How Low Can You Go? Low Barrier Buprenorphine Care Delivery Models

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ASAM Annual Meeting 2025
April 25, 2025

Disclosure Information

- Elizabeth Salisbury-Afshar, MD, MPH, FAAFP, DFASAM, FACPM
  - No Disclosures
- Sarah Messmer, MD
  - No Disclosures
- Katrina Ciraldo, MD
  - No Disclosures
- Edward Suarez, Jr., Psy.D.
  - No Disclosures
- Madi Simpson, RN
  - No Disclosures
- Maggie Williams, PA
  - No Disclosures
- Abigail Elmes, PharmD, MHPE
  - No Disclosures
- Albert Murphy, MPH
  - No Disclosures

Learning Objectives

1. List the principles of low barrier care as defined by SAMHSA
2. Describe how local context should be considered when identifying possible clinical delivery models
3. Identify at least one way you can work to lower the barriers to care in your own clinical setting

Advisory highlights:

- 6 Principles
- 5 Components
- Multiple case examples
- Comparison of low-barrier and high-barrier care

"Low barrier care reduces requirements and restrictions that may limit access to care."

[Advisory: Low Barrier Models of Care for Substance Use Disorders]

Principles of Low Barrier Care

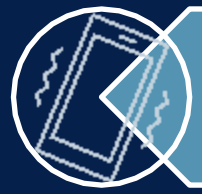
- Person-centered Care
- Harm reduction oriented & meeting the person where they are
- Flexible in service provision
- Provides comprehensive services
- Culturally responsive and inclusive care
- Recognizes the impact of trauma

Advisory: Low Barrier Models of Care for Substance Use Disorders

Components of Low Barrier Care Models

Available and accessible

Flexible



Responsive

Collaborative

Engaged in learning and quality improvement

Advisory: Low Barrier Models of Care for Substance Use Disorders

Barrier Level	Requirements/approach	Requirements/approach (Medication Only)	Availability
Low Barrier Care	• No service conditions/ preconditions • Visit frequency based on clinical stability • Ongoing SU doesn't result in automatic termination • Client's goals are prioritized • Reduced/less risky SU is an acceptable goal	• Medication at first visit • Home initiation allowed • Various medication formulations offered • Individualized medication dosage • Rapid re-initiation of medication after short-term disruption	• Treatment available in non-specialty SUD settings • Other clinical and non-clinical services incorporated • Same day treatment available, no appointment required • Extended hours of operation • Telehealth and in-person
High Barrier Care	• Requirements for engagement for specific services • Visit frequency based on pre-determined schedule • Treatment discontinuation based on ongoing substance use • Treatment goals imposed • Abstinence as primary goal set for all patients	• ≥2 visits before medication • Clinic initiation required • Limited medication formulation options • Uniform maximum dose • Induction required to restart medication after brief disruption	• Treatment available only at specialty SUD settings • Non-integrated or limited services available • ≥1 day wait for treatment availability • Traditional hours of operation • In-person only

Advisory: Low Barrier Models of Care for Substance Use Disorders

Audience Poll

- On a scale of 1 to 5, where would you rate your current clinical environment in terms of providing low barrier care?
  - 1= we have high barrier care
  - 5= we have low barrier care

UW Compass Program- Local Context

- Access to MOUD:
  - Many PCPs not prescribing MOUD
  - Access challenges - closed panels and limited availability in existing panels
  - Payer network limitations (HMO market)
  - Not a Medicaid expansion state/lack of insurance
  - Most programs offer only high barrier care

- PWUD often afraid to access care for fear of stigma, making people less likely to access:
  - Wound care
  - HCV treatment
  - Reproductive health care

UW Compass Program- Model of Care

GOALS:

- Low barrier clinic where PWUD can walk in to receive same-day care
- Ability to provide care regardless of insurance status
- Offer services that PWUD often need & have trouble accessing:
  - MOUD
  - HCV treatment
  - Wound care
  - Harm reduction ed and naloxone
  - STI testing/Tx
  - Family planning/contraceptive access
  - Peer support services
  - Transportation assistance
  - Housing assistance
  - Medical case management

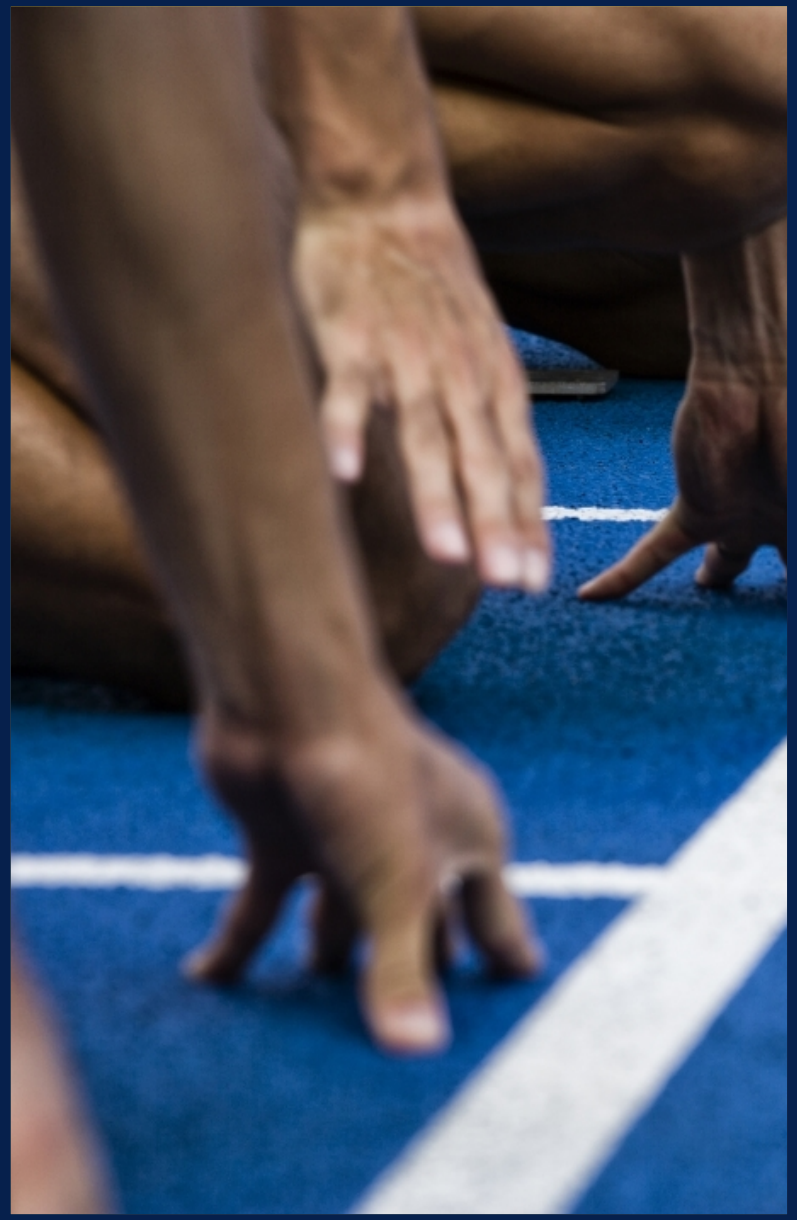
Challenges in Building a Clinic Like This

