



SOCIAL DETERMINANTS



OF HEALTH :



**BUPRENORPHINE USE IN
PALLIATIVE MEDICINE**

UNDERSTANDING BARRIERS AND OPPORTUNITIES FOR EQUITABLE PAIN & ADDICTION CARE

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21 May 2025 ECHO

No Financial OR Conflict of Interest Disclosures

Objectives

1. **Define** social determinants of health (SDOH) and explain their relevance in palliative medicine.
2. **Describe** the pharmacologic properties and clinical applications of buprenorphine in palliative care settings.
3. **Identify** key social and structural barriers to accessing buprenorphine for patients with serious illness.
4. **Analyze** how factors such as income, geography, race, and stigma influence buprenorphine prescribing.
5. **Explore** strategies for clinicians to address inequities & advocate for integrated, patient-centered care.
6. **Discuss** potential policy and system-level interventions to improve access and reduce disparities.



DEFINING SOCIAL DETERMINANTS OF HEALTH (SDOH):



Domains: Economic Stability, Education,
Healthcare Access, Neighborhood,
Social Context

Conditions in environments
where people live, learn,
work, and play

CURRENT ENVIRONMENT:

live, learn, work, & play

Opioid overdose epidemic continues to kill tens of thousands of Americans

- Increased 6 fold between 1999 and 2023

Pre-existing OUD in Palliative Care Patients

- More likely to develop:
 - Chronic life-threatening conditions
- High symptom burden needing palliative support
- 8% of cancer patients have OUD

Cancer survivorship cohort is growing nationally

- Over 1/3 have attendant chronic pain

Palliative Care has moved “upstream” earlier in disease courses

- Leading to more patient encounters
- Potentially increasing long-term opioid prescribing

Anxiety/Depression

- rates increasing last 10y
- Adolescents have higher rates than adults
- Females>Males
- Lower income associated with higher amounts of depression

RISKS OF LONG
TERM OPIOID
PRESCRIBING:

Sleep disordered breathing

Tolerance

Opioid dependence

Dysphoria

Allodynia

Hyperalgesia

Polypharmacy

OUD

What is Buprenorphine?

Partial
opioid
agonist

Ceiling effect
on
respiratory
depression

Used for
pain and
opioid use
disorder

Favorable
safety profile
for palliative
care

SCHEDULE III

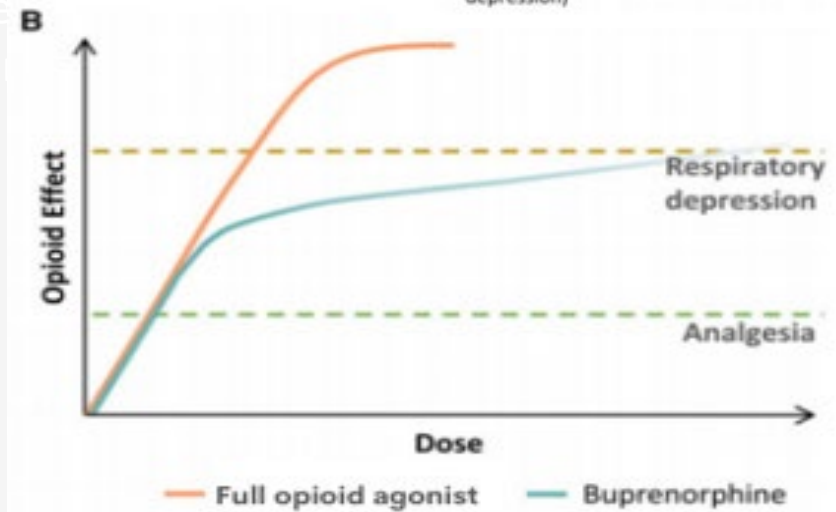
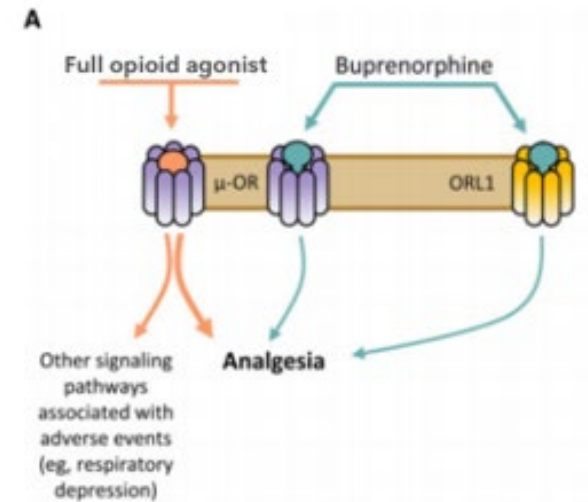


Fig. (A) Potential mechanism of action for buprenorphine and (B) Possible effects compared with those of full opioids agonist such as morphine, oxycodone, hydromorphone

Decreased:
respiratory depression
sedation
euphoria, craving,
dysphoria, hyperalgesia,
and constipation/GI
tolerance events

Buprenorphine MOA

Receptor	Buprenorphine	Full Agonist Opioid	Effect w/ Buprenorphine
Mu Opioid Receptor	Partial Agonist	Full Agonist	Analgesia – threshold at higher doses, less respiratory suppression
Kappa	Inverse Agonist/ Antagonist	Agonist	Indirect NMDA antagonist: decreases hyperalgesia, decreases for centralization of pain, mild antidepressant, less addiction potential
Delta	Antagonist	Agonist	Decreased constipation
ORL-1 (NOP)	Agonist	n/a	Decreased tolerance

ANTIDEPRESSANT ACTIVITY

Does not block monoamine reuptake

-Safe use with anti-depressants

-WITHOUT RISK FOR SEROTONIN SYNDROME

UNIQUE ADVANTAGES OF BUPRENORPHINE

Less effect on the hypothalamic pituitary axis

- thus less risk for hypogonadism and associated complications in men compared to methadone
- Less sexual dysfunction, decreased libido, and osteopenia

Less immunosuppressive than fentanyl or morphine

CANCER THERAPY
check point
inhibitors

Pharmacokinetics are unchanged in OLDER ADULTS

- Has long-acting sublingual (SL) or buccal formulation when patients can't swallow

