



Paramedic Administered Buprenorphine as a Bridge to MAT

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**National Drug Abuse Treatment Clinical Trials
Network**

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Presentation topics

- Preface
- Background & History
- Intervention and Study
- Preliminary quantitative findings
- Preliminary qualitative findings



Preface



Background and History

Background Story

- As a paramedic and former behavioral health provider, Tara Tucker, (Community Paramedic) was a key proponent for the concept of paramedics providing buprenorphine to overdose survivors.
- EMS was “treating” opioid addiction with Narcan, putting them into precipitated withdrawal and leaving them little choice but to use again to relieve symptoms.
- Thus, increasing the likelihood of a repeat overdose and death.

Background Story continued...

- Captain Tucker reached out to Addiction Psychiatrist & buprenorphine prescriber, Margaret Rukstalis, MD about EMS providing buprenorphine immediately following overdose.
- NC State EMS Medical Director, Dr. James “Tripp” Winslow, was willing to entertain the idea as well.

Background Story continued...

- A committee was formed in 2018 to develop the protocol for Community Paramedics (CPs) to provide buprenorphine as a bridge to MAT that included the local EMS Director, addiction psychiatrists from 3 major hospitals, Dr. Winslow, Dr. Rukstalis, and Captain Tucker.
- In July 2019, the Governor signed HB 325- the Opioid Response Act, making it easier for physicians to prescribe buprenorphine and NC DHHS signed off on the process allowing paramedics to administer buprenorphine.
- The two counties then needed to get permission from the county commissioners to implement the intervention.

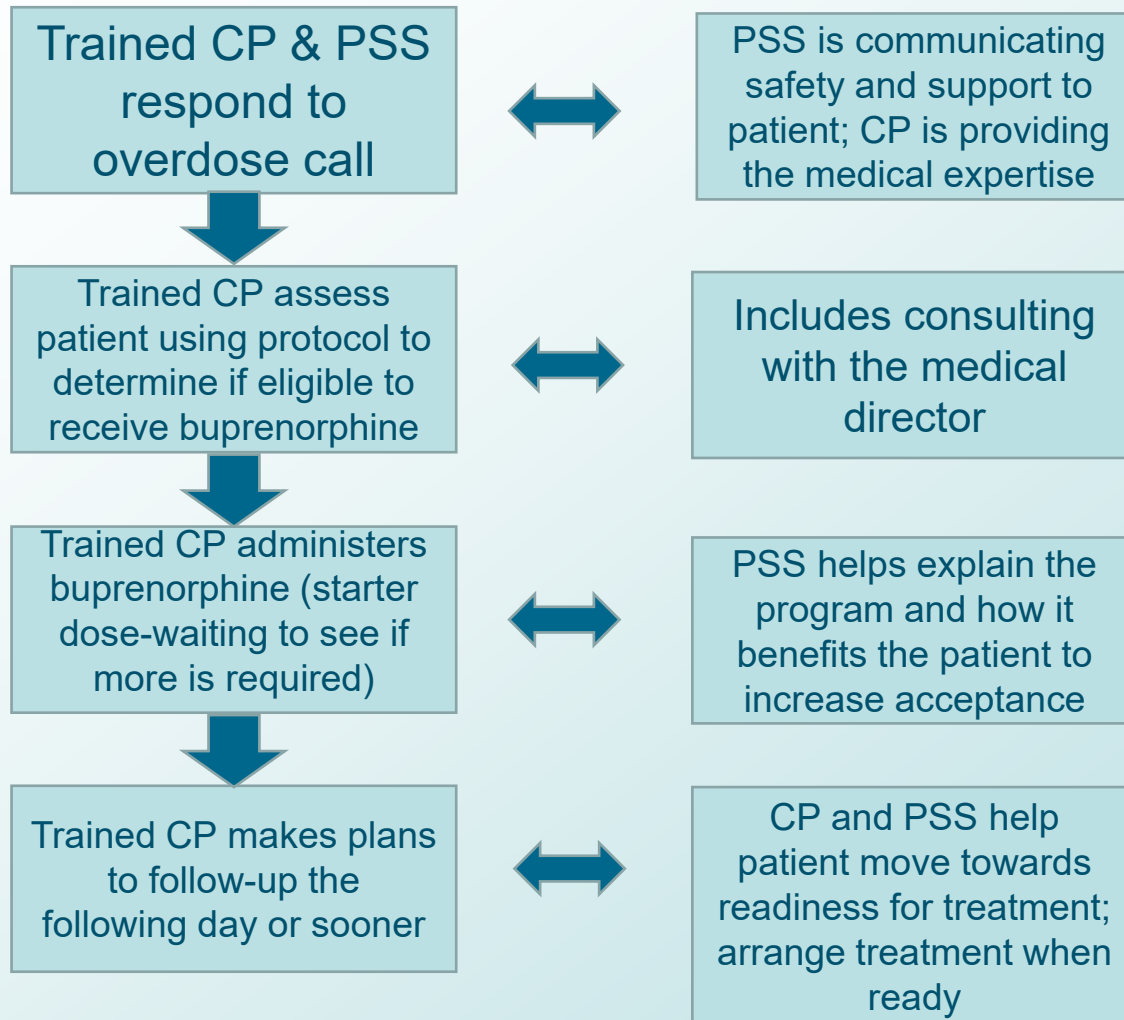


The Intervention

Study Intervention – In a Nutshell

- A coordinated community-based system that:
 - delivers buprenorphine immediately to opioid overdose survivors (CP)
 - successfully persuades them to begin using it as a bridge to MAT (CP and Peer Support Specialist (PSS))

