CONNECTING CARE PODCAST // EPIDSODE #7 // TRANSCRIPTS

Strengthening Methadone Programs: Advancing Policy and Practice in the U.S.

Dr. Alex Walley:

For many patients, methadone is a potentially life-saving treatment, but policies and other health system barriers present obstacles that can make it out of reach for those who need it most.

Dr. Jessica Taylor:

Methadone is an incredibly effective treatment for opioid use disorder, perhaps even the most effective. And yet, the system where it's required to be delivered in the United States presents all these barriers that really turn patients away, and certainly turn patients off.

Dr. Alex Walley:

You're listening to Connecting Care. I'm Alex Walley, an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. Today, my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel, join me for the second part of a two-part series about methadone to treat opioid use disorder. During today's podcast, we'll use a case study to continue the conversation about stigma, barriers to methadone treatment for patients, and what we can learn from other countries to advance policy and practice for methadone in the United States.

Dr. Alex Walley:

You're listening to Connecting Care, the intersection of HIV and opioid use disorder. I'm Alex Walley. I'm an HIV primary care doctor and addiction medicine specialist in Boston, Massachusetts. I'm joined again by my colleagues, Dr. Jessica Taylor and Dr. Sim Kimmel. Last podcast, we were joined by Hiawatha Collins from the National Harm Reduction Coalition and VOCAL-New York. He is also a patient treated with methadone in an opioid treatment program.

Dr. Alex Walley:

He gave us a firsthand look about the benefits of methadone treatment for patients, and also some of the challenges. Today, we're going to take a deeper dive into some of these issues. As we've done before, Jess, Sim and I are going to use a case to talk through the evidence about methadone, and what we can learn from other countries, and more. Last podcast, Hiawatha told us that methadone saved his life. We need to hear more stories like this one. Sim, as a clinician, can you tell us when you would consider recommending methadone for a patient and what you think it offers?

Dr. Sim Kimmel:

Thanks, Alex. I'm really excited to have a chance to talk more about methadone today. Methadone, as we heard from Hiawatha, is really relegated to a separate addiction treatment system. As we'll go through in this discussion today, I think will really highlight how important it is that methadone be available anywhere other forms of addiction treatment are available. So, there's a number of things to consider when talking to a patient about methadone. First of all, if a patient is interested in methadone, then I'm interested in getting that patient to methadone.

Dr. Sim Kimmel:

What are the advantages of methadone? So methadone is a full opioid agonist, compared to buprenorphine, which is a partial opioid agonist. And because of that, some people find that methadone offers better control of their cravings. The delivery of methadone is in an opioid treatment program, and that provides more structure and more support. There's some down sides for some patients with that, as well, but for some people, the structure of going to a methadone clinic every day, the structure of having meetings, really provides a lot of benefit. There's a lot of evidence that it reduces overdose, that it reduces HIV risk, there's evidence that it reduces criminal activity. There's another benefit of methadone, which is that in order to get started on methadone, a patient doesn't need to be off of all opioids, so a patient doesn't need to go through withdrawal in order to initiate methadone. So there's a lot of reasons why methadone might be considered for a patient.

Dr. Alex Walley:

Great, Sim. I just want to add a little bit on the evidence for methadone. So, a lot of people think that the evidence is equal, or that buprenorphine is just as good or better than methadone from an evidence perspective, and similarly for naltrexone. And in my view, looking across multiple studies, and in the view of some systematic reviews, there is an advantage to methadone over some of the others, which is a retention benefit. And what I mean by that is that once people are on methadone, the likelihood that they'll stay on it is generally, in most studies, better than buprenorphine, and certainly than naltrexone. And so that's another real advantage to methadone. So once you're on it, it's much easier to stay on it, that's an advantage. But getting on it, that can sometimes be a challenge, and I think Hiawatha reflected some of those challenges. How do you, Sim, go about getting somebody onto methadone?