Less QTc prolongation (no association with TORSADES)

- less sudden death when compared to methadone
- Does not require EKG monitoring
- Safe in heart failure and in prolonged QTc individuals

Safe for use in renal failure or during dialysis

Well tolerated in patients with liver disease

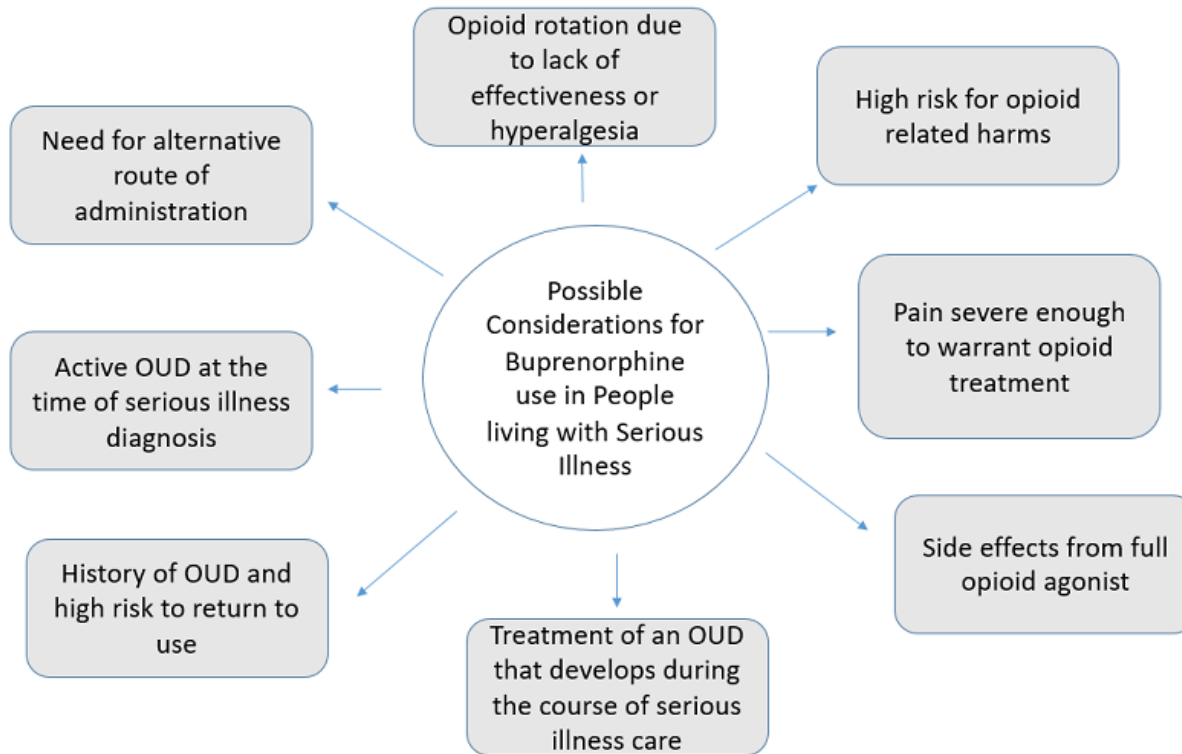
CIRRHOSIS
Start low
Increase dose after
8-10day

Helpful to mitigate opioid induced hyperalgesia

If buprenorphine doses have been stable,

- co-prescribing with short-acting opioid agonists can be done safely (post-operative pain)

Who gets BUP rx?



Center to Advance Palliative Care

“While historically buprenorphine has not been considered first-line opioid therapy, **it may be a good initial option for patients with an increased risk of harm with a full opioid agonist.** This (e.g., constipation, may include individuals with a history of opioid misuse, OUD, or other **substance use disorder**; uncontrolled **psychiatric disorder** who are at higher risk of experiencing opioid misuse or OUD; or **older adults with a higher risk of experiencing opioid side effects** delirium, or respiratory depression).”

DEPARTMENT OF HEALTH AND HUMAN SERVICES

encourages BUPRENORPHINE be considered
BEFORE SCHEDULE II OPIOIDS in management of CHRONIC PAIN

Nursing home

1. Tylenol
2. 5mcg TD patch

REGULATIONS HAVE LIMITED UTILIZATION:

Who can prescribe buprenorphine?

FEDERAL

Waiver Elimination (MAT Act AKA Omnibus Bill)

- Section 1262 of the Consolidated Appropriations Act, 2023 (also known as Omnibus bill), removes the federal requirement for practitioners to submit a Notice of Intent (have a waiver) to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD). With this provision, and effective immediately, SAMHSA will no longer be accepting NOIs (waiver applications).
- All practitioners who have a current DEA registration that includes Schedule III authority, may now prescribe buprenorphine for opioid use disorder in their practice if permitted by applicable state law.
- Clinicians have always been able to prescribe buprenorphine for PAIN, even WITHOUT a waiver.

What are the new training requirements to obtain or renew a DEA registration? —

Section 1263 of the Consolidated Appropriations Act of 2023 requires that beginning June 27, 2023, practitioners applying for a new or renewed Drug Enforcement Administration (DEA) registration will need to attest to having completed a total of at least 8 hours of training on opioid or other substance use disorders, as well as the safe pharmacological management of dental pain.

[Waiver Elimination \(MAT Act\) | SAMHSA](#)

REGULATIONS HAVE LIMITED UTILIZATION:

Who can prescribe buprenorphine?

VIRGINIA

§ 54.1-2928.2. Board to adopt regulations related to prescribing of opioids and buprenorphine.

The Board shall adopt regulations for the prescribing of opioids and products containing buprenorphine. Such regulations shall include guidelines for:

1. The treatment of acute pain, which shall include (i) requirements for an appropriate patient history and evaluation, (ii) limitations on dosages or day supply of drugs prescribed, (iii) requirements for appropriate documentation in the patient's health record, and (iv) a requirement that the prescriber request and review information contained in the Prescription Monitoring Program in accordance with § 54.1-2522.1;
2. The treatment of **CHRONIC PAIN**, which shall include, in addition to the requirements for treatment of acute pain set forth in subdivision 1, requirements for (i) development of a **treatment plan** for the patient, (ii) an **agreement** for treatment **signed by the provider and the patient** that includes **permission to obtain urine drug screens**, and (iii) periodic **review** of the treatment provided **at specific intervals** to determine the continued **appropriateness** of such treatment; and
3. The use of **buprenorphine in the TREATMENT OF ADDICTION**, including a **requirement for referral to or consultation with a provider of substance abuse counseling** in conjunction with treatment of opioid dependency with products containing buprenorphine.

