HIV & Opioid Use: Trends, Prevention and Treatment Options Part 1

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Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

Disclosure:
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WELCOME to the virtual CoP webinar

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Mr. Williams has over fifteen years of experience in the field of behavioral health services with an emphasis on substance use disorder treatment, substance abuse prevention, workforce development, and the use and implementation of evidence-based-practices in clinical settings.
Commonly used substances and HIV risk

- **Alcohol.** Excessive alcohol consumption, notably binge drinking, can be an important risk factor for HIV because it is linked to risky sexual behaviors and for people living with HIV (PLWH), can negatively affect treatment outcomes.

- **Opioids.** Opioids, a class of drugs that can reduce pain, includes both commonly used prescription drugs and the illegal drug, heroin. Opioid use is associated with HIV risk behaviors such as needle sharing where infected and risky sex behavior have been linked to recent HIV outbreaks.

- **Methamphetamine.** “Meth” is linked to risky sexual behavior that places people at greater HIV risk. It can be injected, which also increases HIV risk if people share needles and other injection equipment.

- **Crack cocaine.** Crack cocaine is a stimulant that can create a cycle in which people quickly exhaust their resources and turn to other ways to get the drug, including trading sex for drugs or money, which increases HIV risk.

- **Inhalants.** Use of amyl nitrite ("poppers") has long been linked to risky sexual behaviors, illicit drug use, and sexually transmitted diseases among gay and bisexual men.

CDC HIV and Substance Use in the U.S., 2018
Challenge of preventing HIV in substance-using populations

Complex health and social needs
People with alcohol dependence or who use drugs often have other complex health and social needs.

Social marginalization and discrimination associated with substance use
Often, illicit drug use is viewed as a criminal activity rather than a medical issue that requires counseling and rehabilitation.

Lack of access to the health care system
Since HIV testing often involves questioning about substance use histories, those who use substances may feel uncomfortable getting tested.

Challenges with adherence to HIV treatment
People living with HIV who use substances are less likely to take antiretroviral therapy (ART) as prescribed due to side effects from drug interaction.

CDC HIV and Substance Use, 2018
Current Opioid Use Trends
Opioid’s grip: Millions continue to misuse Rx pain relievers

11.8 MILLION PEOPLE WITH OPIOID MISUSE (4.4% OF TOTAL POPULATION)

Including:

6.9 MILLION
Rx Hydrocodone

3.9 MILLION
Rx Oxycodone

228,000
Rx Fentanyl

948,000
Heroin Users
(8% of opioid misusers)

641,000
Rx Pain Reliever Misusers & Heroin Users
(5.4% of opioid misusers)

11.5 MILLION
Rx Pain Reliever Misusers
(97.4% of opioid misusers)

2016 NSDUH results
Opioid overdose is a significant public health problem

“Drug overdose deaths and opioid-involved deaths continue to increase in the United States. The majority of drug overdose deaths (66%) involve an opioid. In 2016, the number of overdose deaths involving opioids (including prescription opioids and heroin) was 5 times higher than in 1999. From 2000 to 2016, more than 600,000 people died from drug overdoses. On average, 115 Americans die every day from an opioid overdose.”
Overdose deaths are increasing at an alarming rate

- Drug overdoses killed roughly 64,000 people in the United States, according to the first governmental account of nationwide drug deaths to cover all of 2016.

- It’s a rise of more than 22 percent over the 52,404 drug deaths recorded the previous year, 2015.
Heroin deaths have skyrocketed

**HEROIN PAST YEAR USE**
- 2002: 404,000 (0.2%)
- 2015: 828,000 (0.3%)
- 2016: 948,000 (0.4%)

230% increase in heroin users
Source: SAMHSA (2017)

**HEROIN DEATHS**
- 2002: 2,089
- 2015: 13,101
- 2016: 13,219*

630% increase in heroin deaths
How Can We Treat and Prevent this Major Public Health Concern?
National response to substance use and HIV: CDC

- Supports intervention programs that deliver services to people who inject drugs
- Supports responses for outbreaks of HIV traced to injection drug use
- Supports programs to develop biomedical approaches to HIV prevention for people who use substances
- Maintains the National HIV Surveillance System
- Conducts the National HIV Behavioral Surveillance survey
- Provides culturally appropriate prevention messages
- Works with the White House and other partners

CDC HIV/Substance Use in the U.S., 2018
Federal response to opiate crisis: CDC recommendations for states

- Address the strongest risk factor for heroin addiction: the addiction to prescription opioid painkillers
- Increase access to substance abuse treatment services, including Medication-Assisted Treatment (MAT), for opioid addiction
- Expand access to and training for administering naloxone to reduce opioid overdose deaths
- Ensure that people have access to integrated prevention services, including access to sterile injection equipment from a reliable source, as allowed by local policy
- Help local jurisdictions to put these effective practices to work in communities where drug addiction is common
So What Can Providers Do?
SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment for individuals at risk for the adverse consequences of alcohol and other drug use, and for those with probable substance use disorders.

**Screening**
The *quick identification* of individuals with issues with substance use through the use of *validated tools*. Screening can be through interview or self-report.