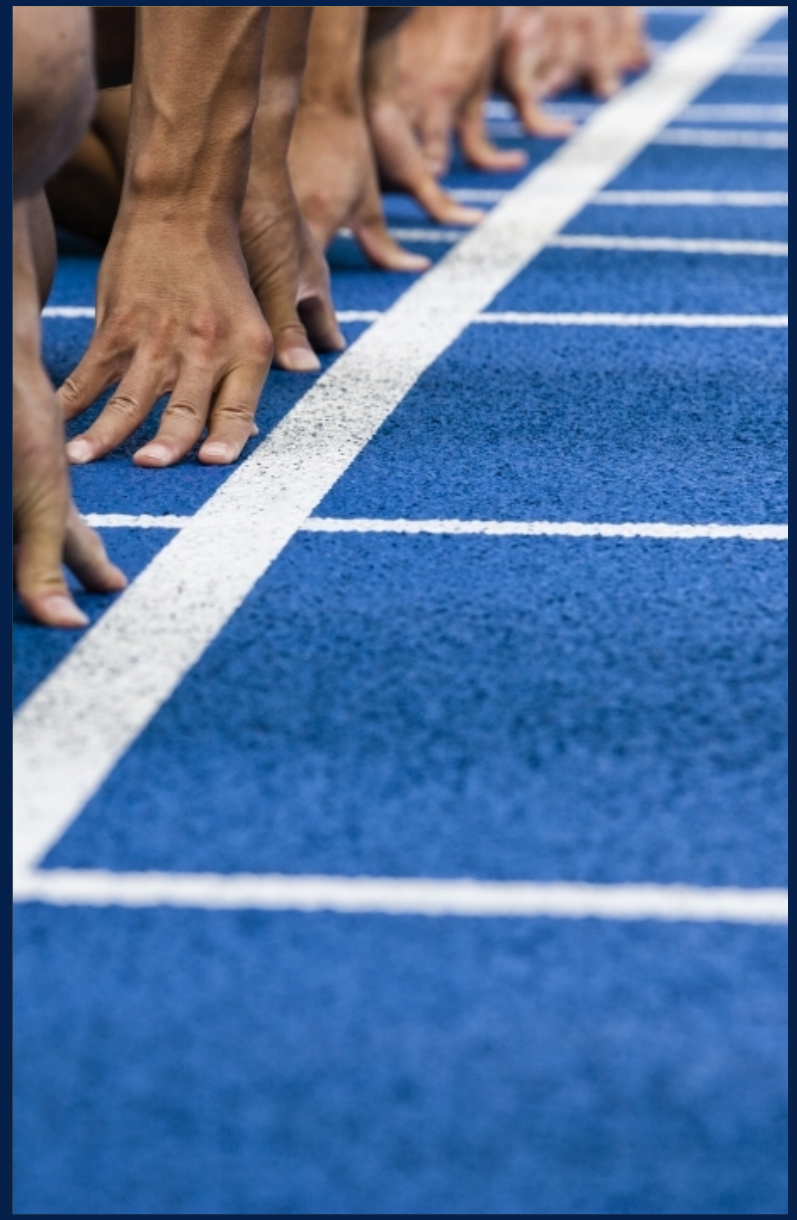
- SUD care typically has a heavy Medicaid payer base = low reimbursement.
- Walk-in models are generally not as efficient as clinics using scheduled visit structures (l volume = less money).
- No ability to provid cost for individuals rance in existing models.
- P ding this model of care often have higher medical acuity and need greater (with lower reimbursement).
- Existing space and staffing challenges
- Health system typically has greater focus on providing care for patients who are in our network

Difficult to make a business case

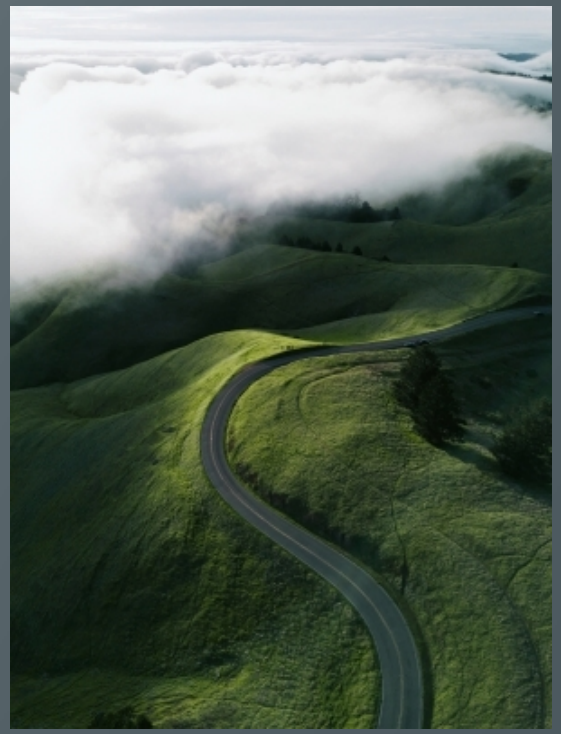
Where and how we started

- State call for proposals for “low barrier MOUD”
- Grant proposal said we would open low-barrier walk-in clinic that would offer walk-in care for:
  - MOUD
  - Wound care
  - HCV treatment
  - Contraceptive access
  - STI testing and treatment





Long path to opening



- Identifying space
- Legal interpretation of service line and 42CFR compliance
- Setting up new cost centers:
  - “Compass insurance”
  - Lab
  - Pharmacy
- Information Systems Build-out
- Staffing
  - Posting
  - Hiring
  - Onboarding
- **Change management**

February 15, 2024

Compass Program hopes to help fill care gap amid opioid crisis

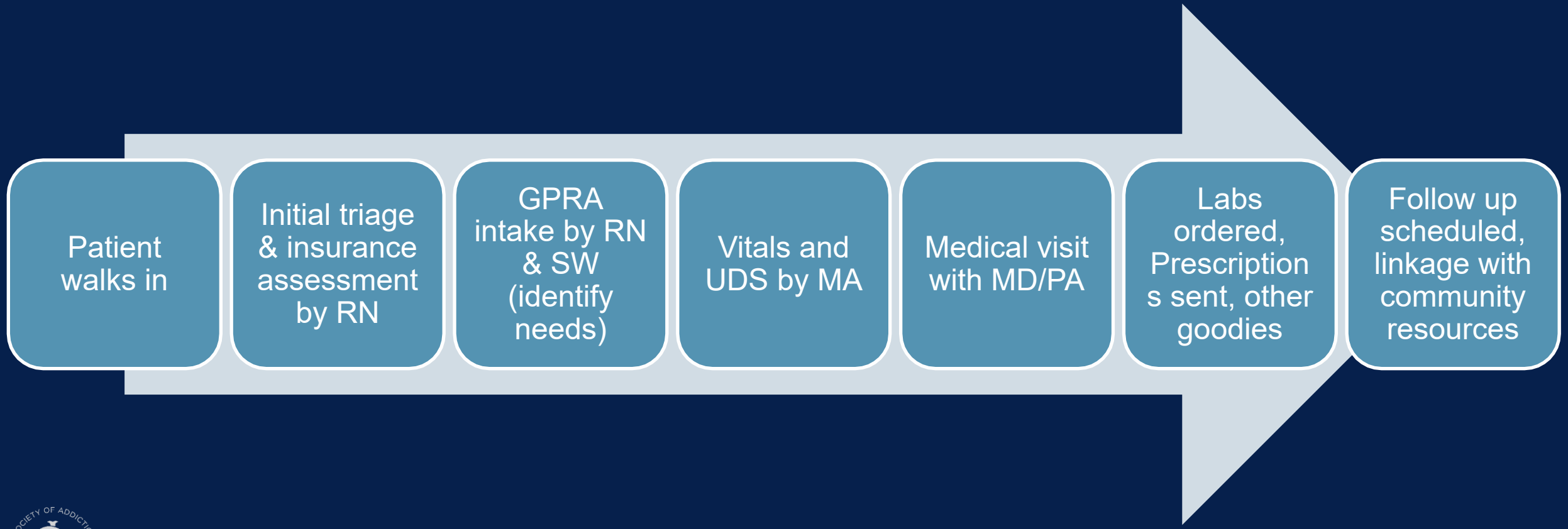
About us

UW Health 1102 S Park St Clinic in Madison, Wis.