2017, cc. 291, 682

CODE OF VIRGINIA: laws as of 1 July 2024 (cont'd)

§ 54.1-2910.3:1. Medicaid recipients; treatment involving prescription of opioids; payment.

- A. No provider licensed pursuant to this chapter, regardless of whether the provider participates in the state plan for medical assistance, shall request or require a patient who is a recipient of medical assistance services pursuant to the state plan for medical assistance and who is a recipient of health care services involving (i) the prescription of an opioid for the management of pain or (ii) the prescription of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction by the U.S. Food and Drug Administration for medication-assisted treatment of opioid addiction to pay costs associated with the provision of such service out-of-pocket. The prohibition on payment of costs shall not apply to a recipient's cost-sharing amounts required by the state plan for medical assistance.
- B. Every provider who does not accept payment from the Department of Medical Assistance Services for health care services who intends to provide health care services described in subsection A to a patient who is a recipient of medical assistance services pursuant to the state plan for medical assistance shall, prior to providing such health care services, provide written notice to such patient that (i) the Commonwealth's program of medical assistance services covers the health care services described in subsection A and the Department of Medical Assistance Services will pay for such health care services if such health care services are determined to meet the Department of Medical Assistance Service's medical necessity criteria and (ii) the provider does not participate in the Commonwealth's program of medical assistance and will not accept payment from the Department of Medical Assistance Services for such health care services. Such notice and the patient's acknowledgment of such notice shall be documented in the patient's medical record and does not exempt the provider from the requirements of subsection A.

Relevance in Palliative Medicine



Effective Analgesic



REDUCES MISUSE RISK



Useful in opioid rotation strategies

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50% of Ambulatory Palliative clinics feel opioid mis-use is a concern for their office



STIGMA & ACCESS

Case: CLAUDIA*

58-year-old Hispanic woman with metastatic breast cancer, history of OUD

- Lives in rural area
- Raising her granddaughter who drives their only vehicle to school
- Medicaid insurance



ACCESS DISPARITIES: zip code

Income and neighborhood

Urban vs Rural location:

- Only ~10% of Rural counties have buprenorphine providers
- Rural counties have higher jail incarceration rates

Regulations

Provider availability and stigma

- willingness of patient to accept/utilize specialists
- provider implicit bias



INDIVIDUALS IN JAIL/PRISON

ACCESS in Jails MATTERS:

- PREVALANCE: Rates of OUD 25-30%
- OVERDOSE RISK Post-release:
 - 10 fold increase compared to general population (>1st 2wk)
 - Individuals who receive methadone or buprenorphine while incarcerated are 75% less likely to die from OD post-release
- Rhode Island provides all three MOUDs (including BUP) in its prison/jail system
 - **61% reduction in post-release overdose deaths** (Brown University)
 - Middlesex County, MA and Rikers Island, NY have similar programs

CONTINUITY of CARE: interrupting buprenorphine tx while incarcerated

- destabilize recovery
- increase relapse risk

INDIVIDUALS IN JAIL/PRISON

CURRENTLY (2024)

- National Institute on Drug Abuse:
 - **Less than half (43.8%) of jails offer any form of medication for OUD (MOUD)**
 - Only 12.8% of jails : available to all individuals (limited access)
- Addiction Policy Forum:
 - Of those with MOUD, **Buprenorphine is the MC available: 70%**

BARRIERS:

- **Stigma** – jail staff & leadership
- **Security concerns** – diversion fear
- Lack of **trained providers**
- **Logistical challenges**
 - daily dosing protocols
 - Telehealth and nurse-led models – scalable ways to expand facility access
 - Post-release linkage: access to community tx upon

legal pressure and policy changes

- Federal & State has started: support MOUD programs in correctional settings
 - Initiation vs Continuation
 - **USDOJ 14Jan2024 letter to Sherriffs: denying MOUD violates ADA**
 - Supreme court in 90's had to determine ADA application

TRAUMA-INFORMED CARE

THE IMPACT OF PHYSICAL, EMOTIONAL AND SYSTEMIC TRAUMA

90% of individuals with SUD have experienced trauma

Many turn to opioids as a form of self-medication to numb psychological pain

Incarceration

Systemic racism

Housing insecure

Childhood abuse

Sexual violence

Domestic abuse

TRAUMA EFFECTS

Behavior

Decision-making

Health

mistrust providers

Fear authority/control

Struggle with rigid structures or punitive rules

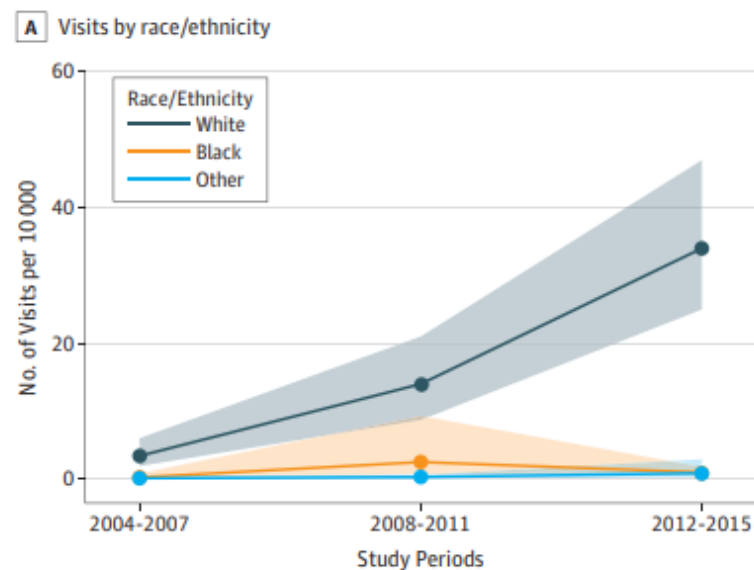
Easily triggered by invasive procedures or withdrawal symptoms

ACCESS DISPARITIES: Race/Ethnicity

- Minorities less likely to receive buprenorphine
 - approximately 88% White, 8% Black, 4% Other
- 51% female.