**Brief Intervention**
A motivational discussion focused on *raising awareness* of client substance use and its consequences, and *motivating toward behavioral change*.

**Referral to Treatment**
A process designed to help clients *work through barriers* and receive *appropriate treatment services*.

Del Boca, 2017
What is SBIRT?

• SBIRT is the framework by which providers can make the identification and treatment of substance use disorders a routine part of the healthcare process.

• Provides an opportunity for prevention and early intervention activities designed to reduce risky substance use and the negative consequences of use.

• Designed to be used in a wide variety of settings: mental health, primary care, emergency departments, schools, or other non-traditional settings to provide opportunities to intervene BEFORE more severe consequences occur.
Screening

- AUDIT
- DAST
- ASSIST
- CRAFFT
- S2BI
- PhQ9
- TWEAK/T-ACE
- Opioid Risk Tool
Prevention Strategies-
Overdose Treatment with Naloxone

Naloxone is an opioid antagonist meaning that it binds to opioid receptors and can reverse or block the effects of other opioids. It can very quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of heroin use, misuse of prescription opioids or accidentally ingesting too much pain medication.
Medications for Addiction Treatment

**Alcohol:**
- Naltrexone – oral
- Naltrexone (Vivitrol) – long-acting, injectable
- Acamprosate
- Disulfiram (Antabuse)

**Opioids:**
- Methadone
- Buprenorphine - pill, implant, injection
- Naltrexone – oral
- Naltrexone (Vivitrol) – long-acting, injectable

**Smoking Cessation**
- Varenicline (Chantix)
- Bupropion (Wellbutrin)
- NRTs
## Medications/Pharmacotherapy for Opioid Use Disorder (OUD)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Frequency of Administration</th>
<th>Route of Administration</th>
<th>Who May Prescribe or Dispense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>Daily</td>
<td>Orally as liquid concentrate, tablet or oral solution of diskette or powder</td>
<td>SAMHSA-certified outpatient treatment programs (OTPs) dispense methadone for daily administration either on site or, for stable patients, at home.</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Daily tablet or film (also alternative dosing regimens)</td>
<td>Oral tablet or film is dissolved under the tongue</td>
<td>Physicians, NPs and PAs with a federal waiver. Prescribers must complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.</td>
</tr>
<tr>
<td>Probuphine (buprenorphine implant)</td>
<td>Every 6 months</td>
<td>Subdermal</td>
<td></td>
</tr>
<tr>
<td>Sublocade (buprenorphine injection)</td>
<td>Monthly</td>
<td>Injection (for moderate to severe OUD)</td>
<td></td>
</tr>
<tr>
<td>Naltrexone</td>
<td>Monthly</td>
<td>Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional</td>
<td>Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.</td>
</tr>
</tbody>
</table>

Adapted from Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide (SMA14-4892R)
• Treatment with methadone or buprenorphine has shown to be associated with more than 60 percent reduction in the incidence of hepatitis C virus infection compared to no treatment. ¹, ²

• Extended Release Injectable Naltrexone has shown clinical efficacy for maintaining abstinence, achieving medication adherence, maintaining retention in treatment, protecting against reestablishment of opioid physical dependence, and reduces craving for opioids for some individuals. ³

¹ Schwartz et al., 2014
² Judith I. Tsui et al., 2014
³ Naltrexone in the Treatment of OUD, 2015
For pregnant women with OUD, the perinatal use of either methadone or buprenorphine, within comprehensive treatment, is the most accepted clinical practice. ¹

“Abrupt discontinuation of opioid use during pregnancy can result in premature labor, fetal distress, and miscarriage. Pregnant women who stop using opioids and subsequently relapse are at greater risk of overdose death and places the fetus at increased risk of harm.” ²

¹ Stacey et al., 2017
² HHS Publication No. (SMA) 16-4978, 2016


• CDC Website: [https://www.cdc.gov/hiv/risk/substanceuse.html](https://www.cdc.gov/hiv/risk/substanceuse.html).


• NCHS Data Brief No. 294, December 2017.
Citations


Selected Web-based Resources

Health and Human Resources


This resource includes the National Helpline – 1-800-662-4357

Web-based Resources (cont.)

SAMHSA’s Prevention of Substance Abuse and Mental Illness Initiatives
SAMHSA promotes and implements prevention and early intervention strategies to reduce the impact of mental and substance use disorders in America’s communities.
https://www.samhsa.gov/prevention

CDC HIV/AIDS
Most of CDC’s HIV/AIDS prevention efforts are the responsibility of the Office of Infectious Diseases National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). Within this Center is the Division of HIV/AIDS Prevention (DHAP), charged with the mission of preventing HIV infection and reducing the incidence of HIV-related illness and death.

