WELCOME!

Today’s Topic:

Harm Reduction Strategies in OUD Patients:

The Meds-First model of care for opioid use disorder

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PANELISTS:
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THE MEDS-FIRST MODEL OF CARE FOR OPIOID USE DISORDER

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University of Washington
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GENERAL DISCLOSURES

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GENERAL DISCLOSURES

UW PACC is also supported by Coordinated Care of Washington
CONFLICT OF INTEREST DISCLOSURE

I have no conflicts of interest to report.
I have never received funding from pharmaceutical companies.

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OUTLINE

• Opioid prescribing
• Adolescent misuse
• Illicit supply- police evidence testing
• Treatment utilization
• Fatal overdoses
• OUD overview and recent MOUD effectiveness research
• Opioid injectors’ experiences and service needs
• Expanding OUD treatment options, care settings and models of care
Washington State Opioid/Major Drug Interactive Data

This site offers a series of interactive data charts and maps featuring Washington state data related to overdose deaths, treatment admissions, statewide opioid sales, and police evidence testing data for opioids and other drugs.

Find data by:

- Geography
- Drug Type
- Indicator/Source

Acknowledgments

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We thank the following for data access:

- King County Medical Examiner
- Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery
- Center for Health Statistics, Washington State Department of Health
- Washington State Patrol Forensic Laboratory Services Bureau
- US Drug Enforcement Agency ARCOs database
- Washington State Office of Financial Management
- Washington State Department of Health Prescription Monitoring Program
- American Community Survey, US Census Bureau
- Looking Glass Analytics
- Washington State Liquor and Cannabis Board

ADAI thanks our geocoding partner, Texas A&M Geoservices.

We thank ColorBrewer for color palette assistance, used on many of our time-series plots.

Icon made by Gregor Cresnar from www.flaticon.com, licensed by CC 3.0 BY.
The total number of daily doses of opioids sold to hospitals and pharmacies in WA State peaked in 2011 at 112 million, declining to 90 million in 2017.
OPIOID-RELATED OVERDOSE DEATHS 2000–2017*

Source: DOH Death Certificates (Note: prescription opioid overdoses exclude synthetic opioid overdoses)
*Data for 2017 are preliminary as of 8/23/2018.
**Opiate use**

**Opiate dependent**

**DIS-ORDER**
- Social problems
  - Relationships
  - Work
  - Crime/Prison/Jail
- Thinking problems
  - Craving
  - Most important thing in life

**Medications**-buprenorphine/methadone

**Social support**

**Counseling**

**PROS:**
- Strong overdose protection
- Some report feeling “normal,” addresses cravings

**CONS:**
- May be side effects
- Some settings not supportive
- Can be intensive care
Background: Opioid overdose survivors have an increased risk for death. Whether use of medications for opioid use disorder (MOUD) after overdose is associated with mortality is not known.

Objective: To identify MOUD use after opioid overdose and its association with all-cause and opioid-related mortality.

Design: Retrospective cohort study.

Setting: 7 individually linked data sets from Massachusetts government agencies.

Participants: 17,568 Massachusetts adults without cancer who survived an opioid overdose between 2012 and 2014.

Measurements: Three types of MOUD were examined: methadone maintenance treatment (MMT), buprenorphine, and naltrexone. Exposure to MOUD was identified at monthly intervals, and persons were considered exposed through the month after last receipt. A multivariable Cox proportional hazards model was used to examine MOUD as a monthly time-varying exposure variable to predict time to all-cause and opioid-related mortality.
Results:

- In the 12 months after a nonfatal overdose, 2040 persons (11%) enrolled in MMT for a median of 5 months (interquartile range, 2 to 9 months), 3022 persons (17%) received buprenorphine for a median of 4 months (interquartile range, 2 to 8 months), and 1099 persons (6%) received naltrexone for a median of 1 month (interquartile range, 1 to 2 months).

- Among the entire cohort, all-cause mortality was 4.7 deaths (95% CI, 4.4 to 5.0 deaths) per 100 person-years and opioid-related mortality was 2.1 deaths (CI, 1.9 to 2.4 deaths) per 100 person-years.

- Compared with no MOUD, MMT was associated with decreased all-cause mortality (adjusted hazard ratio [AHR], 0.47 [CI, 0.32 to 0.71]) and opioid-related mortality (AHR, 0.41 [CI, 0.24 to 0.70]).

- Buprenorphine was associated with decreased all-cause mortality (AHR, 0.63 [CI, 0.46 to 0.87]) and opioid-related mortality (AHR, 0.62 [CI, 0.41 to 0.92]).

- No associations between naltrexone and all-cause mortality (AHR, 1.44 [CI, 0.84 to 2.46]) or opioid-related mortality (AHR, 1.42 [CI, 0.73 to 2.79]) were identified.

Limitation: Few events among naltrexone recipients preclude confident conclusions.