Dr. Sim Kimmel:

That's a good question. It can be really challenging to get somebody onto methadone in the current system. If somebody walks into my HIV clinic and says, "I'm struggling with opioid use disorder, I'd like to be treated with methadone," essentially, we start calling methadone clinics with them and try to get them into a clinic, get an appointment set up for them. And there can often be delays, it's unlikely that we'll be able to find somebody, a clinic that day, or the day after, but basically we're calling an outside care provider and trying to get them set up to have an intake, and then to ultimately get dosed with their first dose of methadone.

Dr. Alex Walley:

So I've been working as a doctor in a methadone clinic for a lot of years, and I've seen it help a lot of people from all walks of life, but it's completely separate from the rest of medical care. I think it's a separate and unequal segregated system of care, and we really need to work towards having it be integrated and be a patient-driven decision about which of the medications for opioid use disorder somebody starts, based on their prior experience and their physical interaction with the medication. But we have a long way to go before we get there.

Dr. Jessica Taylor:

And Alex, I think that's really the heart of the issue, is that methadone is an incredibly effective treatment for opioid use disorder, perhaps even the most effective, as we've discussed. And yet, the system where it's required to be delivered in the United States presents all these barriers that really turn patients away, and certainly turn patients off. And that includes the access issues that we were just talking about in terms of difficulty getting into a clinic. I can say when we call around for clinic access in our area in Boston, which is highly resourced, if we're lucky, we might be able to get someone in within

a couple of days to a local opioid treatment program. Very often though, our patients are told two weeks and sometimes even four weeks, and we're talking about a life-threatening illness where two to four weeks of more illicitly manufactured fentanyl use is really a life-threatening situation. So we have the access issues.

Dr. Jessica Taylor:

We also have challenges with the way patients are treated in the current system, the stigma that they face when they get to the dosing window and are asked to provide their number, not their name, to get their methadone dose. The reality that, in the United States, methadone clinics are not geographically accessible, particularly in rural areas, but also that when they are available and when people try to open new programs, the nimbyism is just a really profound challenge and results in methadone clinics being concentrated in underserved sections of cities typically, cities that are segregated, neighborhoods that are segregated, further stigmatizing this treatment.

Dr. Jessica Taylor:

I think the other challenge is that the current system groups people who may have ongoing active substance use or may be early in recovery, and we certainly have witnessed predatory behavior among our patients that are treated in methadone clinics that may be targeted to be sold substances, or just maybe in a situation that's very triggering, surrounded by a lot of people who may continue to have substance use, and that furthers the stigma. We heard this from Hiawatha, I think really clearly last week, in our last podcast, when he talked about liquid handcuffs and just being stuck in a system that is so protocolized, that is not nimble and able to react to changes in someone's recovery trajectory or recovery journey, and the limitations of daily dosing, which patients are really required to do until they demonstrate or prove that they are ready for unlimited number of take homes. So just a lot of challenges with the current system that make a life-saving treatment not as successful as it needs to be.

Dr. Alex Walley:

Concepts like liquid handcuffs and the rules that are required for people who are on methadone that are imposed by the methadone treatment system, both through the regulations and the practices of methadone clinics, really reinforce the stigmatizing, not just of drugs themselves, the people who use drugs, but now, one of the most effective treatments for the substance use. So the irony that we're actually stigmatizing the treatment, which undermines our ability to get people on treatment and stay on it, is I think just a real challenge that we have. And it's an opportunity for policymakers to work to try to de-stigmatize methadone.

Dr. Alex Walley:

I remember where I was when Magic Johnson announced in a press conference that he had HIV infection. I remember the impact that had in mainstreaming and de-stigmatizing the disease of HIV infection. Methadone does not have its Magic Johnson yet, even though it's been around for a much longer period of time than HIV has. I still have patients today, some of my most successful methadone patients, who have gone 20-30 years successfully being treated with methadone, living a so-called normal lifestyle, and haven't told their children that they're being treated with methadone and have no one be aware at work that they're being treated with methadone. So, while on the one hand it's great that methadone clinics can offer privacy to people, on the other hand, it's a real shame that people are so stigmatized, that they're so uncomfortable disclosing to their loved ones or to the people that they work with.

