Treat OUD like the Chronic Disease It Is: Low-Threshold Buprenorphine

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Conflicts of Interest

- No conflicts of interest to disclose.
- Notes:
  - Short-hand – bupe for buprenorphine/naloxone (Suboxone)
  - Person-first language

Changing the Language of Addiction

ASAM American Society of Addiction Medicine

Terms that stigmatize addiction can affect the perspective and behavior of patients, clients, scientists, and clinicians. Clinicians especially need to be aware of person-first language and avoid more stigmatizing terms.

Terms Not to Use	Terms to Use
addict, abuser, user, junkie, druggie	person with a substance use disorder
alcoholic, drunk	person with an alcohol use disorder
oxy-addict, meth-head	person with an opioid use disorder
ex-addict, former alcoholic	person in recovery
clean/dirty (drug test)	negative/positive result(s)
addictions, addictive disorders	addiction, substance use disorder

National Addiction Treatment Week

351 overdose deaths in Idaho in 2021

75% due to opioids

>100,000 overdose deaths annually nationwide

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm; https://www.gethealthy.dhw.idaho.gov/drug-overdose-dashboard; photo from personal collection

Idaho Statesman

BUSINESS

US overdose deaths appear to rise amid coronavirus pandemic

BY MIKE STOBBE AND ADRIAN SAINZ *ASSOCIATED PRESS*
OCTOBER 20, 2020 09:33 AM

Comparison of a potentially lethal dose of fentanyl to a U.S. penny

Source: GAO adaptation of U.S. Drug Enforcement Administration information. | GAO-21-499

'The Drug Became His Friend': Pandemic Drives Hike in Opioid Deaths

In the months since the pandemic took hold in the U.S., the opioid epidemic has taken a sharp turn for the worse. More than 40 states have seen evidence of increases in overdoses.

Family and friends mourned Jefrey Scott Cameron, who died of an accidental overdose earlier this year, in Barre, Vt.

By Hilary Swift and Abby Goodnough Photographs by Hilary Swift

Published Sept. 29, 2020 Updated Sept. 30, 2020

OVERDOSE DEATHS

Per 100,000 People

39 Black/Non-Hispanic

36 American Indian, Alaska Native/ Non-Hispanic

Drug Overdose Deaths Rise, Disparities Widen

Differences Grew by Race, Ethnicity, and Other Factors

View All Topics

2 X In counties with more income inequality, overdose death rates for Black people were more than two times as high as in counties with less income inequality in 2020.

7 X Overdose death rates in older Black men were nearly seven times as high as those in older White men in 2020.

2 X Overdose death rates for younger American Indian and Alaska Native (AI/AN) women were nearly two times those of younger White women in 2020.

3 — **3** Asian, Pacific Islander/ Non-Hispanic

2019 **2020**

https://www.cdc.gov/vitalsigns/overdose-death-disparities/index.html

CDC's Unique Work In Action:
Overdose Deaths are the Tip of the Iceberg

For every **1** prescription or illicit opioid overdose death in 2015 there were…

18 people who had a substance use disorder involving heroin

62 people who had a substance use disorder involving prescription opioids

377 people who misused prescription opioids in the past year

2,946 people who used prescription opioids in the past year

Results from the 2015 National Survey on Drug Use and Health: Detailed Tables https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.htm#tab1-23a

Rudd RA, Seth P, David F, Scholl L. *Increases in Drug and Opioid-Involved Overdose Deaths* — United States, 2010–2015. MMWR Morb Mortal Wkly Rep 2016;65:1445–1452. DOI: http://dx.doi.org/10.15585/mmwr.mm655051e1.

Learning Objectives

- Understand the urgency of the opioid epidemic
- Define and diagnose opioid use disorder (OUD); understand OUD as a chronic disease
- Describe the evidence for medications for OUD
- Recognize buprenorphine as *the life-saving and primary treatment* for OUD
- Identify persons likely to benefit from buprenorphine
- Review logistics of prescribing buprenorphine
- Apply the principles of harm reduction to OUD treatment
- Recognize the role of *low-threshold buprenorphine* in halting the opioid epidemic
- Review local resources & a call to action!

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Case

- HPI: 25yo interested in bupe after friend near overdose event
- Use recently escalated, expensive
- Injects multiple times per day, ER with skin infection
- Mostly syringes from SSP but sometimes shares
- Occasional alcohol and benzos, regular marijuana; no meth, cocaine or other drugs; + tobacco
- Longest sobriety 2 yrs @ IDOC; doesn't like AA; not interested in counseling or groups; has tried bupe
- First opioids after appendectomy @ 21
- Last opioid earlier this AM, + cravings & withdrawal

- PMH: depression, no hosp or suicide attempt, prior SSRI & counseling
- PSH: appendectomy
- FH: parent alcohol use disorder
- SH: no kids, some college, prior shop manager but recently unemployed, lives in apt w partner who also uses, relationship rocky
- Exam: well-appearing, neatly dressed, good eye contact, somewhat fidgety, track marks antecubital fossa b/l
- Labs:
  - UDS: + marijuana, opiates
  - Rapid HIV neg, rapid HCV pos
- PDMP: no controlled substances

Defining OUD (DSM-5)

- Impaired Control
  - ✓ Larger amounts, longer time
  - ✓ Inability to cutback
  - ✓ More time spent, getting, using, recovering
  - ✓ Craving
- Social Impairment
  - ✓ Failure to fulfill major role obligations
  - ✓ Social or interpersonal problems related to use
  - ✓ Important social activities given up to use.
- Risky use
  - ✓ Physically hazardous use
  - ✓ Continued use despite associated recurrent physical or psychological problems.
- Pharmacological
  - ✓ Tolerance
  - ✓ Withdrawal

- Symptoms over past year
- Withdrawal and tolerance alone not sufficient if opioids under appropriate medical supervision
- Severity:
  - 2-3: mild
  - 4-5: moderate
  - 6+: Severe

our patient has severe OUD (10/11 criteria)