• surveys, which provide nationally-representative estimates of outpatient care provided in the United States by non-federally-employed physicians, capture physician-reported medications prescribed during each office visit as well as demographic characteristics and expected source of payment. Notably, results reflect buprenorphine prescriptions for all individuals (not just OUD)

Figure. Buprenorphine Visits by Race/Ethnicity and Payment Type, 2004-2015



Buprenorphine visits (n = 1369) and 95% CIs per 10 000 visits (shaded areas), grouped account for complex survey design elements and are nationally representative.

In 2022, the distribution of **MEDICAID/CHIP** enrollees by ethnicity in the USA was:

- 5.3% Asian
- 20% Black
- 29.3% Hispanic
- 39.6% White

In 2023, the distribution of **MEDICARE** beneficiaries

- 72.3% White
- 10.1% Black
- 9.8% Hispanic
- 4.6% Asian/Native Hawaiian and pacific islander
- 0.4% American Indian/Alaska Native
- 2.7% Multiple races

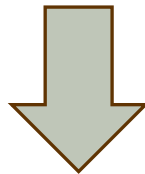
ACCESS DISPARITIES: Insurance vs \$\$\$

- Gaps in Medicaid/Medicare coverage
 - Formulary restrictions
 - Medicaid varies by state

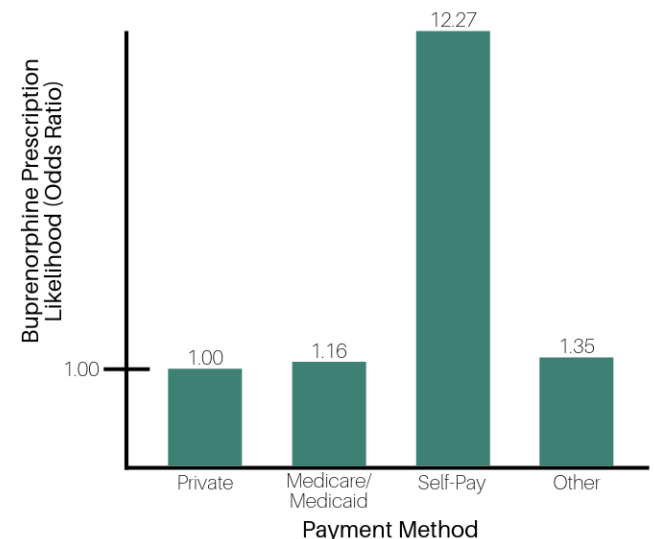
how can we expect private insurance to be consistent?

SELF-PAY PATIENTS

- 12.3 times more likely to be prescribed buprenorphine compared to those with private insurance.
- marked increase in the number of individuals receiving buprenorphine via self-pay from 2008-2015



Limited buprenorphine access in underserved areas





Financial Barriers to Access - **COST**

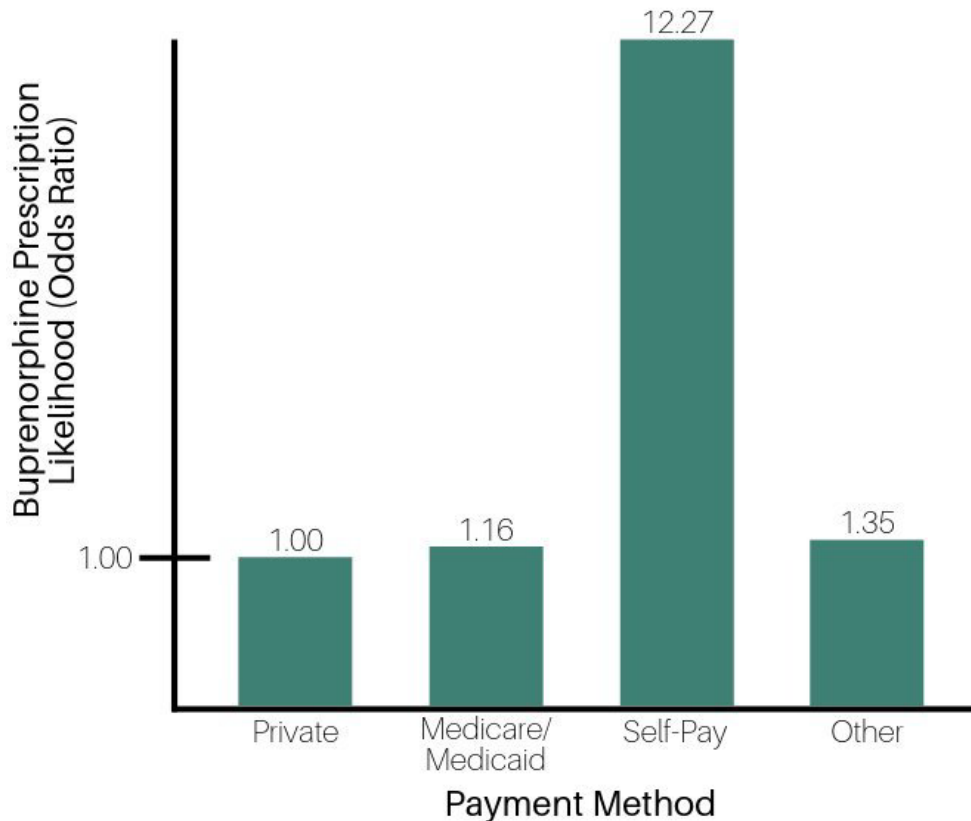
Outpatient Pharmacies

Inpatient Pharmacies

Free Clinics

VA hospital system

What is the cash pay cost of buprenorphine?