Conclusion: A minority of opioid overdose survivors received MOUD. Buprenorphine and MMT were associated with reduced all-cause and opioid-related mortality.
Despite what we may hear, see and believe: most people with substance use disorders do NOT want to be using drugs and alcohol in a harmful way.

2017 WA State Syringe Exchange Survey

http://adai.uw.edu/pubs/pdf/2017syringeexchangehealthsurvey.pdf

Figure 9. Interest in reducing/stopping use of main drug, among those not in treatment

Interest in reducing opioid use, heroin is main drug (n=552)

- Very: 55%
- Somewhat: 23%
- Not sure: 8%
- Not interested: 14%

Dots randomly placed in reported ZIP Code
16 (of 1079) missing due to missing or unmatchable ZIP Code
Most people use multiple drugs
Many are homeless
Some can’t engage in counseling
  - Anxiety, trauma...

2017 WA State Syringe Exchange Survey
http://adai.uw.edu/pubs/pdf/2017syringeexchangehealthsurvey.pdf
What treatment options would you be interested in if they were easy to get?

- Pain treatment: 1%
- Don't want or need help: 3%
- Other: 6%
- Inpatient: 34%
- Mental health care medications: 37%
- Outpatient: 41%
- 1:1 counseling for addiction: 44%
- Detox: 45%
- Treatment Medications: 70%
- Methadone: 38%
- Buprenorphine: 39%
- Naltrexone: 4%
POTENTIAL “FRONT DOORS” TO CARE

“After 3 appointments over 3 weeks we can get you started on treatment medications.”

“Let’s see if we can get you started on treatment medications this afternoon.”
Review

Opioid substitution therapy: Lowering the treatment thresholds

Georgios Kourounis a, b, Brian David Wensley Richards a, b, Evdokia Kyprianou c, Eva Symeonidou c, Minerva-Melpomeni Malliori d, Lampros Samartzis a, b ø, ❇

Show more

https://doi.org/10.1016/j.drugalcdep.2015.12.021
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<th>High threshold treatment design</th>
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<td>Admission criteria</td>
<td>Inflexible</td>
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<td>Treatment design</td>
<td>Universally the same for all patient groups</td>
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<td>Standard and limited</td>
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# TREATING OPIOID USE DISORDER WITH AGONIST MEDICATION(S)

## CHANGING SETTINGS, MODELS, POPULATIONS

<table>
<thead>
<tr>
<th>Setting</th>
<th>Type</th>
<th>Clients</th>
<th>Requirements</th>
<th>Facilities</th>
<th>Care Services</th>
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</thead>
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<tr>
<td><strong>OPIOID TREATMENT PROGRAM</strong></td>
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<td>High needs*</td>
<td>High requirements</td>
<td>Large facilities</td>
<td>Counseling req.</td>
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<tr>
<td><strong>OFFICE BASED OPIOID TREATMENT</strong></td>
<td>Lower needs</td>
<td>Moderate requirements</td>
<td>Facilities vary</td>
<td>Counseling may be required somewhere</td>
<td>Nurse care manager</td>
</tr>
<tr>
<td><strong>NON-OFFICE BASED (Non-care Seeking clients) OPIOID TREATMENT</strong></td>
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<td>Facilities vary</td>
<td>Public health (SF)</td>
<td>Nurse care manager</td>
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<td>Emergency Dept. (Yale, being replicated)</td>
<td>Care navigator</td>
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<td>Syringe exchange (NY past/Seattle now)</td>
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<td>Jail/Prison (increasing)</td>
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<td>Drop in center (Seattle)</td>
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</tbody>
</table>

*High needs is typical- 85% poly-substance use, substantial % homeless

This figure is a generalization to show the evolution of care.

Yellow text indicates service that substantially increases capacity/uptake
MEDICATION-FIRST MODEL
ESSENTIAL ELEMENTS

Medication-first-treatment generally involves:
• drop-in visits,
• short time to medication start,
• poly-substance use allowed initially and ongoing,
• no counseling or support group mandates, always offered
• regular urinalysis
  – to document buprenorphine adherence and understand other ongoing substance use.
MEDICATION FIRST MODEL-
VARIABLE PROGRAM COMPONENTS

• **Duration**-Programs may provide time limited or ongoing care.