STAFFING MODEL

- Behavioral Health Nurse Care Manager
- Social Worker
- Peer Support Specialist
- Medical Assistant
- Prescriber (PA, NP, MD)

Patient Experience



Supplies

- Bus passes
- Back packs
- Naloxone
- Test strips
- Basic wound care supplies

- Lock boxes
- Gun locks
- Hand warmers
- Menstruation packs
- Safer sex supplies
- Gloves/warm weather supplies
- Harm Reduction supplies
- Snacks!

Early Outcomes (process measures)

In the first year of operations (2 days/week):

- 125 unique patients served
- 646 total encounters

Payer status:

- 55 patients with Medicaid
- 30 have private insurance
- 29 patients have utilized Compass grant (uninsured)
- 11 Medicare

Patient Feedback

3. What did you like best about your experience? Please describe what happened, and how it felt to you.

They listen to you

3. What did you like best about your experience? Please describe what happened, and how it felt to you.

that they were availble for walk ins immeadetly Felt AMAZING

3. What did you like best about your experience? Please describe what happened, and how it felt to you.

Everyone made me feel so comfortable like family
Always so Kind & non-judgmental

3. What did you like best about your experience? Please describe what happened, and how it felt to you.

The people and the amount of support and care that they give

4. What do you wish had gone differently? Please describe what happened, and how it felt to you.

I wished I had known about this program earlier. I think many People who could benefit from this program just unfortunately never find out about it.

4. What do you wish had gone differently? Please describe what happened, and how it felt to you.

Everything went great. I wouldn't change any thing I Really Feel welcome here and that's not so common those days

2a. Please share other support or supplies you would like to have available at the Compass Program

I'd like to see pipes added to harm reduction supplies

4. What do you wish had gone differently? Please describe what happened, and how it felt to you.

more help with emergency housing
*currently sleeping / living in vehicle)

discriminated against, hassled, or treated unfairly while at the Compass Program?

4. What do you wish had gone differently? Please describe what happened, and how it felt to you.

If anything, I wish they followed up more & were available for more freq. visits like therapy

Early Lessons Learned

- New service model within an existing clinic is challenging- change management!!
- New service line in a big system is time intensive.
- If you build it…. It takes a little while before they come.
- Community partnerships are critical.
- Safety net programming typically requires grant funding or enhanced billing models
  - Start sustainability planning early.
- Understand patient needs and address them:
  - Food
  - Clothing
  - Housing
  - Transportation
  - Health care navigation.
- Teamwork makes the dream work!

Future directions

- Expand hours to additional days of week, evenings and weekends
- Identify more efficient ways to register new patients remotely (for telemed)
- Develop patient advisory board
- Identify funding:
  - Uninsured care
  - Food/snacks
  - Bus passes
  - Coats, gloves, hats, socks, etc.
- Continue to identify community referral sources for patients with greater stability
- Continue to facilitate community partnerships

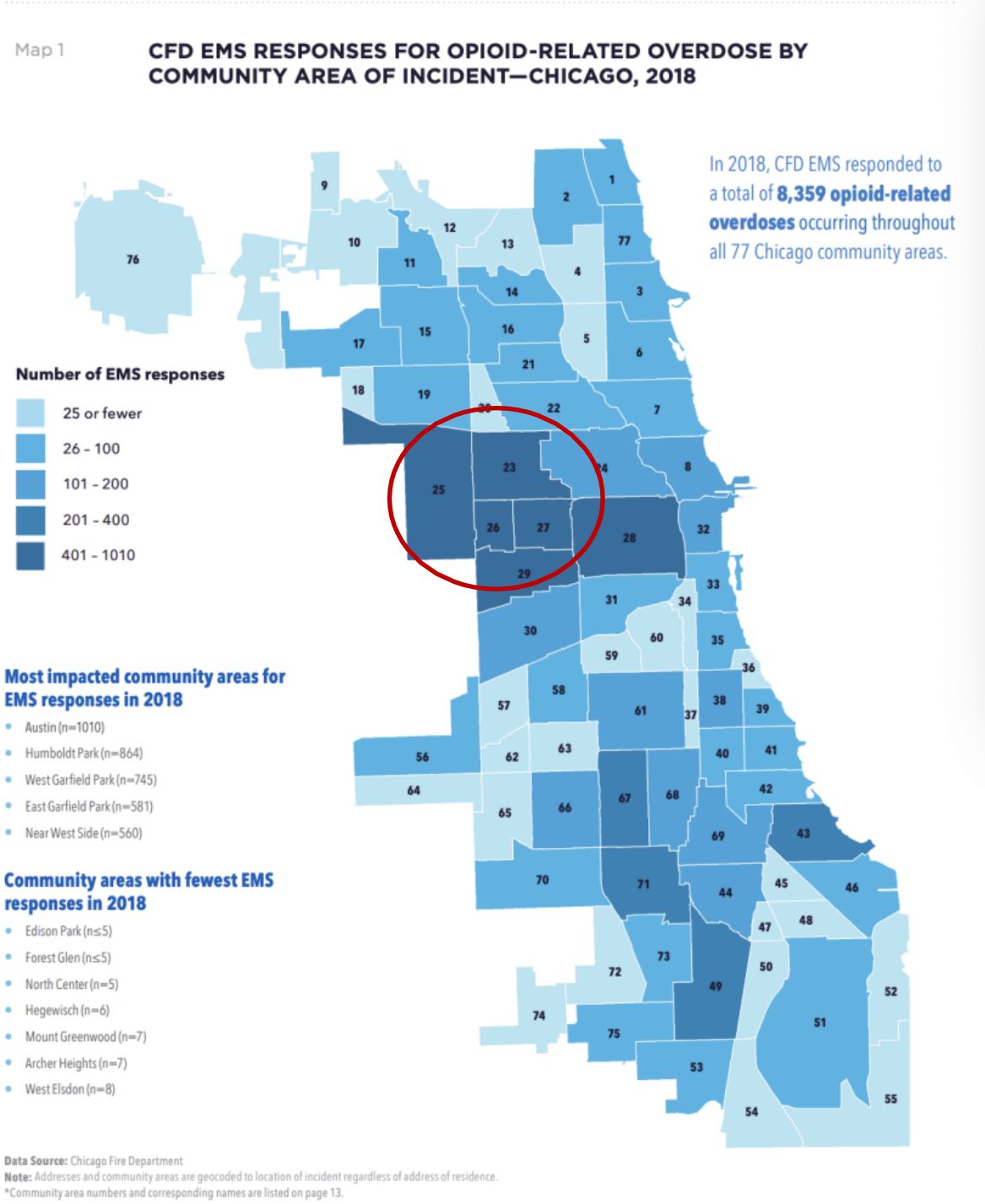
Thank you

- WI DHS for this funding opportunity!
- Randy Brown
- Megan Ringo
- Matt Johannsen
- Kristen Brey
- Cailey Clam
- Tom Carroll
- Nicole Riechers
- Tyler Ho
- Natalie Tischler
- Casey Chizek
- Madi Simpson
- Maggie Williams
- Wes Arnett
- Andrew Mullen
- Sue Wright
- Lizzy LeMere
- MANY, MANY community partners

Chicago - Local Context

- West and South Sides most impacted
- Opioid fatalities exceed traffic accidents and homicides combined
- Overdoses are one of the top drivers of the racial life expectancy gap in Chicago

