Q&A from WPSI Webinar 03/02/2020

Continuing the Conversation with Cheryl Ho, MD

<u>Shared Medical Appointments</u>

Question: Were any parents involved in the process?

Answer: When family is available and willing to help, it's great to have them get involved, but I find that some families are reluctant to attend. Sally's family, for instance, spoke Spanish and we unfortunately didn't have translators available at the clinic.

Question: Were grief and loss addressed?

Answer: Stan experienced lots of grief and a sense of loss due to the death of close family members. When he went through that process, we took a few weeks in the shared setting to talk about grief and loss. These topics took precedence, even if we had others on the agenda. It was a very therapeutic time. This is one of the benefits of the shared appointment model – other patients in attendance were able to chime in with their own experiences, and Stan felt truly supported. He bonded with his fellow patients. Stan's anger was very complicated; his grief and loss fueled that. He's chummy and friendly, but his anger would seep out at times. We were able to address that away from the group setting on a one-on-one basis.

Question: What are your top 3 pieces of advice for programs that are considering starting SMVs?

Answer: I recommend gathering your team first. Team members are vital – like medical assistants and nurses. They're on the front lines and are often able to affect patients positively too. Communicate with them about your new buprenorphine program.

Next, start small. We started with just a handful of people and grew from there. One time, 5 patients walked in on buprenorphine and instead of turning them away, we turned them into one group so we could see them all and address their needs. Follow the SMV model for a few weeks or months and see how it goes.

Finally, expect the ugly! I think that as providers we can sometimes be hard on ourselves when things don't go well, but understand that it's not always easy to work as a team and that the patients we treat are difficult to help at times. It's not your fault if things don't always go well. Set the bar high, but not too high all at once. Allow yourself room to grow.

Question: How do you suggest we sensitively build a platform for patients to share their stories in a safe space?

Answer: We sometimes tokenize folks because we so readily want to hear traditional, easy-to-digest success stories – for instance, that patients are off drugs permanently or that they've reached new milestones in their careers. But everyone has their own trajectory and they don't all fit into these "good outcome, bad outcome" boxes. We've tried to give folks different avenues to share through which they can be involved. FQHC clinics have an advisory board, and patients in recovery can participate in them. We also have an advocacy group and people are starting to organize in general. We also ask patients pointed questions about what works and what doesn't. It won't lead to one answer, but it does help. Stan's story gave us more awareness than we had before.

Question: The use of patients in a peer mentor role in the group setting may be a safer space to start. What do you think about using them in this capacity?

Answer: I think it's a great idea. Two groups have so far made effective use of peer mentorships. FQHC funding provided help to establish this. It provides safety and reassurance and adds another wonderful dimension. For people who don't have a sense of how to start SMV, peer mentor is a valuable method to consider starting with.

Question: I understand the nervousness you had in treating these two patients in the case studies. We know that the most likely outcome for patients like these is death. We have to balance our fear with the risk the patients are encountering. If you didn't have the team you had when you first started this treatment, would you still make the decision to enter these patients into treatment, given their precarious condition?

Answer: My philosophy has evolved over the years. As care providers we are not always well-trained in harm reduction. In 2009, we certainly weren't as well trained in harm reduction as we are now. Initially, when we started our buprenorphine program, there hadn't been a lot of providers who provided buprenorphine for the homeless population. We were cautious because we felt like the methadone approach in the OTP clinics would serve our homeless patients better. But patients were coming to us in droves, unable to make it to the methadone clinic. We felt it was necessary for us to try treating them ourselves. We really evolved. Looking back, it seems like an easy decision, but we really had to think about it. Harm reduction was more of a theory back then, but now, more providers are comfortable with the concept in practice. I came into addiction medicine later in my career and learned on the job as opposed to starting right out of the gate.

Comment from Dr. Ho: This is hard work. When we first started our buprenorphine clinic, people in various stages of recovery would sometimes yell at my staff and me. There were safety concerns. We had a large Come-to-Jesus meeting around 2012 because we had a large number of patients who wanted buprenorphine treatment. We had to discuss our mission and undergo some growing pains. Caring for each other was vital. Every patient was different, and we connected with some more than others. It felt good to have team members in the room with me, backing me up and helping alleviate burnout.

Question: Is it difficult for homeless individuals to protect their buprenorphine from diversion, and is it difficult for them to protect their meds?

Answer: The question of diversion is real. When patients state they have cravings but don't seem to be in any worse of a condition, we question diversion a lot. It goes back to our evolving harm reduction approach. We'll never know for sure – all we have is our clinical sense or suspicions, but those are oftentimes mixed with bias. Buprenorphine that's diverted is still safer than other opiates, although diverted use is still far from ideal. The context in which buprenorphine is used on the street is primarily to wean off opiates. Anecdotally, the homeless population is still using buprenorphine to wean off opiates instead of as a primary opiate.

And yes, to address the second question, it's difficult for them to protect their medications. We give them a one-time pass if they lose their medicine, but if they lose it often, we'll bring them in to the clinic more often. We have a stepwise approach to address this.

Question: Homelessness isn't a primary contraindication to buprenorphine treatment anymore?

Answer: Ten years ago, I'd have given pause to this, but now I'm embracing the harm reduction model for homeless people when it comes to buprenorphine treatment. It's contributing to fewer people dying from overdose.

Final comments: If you're thinking you don't have much of a team in place in your organization, you probably have more resources than you think you do. We've found that we learn more from each other and more about other disciplines in the shared setting.