Study Intervention – (As originally intended)



Breakdowns

CP and/or PSS may not be available

If not eligible, other support needs to be available & offered

If offered, patient may not accept

Patient may not be located

Other Complicating Factors

- COVID - no longer safe for peers to join the CP; followed-up by phone with patients
- CPs were pulled away from the work to focus on COVID related tasks including immunizations
- Truck paramedics not always on board and/or trained
- Barriers to treatment access

Study Questions:

1. To what extent will opioid overdose survivors accept buprenorphine from a CP immediately following an overdose?
2. Are opioid overdose survivors more likely to accept the medication when a peer navigator is involved at the scene of the overdose?
3. To what extent do opioid overdose survivors engage in MAT programs when participating in the program?



Preliminary Results

Quantitative Methodology

- Data collection tools were created in collaboration with CPs, PSS, consultants, and using the approved protocol from DHHS.
 - Basic demographic data and data on the incident itself were collected from the electronic reporting system used by truck paramedics
 - CPs collected screening data, substance use history and behavioral health data needed by MAT and other treatment providers
 - CPs collected daily COWs data when providing additional doses as well as information on who attended (i.e., CP only, CP & PSS) and how much was given

Demographics:

(From one county only; November 2019-April 2021)

Demographic		N	%
Sex	Male	110	60.4
	Female	72	39.6
	Total	182	
Race	White	151	87.8
	African American	18	10.5
	Native American	3	1.7
	Total	172	
Hispanic	No	169	92.9
	Yes	12	6.6
	Declined	1	0.5
	Total	182	

Buprenorphine acceptance*

	Yes
Patient offered BUP (n=179)	153 (85.5%)
Patient accepted BUP* (n=147)	44 (29.9%)
Patients previously tried MAT using Methadone or BUP or Naltrexone (n=179)	30 (16.8%)

* Numbers do not match due to missing data

Days receiving buprenorphine*

# of days BUP was given	N	%
1	19	18.3
2	11	10.6
3	14	13.5
4	16	15.4
5	16	15.4
6	8	7.7
7	18	17.3
7+	2	1.9
Total	104	100.0

* We are still working with the county EMS to sort out these numbers

Qualitative methods

- Study period: July 2020 to February 2021
- Remote in-depth interviews with 24 participants from two counties (from 2 counties)
- Interviewees: 6 community paramedics, 4 EMS administrators, 4 opioid harm reduction stakeholders, 3 peer support specialists, 2 EMS medical supervisors, 2 treatment providers, 1 social worker, 1 politician, and 1 EMS independent professional
- Interview topic themes included program origins, implementation, lessons learned, and COVID-19

Three Key takeaways from preliminary qualitative data analysis

1. Barriers and Challenges
2. The value of peer support specialists
3. Unexpected effects prompted changes in practice

Key takeaway 1: Barriers/Challenges

Interviewees reported institutional, political, and interpersonal barriers to program development and implementation:

- State laws, program approval delays, DEA-X waivers
- County authorities prohibiting the hiring of peer support specialists due to criminal histories
- Stigma and compassion fatigue concerning people who use opioids among some first responders (EMTs, police, and fire).
- Concerns about “enabling” users by providing BUP
- Issues with MAT provider partner organizations: namely, difficulties getting patients into care (already full, new patient induction limited to 1, 2 days a week, long waits during induction)

Key takeaway 2: Peer support specialists

When asked, almost every interviewee agreed that peer support specialists are an essential component of the program. Statement from an EMS Manager:

They [patients] [must] have the medication [BUP]. [...] But without that peer, the medication won't work.... They have nobody there to help mentor them, to help coach them. [...] A peer will help you through that process. So even if we don't have the medication, a peer is your key, because a peer can get you to that medication or to that place to help. They can speak the language; they can help you. So yeah, number one is going to be the peer. But you [must] have the medication as well. You just can't give it to them and let him try to do it on their own.

Key takeaway 3: Unexpected effects (and changes in practice)

- In practice, CPs adapted to meet demand in unexpected ways:
 - Information about the program began to spread among user informal networks (friends, family, etc.)
 - BUP requests by referral (truck paramedics, other first responders, opioid harm reduction stakeholders)
 - Users contacting CPs directly (or indirectly) in order to access to BUP and MAT.



Final Thoughts

Lessons Learned as a Researcher

- Significant preparation time needed at the community level to build capacity including relationships and resources, addressing stigma, training, hiring of peers
- Identifying how to handle staff turnover and ongoing continuous training
- Data collection: hiring someone specifically designated to handle data entry or ensuring the electronic system is set up to handle data entry

QUESTIONS



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