• **Settings**- Primary care, “treatment agencies”, behavioral health, E.D., community settings

• **Community based Meds First**-Where people already get other care and have trusting relationships.
  – These are people who are NOT looking for “treatment”
  – Syringe exchange, social service providers...
  – Model can also be incorporated into primary care and substance use disorder treatment agencies
Medication-first program’s place in the context of an opioid treatment network

CARE Navigation

Referred by:
- Jail/Prison
- First responder
- Syringe exchange
- Social services
- Inpatient/Hospital
- Self

Medication first program
@ Syringe exchange
Social service
Housing provider
FQHC-clinic

Primary care in medical settings
Primary care in medical settings
Primary care in medical settings

Opioid treatment programs
Pilot program - **Buprenorphine Pathways**
at Downtown Seattle Public Health clinic

**INITIAL SERVICE DELIVERY MODEL**

- Needle Exchange staff approach clients to engage and gauge interest in program
- Clients also present at clinic, requesting buprenorphine
- Nurse conducts a clinical assessment, develop a buprenorphine induction and care plan tailored to each patient’s needs
- Nurse consults with DEA waivered prescriber, who orders the initial buprenorphine-naloxone prescription
- Medications dispensed at on-site pharmacy
Engaging an unstably housed population with low-barrier buprenorphine treatment at a syringe services program: Lessons learned from Seattle, Washington

Julia E. Hood, Caleb J. Banta-Green, Jeffrey S. Duchin, Joseph Breuner, Wendy Dell, Brad Finegood, Sara N. Glick, Malin Hamblin, Shayla Holcomb, Darla Mosse, Thea Oliphant-Wells & Mi-Hyun Mia Shim

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ABSTRACT

**Background**: Clinic-imposed barriers can impede access to medication for opioid use disorder (MOUD). We evaluated a low-barrier buprenorphine program that is co-located with a syringe services program (SSP) in Seattle, Washington, USA.

**Methods**: We analyzed medical record data corresponding to patients who enrolled into the buprenorphine program in its first year of operation. We used descriptive statistics and tests of association to longitudinally evaluate retention, cumulative number of days buprenorphine was prescribed, and toxicology results.

**Results**: Demand for buprenorphine among SSP clients initially surpassed programmatic capacity. Of the 146 enrolled patients, the majority (82%) were unstably housed. Patients were prescribed buprenorphine for a median of 47 days (interquartile range [IQR] 8–147) in the 180 days following enrollment. Between the first and sixth visits, the percentage of toxicology tests that was positive for buprenorphine significantly increased (33% to 96%, \( P < .0001 \)) and other opioids significantly decreased (90% to 41%, \( P < .0001 \)) and plateaued thereafter. Toxicology test results for stimulants, benzodiazepines, and barbiturates did not significantly change.

**Conclusions**: SSP served as an effective point of entry for a low-barrier MOUD program. A large proportion of enrolled patients demonstrated sustained retention and reductions in opioid use, despite housing instability and polysubstance use.
Figure 1. Discussions about buprenorphine among syringe services program clients in the 20 weeks following the launch of Bupe Pathways, Seattle, Washington, 2017–2018. This figure measures the number of conversations about Bupe Pathways initiated by either SSP clients or SSP staff.
Figure 2. Retention in care among patients with single care episode (A) and among patients with intermittent care episodes (B), Seattle, Washington, 2017–2018. “Care episode” was defined as a collection of visits occurring within 30 days of one another. Panel A represents the proportion of patients with a single care episode \((n = 95)\) that was retained each day following enrollment. Panel B represents the 51 patients who exhibited intermittent care; each of the rows in Panel B represents a unique patient.
(A) Buprenorphine:

Never Returned after 1st Visit (n=25)

Low Retention (n=40)

Moderate Retention (n=17)

High Retention (n=39)

(B) Opioids:

Transferred to Another Clinic (n=25)
TAKEAWAYS

• High client demand
• High needs population e.g. 82% homeless
• Most poly-substance users initially and ongoing
• Buprenorphine was almost always documented in UA
• Significant decrease in illicit opioid use
• Mortality rate appears to have been decreased
• Transitions/transfers into primary care for only a minority of patients
NEXT STEPS

• Many similar programs launched or launching across WA State

• 4 site replication study of Meds First + 6-months of care navigation (PI Banta-Green)
INTERACTIVE OPIOID/MAJOR DRUG DATA

Find a series of interactive data charts and maps featuring Washington State data related to overdose deaths, treatment admissions, statewide opioid sales, and police evidence testing.

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ANNOUNCEMENTS
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Panel Member: Nadejda Bespalova

Chat Moderator: Jeeven Padda

Recommendation Writer: Angela Argyropoulos
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-Check out this resource if you are providing telehealth or would like to provide it.

See: https://nrtrc.org/
ANNOUNCEMENTS

Case Submission
When you submit a case you will be entered into a monthly drawing for a gift card!

UPDATE: We will now be giving the option to choose to present your case at the beginning of the session or the end. You may select this option directly on the case form.

Submit your cases:
http://ictp.uw.edu/programs/case-conferences

*Note: If you are employed by the UW or receive any sort of compensation from the UW, you may not be eligible for a gift card
ANNOUNCEMENTS

UW PACC Schedule

September 19: Medically Unexplained Symptoms
September 26: Tobacco Update
October 3: Borderline Personality Disorder: Diagnosing and Treatment
October 10: Identifying and Addressing Ambivalence to Keep Patients in MAT

• Opioid Thursdays-2nd Thursday’s of the month have a didactic focus on opioids

Please continue to submit cases!
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