Dr. Alex Walley:

So, there's methadone the medication, and methadone the delivery system. It's really hard to untangle them because of these stigmatizing structures and regulations. Jess, as the Medical Director of Faster Paths, a low barrier addiction treatment program, you saw a need to improve methadone access, and now because of the 72 hour rule, you are meeting this need. Can you walk us through a patient story that exemplifies the opportunities for the 72 hour rule in improving access to methadone treatment?

Dr. Jessica Taylor:

Sure, thanks Alex. So I'm going to actually talk you through the case of the first patient that my program, Faster Paths, which is a low barrier substance use disorder bridge clinic, the first patient that we treated with methadone for emergency opioid withdrawal management. This case, it comes from a couple months back, and our patient has generously agreed that we can share her story to improve access and advocacy around methadone.

Dr. Jessica Taylor:

So this is a typical day in our bridge clinic, which has historically focused on buprenorphine access. We offer a number of services, but top of the list is same day access to buprenorphine or Suboxone medication. And we saw a patient who was added to our schedule same day, from the emergency department, referred because she had gone to the emergency room requesting help getting off of heroin and fentanyl. And so was referred down the hall to our bridge clinic, and shared a bit, she had had a severe opioid use disorder for 16 years, she had some prior treatment experience, including being treated with Suboxone in the past, and found that Suboxone was partially effective, but that she never actually had good craving control on Suboxone. In terms of just other treatment experience, she had never been on a methadone maintenance program or in an opiate treatment program, but had been treated with methadone for withdrawal management in an inpatient, medically managed withdrawal setting, which we would typically call a detox in the past.

Dr. Jessica Taylor:

And so, came in reporting daily use of heroin and fentanyl, prior opioid overdose, and said that she had last used heroin and fentanyl about 15 hours before she came in to see us. And at that point, our team did an assessment. She had an initial Clinical Opioid Withdrawal Scale score, which is a common scale that we use to measure the severity of opiod withdrawal, had a score of about 12, which any providers listening in will recognize as fairly symptomatic withdrawal. And she had the chance to talk to our team about her goals for her treatment. She told us she was extremely motivated to get into treatment, and this time around really wanted to try methadone maintenance, which was something that she hadn't tried in the past, but had heard that it might be more effective for managing the craving component for opioid use disorder.

Dr. Jessica Taylor:

And so this case gave us an opportunity to pilot a new pathway that we had been brainstorming about over the winter months, which is leveraging an exception to the usual requirement that you can only use methadone for opioid use disorder in an opiod treatment program, and use it for emergency opioid withdrawal management for up to 72 hours. So Alex mentioned the 72 hour rule, that's what we're talking about. It is an exception to the usual requirement to be in an opioid treatment program to administer methadone, and it lets providers like us that are not in an opioid treatment program, that are not licensed as an opiate treatment program, to treat a patient for up to three days, or 72 hours, by administering methadone for opioid withdrawal, not prescribing it, administering it in an observed way,

administering no more than one day's supply at a time, and doing so while we arrange linkage to ongoing care.

Dr. Jessica Taylor:

So here we had a perfect opportunity to pilot a new pathway in front of us. We had a patient who came to us very interested in methadone, who was an appropriate medical candidate for methadone. And we actually did that process that some described of calling around to local clinics, and were able to secure an appointment two business days later for our patient to start getting treatment with methadone at the opiate treatment program. So what we did is we collaborated with our pharmacy and emergency department colleagues, and we were able to administer 20 milligrams of methadone, under observation that day, she did great with the 20 milligrams. She came back the next day, and was still having pretty significant withdrawal symptoms, her COWS score was 11 on that next day, and so we treated with 40 milligrams of methadone, and then we worked on some transportation issues to make sure that she would be able to get to the opiate treatment program the following day, worked on some case management pieces, and she was successfully linked to the OTP on the third day of our care for her.