Chicago Dept of Public Health; reference 1

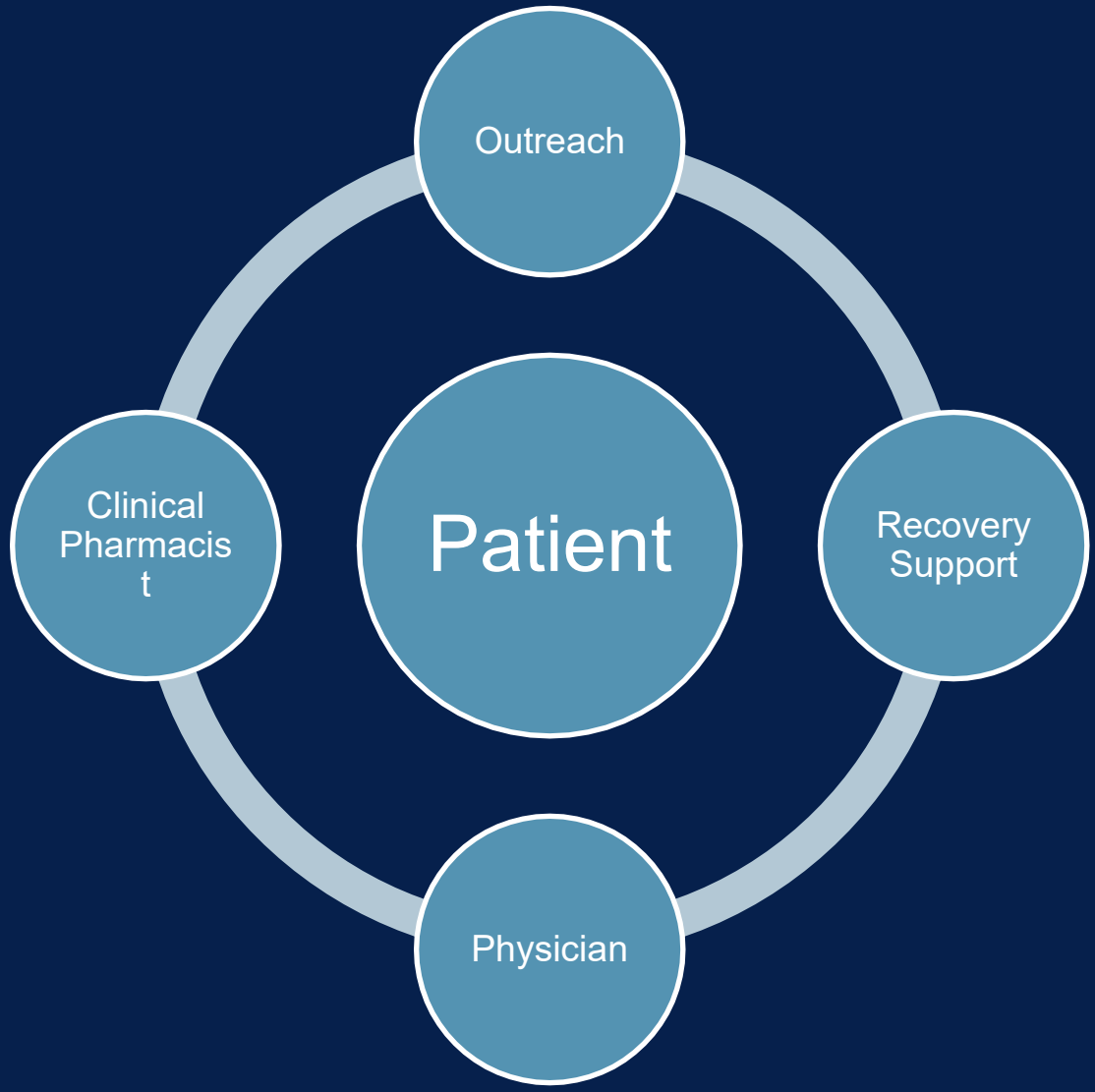


COIP - Background

- Founded in 1986 in the UIC School of Public Health to address HIV among people who use drugs
- Focus: peer support and harm reduction
- Storefront sites across Chicago, primarily West and South Side
- Mobile harm reduction units, syringe service program, and street outreach teams
- Indigenous Leader Outreach Model

COIP; reference 2

COIP- Model of Care



Chicago Sun Times; reference 3

COIP- Sobering Tent

- People came to the van for post-use monitoring
  - Hesitance to engage with EMS
- Funded by Chicago Dept of Public Health to develop a sobering tent
  - Collaboration with West Side Heroin/Opioid Task Force
  - Safe space for people to be observed post-use or post-overdose

Chicago Sun Times; reference 3

COIP- Model of Care

- Partnered with Family Guidance Centers (opioid treatment center) to dispense buprenorphine
  - Fixed dose packs to fit OTP model
  - High dose induction protocol
    - Tested low dose overlap protocol, with minimal uptake
- Started dispensing July 2022 - took one full year to get DEA approval
  - Alarm system and safe
  - Armed security guard
  - Enclosed van storage

COIP- Financing

- Grant funded: Substance Use Prevention & Recovery (SUPR) branch of the Illinois Department of Human Services
  - Specific for buprenorphine treatment
  - Covers meds for uninsured pts
- Billing for medical visits: primarily Medicaid
  - Covers additional primary care
- Additional funding for new projects
  - Example: adapting contingency management for the mobile unit (HEAL Initiative/NIH)

Chicago Sun Times; reference 3

Patient demographics 7/2021 – 6/2023

Characteristic	n (%)
Age [(mean years (SD)]	46.5 +/- 12.6
Gender (n=1083)	
Male	741 (68.4)
Female	341 (31.5)
Nonbinary	1 (0.09)
Undisclosed/unknown	2 (0.2)
Race/Ethnicity (n=1053)	
Black or African American	672 (63.8)
White	224 (21.2)
Hispanic/Latinx	124 (11.8)
Other/Unspecified	66 (6.3)
Asian	4 (0.4)
American Indian/Alaska Native	2 (0.2)
Insurance status (n=911)	
Insured	642 (70.4)
Insured by Medicaid	423 (46.4)
Uninsured	269 (29.5)