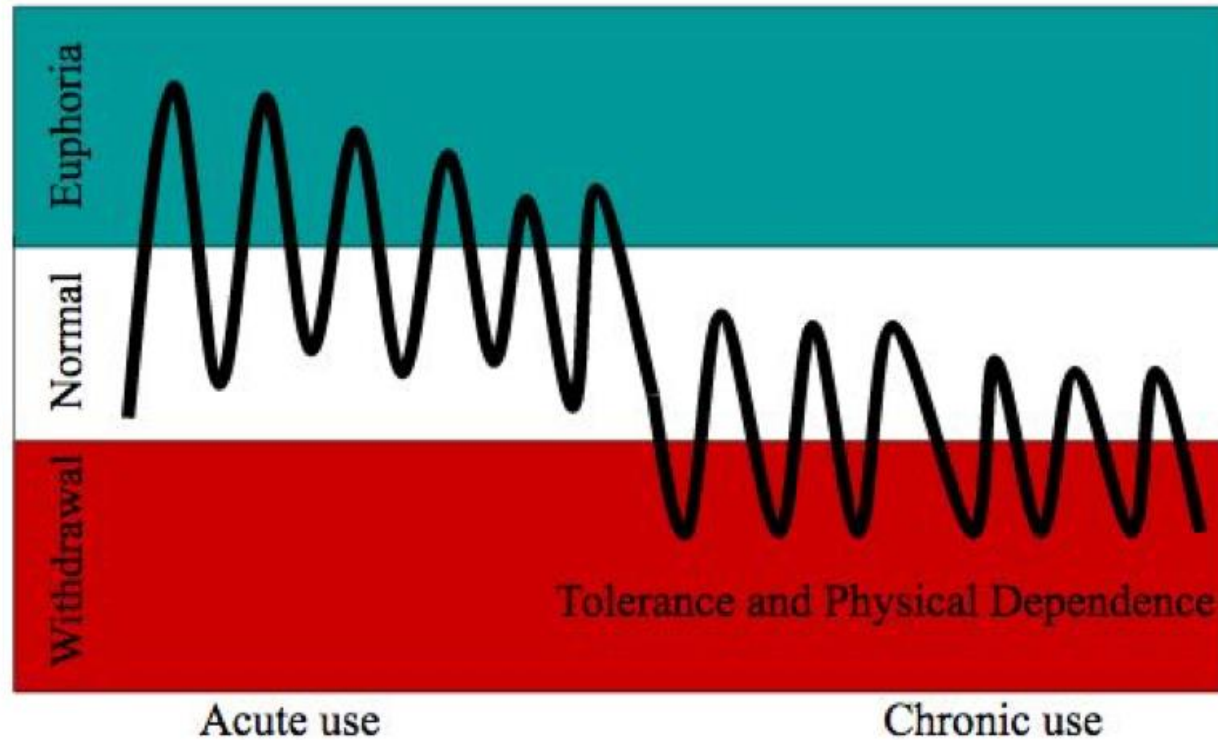
https://dsm.psychiatryonline.org

Defining Addiction (ASAM)

- “a primary, **chronic disease** of brain reward, motivation, memory and related circuitry…
- …pathologically pursuing reward and/or relief of withdrawal symptoms by substance use…
- …Without treatment or engagement in recovery, addiction is progressive and **can result in disability or death.”**

ASAM American Society of Addiction Medicine

Natural History of Opioid Dependence



"When you can stop you don't want to, and when you want to stop, you can't."

Luke Davies, *Candy*. 1998.

Slide credit: Dr. John Giftos, Clinical Director, SUD Treatment, Correctional Health Services Rikers Island, NYC Health & Hospitals

Biology / Genetics ↔ **Environment**

- Genetics ~ 50% of risk

- Poverty
- Trauma
- Education
- Parents/Peers

Drugs

- Early Use
- Effect of Drug
- Route of Use
- Availability
- Cost

Brain Chemistry

- Brain Development
- Reward Pathway
- Tolerance/Withdrawal

Addiction

Adapted from NIDA 2018

Slide credit: Dr. John Giftos, Clinical Director, SUD Treatment, Correctional Health Services Rikers Island, NYC Health & Hospitals

Defining Recovery (ASAM)

- “a process of **sustained action** that addresses the biological, psychological, social and spiritual disturbances…
- …aims to improve the quality of life…
- …is the consistent **pursuit** of abstinence.”

ASAM American Society *of* Addiction Medicine

Addiction a Chronic Disease

- Chronic disease requiring long-term management
  - 59.3 million 12yo+ (21.4%) illicit drug use past year (NSDUH 2020)
    - 9.5 million (9.5%) opioids
  - 40.3 million people 12yo+ (14.5%) SUD in past year (NSDUH 2020)
    - 2.7 million OUD (1%)
- 37.3 million diabetes (11.3%) (CDC 2019)
- 2.4 million hepatitis C (CDC 2018)
- 100,000 drug overdose deaths (CDC 2022)
  - 43,250 breast cancer deaths (ACS 2022)

this is a primary care issue

https://www.cdc.gov/diabetes/data/statistics-report/index.html; https://www.samhsa.gov/data/release/2020-national-survey-drug-use-and-health-nsduh-releases; https://www.cancer.org/cancer/breast-cancer/about/how-common-is-breast-cancer.htmlhttps://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm; https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/Hepatitis-c-by-the-numbers.pdf

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- Understand the urgency of the opioid epidemic
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- Recognize the important role of buprenorphine as the *life-saving foundation* of OUD treatment