Dr. Jessica Taylor:

And so that was incredibly exciting for us, it was something we'd never done before. This exception, the 72 hour rule, is something that is pretty commonly invoked in emergency departments across the country, but as far as we're aware, not as commonly able to be done in outpatient settings, and that's because it actually requires a lot of infrastructure. So at this point we use a medication dispensing cabinet to manage our methadone, and that allows us to document really accurately and appropriately in the medical record, what the dose was, when we administered it, to make sure that if we need to waste part of the medication, meaning discard part of it that isn't going to be administered, that we do it in a DEA compliant way, under observation and documented, and even that we also have the capacity to assess and administer the medication in our clinic because of the services that we have available.

Dr. Jessica Taylor:

So we were incredibly excited about this. We were also incredibly appreciative that our patient agreed for us to be able to share her story. And now it's been a little over three months since this case happened, she actually remains at the methadone program and her dose has been increased to 80 milligrams, which feels like a good dose, so she's doing really well in her treatment and has stayed engaged and routined over three months after that first visit at Faster Paths.

Dr. Alex Walley:

As I mentioned, I've been working in a methadone program since 2007. So you kept saying you were incredibly excited, and I too am incredibly excited about this, but I imagine if you're listening to this podcast and you're from another country, like Canada, or like the UK, you're saying, "Well, what's the big deal? We do this all the time. We start people on methadone in primary care and people do fine." Well, it's not set up that way in the United States, and this 72 hour exception is designed for people who are in withdrawal, who are in substantial distress, and present typically to an emergency department. With the availability of bridge clinics, low barrier access clinics, there's an opportunity to use a 72 hour rule, but you certainly need a lot of infrastructure to support it, at least having methadone on hand that can be dispensed and observed in the dosing. So Sim, you described earlier what you have to go through if a patient comes into your outreach program looking for methadone. What are your thoughts about this approach?

Dr. Sim Kimmel:

I think this is a game changer for our patients because people come in, there's a moment where people are motivated, and we want to capitalize on that moment. We want to engage them the minute they say, "Right now, I'd really like to stop using, and this is how I want to go about doing it." And a lot of people don't want to be on Suboxone or buprenorphine, they've had experiences with it before, people who are experiencing homelessness sometimes have a hard time managing the prescription itself, and sometimes people really just want to be on methadone. And it's so satisfying to be able to say to somebody, "That's great, come on over. I'm going to call Faster Paths and we'll have one of our outreach workers walk you over, and you'll be seen and dosed in a couple hours." It really makes a huge difference for our patients.

Dr. Alex Walley:

This gets to what I call the initiation retention paradox. So in general, in the history of addiction treatment, one way to be successful in treating people with substance use disorders was by making the barriers to treatment as high as possible so that you ensure that the people that you do start treating are very motivated and have a lot of either financial capital or social support capital or recovery capital. And if you do that, then you're more likely to have people be successful. If you increase the barriers to care, then you're more likely to have people be successful, and what is generally considered success is retention. Can people stay in care? One of the concerns I think we have as we go into what we really need to do from a public health perspective, which is lower the barriers to care, is that we're going to start treating people who may be less motivated or who have other competing interests, especially those folks who are vulnerable to poverty or homelessness. They have other things that they need to worry about every day, other than just getting to the methadone clinic, for example.

Dr. Alex Walley:

And so this means that as you lower barriers to care, you may reduce retention. And I think Jessica's case here really is an example where you can kind of break this paradox, where you can lower the barrier to access to methadone, and then if you provide it in a patient center manner, you can also potentially increase retention. Now, I don't want to paint too rosy of a picture because we still have lots of problems around ensuring the treatment meets people where they are at. This person that, I think, Jess, you guys started, I don't know if they are going to the methadone clinic every day, but certainly a methadone clinic could require them to come every day and provide urine toxicology testing, require counseling, for example, which can really make it more difficult for people to stay retained in care.