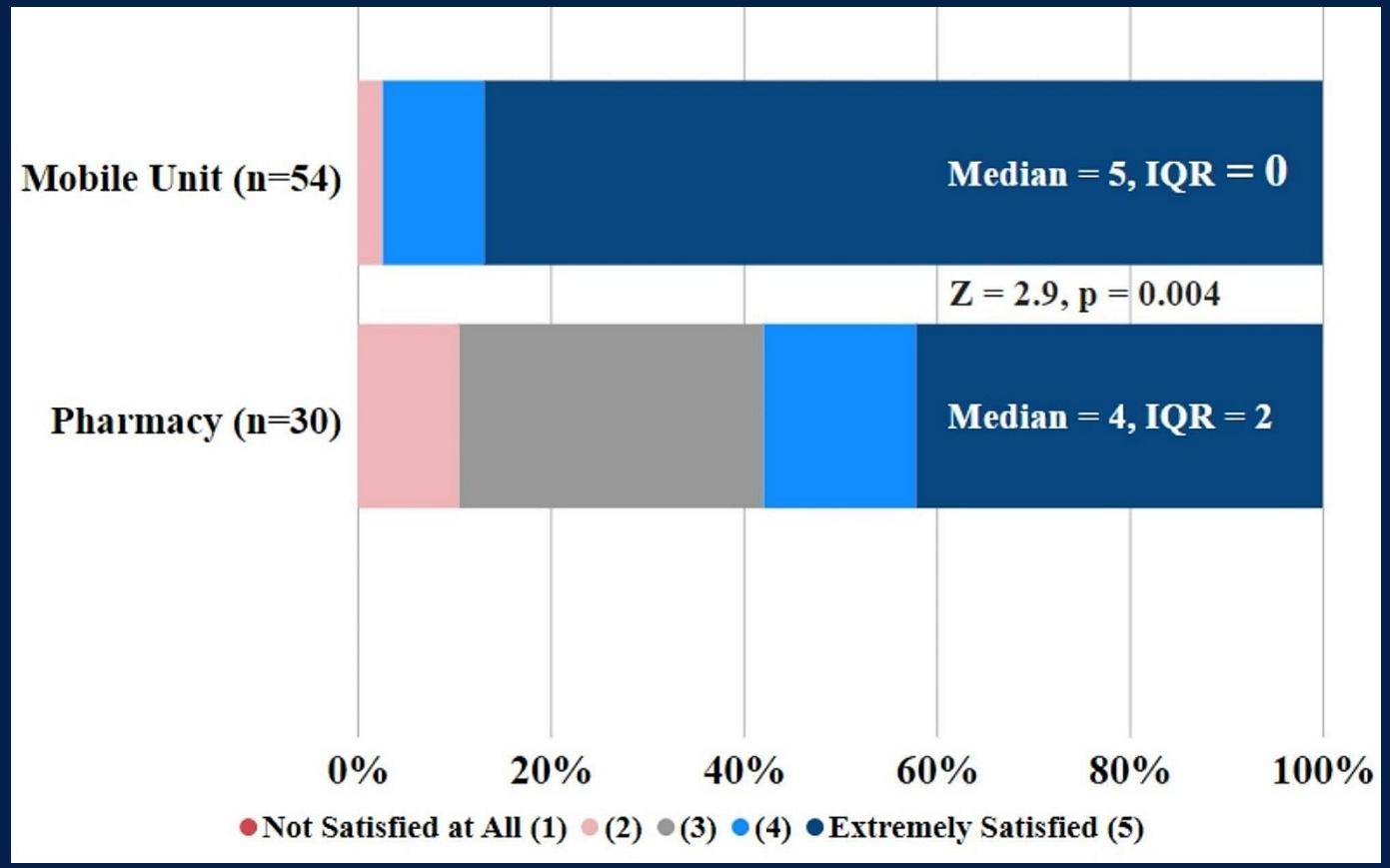
Buprenorphine Dispensing: Year 1

	n (%)
Total buprenorphine packs dispensed*	451
7-day supply	371 (82.2)
2-day supply	50 (11.0)
3-day supply	30 (6.7)
Unduplicated patients dispensed buprenorphine	229 (54.4)

Common Reasons for NOT dispensing buprenorphine during an MAR encounter	n (%)
Indication for shorter duration	37 (5.6)
Indication for longer duration	21 (3.2)
Premade pack dosing inappropriate for individual patient	12 (1.8)

Patient survey: dispensing process

- Survey of 54 individuals who were dispensed buprenorphine



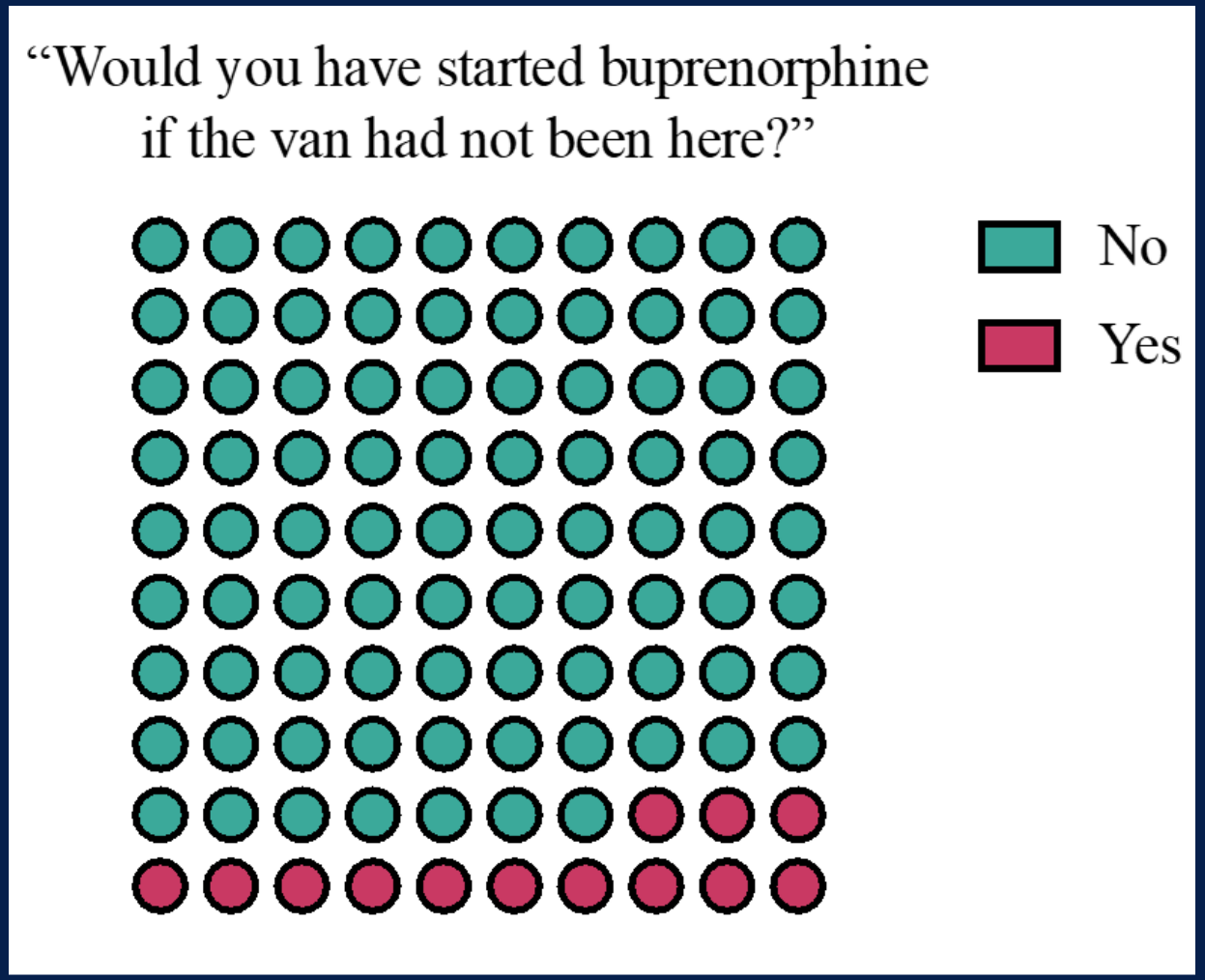
Addiction Science & Clinical Practice, reference 4

Patient survey: dispensing process

Barrier	Number of Respondents (*n*)
Time delay in filling prescription	16
Lack of transportation to community pharmacy	15
Experiencing opioid withdrawal and unable to go to pharmacy	14
Lack of identification to pick-up prescription	10
No buprenorphine in stock at the community pharmacy	9
Stigma experienced by the patient	7
No pharmacy nearby	4
Pharmacist refused to fill prescription	1
Other (lack of money, pharmacy hours)	2

Addiction Science & Clinical Practice, reference 4

Patient survey: dispensing process



Addiction Science & Clinical Practice, reference 4

Patient experiences

Convenient, keep up the good work, coming to ground zero where drug deals are happening is great.

It's awesome y'all come out because some people like me are afraid to come to the clinic where I'm worried I'll run into people I know, and I don't have transportation, so it's way more affordable and comforting.

I've been wanting to get on buprenorphine after being hospitalized recently, but I didn't know where to get it, being uninsured, so this was truly a life-saver.

