.
    - The measures exist, but we don't have teeth to enforce
- Talked a lot about methadone, haven't talked about bupe, really important and probably more opportunities to increase access to bupe.
- Do we know why treatment utilization has been decreasing?
    - We're seeing this, also seeing nationally, more of a leveling off than decrease. Interesting since there have been so many changes in the regulations but it hasn't been followed by increased utilization.

- Will reconvene in fall and continue our conversation.