Dr. Jessica Taylor:

And I think that's where we're starting to see the benefit, now being a couple months into this pathway of the couple of days of intensive case management and nursing care management and navigation. And it's been interesting because this is brand new, as we're saying, we really weren't sure how this would go. The demand has been staggering for this same day access to opioid withdrawal management and rapid linkage to an OTP. And the feedback that we're getting from our Opiate Treatment Program, methadone maintenance clinic partners, is that our patients had very high linkage rates, which actually has been a little bit surprising to everyone involved that our patients do seem to be getting to that methadone maintenance first appointment at a pretty high rate. And we think that the reason for that is that we're offering three days of stabilization.

Dr. Jessica Taylor:

And in our clinic, we have the bandwidth to see people if they turn up late to their appointment. Actually just two days ago, we had two patients come in for their appointment first thing in the morning who were really too sedated to safely administer methadone. And rather than a highly structured setting where you might have to say, "Look, you've missed your appointment," we were able to say, "We think that it may be risky to give you methadone right now because we see that you're sedated, and we want to make sure that we treat you today as soon as it's safe. So let's let you hang out for a little bit, let's grab some breakfast, let's be flexible, and then reassess." And in both of those cases, we were able to treat with methadone later in the day, when the patients we were taking care of were not sedated and were in more active opioid withdrawal.

Dr. Jessica Taylor:

So that really allowed a continuity of the bridge, I guess, would be fair to say. And in that time, when someone's sitting in our waiting room, we can talk about, "How are you going to get to the clinic? What's your transportation situation? What else is going on that we need to address? What are the other active medical issues?," which can include things like wound issues, or infection needs, or screening needs. Sometimes to buy a little time, if someone isn't quite in opioid withdrawal, we might send them to the lab to do screening tests for HIV. So I think even three days of that flexible and intensive approach can actually really improve the linkage rates and support patients to succeed when they do get to the opioid treatment program.

Dr. Alex Walley:

So Sim, you have thought about and worked with some colleagues in Canada on other models of medication for opiod use disorder, including methadone. Can you give us a sense about how different the US context is for methadone than a country like Canada?

Dr. Sim Kimmel:

I think we've alluded to some of these ideas already, but to be more explicitive, in Canada, primary care doctors can prescribe methadone from their primary care practice. In some provinces, the primary care doctor actually needs to have a special license, but not everywhere. And so a patient can come in, and the primary care doctor will assess that patient and prescribe the methadone. That methadone can then be administered at a pharmacy. So essentially, the methadone can be written for a daily witness dosing at a pharmacy. So instead of the centralized treatment that would happen in an opioid treatment program, the patient can take that prescription to any pharmacy that administers methadone and then get their methadone. And the doctor can then change the number of doses that the patient can take home, a little bit like take homes, I think they call it carries in Canada.

Dr. Sim Kimmel:

So the context is really different and it allows for a kind of flexibility and an individualized assessment that really can't happen in the opioid treatment programs in the United States. And I think there's a number of advantages to this kind of structure. One of them is that people with opioid use disorder aren't all centralized in one place, so it really can de-stigmatize the treatment because people are going to the pharmacy to get their medication like any other medication. And it also, I think, can improve access and flexibility. So Jess referred earlier to the fact that methadone clinics are concentrated in poor neighborhoods in US cities, and it can be really difficult to access methadone clinics from rural areas, for instance. So pharmacies are the most prevalent health care institution in our country, most communities have a pharmacy that's readily available to them, or at least not too far away. And so being able to access methadone in the pharmacy really can change people's experience with this treatment.

Dr. Alex Walley:

I love the idea of methadone through pharmacy, and it has really been successful in other countries, not just Canada, but also Australia. You have the opportunity to still do daily dosing if that's what's safest for the patient, and I think we should acknowledge that methadone has a potential for overdose, particularly in the first few weeks of treatment if the dose is ramped up more quickly than somebody can tolerate. And so because of its pharmacodynamics and pharmacokinetics, it can accumulate in ways that can catch both the prescriber and the patient by surprise. Although, overall, the deaths from methadone are much less common, particularly in people who are involved in addiction treatment, deaths from methadone are very, very rare, much rarer than the alternatives where somebody is continuing to use substances, opioids. So overall, methadone is a life-saving treatment.