Addiction Science & Clinical Practice, reference 4

COIP- Lessons Learned

- Working with an opioid treatment program is the key to developing a buprenorphine dispensing program
- The process of obtaining DEA approval takes time, but patients appreciate it
  - Provides a mechanism to provide buprenorphine at no cost
- There are likely regional differences in DEA requirements

COIP- Next Steps

- Rapid start of extended-release buprenorphine on the mobile unit
- Rapid start HCV treatment with rapid PCR testing
- Integrating contingency management to improve retention in care and address co-occurring stimulant use
- Adapt the model to new settings
  - South Side of Chicago
  - Nonurban areas

References

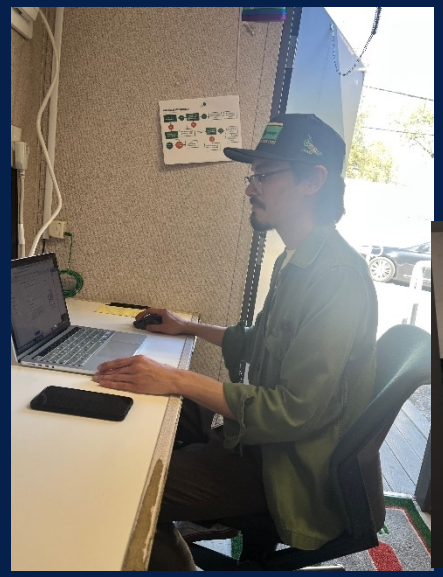
1. Chicago Department of Public Health Opioid Report https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/CDPH-005_OpioidReport_Final.pdf
2. Community Outreach Intervention Projects website. https://coip.uic.edu
3. Chicago Sun Times. https://chicago.suntimes.com/2022/8/22/23298305/opioid-users-treatment-mobile-suboxone-pharmacy-west-side-rv
4. Addiction Science & Clinical Practice https://link.springer.com/article/10.1186/s13722-024-00484-4

IDEA Miami SSP Context

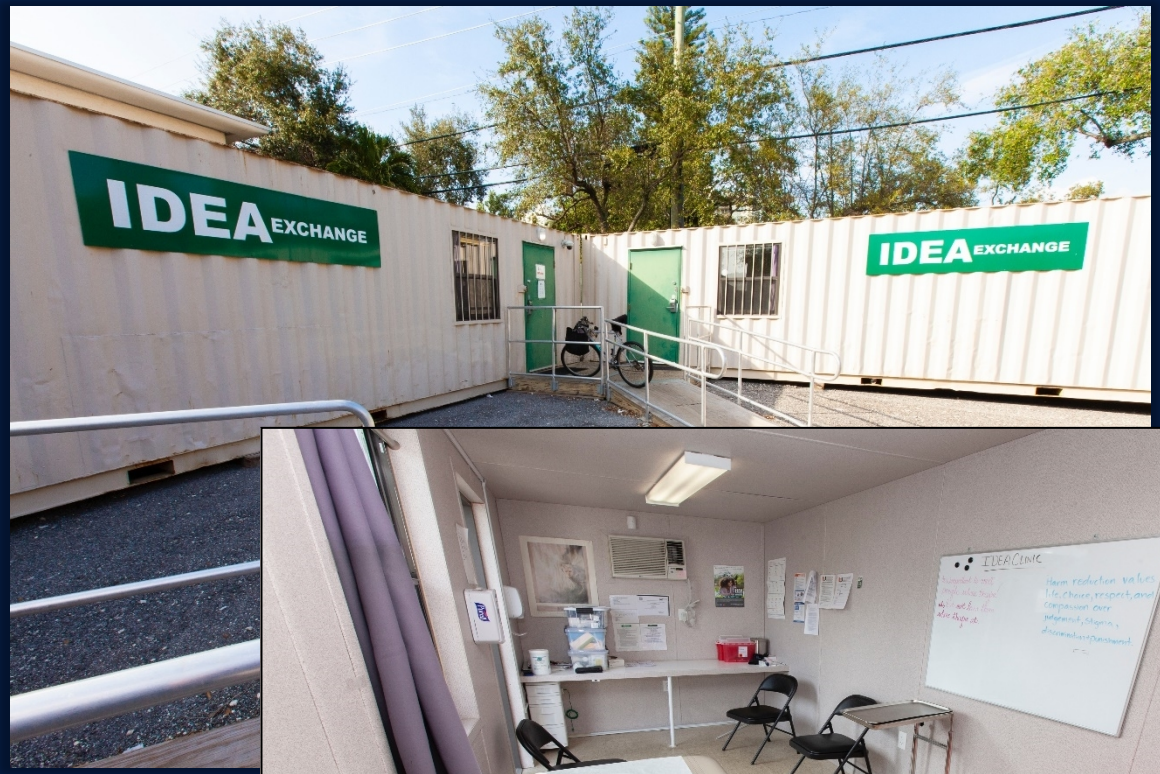
- IDEA Miami is the first legal syringe services program in the State of Florida
- Stands for Infectious Disease Elimination ACT
- Approved after years of advocacy
- Opened on World AIDS Day, 2016
- Wellness Clinic started in February 2017 with student leadership

IDEA Miami SSP Context

- IDEA offer anonymous harm-reduction services in Miami Dade County
- One-for-one syringe exchange
- Opt-out routine anonymous HIV and HCV rapid testing
- UM Pathways to Wellness Clinic provides confidential services, including:
    - linkage to telemedicine-enhanced care for HIV treatment and prevention
    - STI testing and treatment
    - Vaccines
    - Buprenorphine
    - Wound care



IDEA Miami SSP Context

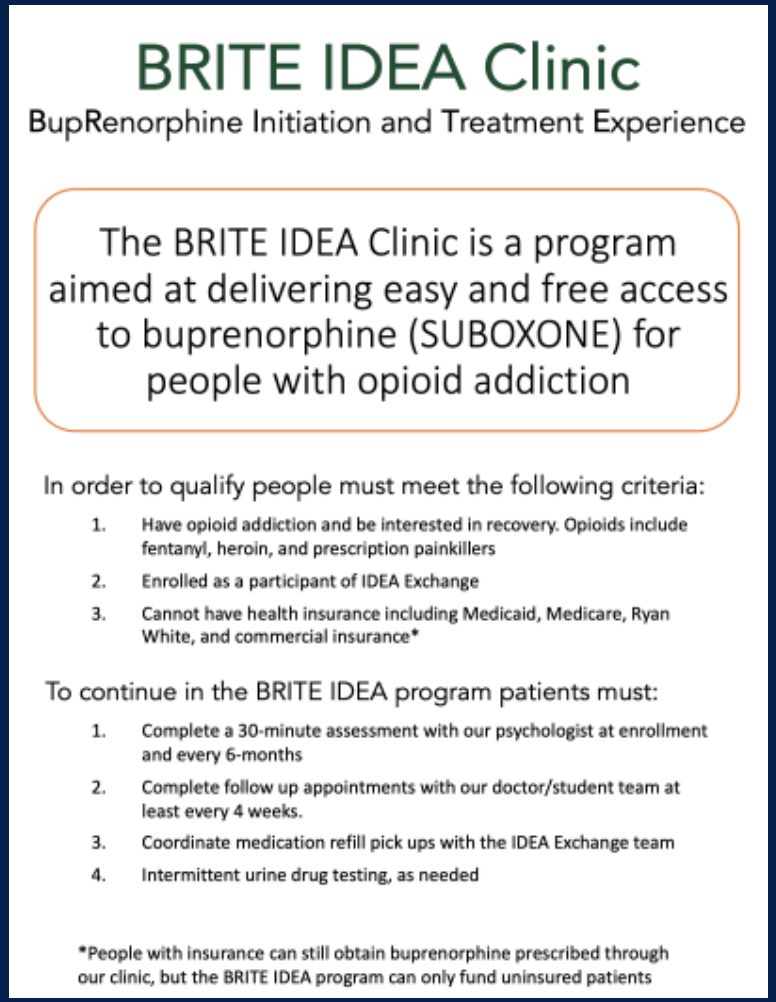


IDEA Miami SSP by the numbers

Miami IDEA Exchange As of Feb 23, 2025	Mobile	Fixed	Total
Number of participants enrolled	597	2001	2598
Naloxone distributed	3144	4791	7935
Overdose reversal (by self-report)	1816	2389	4205
Self-report HIV+ at enrollment	57	195	252
Number of HIV tests at enrollment	343	1555	1898
Number of HIV+ tests at enrollment	33	143	176
HCV infection rate at enrollment	41.6%	38.1%	38.76%