Generic buprenorphine vs. Butrans 5mcg

Prescription

Buprenorphine 4 patches of 5mcg (1 carton)













 CVS Pharmacy	from \$51.05
 Walgreens	\$93.41
 Carilion Clinic Pharmacy	\$100.30
 Target (CVS)	from \$51.05
 Rite Aid	from \$94.40
 Community, a Walgreens Pharmacy	\$93.41
 Publix	from \$87.40
 Wegmans	\$106.30
 Costco	\$131.94
 Safeway	from \$163.51

Prescription

Butrans 4 patches of 5mcg (1 carton)













 CVS Pharmacy	from \$226.06
 Walgreens	\$224.80
 Carilion Clinic Pharmacy	\$209.82
 Target (CVS)	from \$226.06
 Rite Aid	from \$206.74
 Wegmans	from \$198.81
 Safeway	from \$209.91
 Community, a Walgreens Pharmacy	\$224.80
 Publix	from \$218.28
 Costco	from \$229.82

Generic Buprenorphine vs. Butrans 10mcg











Prescription
Buprenorphine 4 patches of 10mcg (1 carton)



 CVS Pharmacy	from \$59.58
 Walgreens	\$135.86
 Target (CVS)	from \$59.58
 Wegmans	\$163.88
 Rite Aid	from \$138.85
 Costco	\$275.64
 Walgreens Specialty Pharmacy	\$135.86
 Publix	from \$131.85
 Carilion Clinic Pharmacy	\$145.32
 Safeway	from \$136.83

Prescription
Butrans 4 patches of 10mcg (1 carton)













 CVS Pharmacy	from \$331.06
 Walgreens	\$324.96
 Carilion Clinic Pharmacy	\$311.92
 Target (CVS)	from \$331.06
 Rite Aid	from \$309.96
 Wegmans	from \$298.43
 Safeway	from \$314.37
 Community, a Walgreens Pharmacy	\$324.96
 Publix	from \$327.09
 Costco	from \$344.23

Generic buprenorphine vs Butrans 15mcg

Prescription

Buprenorphine 4 patches of 15mcg (1 carton)













 CVS Pharmacy	from \$76.91
 Walgreens	\$192.22
 Target (CVS)	from \$76.91
 Wegmans	\$232.69
 Rite Aid	\$203.03
 Costco	\$347.39
 Walgreens Specialty Pharmacy	\$192.22
 Publix	from \$218.39
 Carilion Clinic Pharmacy	\$227.01
 Safeway	\$260.45

Prescription

Butrans 4 patches of 15mcg (1 carton)













 CVS Pharmacy	\$538.49
 Walgreens	\$543.66
 Carilion Clinic Pharmacy	\$522.42
 Target (CVS)	\$538.49
 Rite Aid	from \$522.77
 Wegmans	from \$503.79
 Safeway	from \$529.74
 Community, a Walgreens Pharma...	\$543.66
 Publix	from \$551.44
 Costco	from \$580.12

Generic buprenorphine vs Butrans 20mcg

Prescription

Buprenorphine 4 patches of 20mcg (1 carton)













 CVS Pharmacy	from \$89.47
 Walgreens	\$233.98
 Carilion Clinic Pharmacy	\$236.48
 Target (CVS)	from \$89.47
 Rite Aid	from \$237.51
 Community, a Walgreens Pharmacy	\$233.98
 Publix	from \$230.51
 Wegmans	\$274.27
 Safeway	from \$353.53
 Costco	\$433.14

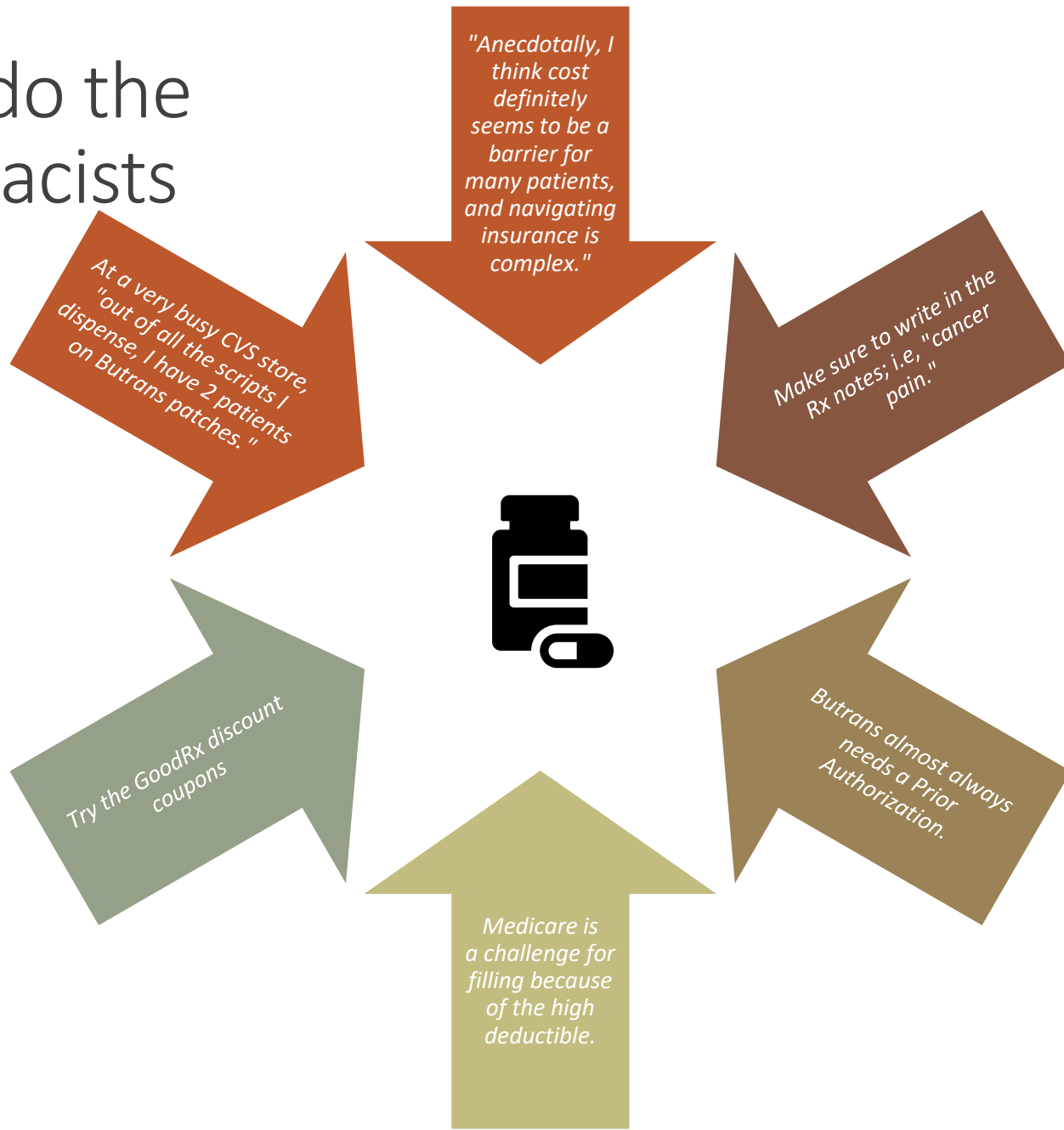
Prescription

Butrans 4 patches of 20mcg (1 carton)