Medications for OUD

Harm Reduction

Psychosocial Interventions

Medication for Opioid Use Disorder

Recovery Support

Housing, Employment, Mental Healthcare

Medications for OUD

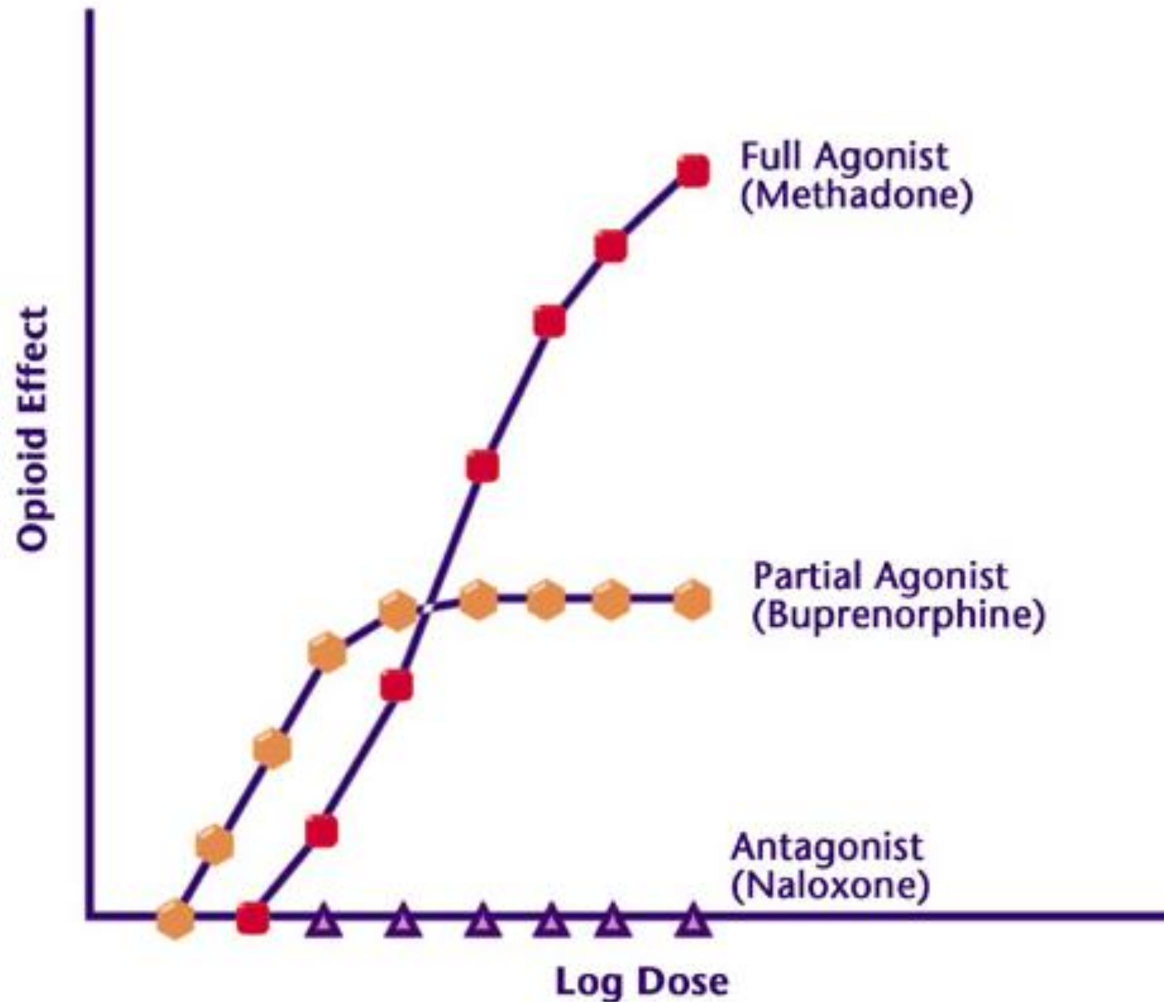
Opioid Agonist Therapy

- Methadone
- Buprenorphine

Opioid Antagonist

- Extended-release Naltrexone

Medications for OUD



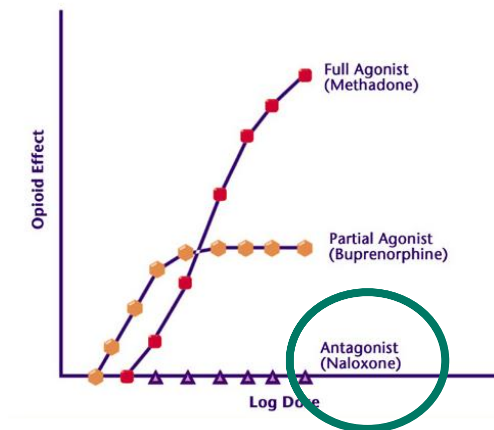
naabt.org

Medications for OUD: Antagonist

Opioid Antagonist

Extended-release Naltrexone

- Once monthly intramuscular injection
- Blocks intoxicating/reinforcing effects of opioids
- High rates of return to use
- *Increased risk of overdose after antagonist wears off*
- *No evidence that saves lives*



Binswanger & Glanz Drug Safety 2018; Drake et al. Addiction 2019; Lee et al. NEJM 2016; Lee et al. Lancet 2018; Morgan et al. Drug & Alc Depend 2019; Tanum et al. JAMA Psych 2017; Wakeman et al. JAMA Network Open 2020.

Medications for OUD: Opioid Agonist

Opioid Agonist Therapy

Methadone	Buprenorphine

Reduce withdrawal symptoms & cravings
→ prevent return to use → allow brain to heal

↓**MORTALITY** ↓ ER/hospital ↓ HIV/HCV ↓ substance use
↓ criminal activity ↑retention in treatment

Amato et al. Cochrane 2011; Cunningham et al. J Subs Abuse Treat 2013; Fiellin et al. NEJM 2006; Fiellin et al. JAMA 2014; Kakko et al. Lancet 2003; Mattick et al. Cochrane 2009; Mayet et al. Cochrane 2010; National Academies of Sciences, Engineering and Medicine 2019; SAMHSA Tip 63; Sordo et al. BMJ 2017; Tsui et al. JAMA 2014; Wakeman et al. JAMA Network Open 2020.

Sordo et al. BMJ 2017; 357

STUDY POPULATION

- 19 cohort studies
- Methadone: 122,885 people, 1.3-13.9 yrs
- Bupe: 15,831 people, 1.1-4.5 yrs

STUDY DESIGN

- Systematic review and meta-analysis
- Medline, Embase, PsycINFO, LILACS to Sept 2016
- Cohort studies of opioid dependence, reporting deaths on & off methadone or buprenorphine; excluded other designs, review articles, absence of mortality data, incarcerated or recently released

RESULTS/CONCLUSIONS

- Methadone all cause mortality:
  - In treatment: 11.3 per 1000 person years
  - Out of treatment: 36.1 per 1000 person years
  - *All cause mortality 3.2 times lower in treatment*
- Methadone overdose mortality:
  - In treatment: 2.6 per 1000 person years
  - Out of treatment: 12.7 per 1000 person years
  - *Overdose mortality 4.8 times lower in treatment*

- Buprenorphine all cause mortality:
  - In treatment: 4.3 per 1000 person years
  - Out of treatment: 9.5 per 1000 person years
  - *All cause mortality 2.2 times lower in treatment*
- Buprenorphine overdose mortality:
  - In treatment: 1.4 per 1000 person years
  - Out of treatment: 4.6 per 1000 person years
  - *Not statistically significant*

methadone & buprenorphine save lives

Wakeman et al. JAMA Network Open 2020; 3(2)

STUDY POPULATION

- Deidentified claims from Optum Labs Data Warehouse & Medicare Advantage 2015-2017
- 40,885 individuals with OUD, mean age 47, 54% M
- 59% nonintensive behavioral health, 16% detox/residential services, 12.5% methadone/bupe, 4.8% intensive behavioral health, 2.4% naltrexone

STUDY DESIGN

- Retrospective, comparative effectiveness research study
- Exposure: 6 mutually exclusive treatment pathways: no treatment, inpatient detox or residential services, intensive behavioral health, bupe or methadone, naltrexone, nonintensive behavioral health
- Outcomes: opioid-related overdose or serious acute care use during 3 and 12 mo after initial treatment

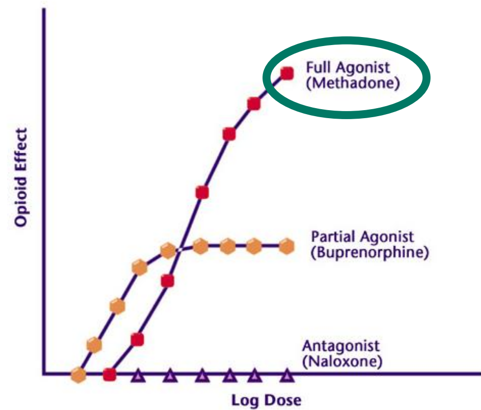
RESULTS/CONCLUSIONS

- 1.7% (707) experienced overdose, 1.9% (773) serious opioid-related acute care use
- Bupe/methadone the ONLY treatment that reduced risk of overdose: 75% at 3mo, 60% at 12mo
- Bupe/methadone the ONLY treatment that reduced serious opioid-related acute care use: 30% at 3mo, 25% at 12mo

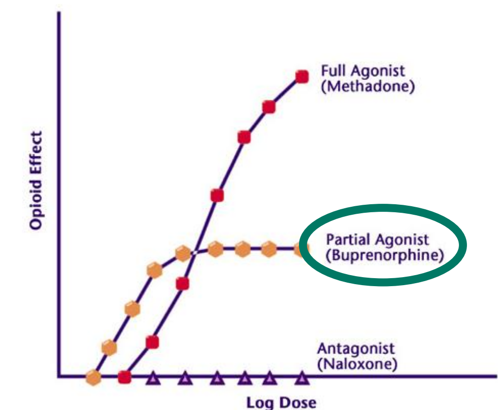
Table 2. Adjusted Hazard Ratios for Overdose and Serious Opioid-Related Acute Care Use by Initial Treatment Group Compared With No Treatment[a]

Variable	Adjusted Hazard Ratio (95% CI) 3 Months	12 Months
Overdose		
No treatment	1 [Reference]	1 [Reference]
Inpatient detoxification or residential services	0.82 (0.57-1.19)	1 (0.79-1.25)
BH IOP	0.81 (0.50-1.32)	0.75 (0.56-1.02)
MOUD treatment with buprenorphine or methadone	0.24 (0.14-0.41)	0.41 (0.31-0.55)
MOUD treatment with naltrexone	0.59 (0.29-1.20)	0.73 (0.48-1.11)
BH other	0.92 (0.67-1.27)	0.69 (0.56-0.85)
ED or inpatient stay		
No treatment	1 [Reference]	1 [Reference]
Inpatient detoxification or residential services	1.05 (0.76-1.45)	1.20 (0.96-1.50)
BH IOP	0.84 (0.54-1.30)	0.90 (0.67-1.20)
MOUD treatment with buprenorphine or methadone	0.68 (0.47-0.99)	0.74 (0.58-0.95)
MOUD treatment with naltrexone	1.15 (0.69-1.92)	1.07 (0.75-1.54)
BH other	0.59 (0.44-0.80)	0.60 (0.48-0.74)

Opioid Agonist Therapy



Methadone	Buprenorphine
Full agonist	**Partial agonist**
Typical dose 80-120mg/d	**Typical dose 16mg/d**
Opioid Treatment Program (daily dosing)	**Office based (prescription)**
Stigma	**Managed like any other chronic illness**
More risky, especially during induction phase	***Protected from overdose (ceiling effect, tight bond)***
Better for patients who need structure, heavier opioid use	**PRIMARY treatment for most patients with OUD**



Stock photos; naabt.org

Addiction

- Escalating use over time
- Loss of control; inability to stop
- Use despite negative consequences
- Unable to fulfill societal obligations

Dependence

- Presence of withdrawal symptoms if substance stopped abruptly

*Methadone and buprenorphine result in physical dependence but **not** addiction.*

Slide credit: Dr. John Giftos, Clinical Director, SUD Treatment, Correctional Health Services Rikers Island, NYC Health & Hospitals

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Going back to our case...