Dr. Alex Walley:

So the context of methadone treatment is structured by policies, and we've heard a bit about how variable these policies are around the world. Jess, if you were the head of the Department of Public Health or the administrator for the Substance Abuse Mental Health Services Administration, can you talk about what kinds of policies that you would want to change?

Dr. Jessica Taylor:

Absolutely. I would love to be in that position to change policy. So, I think the idea of pharmacy-based methadone is one whose time has more than come in the United States for all the reasons that you and Sim just mentioned. I think what we also learned during the COVID-19 pandemic is that there are many people enrolled in opioid treatment programs that do very well with more access to take home doses and fewer in-person visits to the opiate treatment program. Some exciting early data has come out of Connecticut showing that with the increase in flexibility during the pandemic, methadone involved overdose deaths did not go up. So I think we'll hopefully have more data in support of relaxation of some of these regulations.

Dr. Jessica Taylor:

And I say that also wanting to acknowledge that the high structure of a methadone maintenance program does have benefit to many people. And I do hear that from some of my patients that needing to go every day, some of the requirements have actually have seemingly been helpful in their recovery. I think the problem is that those requirements currently are applied pretty much across the board and without the ability to adjust or titrate as people get into recovery, or have different priorities in their recovery and treatment, and different needs. So I would love to see methadone available or pharmacy dosing, like we mentioned.

Dr. Jessica Taylor:

I would love to eliminate the restrictions on who can prescribe methadone. Like buprenorphine, this is an area of medicine where we have restrictions that are not applied in other areas, including for more dangerous medications. So for example, any old provider can prescribe a very high dose of hydromorphone, which is a potent opioid pain medication, without this type of regulation and safety concern, and that doesn't make sense. Methadone is a life-saving medication. As Alex mentioned, it certainly is a medication where we need to consider risks and benefits, and use appropriate clinical caution in how we start and how we adjust the dose, but one that providers are more than capable of managing.

Dr. Jessica Taylor:

I think what we have also seen is the need for more of a harm reduction approach in the prescribing of methadone. So we know that in clinics across the country, patients might have their dose decreased if they use other substances, or if they have relapsed with heroin and fentanyl. And that's really not consistent with the goals of supporting people at getting in and staying in recovery, and very often increases risks. So I would adjust current regulations that are punitive around ongoing use of other substances because we recognize that substance use disorders are chronic diseases, and ongoing use often indicates the need for more treatment, not less.

Dr. Jessica Taylor:

I think the other change that would be incredibly exciting and helpful to our patients would be the ability to apply for a more limited OTP license in settings like academic medical centers, like community health centers, other settings that are already existing and out in communities, that may not need or be able to support the infrastructure of a full opioid treatment program pathway, but would like to treat the patients that are currently in their programs, and do so successfully in their communities.

Dr. Jessica Taylor:

The other area that is just incredibly important for methadone access is carceral settings, jails and prisons. So we've seen in some states, Rhode Island, to a more limited degree in Massachusetts, there has been innovation, and in other places across the country, in offering medications for opioid use disorder, including methadone, but we have a long way to ago. We know that people, when they come out of incarceration are at extraordinarily high risk of overdose death, and we need to be offering standard of care treatment, which include methadone and buprenorphine for opioid use disorder in correctional settings, as we would provide standard of care treatment for any medical condition like diabetes. If we were to say that some jails and prisons offer insulin and others don't because they don't do that, folks listening to this call will be pretty horrified, and it is equally horrifying that we are limited in being able to treat people who are incarcerated with methadone and buprenorphine for their opioid use disorder, which again, is a highly treatable, but potentially life-threatening condition if it's not treated correctly.