IDEA Miami - Model of Care

- Wellness Clinic started onsite by students in Feb 2017 with wound care, HIV testing
- Need for MOUD became clear
- Applied for funding from DCF to provide services to those experiencing Opioid Use Disorder: BRITE was born.
- The project started February 2021.
- The BRITE Team Consists of
  - Medical Doctors
  - Psychologist
  - Peers who lead our interventions



BRITE IDEA Clinic

BupRenorphine Initiation and Treatment Experience

The BRITE IDEA Clinic is a program aimed at delivering easy and free access to buprenorphine (SUBOXONE) for people with opioid addiction

In order to qualify people must meet the following criteria:

1. Have opioid addiction and be interested in recovery. Opioids include fentanyl, heroin, and prescription painkillers
2. Enrolled as a participant of IDEA Exchange
3. Cannot have health insurance including Medicaid, Medicare, Ryan White, and commercial insurance*

To continue in the BRITE IDEA program patients must:

1. Complete a 30-minute assessment with our psychologist at enrollment and every 6-months
2. Complete follow up appointments with our doctor/student team at least every 4 weeks.
3. Coordinate medication refill pick ups with the IDEA Exchange team
4. Intermittent urine drug testing, as needed

*People with insurance can still obtain buprenorphine prescribed through our clinic, but the BRITE IDEA program can only fund uninsured patients

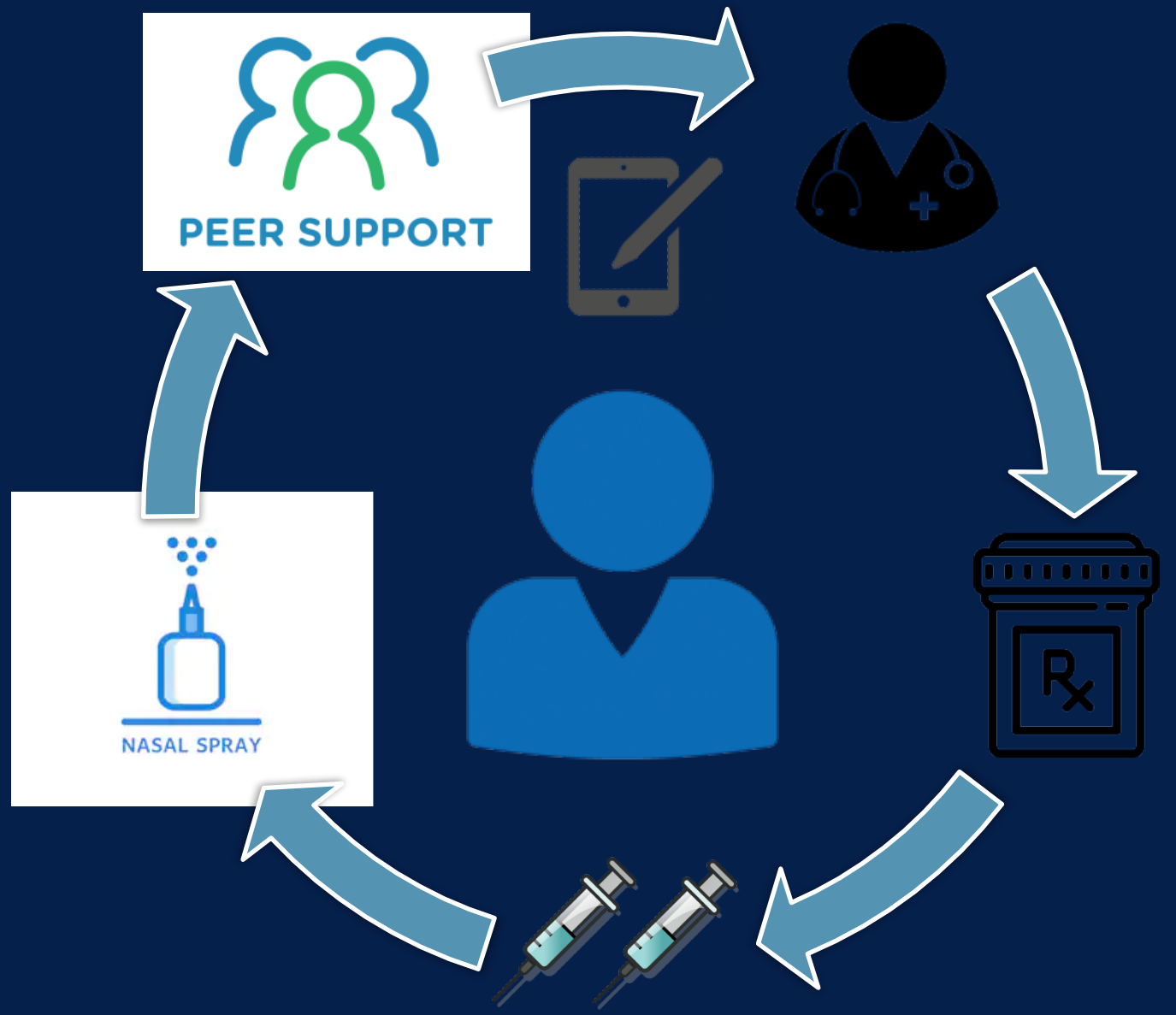
Florida's State Opioid Response objectives

- Increase access to Medication Opioid Use Disorder
- Increase the number of individuals with opioid use disorder on buprenorphine
- Increase the number of people who receive recovery support services
- Increase retention of individual in services by 10%
- At least 50% of individuals who completed treatment successfully will have eliminated or reduced opioid misuse 3 months and 6 months after discharge

https://www.myflfamilies.com/service-programs/samh/docs/opioid/FL%20SOR%20Project%20Narrative.pdf

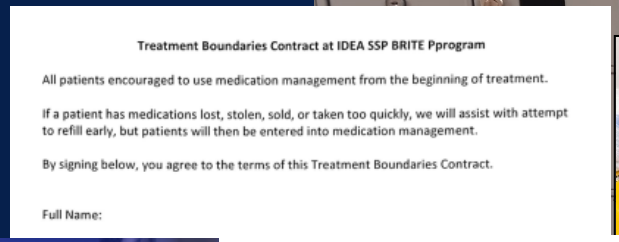
Tele-Harm Reduction

- Peer harm reduction counselor available via drop-in.
- Can collect UDS and connect patient to off-site on-call physician via telemedicine
- Peer can help patient access harm reduction supplies on-site
- Peer can pick up meds from pharmacy; can store in on-site lockers
- Peer can help with referrals



Decreasing barriers

- Consent to store medication signed by patients
- Treatment boundaries contract signed
- Assist both insured, underinsured, and uninsured
- Peer can pick up meds if patient doesn't have ID
- Drop-in hours all week long



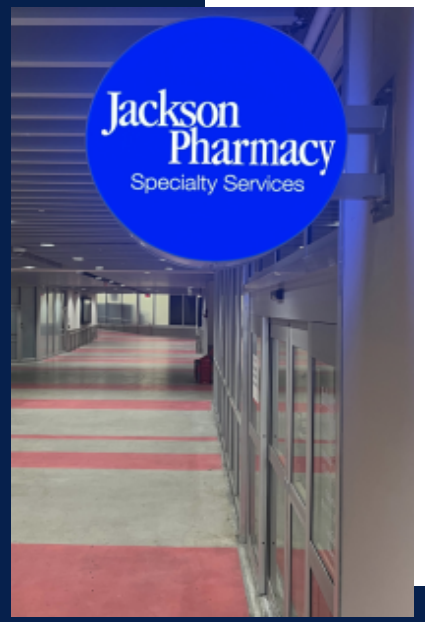
Treatment Boundaries Contract at IDEA SSP BRITE Pprogram

All patients encouraged to use medication management from the beginning of treatment.

If a patient has medications lost, stolen, sold, or taken too quickly, we will assist with attempt to refill early, but patients will then be entered into medication management.