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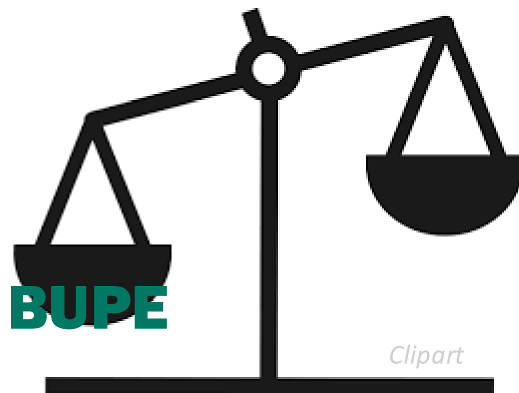
- Labs:
  - UDS: + marijuana, opiates
  - Rapid HIV neg, rapid HCV pos
- PDMP: no controlled substances

25yo w depression, severe OUD & occasional meth/alcohol/benzo

Office-based Buprenorphine Therapy

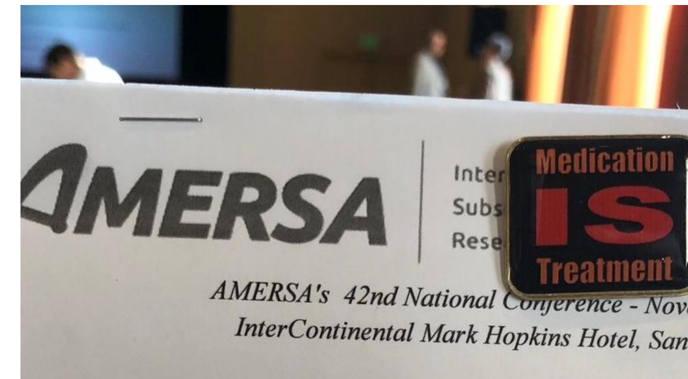
- Is this person a candidate for office-based buprenorphine therapy?
  - YES!
- Should we start them today?
  - YES!
- Are they too complex for office-based treatment?
  - NO!



Bupe + benzo/alcohol *always* safer than heroin (or fentanyl) + benzo/alcohol
Polysubstance use the norm

Office-based Buprenorphine Therapy

- Bupe is a *life-saving* medicine
- It is THE primary treatment for OUD
- It is safe and effective because
  - Ceiling effect
  - Strong affinity
  - Slow onset of action
  - Long half life
  - Combined with naloxone
- It is NOT replacing one drug with another; someone is in treatment, in recovery, abstinent, SOBER when taking bupe
- Treatment is long-term – likely years.



National Academies 2019; Sordo et al. BMJ 2017; 357; SAMHSA TIP 63 2021; Wakeman et al. JAMA Netw Open 2020; 3(2); personal photo

Logistics

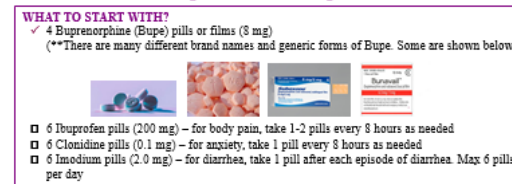
- *DATA 2000 X-waivered prescriber*
  - *Register: https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner*
  - *Training if prescribe to >30 patients*
- Treatment goals
  - May not be abstinence
- Treatment agreement
- Prescription drug monitoring program
- Labs: urine drug screen, Hep B, Hep C, HIV, liver tests
- NALOXONE for reversal of opioid overdose

Logistics: Induction Goals

1. Prevent precipitated withdrawal
   - Buprenorphine binds tightly to opioid receptor (high affinity)
   - Will push off & replace full agonist opioids, causing sudden and intense withdrawal
   - Precipitated withdrawal not dangerous, but should be avoided
2. Identify therapeutic dose

STARTING BUPRENORPHINE ("Bupe" or "Suboxone")
Congratulations on starting treatment!

WHAT TO START WITH?
- ✓ 4 Buprenorphine (Bupe) pills or films (8 mg)
  (**There are many different brand names and generic forms of Bupe. Some are shown below.)



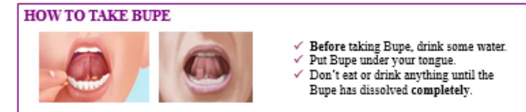
- ☐ 6 Ibuprofen pills (200 mg) – for body pain, take 1-2 pills every 8 hours as needed
- ☐ 6 Clonidine pills (0.1 mg) – for anxiety, take 1 pill every 8 hours as needed
- ☐ 6 Imodium pills (2.0 mg) – for diarrhea, take 1 pill after each episode of diarrhea. Max 6 pills per day

WHEN AM I READY TO START BUPE?
- ✓ Use the list of symptoms below to see when you are ready to start Bupe.
- ✓ Wait until you have **at least 5 symptoms** to start Bupe. If you don't have 5 symptoms, wait a bit longer and review the symptoms again. It is very important that you wait until you feel at least 5 symptoms before starting Bupe! To be sure that you are ready to start, it's best to have at least 1 of the 5 symptoms in the grey shaded area.

Symptoms	Do I have this?
I feel like yawning	☐ Yes
My nose is running	☐ Yes
I have goose bumps	☐ Yes
My muscles twitch	☐ Yes
My bones & muscles ache	☐ Yes
I have hot flashes	☐ Yes
I'm sweating	☐ Yes
I feel unable to sit still	☐ Yes
I am shaking	☐ Yes
I feel nauseous	☐ Yes
I feel like vomiting	☐ Yes
I have cramps in my stomach	☐ Yes
I feel like using	☐ Yes

THINGS *NOT TO DO* WITH BUPE
- DON'T use Bupe when you are high—it will make you dope sick!
- DON'T use Bupe with alcohol –this combination is **not safe**.
- DON'T use Bupe with benzos (like Xanax ("sticks"), Klonopin, Valium, Ativan) unless prescribed by a doctor who knows you are taking Bupe.
- DON'T use Bupe if you are taking pain killers until you talk to your doctor.
- DON'T use Bupe if you are taking more than 60 mg of methadone.
- DON'T swallow Bupe – it gets into your body by melting under your tongue.
- DON'T lose your Bupe – it can't be refilled early.

HOW TO TAKE BUPE



- ✓ **Before** taking Bupe, drink some water.
- ✓ Put Bupe under your tongue.
- ✓ Don't eat or drink anything until the Bupe has dissolved **completely**.

PLAN
- Use your last heroin / methadone / pain pill: ____________________
- When you have at least 5 symptoms from the list, then you are ready to start.
- Start with ______ pill or film under your tongue.
- Wait ______ minutes.
- If you feel the same or just a little better, then take another______ pill or film
- Wait 2 hours – if you still feel sick or uncomfortable, take another _______ pill or film.

PROBLEMS? QUESTIONS?
- Call ____________ at ___________________.
- Call ____________ if you still feel sick after taking a total of _____ pills or film (____ mg).

