

Low Threshold Telemedicine-based Opioid Treatment for Criminal Justice Involved Adults During the COVID-19 Pandemic: A Case Report

Lila Flavin, MD, Babak Tofighi, MD, MSc, NYUMC, Noa Krawczyk, NYUMC, Daniel Schatz, MD, MSc, Jennifer McNeely, MD, MS, and Jenna Butner, MD, NYUMC

Criminal justice involved individuals have a high rate of opioid overdose death following release. In March 2020, New York City jails released over 1000 inmates due to concern of COVID-19 outbreaks in county jails. The closure of addiction treatment clinics further complicated efforts to expand access to medications for opioid use disorder among criminal justice involved adults. The New York City Health + Hospitals Virtual Buprenorphine Clinic established in March 2020 offered low-threshold telemedicine-based opioid treatment with buprenorphine-naloxone, specifically for criminal justice involved adults post-release. We describe a case report of the novel role of tele-conferencing for the provision of buprenorphine-naloxone for jail-released adults with opioid use disorder experiencing homelessness during the COVID-19 pandemic. The patient is a 49-year-old male with severe opioid use disorder released from New York City jail as part of its early release program. He then started using diverted buprenorphine-naloxone, and 1 month later a harm-reduction specialist at his temporary housing at a hotel referred him to an affiliated buprenorphine provider and then eventually to the New York City Health + Hospitals Virtual Buprenorphine Clinic, where he was continued on buprenorphine-naloxone, and was followed biweekly thereafter until being referred to an office-based opioid treatment program. For this patient, telemedicine-based opioid treatment offered a safe and feasible approach to accessing medication for opioid use disorder during the COVID-19 pandemic and following incarceration.

Key Words: buprenorphine, COVID-19, criminal justice, homelessness, opioid use, telemedicine

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From the Department of Psychiatry, NYU Langone, New York, NY (LF); Department of Population Health, Bellevue Hospital Center, New York, NY (BT, NK); Office of Behavioral Health, Health + Hospitals, NYUMC, Department of Population Health (NK); Department of Population Health, Section on Tobacco, Alcohol, and Drug Use, Bellevue Hospital, New York, NY Center (JM).

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Send correspondence to Lila Flavin, MD, One, 8, Park Avenue, New York, NY 10016. E-mail: lila.flavin@nyulangone.org.

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The prevalence of opioid use disorder (OUD) and opioid overdose fatalities remains high among criminal justice involved (CJI) adults.¹ Drug overdose deaths account for 85% of all deaths among CJI adults following prison release,² and risk of death is three-fold higher during the first 2 weeks following release compared to later weeks.³ Exposure to prison-based medications for treatment of OUD such as buprenorphine-naloxone (BUP-NX) has been shown to reduce all-cause mortality by 75% in the first month after release.⁴ However, receipt of BUP-NX in the criminal justice system (CJS) is rare,⁵ often due to stigma and concerns for diversion among CJS administrators,⁶ and a lack of clinicians to prescribe medications for OUD in criminal justice and community treatment settings.

Between March and April 2020 of the COVID-19 pandemic, the New York City (NYC) department of corrections released over one-thousand inmates.⁷ Early-release measures posed new challenges to jail reentry programs that refer people to OUD treatment programs at public hospitals throughout the city. Office-based opioid treatment (OBOT) programs all throughout the city, including the one at Bellevue Hospital, a tertiary care facility of NYC Health + Hospitals (H+H), were disrupted due to COVID-19.

The NYC H+H Virtual Buprenorphine Clinic (VBC) was established in March 2020 to offer low-threshold telemedicine-based opioid treatment with BUP-NX for NYC residents, some of whom were referred from NYC jails. Low threshold treatment is an approach that limits barriers to care by eliminating strict rules for who can access treatment, by allowing for same-day treatment entry and flexibility in scheduling, promoting harm reduction rather than abstinence, and offering wide availability in various clinical settings.⁸ To date, 130 patients have received treatment at NYC H+H VBC from a team of physicians, social workers, and administrators. The regulation changes at the Drug Enforcement Agency and the Office of Addiction Services and Supports (OASAS) made the program possible by allowing for the use of telemedicine-based treatment of OUD with BUP-NX. To date, telemedicine-based opioid treatment studies that have shown high patient satisfaction with visits and no decrease in disease outcomes.⁹ Initial evaluations of telemedicine-based treatment for maintenance of BUP-NX have shown effectiveness in increasing access,¹⁰ however more

research is needed to evaluate using telemedicine for initiation of BUP-NX.

The patient described below is an example of how telemedicine-based opioid treatment with phone-only initiation of buprenorphine allows recently released CJI adults to access treatment during COVID-19. The patient described provided verbal consent to publish this case report.

CASE

The patient is a 49-year-old male with severe OUD, recently released from an NYC jail. After release, he was placed in hotel as a temporary housing alternative to the shelter system during the pandemic. He received information about NYC H+H VBC from a harm reduction specialist stationed at the hotel. The patient successfully scheduled and completed his intake.

The patient reported using illicit opioids for 17 years, with current use of 5 bags of intranasal heroin daily, consistent with severe OUD. He denied any other illicit substance or alcohol use. He had 2 prior nonfatal overdoses after inhaling fentanyl-laced heroin and on both occasions, he received naloxone from a friend. He has been incarcerated multiple times due to nonviolent crimes in jail and prison facilities, had periods of homelessness, and ongoing estrangement from friends and family. He has received treatment with methadone multiple times while incarcerated, but typically returned to opioid use following release. After his most recent release from NYC jail, he continued methadone at a community-based clinic for 2 weeks, then stopped due to sedating effect, fear of contracting COVID-19, and inconvenient location of the clinic.