 CVS Pharmacy	\$565.11
 Walgreens	\$571.35
 Carilion Clinic Pharmacy	\$549.07
 Target (CVS)	\$565.11
 Rite Aid	from \$549.70
 Wegmans	from \$529.79
 Safeway	from \$557.00
 Community, a Walgreens Pharmacy	\$571.35
 Publix	from \$579.83
 Costco	from \$609.97

What do the pharmacists say?



What happens inpatient?

Carilion's contract pricing is private – but this is the Average Wholesale Price

Buprenorphine tablet

2 mg - \$2

8 mg - \$4.5

Buprenorphine film

75 mcg - \$9

150 mcg - \$9

300 mcg - \$14.2

450 mcg - \$19.3

600 mcg - \$20.6

750 mcg - \$21.6

900 mcg - \$22.3

Buprenorphine patch

5 mcg/hr - \$61.4

7.5 mcg/hr - \$86.3

10 mcg/hr - \$ 92.5

15 mcg/hr - \$156.6

20 mcg/hr - \$164.7

0.3 mg/mL injection

\$16.50 per dose

What happens inpatient?

According to Carilion inpatient pharmacist:

No restrictions to access for admitted patients:

- In-hospital use is typically independent of patient insurance
- Covered irrespective of indication (pain or SUD)

If being discharged with buprenorphine:

- Carilion retail pharmacy will only dispense if the indication is for **pain** management
- If indication is OUD, the retail pharmacy cannot fill the prescription
- GoodRx is not accepted at Carilion

Carilion Retail Pharmacy

Carilion's contract pricing is private

1 box of GENERIC
buprenorphine
patches

- 5mcg: \$330
- 10mcg: \$495
- 15mcg: \$480
- 20mcg: \$880

Belbuca 300mg Films,
1 box #30

- Cash price: \$1015
- Only 1 patient since December

Carilion will not accept GoodRx pricing or coupons

****CVS will accept GoodRx discount cards****



Free Clinics

Our local free clinic
will not dispense any
controlled
substances.



VA

U.S. Department
of Veterans Affairs

What about the
Veteran's
Administration?

Medication Requested:
Local Drug Name with Dose

BUPRENORPHINE 100MG/0.5ML SA INJ SYR
BUPRENORPHINE 10MCG/HR PATCH
BUPRENORPHINE 128MG/0.36ML SA INJ SYR
BUPRENORPHINE 12MG/NALOXONE 3MG SL FILM
BUPRENORPHINE 150MCG BUCCAL FILM
BUPRENORPHINE 15MCG/HR PATCH
BUPRENORPHINE 16MG/0.32ML SA INJ SYR
BUPRENORPHINE 20MCG/HR PATCH
BUPRENORPHINE 24MG/0.48ML SA INJ SYR
BUPRENORPHINE 2MG/NALOXONE 0.5MG SL FILM
BUPRENORPHINE 2MG/NALOXONE 0.5MG SL TAB
BUPRENORPHINE 2MG/NALOXONE 0.5MG UD SL
BUPRENORPHINE 300MCG BUCCAL FILM
BUPRENORPHINE 300MG/1.5ML SA INJ SYR
BUPRENORPHINE 32MG/0.64ML SA INJ SYR
BUPRENORPHINE 450MCG BUCCAL FILM
BUPRENORPHINE 4MG/NALOXONE 1MG SL FILM
BUPRENORPHINE 5MCG/HR PATCH
BUPRENORPHINE 64MG/0.18ML SA INJ SYR
BUPRENORPHINE 7.5MCG/HR PATCH
BUPRENORPHINE 75MCG BUCCAL FILM
BUPRENORPHINE 8MG/0.16ML INJ,SA,SYRINGE
BUPRENORPHINE 8MG/NALOXONE 2MG SL FILM
BUPRENORPHINE 8MG/NALOXONE 2MG SL TAB
BUPRENORPHINE 8MG/NALOXONE 2MG UD SL TAB
BUPRENORPHINE 96MG/0.27ML SA INJ SYR
BUPRENORPHINE HCL 2MG SUBLINGUAL TAB
ZBUPRENORPHINE 4MG/NALOXONE 1MG SL FILM



VA | U.S. Department
of Veterans Affairs

What about the
Veteran's
Administration?

Buprenorphine indications at the VA

- Pain
 - o Lower dose formulations (mcg)
- SUD
 - o High dose formulations (mg)

COST:

- Copay is determined by the level of service connection.
- 50% service-connected disability, then in Priority group 1 and no fees



VA | U.S. Department
of Veterans Affairs

What about the
Veteran's
Administration?

PRESCRIBING LIMITATIONS:

Patients can receive buprenorphine

- as inpatient
- as an outpatient
- or in a long-term care facility

Must have a diagnosis for pain and/or SUD

PHYSICAL ACCESS:

How do VA patients get their Bup Rx?

- VA prefers via **shipping to home**
- Cost-effective

*There is available stock for emergency situations or misplaced/stolen mail

EDUCATION AND HEALTH LITERACY

Differences in educational opportunities and outcomes can contribute to disparities in health literacy across racial and ethnicity groups.