NEXT STEPS
- Appointment with _____________ at ________________________
- Appointment with Dr. _____________ at ________________________

WHAT I TOOK

	Time	Amount of pills or films
Day 1	______am / pm	_______
	am / pm	
	______am / pm	_______
	______am / pm	_______
Day 2	______am / pm	_______
	am / pm	
	______am / pm	_______
	______am / pm	_______
Day 3	______am / pm	_______
	______am / pm	_______
	______am / pm	_______

Unpublished protocol, Cunningham et al, Montefiore Medical Center, Bronx, NY 2018

Logistics: Induction Approaches

Traditional Home Induction

- Mild to moderate withdrawal
- Supportive medications
- Increase dose over a few days
- Max dose 24mg/day

Microdosing

- No need for withdrawal or supportive medications
- Start very low and increase doses over a week
- Stop illicit or prescribed opioid once buprenorphine dose high enough that displaced most of full agonist opioid (typically around 10-12mg)
- Max dose 24mg/day

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Buprenorphine dose	0.5mg daily	0.5mg BID	1mg BID	2mg BID	4mg BID	4mg TID	8mg BID
Film size	2mg	2mg	2mg	2mg	2mg	2mg	8mg
Morning dose							
Afternoon Dose							
Night dose							
Full agonist	Continue	Continue	Continue	Continue	Continue	Continue	STOP

BID=twice per day
TID=Three times per day
A Dosing Guide for an example low dose initiation regimen

Cunningham et al. J Subst Abuse Treat 2011; Lee et al. JGIM 2008; Martin et al. Annals 2018; SAMHSA Tip 63 2021SAMHSA Tip 63 2021; http://pcssnow.org/wp-content/uploads/2015/01/Models-of-Buprenorphine-Induction.pdf; Cohen et al. J Addict Med 2022; 16(4); stock photos

Logistics: Follow-up

- Follow closely initially to help set patient up for success
- Follow up visits can be combination of virtual and in-person
  - Typically see twice during first week
  - Once per week for a few weeks
  - Once every two weeks for a month or two
  - Once monthly
- Drug testing most visits initially, then as needed
- Prescribe BEYOND follow up date
  - Dangerous to run out
  - Anxiety-provoking
  - Allows flexibility – transportation, childcare, work

Going back to our case…

- Micro-dosing or traditional home induction appropriate
- Given drug of choice heroin and recently supply largely contaminated w fentanyl, microdosing may be easier
- Regardless of approach, close follow up initially
  - But appreciating that too many hoops could preclude success – and buprenorphine is a safe and life-saving medication
- OUD is a chronic disease
  - Returns to use do not mean treatment failure; they are expected! And protected from overdose if on bupe
  - Polysubstance use the norm
  - Offer counseling and psychosocial supports, but patient choice

Disparities in Access

- <15% of patients with active OUD receive medications
- Most providers who obtain X waiver do not use it; those who use it, do not prescribe to full ability
- Access differs by race
  - 77% lower likelihood of buprenorphine prescription if black
- Access differs by gender & pregnancy status
  - Only 50% pregnant persons with OUD receive MAT
  - Women less likely to utilize treatment than men

Andrilla et al. J Rural Health 2019; 35; Huhn & Dunn. J Subst Abuse Treat 2017; 78; Krawczyk et al. Int J Drug Policy 2022 online; Lagisetty et al. JAMA Psych 2019; 76(9); Lanham et al. JAMA Network Open 2022; 5(5); Office on Women's Health 2017 Report; Schiff et al JAMA Network Open 2020; 3(5).

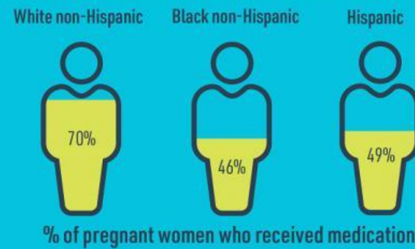
Disparities in Access

Significant Racial and Ethnic Disparities Exist in the Use of Medication to Treat Opioid Use Disorder in Pregnancy in Massachusetts

Schiff, DM et al. JAMA Network Open, 2020; 3(5)
DOI:10,1001/jamanetworkopen.20205734

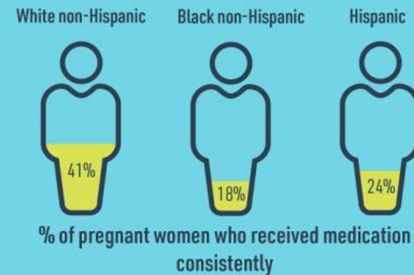
Importance: The use of medications, such as methadone or buprenorphine, for the treatment of opioid use disorder (OUD) has been associated with improvements in the outcomes of mothers and infants; however, only half of all pregnant women with OUD receive these medications.

Question: Do differences by maternal race and ethnicity exist in the use of methadone and buprenorphine medications for the treatment of opioid use disorder during pregnancy?



% of pregnant women who received medication

In adjusted models, Black non-Hispanic women and Hispanic women were **58-63% less likely to receive any medications** to treat opioid use disorder compared to white non-Hispanic women in pregnancy.



% of pregnant women who received medication consistently

In adjusted models, Black non-Hispanic women and Hispanic women were **66-76% less likely to consistently receive medication** to treat opioid use disorder compared to white non-Hispanic women in pregnancy

BOTTOM LINE

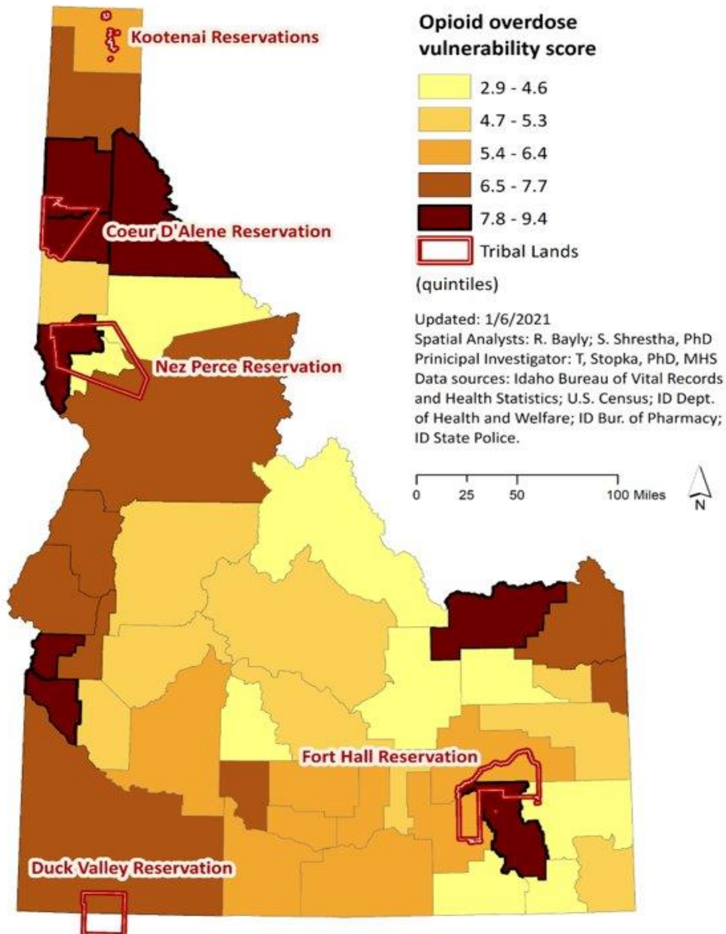
Significant racial and ethnic disparities exist in prenatal use of medication for OUD. Further investigation needed to explore factors associated with inequitable access to and receipt of medication.