After he stopped methadone, he acquired diverted BUP-NX through unknown means and used this for 2 weeks. He saw another provider referred through the outreach worker at his hotel and was prescribed BUP-NX 8–2 mg 2 daily for 1 month but stopped due to insurance interruption. When he started treatment with NYC H+H VBC two months after release, he needed help managing cravings, was fearful of overdosing again, wanted to reconnect with family, and wanted break his typical cycle of return to use.

On initial visit, the patient confirmed he could only use the telephone feature due to limited capabilities of his device, and was reassured that confidentiality applied to telehealth services. He was cooperative with linear, logical, and goal-directed thought processes. He had normal speech tone and good affect. He denied psychiatric history other than substance use and denied any medical history, including HIV or Hepatitis C infection. He confirmed that he had been using diverted BUP-NX 8/2 mg 2 daily, however, he had not taken any in 4 days and had mild withdrawal symptoms.

The buprenorphine re-initiation process was described as per the standard protocol established for home induction of BUP-NX.¹¹ He was instructed to continue current effective dose of BUP-NX 8/2 mg 2 daily and prescribed a 14-day supply to his local pharmacy filled with Medicaid. He was counseled on naloxone, connected with primary care at NYC H+H, offered free legal aid, and encouraged to link with telephone counseling. All services provided were part of NYC H+H VBC program and covered by Medicaid except for

telephone counseling services provided through harm reduction specialist at hotel and not affiliated with NYC H+H VBC.

At the 2 weeks follow-up visit, he denied withdrawal symptoms, craving, or recent heroin use. He was stable, with no changes required in his dose, and had started group and individual counseling sessions three times weekly. He was informed he would be referred from the virtual clinic to an OBOT with assistance from the social worker. He felt confident that “if things go bad” he would be able to reconnect with the clinic, and rely on the support of his family with whom he reconnected. He was prescribed a 14-day supply of BUP-NX twice in July. On his final appointment with VBC, he was given information about the upcoming appointment and on follow-up with primary care several weeks later, confirmed that he attended the appointment, remained abstinent from opioids, was preparing to transition out of temporary housing, and applied for permanent housing and employment.

He described enrollment in the clinic as a turning point: “I would not have been able to fight the cravings. I was lucky that the help was there when I needed it.” He appreciated the safety, convenience, and privacy of the telephone visits and felt it was “the only type of treatment program where I felt respected and motivated to not use after release from prison.” The patient also lauded the multidisciplinary team who supported him.

DISCUSSION

This case highlights the feasibility of offering telemedicine-based opioid treatment to CJI adults with OUD, unstable housing, and limited social support. Due to changes in regulations, he was able to access a VBC during a pandemic when access to treatment for addictions was uncertain.

Access to OUD treatment in primary care settings has been limited by in-person monthly visits, and has lost priority over chronic disease management, and this has only worsened during the COVID-19 pandemic.¹⁴ OUD treatment paradigms have shifted during the pandemic, where methadone clinics delivering take-home doses are overcrowded putting staff and patients at risk.¹⁵ As a result of this crisis, buprenorphine providers have had to resort to new methods of service delivery such as telemedicine, which has allowed people to access BUP-NX who may not have been able to previously.

A prior case report on linkage to VBC postincarceration during the COVID-19 pandemic showed street outreach to be essential in pairing vulnerable patients with OUD treatment.¹² The case report describes 2 undomiciled individuals who were linked to a VBC-type clinic via harm reduction specialists. In another case, a “tele-bridge” clinic in Rhode Island served as a hotline, where people with OUD were assessed, and offered unobserved induction followed by linkage to an OBOT.¹³ Models such as this reinforce the importance of providing low-threshold OUD treatment in an urban setting utilizing telehealth and virtual platforms. Our case expands on prior research to show how the tele-medicine model can be used for CJI individuals who are at particularly high risk of overdose. This is a harm reduction model in that it provides ongoing care for patients including preventative care even if they are not initiating buprenorphine or are not abstinent from opioids.

A telemedicine program embedded within a publicly funded hospital system, such as NYC H+H VBC, has the potential to increase access, overcome stigma, and increase linkage with specialty care. Those released from the CJS often have trouble filling medications or following up with primary care because their insurance coverage has lapsed while incarcerated. The NYC H+H VBC has the capability of offering OUD treatment to individuals at a particularly vulnerable time regardless of insurance status by enrolling those who are eligible onto Medicaid and billing retrospectively or if ineligible in some cases covering the cost of care. When patients are unable to come into the clinic, telemedicine embedded within a public health system can continue to use interdisciplinary clinical teams to address social hardships beyond OUD.

This single case report is limited due to the setting in an urban hospital, the specific selection of patients targeted, and limited time period of treatment. More research is needed on the efficacy of telemedicine-based opioid treatment in treating CJI adults with OUD and whether it impacts overdose rates following release. It is necessary to identify ethical strategies that address patient privacy issues when working with CJI adults who may lack internet connections or private locations to conduct the visit. Our patient was able to conduct visits in his private hotel room but may have had more difficulty if he were within the traditional shelter system. Some have raised concern that VBCs have less potential for monitoring and innovative ways to address this need to be identified. For the time being, this clinic is a bridge to help patients connect to BUP-NX treatment then link them to office-based treatment where closer monitoring can be done.

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