Higher levels of education correlates with access to health information and resources

- better health literacy
- informed decision making

Lower levels of education may result in struggles with health literacy causing:

- Difficulty navigating healthcare systems
- Limited understanding of therapy goals
 - affecting consent and adherence
- Poor health outcomes=higher rates of
 - chronic disease
 - medication non-adherence

- Language barriers

HEALTHCARE ACCESS AND QUALITY



Limited access to palliative or addiction-trained clinicians



Overburdened safety-net systems

- community health centers and public hospitals are under significant financial and workforce pressures
- negative impacts on patient outcomes (higher mortality rates)



Telehealth pros and cons

- centers providing increased from 43% in 1999 to 99% in 2020
- reimbursements for services and related expenses to implement/maintain platform are challenges

SOCIAL & COMMUNITY CONTEXT

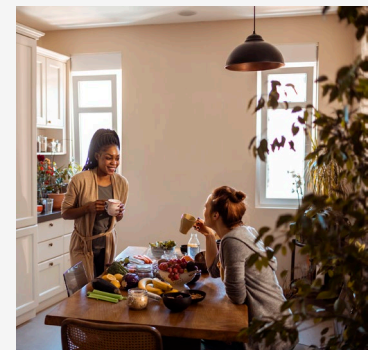
Cultural norms
about addiction and
opioids



Family support
systems



Peer and caregiver
influence on
treatment decisions



STRUCTURAL STIGMA & DISPARITIES

Discrimination
based on race,
class, addiction
history

Bias in healthcare
settings

Distrust affects
care uptake

may require more
frequent visits
initially

LEGAL & POLICY BARRIERS

- Buprenorphine waiver requirements (X-waiver)
 - added a level of complexity to Buprenorphine that remains
- DEA regulations on opioid prescribing
 - providers hesitate to pursue needed training to prescribe
 - can limit access to treatment
- Legal fears limit provider prescribing
 - PROVIDER HESITANCY to prescribe BUPRENORPHINE
 - fear of diversion and misuse
 - being investigated for violating federal laws even though acting in good faith
 - PHARMACY BARRIERS
 - may hesitate to stock buprenorphine due to fear of:
 - fear being flagged for suspicious activity
 - legal consequences for dispensing a prescription that might not be legitimate

HEALTH SYSTEM BIASES

- Providers may undertreat pain in opioid-experienced patients
- Misconceptions about addiction in palliative care
 - Until recently the belief that problematic substance use would diminish and vanish with age was widely held (1960's 50% not active by age 32)
 - As baby boomer cohort ages, medication misuse is predicted to increase (2x 2006 levels)
 - among adults >50year in USA, nearly 5million (>5%) of the age group report using illicit substances within the last 1 year
- Disproportionate monitoring burdens (UDS,interval appt,DEA)
- Military vs. Private sector

Case: CLAUDIA

58-year-old Hispanic woman with metastatic breast cancer, history of OUD

- Lives in rural area
- Raising her granddaughter who drives their only vehicle to school
- Medicaid insurance

I am a veteran.
My VA provider comes to me.
They offered telehealth PC
and said they can deliver the
medication to my door.



ETHICAL CONSIDERATIONS

- Balancing beneficence, autonomy, and justice
 - great medication option that not all patients have access
 - SEEK EQUITY
- Addressing implicit bias
 - negative associations that people unknowingly hold
- Ensuring non-abandonment in opioid-dependent patients

Role of Palliative Providers to mitigate SDOH

- Prescribe buprenorphine when indicated
 - Education and comfort with prescribing
 - Telemedicine for rural access
 - Use interdisciplinary teams
 - case management/social work
 - peer support
 - Advocate for patient needs
 - prior auth
 - letters to congress
- Coordinate/Collaborate care across disciplines
- Advocate for equitable access/policy change
 - ✓ Eliminate waiver requirements
 - ☐ Integrate addiction training in palliative fellowships
 - IV.C.2. The program must provide instruction and experience in pain management if applicable for the subspecialty, including recognition of the signs of addiction
 - ☐ Expand Medicaid coverage

Buprenorphine use in Palliative CARE

*Healing-centered, dignity driven support for patients with
PAIN and OUD*

Restoring dignity, safety & trust in systems that are sources of trauma
(criminal justice and healthcare alike)



REDUCE all-cause mortality by 50%

REDUCE Risk of dying from overdose by 50-70% by treating w/ **BUPRENORPHINE**

REDUCE Risk of Hep C & HIV infection (decreased injection)

Reduced Arrests and incarceration due to social stability & <drug-seeking behavior

Promote TRUST

Choices & information given (no pressure)

Intake process w/o shaming, rushing or coercion

Avoid language that stigmatizes relapse/nonadherence

SUPPORT

Flexible protocols reflecting reality - trauma and chaos in life

Avoid with-holding medication as punishment

Low-barrier clinics-walk-in or same day start models

Partner for SUCCESS

Integrate therapy or peer support

Assist with navigating health system, pharmacies

EMPOWER

Greater focus on living life & their activities

Regular Pharmacy

DECREASED respiratory depression, sedation, craving, dysphoria, hyperalgesia, & constipation/GI tolerance events

Don't need EKGs

No risk of serotonin syndrome when medicated for Depression/Anxiety



CONCLUSION & CALL TO ACTION

- Addressing SDOH improves buprenorphine outcomes

- **Equity is essential in palliative care**
should transcend all of medicine

* [Who's My Legislator?](https://whosmy.viriniageneralassembly.gov/)

-<https://whosmy.viriniageneralassembly.gov/>



• **ADVOCATE**

*for compassionate, accessible treatment models

-**PROFESSIONAL ORGANIZATIONS**

*local, state, national, international

-**Personally**

*letter writing



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We can make a difference

Letters to congress people

can be surprisingly effective, especially when done strategically.

- 1. Constituent Influence:** Elected officials are very responsive to constituents—your opinion matters more than someone from outside their district.
- 2. Volume Signals Priority:** A large number of personalized letters on an issue signals that it's important to voters, which can influence a lawmaker's agenda or vote.
- 3. Personal Stories Stand Out:** Letters that include real-life stories or impacts are more memorable and persuasive than form letters or mass emails.
- 4. Policy Shaping:** Congressional staffers often track issues constituents write about. Your letter might directly affect how a representative frames or prioritizes a bill.



LIMITATIONS

- **One letter won't move mountains**, but a coordinated effort—especially with many personalized messages—can absolutely shift attention.
- **Timing matters:** Letters sent while legislation is being debated are more impactful than after a decision is made.
- **Boilerplate or angry rants are usually ignored**—genuine, respectful, and well-informed letters are much more effective.