Disparities in Access

- Access differs by geography
  - About half of rural counties across the US lack waivered provider; in 2017, ~1/3 rural Americans lived in county without buprenorphine prescriber
  - More urban than rural pharmacies; only ~75% stock buprenorphine
    - 1/5 pharmacies in counties with high overdose mortality do not dispense buprenorphine
- Dramatic increase in buprenorphine prescribers in Idaho
  - 314 listed in SAMHSA treatment locator but still limited access

Andrilla et al. J Rural Health 2019; 35; Kazerouni et al. Drug Alcohol Depend 2021; 224; Lagisetty et al. JAMA Psych 2019; 76(9); https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator

Idaho: Opioid Overdose Vulnerability



Results: Vulnerability Assessment

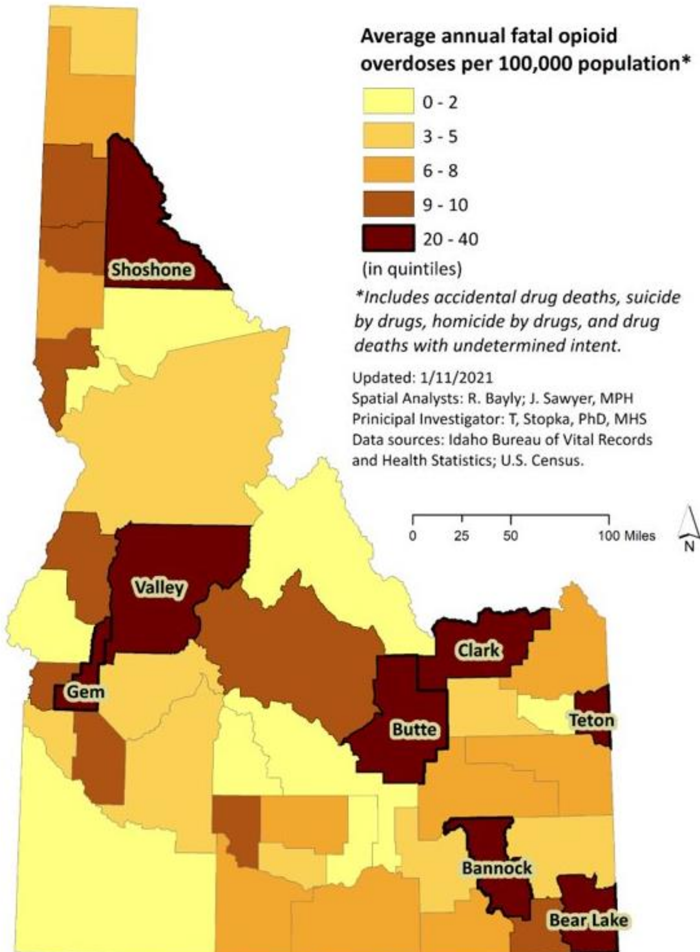
Opioid overdose vulnerability quintiles (alphabetical)

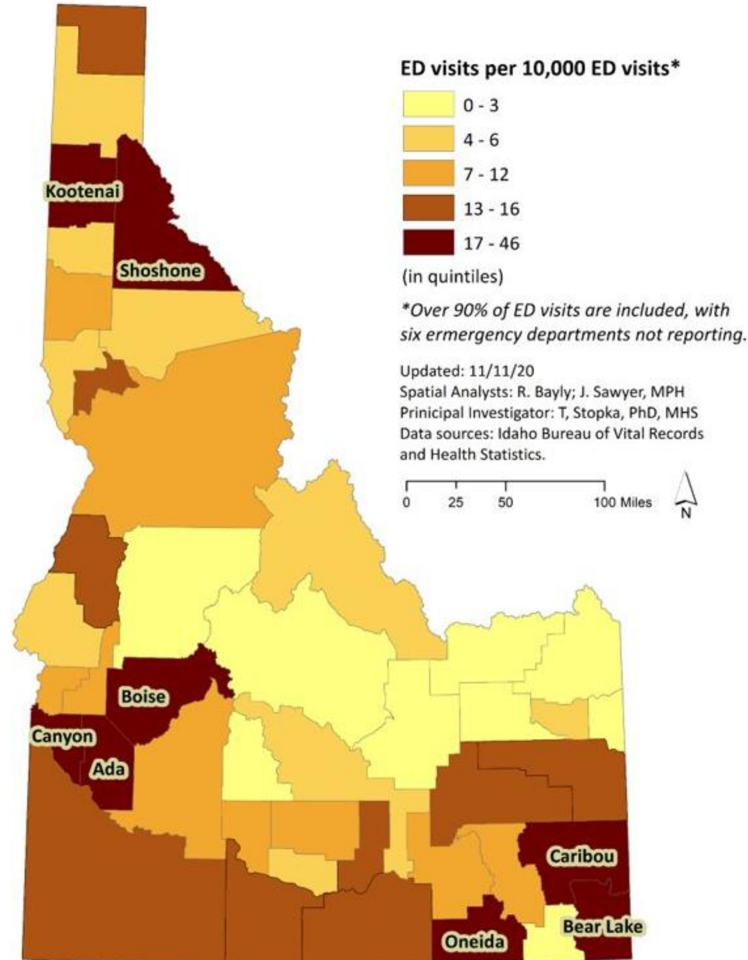
Most ← → Least

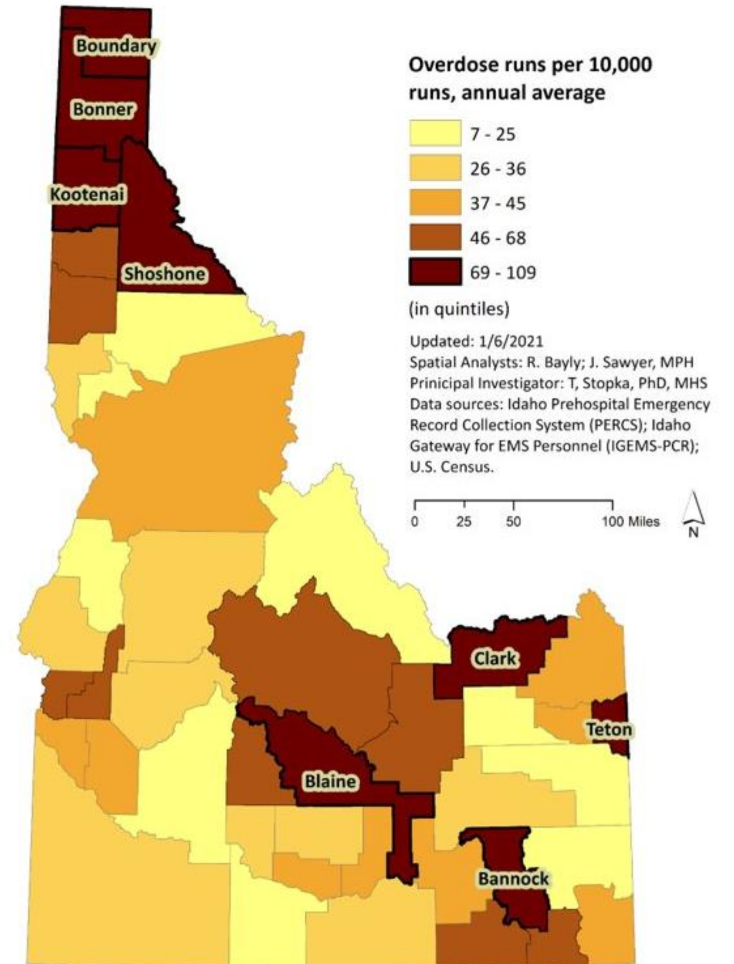
Bannock	Adams	Bingham	Ada	Butte
Benewah	Bonner	Boundary	Bear Lake	Camas
Canyon	Fremont	Cassia	Blaine	Caribou
Clark	Gem	Elmore	Boise	Clearwater
Kootenai	Gooding	Jerome	Bonneville	Franklin
Nez Perce	Idaho	Lincoln	Custer	Jefferson
Payette	Owyhee	Minidoka	Latah	Lemhi
Shoshone	Teton	Power	Madison	Lewis
	Washington	Twin Falls	Valley	Oneida

Bayly et al. Idaho Opioid Overdose Vulnerability Assessment, January 2021.