Dr. Alex Walley:

Another piece I think we need to add is, methadone has a long history and legacy of being associated with coercive forms of care and social control, which I think is particularly a sensitive issue in communities of color. I think methadone appropriately has been tainted as criminal justice light in the way it feels for people who go through it. And that, I think is particularly problematic for, as I said, those who in our society have largely been subject to the war on drugs through criminalization. What I'd like to see is methadone treatment getting a real facelift where it gets applied in a way that is really culturally humble and accessible to our vulnerable communities, our communities that have historically been victimized by the war on drugs. Sim, zooming out a bit, what kind of federal policies would you like changed?

Dr. Sim Kimmel:

The reason why methadone is so difficult to access has to do with federal regulations. And so it really will take an act of Congress to change the methadone access. So in order for methadone to be able to be used in primary care, to be delivered in pharmacies, we really need federal regulation. And it's exciting that President Biden has recommended reviewing this, we still have a long way to go for it actually to change, but I think that's encouraging.

Dr. Sim Kimmel:

I want to circle back, also, to the jail point that Jess made. In addition to the fact that jails interrupt treatment, and then people have a high risk of overdose after they're released, people who have experienced withdrawal in jail also don't want to go through that again. I often hear people say that they don't want to be treated with methadone or buprenorphine just because how bad the withdrawal was when they were incarcerated, and they're worried that they're going to be incarcerated again, or they're not going to be able to access the medication again. And so the lack of flexibility in our system makes it so that people are really, really afraid of those experiences.

Dr. Alex Walley:

So this is a podcast series that is about opioid use disorder and HIV, and so we talked a lot about methadone and how it's an important treatment for opioid use disorder. I think we should take a minute to really reflect on how it can specifically have benefits for HIV infection. So Jessica, you're an HIV provider and an addiction specialist, what do you think about when you think about methadone and HIV?

Dr. Jessica Taylor:

I think this is such an important point. So the main thing that comes to mind for me is that a lot of my patients who are at the highest risk of acquiring HIV, because their substance use disorder might be very unstable, they might be sharing syringes, they might be involved in transactional sex and not in a position to negotiate condom use. Many of those folks have barriers to getting on to other forms of treatment besides methadone. So if someone is really actively using opioids, for example, and particularly in the era of illicitly manufactured fentanyl, which is what we call lipophilic, and can have kind of an unpredictable tail, it can last for an unpredictable amount of time, folks are finding it hard to get on buprenorphine. So if you were struggling with really active heroin and fentanyl use, the buprenorphine has become more difficult. I will say, as an aside, we have ways to help people get on buprenorphine successfully, but that's not to minimize the challenges people have faced in the community with trying to start by themselves.

Dr. Jessica Taylor:

Methadone then becomes the preferred and really best treatment option, and so we have to make methadone available in places where people are at HIV risk. I can say in Boston, we've been dealing with an HIV outbreak among people who inject drugs since 2019. It is ongoing. And if we want to deliver meds for opioid use disorder to the population of patients at the highest risk of HIV, we have to make methadone easy to access and easy to get. And I can say that in our pilot, even having just done this a couple months, almost 20% of the people we've treated with methadone have had HIV infection. That is staggering, that is many orders of magnitude higher than our overall bridge clinic population. And to me, even as someone that does this work and thinks about HIV treatment and HIV prevention all the time, to me, that is just an incredibly eye-opening statistic that points to the need to deliver methadone, as well as other treatment options, to people that are at risk of HIV and also have HIV infection.

Dr. Jessica Taylor:

And that latter point is so important too, because the most effective way that we can prevent HIV, one of the most effective ways, is by helping people with HIV infection get on and stay on antiretroviral treatment for their HIV. And very commonly, if someone's dealing with active, unstable opioid use disorder, it's just a challenge to take a medication every day to manage your HIV. So supporting people to get on and stay on the medication that they want for their opioid use disorder, and have incredible

individual benefits in terms of controlling HIV, but also public health benefits by lowering the community viral load and decreasing HIV transmission.