Tips for Writing an Effective Letter:

- Be brief (1 page max).
- State you're a constituent.
- Be specific about what you want them to do (e.g., "Vote yes on H.R. 1234").
- Include a personal story or reason why it matters to you.

[Physician's Full Name]

[Physician's Title and Specialty]
[Medical Practice / Institution Name]
[Address]
[City, State, ZIP Code]
[Phone Number]
[Email Address]
[Date]

The Honorable [Congressman's Full Name]

[Office Address]
[City, State, ZIP Code]

Dear Congressman [Last Name],

I hope this message finds you well. I am Dr. [Full Name], a [specialty] based in [location], writing to urge your immediate action to improve access to buprenorphine—an underutilized, life-changing treatment for chronic pain, serious illness, and opioid dependence. As a physician, I see daily how access to buprenorphine can improve outcomes, reduce opioid misuse, and significantly enhance patient safety—especially for our most vulnerable populations.

Buprenorphine offers crucial benefits over traditional opioids. For patients with chronic pain, cancer, COPD, heart disease, and especially the elderly, its once-weekly patch formulation reduces cravings, alleviates withdrawal, and offers a much safer profile—minimizing risks like overdose, diversion, and medication errors. Moreover, despite its proven safety and efficacy, access is severely limited by insurance gaps, outdated policies, and widespread stigma. This must change.

As you know, the X-waiver program has helped expand access to buprenorphine, but it's only the first step. Now we must build on this momentum and ensure that this medication is available to all patients who could benefit from it, not just those with opioid use disorder. This includes expanding Medicaid and Medicare coverage for buprenorphine patches, supporting rural providers, and addressing hospice care gaps, which remain significant barriers to access.

In addition, buprenorphine's unique formulation presents clear household safety advantages. Unlike immediate-release opioids, which pose a risk of accidental overdose in homes with children, the long-acting patch offers consistent dosing with much lower risks of misuse or diversion. This is essential for keeping patients, families, and caregivers safe—particularly as we strive to address the opioid crisis.

Here's what needs to be done to make a meaningful difference:

1. **Expand Medicaid coverage** for buprenorphine patches without state-level restrictions.
2. **Support rural healthcare initiatives** to increase waivered providers.
3. **Incentivize long-acting buprenorphine** for both chronic pain and opioid use disorder, especially in nursing homes and hospice settings.
4. **Advocate for broader Medicare and hospice coverage** for buprenorphine, ensuring it's available for end-of-life care.
5. **Support telemedicine initiatives** to increase access in underserved areas.

The time to act is now. By improving access to buprenorphine, we not only save lives but also protect communities from the dangers of opioid misuse and overdose. I would be honored to discuss these issues with you further and collaborate on solutions that can improve patient outcomes across the country.

Thank you for your time and commitment to improving healthcare access for all.

Sincerely,
[Physician's Full Name]
[Physician's Title]
[Medical Practice / Institution Name]

[Physician's Full Name]

[Physician's Title and Specialty]
[Medical Practice / Institution Name]
[Address Line]
[City, State, ZIP Code]
[Phone Number]
[Email Address]
[Date]

The Honorable [Congressman's Full Name]

[Office Address]
[City, State, ZIP Code]

Dear Congressman [Last Name],

I hope this message finds you well. I am Dr. [Full Name], a [specialty] in [location], writing to urge you to advocate for improved access to buprenorphine—a medication with the potential to transform care for patients with chronic pain, serious illness, and respiratory conditions.

As a physician, I see firsthand how social determinants of health (SDOH)—like income, location, and past substance use—create insurmountable barriers to vital treatments for our most vulnerable populations. Buprenorphine, in its long-acting patch form, offers profound benefits for managing chronic pain, cancer-related pain, COPD, advanced heart disease, and for elderly patients. It reduces cravings, alleviates withdrawal symptoms, and prevents the misuse associated with traditional opioids, making it an essential and safer alternative.

Despite its proven advantages, access to buprenorphine is limited by cost, inconsistent insurance coverage, and stigma. While Medicaid and most insurances cover buprenorphine in tablet or film form for opioid use disorder, the patch—which provides long-acting relief and reduces administration frequency—often requires prior authorization and a firm fight for approval, creating additional burdens for patients, healthcare providers, pharmacies and staff. This is especially concerning in nursing homes, long-term care facilities, and hospice settings, where the patch formulation's benefits are most impactful.

This issue is particularly pressing for elderly patients and those with impaired renal or hepatic function, who are at a higher risk for complications from traditional opioids. By expanding access to buprenorphine, we can provide a safer, more effective solution, ensuring vulnerable patients are not denied this life-improving treatment due to systemic barriers.

To make this vision a reality, I respectfully urge you to:

1. **Expand Medicaid coverage for buprenorphine patches, films, and tablets without state-level restrictions.**
2. **Increase support** for rural healthcare initiatives to expand the pool of waivered providers, uniformly remove patient number limits.
3. **Incentivize the use** of long-acting buprenorphine in managing pain and symptoms in outpatient care, nursing homes, and hospice.
4. **Champion telemedicine** to increase access in underserved areas.

Your action is needed to ensure that all patients—especially the elderly and those with serious illnesses—receive the care they deserve. The benefits are clear: reduced risk of overdose, fewer medication errors, and less strain on overburdened healthcare systems. With your leadership, we can pave the way for more equitable, effective care for those who need it most.

Thank you for your time and for your commitment to improving healthcare for all Americans.

Sincerely,
[Physician's Full Name]
[Physician's Title]
[Medical Practice / Institution Name]

Discussion

Do you have
a **Buprenorphine**
algorithm for pain?

Drop in
CHAT



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- What have been your barriers to prescribing?
- How often are you prescribing buprenorphine?
- What have been your patients' barriers to taking or accessing buprenorphine?
- What ways have you been able to overcome barriers for your patients?
- How often do your patients have success with it as a treatment?

Buprenorphine in Palliative Care Settings

Aimee Conley, MD

Meredith Arthur, DO

Hospice and Palliative Medicine Fellowship, Carilion Clinic

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 - b. Program Eligibility: <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels>
 - c. Healthcare.gov. Medicaid & CHIP <https://www.healthcare.gov/medicaid-chip/>
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