Idaho: Opioid Overdose Vulnerability







Bayly et al. Idaho Opioid Overdose Vulnerability Assessment, January 2021.

Idaho: Opioid Overdose Vulnerability

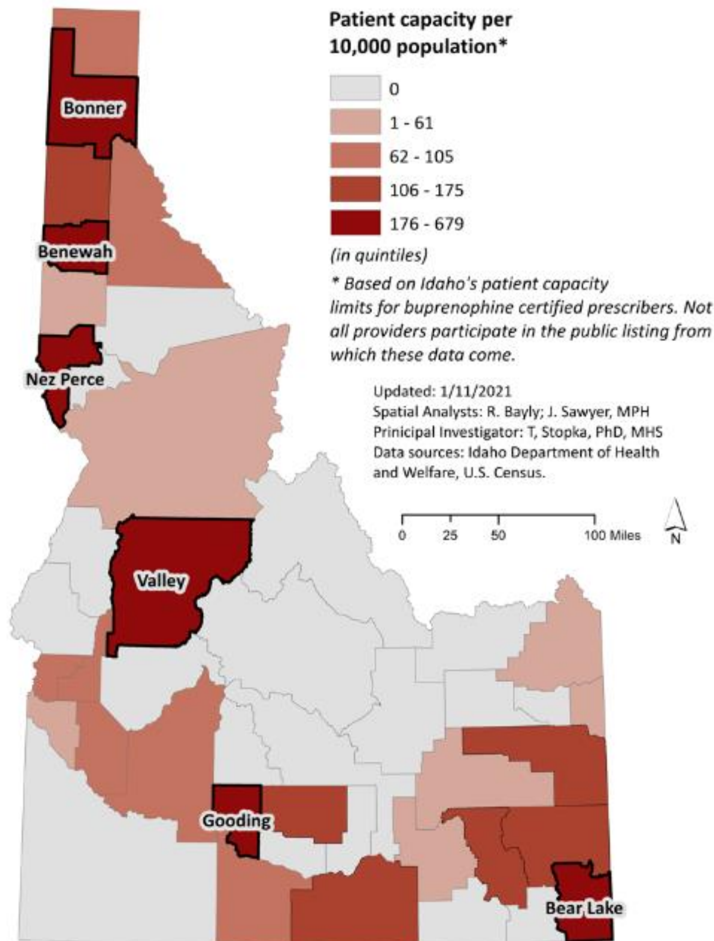


Figure 7. Buprenorphine prescription capacity, Idaho counties, 2020

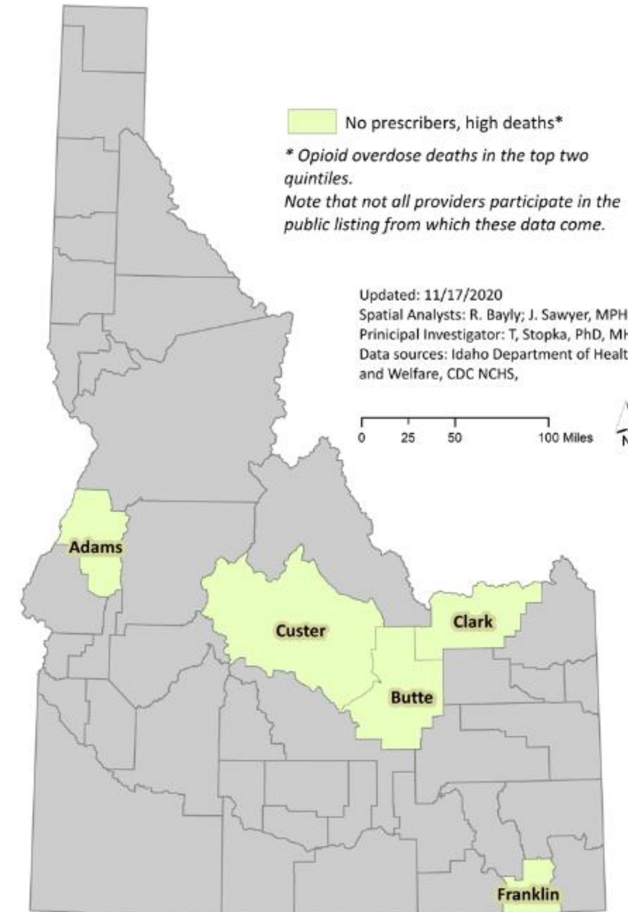
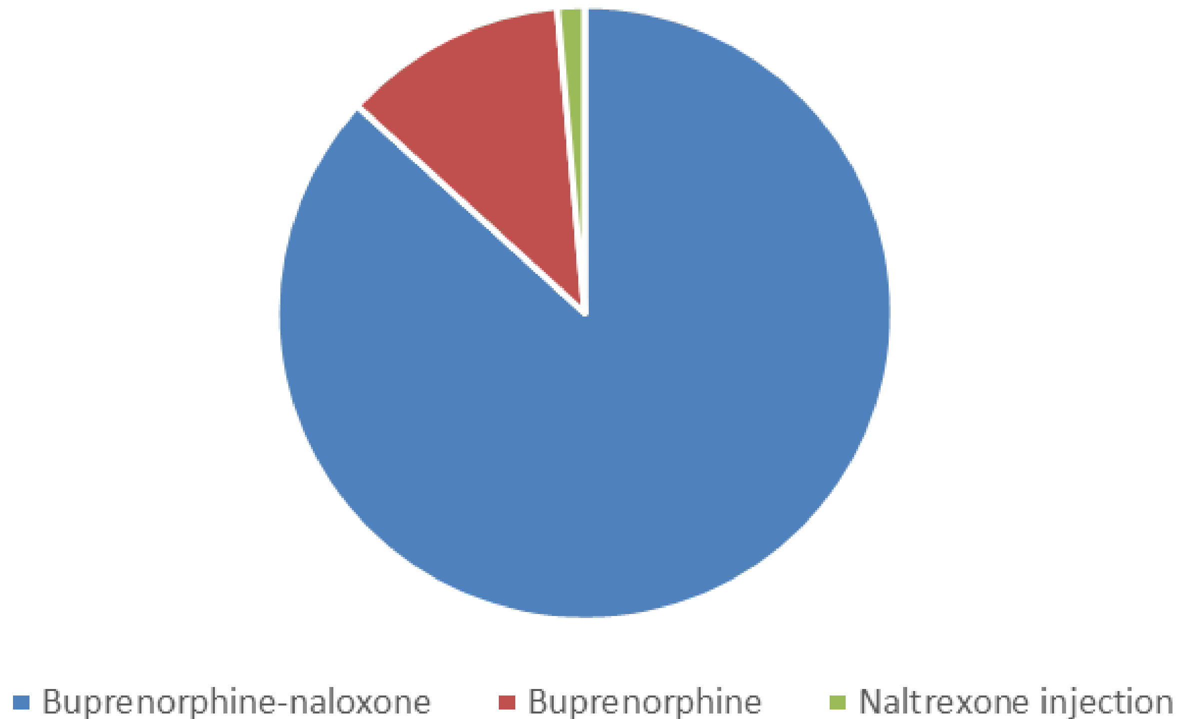


Figure 10. High opioid death rates, but no medication for opioid use disorder prescribers, 2020

Bayly et al. Idaho Opioid Overdose Vulnerability Assessment, January 2021.