Dr. Alex Walley:

Methadone is a treatment for opioid use disorder that works in many of its key outcomes, even if the person does not achieve abstinence, and when I'm talking about abstinence, I'm talking about abstinence from opioids, so people may continue to inject or continue to use opioids on methadone, but they're almost always going to inject less. And they are going to have, typically, as I mentioned earlier, methadone has a high rate of retention, so people are going to stay engaged in that care. And what comes with that daily contact with a methadone program is a structure that comes to people's lives that also makes it easier for them to take other medications. For those people who struggled to take their HIV medications on methadone, one really other innovative policy that we didn't discuss, which I'd like to add, is the sort of directly observed therapy or dosing with methadone, or co-dosing with methadone, of HIV medication or even other medications.

Dr. Alex Walley:

So that's quite common in New York City methadone clinics, where they have the dosing of other medications along with methadone, including making take home blister packs for those folks who are getting take home methadone. So adherence to HIV medications has definitely been shown to be increased with those people on methadone treatment, even if you're not abstinence from opioids on methadone, the number of injections goes down, and the number of unsafe injections goes down. And so there's a lot of synergies when it comes to addressing the sort of co-crises that we're seeing of overdose HIV and injection drug use that comes with treatment for methadone. Sim, anything you'd like to add as we close this session down?

Dr. Sim Kimmel:

I just want to circle back to that point that you just made about co-dosing of antiretrovirals and methadone. And we haven't talked very much about how the methadone system of delivery, in some places it's a public system, in some places it's a private system, and the structure of funding really impacts what kind of services can be co-located with the methadone clinic. So we've talked in this podcast a lot about integrating methadone with primary care, or with HIV care, but there's a whole other conversation to be had about integrating primary care and HIV care into methadone and setting up funding and structures so that can happen.

Dr. Alex Walley:

Yeah, that is a really great point, and this gets to sort of, I think, hopefully an overall theme that people get, which is ideally what we want is all treatments in all venues. We want to really make this patient centered so that we can make the treatment work for the patient and not make the patient work for the treatment, which I think is historically how addiction care has been delivered. And so, yes, it's a great idea to bring methadone into primary care or into medical care, but we also, for those people who are better off in an addiction treatment setting, we need to bring medical care into that setting, and that includes prevention of other infections, it includes the treatment of other underlying medical conditions like HIV, but also, you can imagine, and actually there's great models for this again in New York, but now elsewhere, of treating hepatitis C through methadone clinics quite efficiently and effectively.

Dr. Alex Walley:

We really, I think, hit a broad swath of what goes on in methadone care. I feel like I could talk about methadone all day and all night, but we'll spare our listeners and we will, I'm sure, come back to this topic in future podcasts. Jess is asking for last word on COVID, so please, Jess, finish us up with your thoughts about methadone and what we've learned during COVID.

Dr. Jessica Taylor:

Thanks, Alex. I just think we're in a really unique place right now, where we have a lot of opportunity to not let our systems return to pre-COVID states of affairs that were broken and imperfect, but actually leverage what we've learned during the pandemic, and really take these lessons that patients actually can do well with more take homes, that overdose deaths related to methadone didn't necessarily increase, really look at additional data as it comes out and try to change our policies for the better. And I think that with all the devastation and all of the death and tragedy and isolation that we saw during the pandemic, I think we need to make sure we don't let this opportunity go by, and really improve methadone access going forward and let that be a legacy of COVID-19.

Dr. Alex Walley:

Well said. Thanks Sim. Thanks Jess. Until next time.

Dr. Alex Walley:

You're listening to Connecting Care. Our program was produced today by JSI and Boston Medical Center. Connecting Care is supported by the HRSA funded project, Strengthening Systems of Care for People with HIV and Opioid Use Disorder. The project aims to enhance system level coordination and networks of care among Ryan White HIV/AIDS program recipients and other federal, state, and local entities. You can learn more about the project and find resources at www.ssc.jsi.com.