By signing below, you agree to the terms of this Treatment Boundaries Contract.

Full Name:



CONSENT TO STORAGE OF MEDICATION, AND RELEASE AND WAIVER

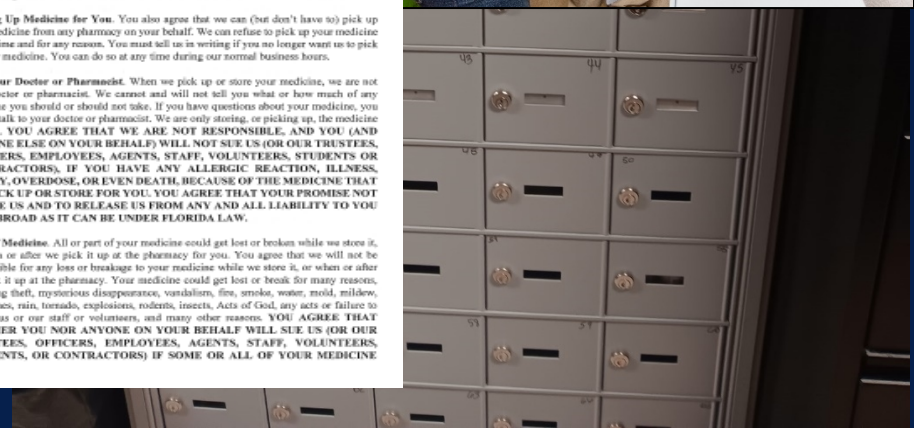
Please read this document very carefully. Only sign it if you understand what it means. If you do not know what this document means, please ask one of the IDEA staff or volunteers. If you sign this document, it will mean that you understand and agree with everything that is written on this document.

1. **Medicine Storage.** We (the IDEA Exchange Program at the University of Miami) have lockers where we can store some of your medicine for you for free. By signing this document, you agree that if you (or someone else doing it for you) bring us your medicine, we can store it for you. We do not have to accept all or any of your medicine. We can refuse to store any of your medicine for any reason and at any time. If you do not pick up your medicine within two (2) days after we tell you that we will no longer store it, you agree that we can throw it away. You can ask us to give you your medicine back at any time during our normal business hours.

2. **Picking Up Medicine for You.** You also agree that we can (but don't have to) pick up your medicine from any pharmacy on your behalf. We can refuse to pick up your medicine at any time and for any reason. You must tell us in writing if you no longer want us to pick up your medicine. You can do so at any time during our normal business hours.

3. **Not Your Doctor or Pharmacist.** When we pick up or store your medicine, we are not your doctor or pharmacist. We cannot and will not tell you what or how much of any medicine you should or should not take. If you have questions about your medicine, you should talk to your doctor or pharmacist. We are only storing, or picking up, the medicine for you. **YOU AGREE THAT WE ARE NOT RESPONSIBLE, AND YOU (AND ANYONE ELSE ON YOUR BEHALF) WILL NOT SUE US (OR OUR TRUSTEES, OFFICERS, EMPLOYEES, AGENTS, STAFF, VOLUNTEERS, STUDENTS OR CONTRACTORS), IF YOU HAVE ANY ALLERGIC REACTION, ILLNESS, INJURY, OVERDOSE, OR EVEN DEATH, BECAUSE OF THE MEDICINE THAT WE PICK UP OR STORE FOR YOU. YOU AGREE THAT YOUR PROMISE NOT TO SUE US AND TO RELEASE US FROM ANY AND ALL LIABILITY TO YOU IS AS BROAD AS IT CAN BE UNDER FLORIDA LAW.**

4. **Loss of Medicine.** All or part of your medicine could get lost or broken while we store it, or when or after we pick it up at the pharmacy for you. You agree that we will not be responsible for any loss or breakage to your medicine while we store it, or when or after we pick it up at the pharmacy. Your medicine could get lost or break for many reasons, including theft, mysterious disappearance, vandalism, fire, smoke, water, mold, mildew, hurricanes, rain, tornado, explosions, rodents, insects, Acts of God, any acts or failure to act by us or our staff or volunteers, and many other reasons. **YOU AGREE THAT NEITHER YOU NOR ANYONE ON YOUR BEHALF WILL SUE US (OR OUR TRUSTEES, OFFICERS, EMPLOYEES, AGENTS, STAFF, VOLUNTEERS, STUDENTS, OR CONTRACTORS) IF SOME OR ALL OF YOUR MEDICINE**



“Urine Good Hands” – Role of UDS

Date: Identifier: DOB:

IDEA Exchange

Urine Drug Screening Results

1. Check temperature strip 2 to 4 minutes after collection. Should be 90-100 degree F (32-38 degree C)
2. Check drug results between 5 and 8 minutes after voiding
3. All positive results are ***preliminary positive*** and for screening only; ***confirmation*** requires LC/MS

	Place **X** if positive
AMP – Amphetamines – 1000 ng/mL	☐
OPI – Morphine – 300 ng/mL	☐
MET – Methamphetamine – 1000 ng/mL	☐
BZO – Benzodiazepines – 300 ng/mL	☐
COC – Cocaine – 300 ng/mL	☐
MTD – Methadone – 300 ng/mL	☐
OXY – Oxycodone – 100 ng/mL	☐
BUP – Buprenorphine – 10 ng/mL	☐
MDMA – MDMA – 500 ng/mL	☐
THC – Cannabis – 50 ng/mL	☐
BAR – Barbiturates – 300 ng/mL	☐
FYL – Fentanyl – 20 ng/mL	☐
ETG – Ethyl glucuronide – 500 ng/mL	☐
TRA – Tramadol – 100 ng/mL	☐
XYL – Xylazine – 1000 ng/mL (CHECK ONE)	Positive ☐ Negative ☐

Result reader name: _____ Signature: _____

WE ARE NOT THE COPS!

REASONS WE GET A UDS:

So you know whats in your system!

So our providers can better serve you!

Our UDS will NOT deter you from receiving the care you need!

Remember, we love you and this is your safe space!

AMERICAN SOCIETY OF ADDICTION MEDICINE FOUNDED 1954 ASAM

BRITE IDEA - Outcomes

- Total BRITE participants since programs Feb 2021: 478
- % BRITE participants uninsured or underinsured: 78%
- Total BRITE participants insured: 22%
- Since 2021, approximately 100 unduplicated encounters a month which involve medications being prescribed and picked up at the pharmacy.
- 3 month retention was 59%
- Tele-health and increased doses associated with higher retention
- Stimulant use at baseline associated with lower retention; need integrated stimulant UD tx

Ann Med. 2023 Dec;55(1):733-743. doi: 10.1080/07853890.2023.2182908.

Adaptation of the Tele-Harm Reduction intervention to promote initiation and retention in buprenorphine treatment among people who inject drugs: a retrospective cohort study

Edward Suarez , Jr [1], Tyler S Bartholomew [2], Marina Plesons [3], Katrina Ciraldo [4], Lily Ostrer [3], David P Serota [5], Teresa A Chueng [5], Morgan Frederick [5], Jason Onugha [6], Hansel E Tookes [5]

Financing

- The overall program budget is about $1.5 million
- Funds cover medications, salary support for on-call physicians, psychologist, peers, coordinator, program director
- New as of April 2025 - Funding allocated for transportation to and from methadone clinic for methadone initiations up to 2 months (pending)

Next Steps

- Integrate Contingency Management
- Improve linkage to methadone treatment for patients who are not retained in care on buprenorphine

Acknowledgements

Special thanks to:

IDEA Miami SSP clients
IDEA Miami Staff and Faculty

The IDEA BRITE Clinic is supported by:

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

Final Takeaways/Summary

- SAMHSA provides a framework for the concept of low barrier care.
- Local context should be considered when identifying possible clinical delivery models.
- Identify at least one way you can work to lower the barriers to care in your own clinical setting.

Questions/Discussion