Idaho Medicaid

- Participants with IBHP (Optum) claim related to OUD 4/2020-3/2021
  - 2435 participants
    - 505 Opioid Treatment Program
    - 1013 Any Prescription for MOUD
    - 56 BOTH OTP and prescription
    - 861 NO MAT



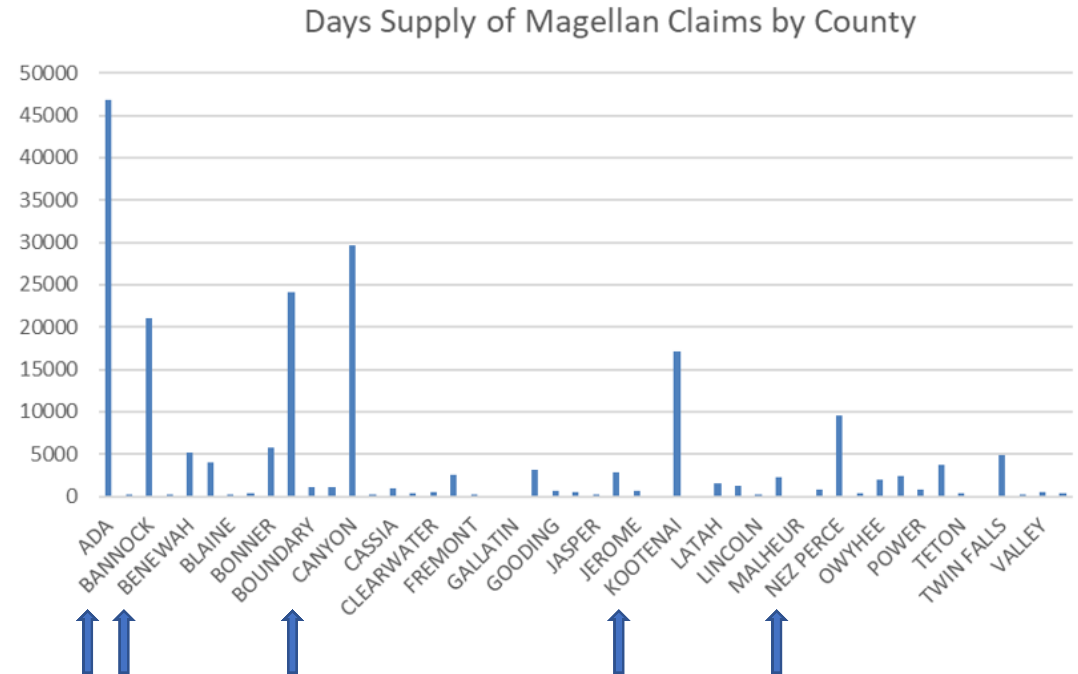
65% of patients

Time on MOUD Apr 2020-Mar 2021

- 1157 participants*
  - 727 participants > 90 days
  - 235 participants 30-89 days
  - 195 participants <30 days
- 62% > 3 months of treatment!

1013 + 88 rx before Apr 2020 + 56 OTP & rx = 1157

MOUD by County



Clark, Payette, Shoshone no prescriptions

Medicaid Interventions

- Expanded access to naloxone
- No prior authorization for buprenorphine
- MOUD at OTPs available through IBHP (Optum) 1/1/2021
- Expanded staff through collaboration
  - Division of Public Health-funded pharmacists focused on safe opioid prescribing
  - Addiction Medicine Fellow volunteers
- Coming soon
  - Telephone-based case management program for pregnant persons w SUD
  - Residential SUD

Learning Objectives

- Understand the urgency of the opioid epidemic
- Define and diagnose opioid use disorder (OUD)
- Describe the evidence for medications for OUD
- Recognize the important role of buprenorphine as the *life-saving foundation* of OUD treatment
- Identify persons likely to benefit from buprenorphine
- Review logistics of prescribing buprenorphine
- Apply the principles of harm reduction to OUD treatment
- Recognize the role of *low-threshold buprenorphine* in halting the opioid epidemic

UPLIFT THE VOICES AND EXPERIENCES OF PEOPLE WHO USE DRUGS

NATIONAL
HARM REDUCTION
COALITION

Harm reduction begins by listening without judgment. We spent months talking to dozens of people who use drugs across various communities in San Francisco. We spoke to people at various intersects who may be impacted by overdose in a spectrum of ways.

Harm Reduction

- Meeting patients where they are at
- Providing person-centered care
- Understanding the continuum of substance use
  - Returns to use are common
  - Abstinence may not be feasible
- Facilitating access to life-saving medication
  - Weigh benefits of refilling without appointment against harms
  - Weigh benefits of requiring counseling against harms
  - Weigh benefits of referring to higher level of care against harn

Jakubowski & Fox. J Addict Med 2020; 14(2); Martin et al Ann Intern Med 2018; 169; Wakeman et al. JAMA 2020; 323(20).

Low Threshold Buprenorphine

- Eliminate barriers
- Make life-saving medication for OUD accessible
- Four key principles
  1. Same-day treatment entry
  2. Harm reduction approach
  3. Flexibility
  4. Wide availability

Jakubowski & Fox. J Addict Med 2020; 14(2); Martin et al Ann Intern Med 2018; 169; Wakeman et al. JAMA 2020; 323(20).

Going back to our case…

1. Same-day treatment entry
   - Prescribe the day of diagnosis & treatment request!
2. Harm reduction approach
   - Bupe + benzo safer than heroin/fentanyl + benzo
   - Polysubstance use the norm; may not be ready for complete sobriety
   - May not be interested/able to pursue behavioral treatments
3. Flexibility
   - Flexible appointment times/modalities
   - Understand impacts of transportation, childcare & work obligations
4. Wide availability
   - Bringing treatment TO patients
   - Moving treatment OUT of traditional healthcare facilities

Learning Objectives

- Understand the urgency of the opioid epidemic
- Define and diagnose opioid use disorder (OUD)
- Describe the evidence for medications for OUD
- Recognize the important role of buprenorphine as the *life-saving foundation* of OUD treatment
- Identify persons likely to benefit from buprenorphine
- Review logistics of prescribing buprenorphine
- Apply the principles of harm reduction to OUD treatment
- Recognize the role of *low-threshold buprenorphine* in halting the opioid epidemic
- Review local resources & call to action!

Summary

- We are in the midst of a COVID pandemic and opioid overdose epidemic
- Buprenorphine is a life-saving treatment for OUD
- Almost all persons with OUD qualify for office-based buprenorphine therapy
- Approach treatment through a harm reduction lens
    - Buprenorphine is life-saving
    - Stopping (or not starting) buprenorphine can be dangerous
    - Be as flexible as possible – too many requirements can cause harm
- Primary care and all behavioral health treatment providers need to embrace buprenorphine as the cornerstone (primary part!) of OUD treatment
- Save a life – many lives! – by facilitating access to buprenorphine

Call to Action this Addiction Treatment Week

1. Ask all your patients with OUD if they are taking MOUD; if not explore why & connect to care
2. Carry naloxone!
3. Encourage all prescribers to obtain X-waiver
   - *No training required for 30 patients or fewer*
   - *https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner*
4. Check out Project ECHO Idaho: https://www.uidaho.edu/academics/wwami/echo
5. Check out your local syringe services program: https://hshslocator.dhw.idaho.gov/prevent/default.aspx
6. Continue the work you are already doing to reduce stigma; use person-first language & normalize medications.

National Addiction Treatment Week

NIDA

Stock photo

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