National Institute on Drug Abuse (NIDA)
Our mission is to advance science on the causes and consequences of drug use and addiction and to apply that knowledge to improve individual and public health.
https://www.drugabuse.gov/drugs-abuse/opioids/opioid-crisis
https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio
SAMHSA Opioid Overdose Prevention Toolkit
This toolkit offers strategies to health care providers, communities, and local governments for developing practices and policies to help prevent opioid-related overdoses and deaths. Access reports for community members, prescribers, patients and families, and those recovering from opioid overdose.

https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/All-New-Products/SMA16-4742

CDC Overdose Prevention Resources
The best ways to prevent opioid overdose deaths are to improve opioid prescribing, reduce exposure to opioids, prevent misuse, and treat opioid use disorder.

https://www.cdc.gov/drugoverdose/prevention/index.html

Health Resources Services Administration (HRSA) The Target Center
The central source of technical assistance (TA) and training resources for the Ryan White HIV/AIDS Program. The site is the one-stop shop for tapping into the full array of TA and training resources funded by the Health Resources and Services Administration’s (HRSA) HIV/AIDS Bureau (HAB).

https://careacttarget.org/
CoP FACULTY CONTACT INFORMATION

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Upon completing the webinar:

• Please use the link below to provide your feedback about this virtual webinar
  [https://www.surveymonkey.com/r/2018OpioidMATVCoPFeedback](https://www.surveymonkey.com/r/2018OpioidMATVCoPFeedback)

• Submit any questions you have about this virtual webinar and TA requests to: Virtual CoP Facilitator, Victor Ramirez, vramirez@mayatech.com
Recordings & Slides

Recordings & Slides for the *Opioid/MAT Virtual CoP webinars* are available [on the CIHS website:](https://www.integration.samhsa.gov/mai-coc-grantees-online-community/communities-of-practice)
Additional Questions

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Additional Comments?
Contact the SAMHSA-HRSA Center for Integrated Health Solutions
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or MAI-COC-TA@mayatech.com
CIHS News and Resources

Visit
www.integration.samhsa.gov
or e-mail
integration@thenationalcouncil.org

Free consultation on any integration-related topic!
Thank you for joining us today. Please take a moment to provide your feedback by completing this survey https://www.surveymonkey.com/r/2018OpioidMATVCoPFeedback

SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.

HIV & Opioid Use: Trends, Prevention and Treatment Options Part 2

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Assessing the evidence: what we know

- People living with HIV (PLWH) have higher rates of substance use than the general population. ¹
- Injection drug use has been a known risk factor for HIV since the beginning of the epidemic, but other forms of substance use are also a strong predictor of risky sexual behavior. ²
- The use of any substance that impairs judgment and decision making is correlated with high-risk sexual and substance-using behaviors and, as such, presents a major risk for transmission and acquisition of HIV and other blood-borne and sexually-transmitted diseases. ³

¹ Meade et al., 2016
² Galvan et al., 2002
³ Christopoulos et al., 2011
There is clear evidence of a high level of effectiveness for both methadone and buprenorphine for treating opioid addiction. Medication assisted treatment for opioids is helpful in leading to:

- Abstention from or reduced use of illicit opiates
- Reduction in other illicit drug use
- Decreased criminal activity
- Decreased risk behavior linked to HIV and hepatitis C

Fullerton et al., 2014
Thomas et al., 2014
Medication-assisted Treatment

“We have highly effective medications, when combined with other behavioral supports, that are the standard of care for the treatment of opiate addiction.” - Michael Botticelli
Former Director ONDCP
Medications for Addiction Treatment

**Alcohol:**
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Research Findings on Medications/Pharmacotherapy for Opioid Use Disorder (OUD)

• Treatment with methadone or buprenorphine has shown to be associated with more than 60 percent reduction in the incidence of hepatitis C virus infection compared to no treatment. ¹

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¹ Schwartz et al., 2014
² Treatment of Opioid Use Disorder: A Brief Guide SAMHSA, 2015
Research Findings on Medications/Pharmacotherapy for OUD (Continued)

• For pregnant women with OUD, the perinatal use of either methadone or buprenorphine, within comprehensive treatment, is the most accepted clinical practice. ¹

• “Abrupt discontinuation of opioid use during pregnancy can result in premature labor, fetal distress, and miscarriage. Pregnant women who stop using opioids and subsequently relapse are at greater risk of overdose death and places the fetus at increased risk of harm.” ²

¹ Stacey, et al., 2017
Medications are Useful as . . .

- a resource for assisting in the treatment of substance use disorders
- a resource to provide higher quality and cost effective care for clients with complex behavioral health needs
- a supplement to existing behavioral health treatments for substance use disorders

Yet, 54 percent of addiction treatment programs have no physician on staff.¹

¹ Knudsen et al., 2011
Why Implement MAT Services in Integrated HIV Care Settings?
Substance Use Disorders (SUD) in integrated care settings

- There is a prevalence of SUDs in populations at risk for or living with HIV
- SUDs add to overall healthcare costs, especially for Medicaid ¹
- SUDs can cause or exacerbate other chronic health conditions ²
- SUD interventions can reduce healthcare utilization and cost ³
- Medication-assisted treatment (MAT) in integrated care settings can seamlessly be expanded to treat SUD
- On-site and in-home services are more effective than a referral for services

¹ Weisner, 2010
² Weisner, 2001
³ Id.
Common elements highlighted across models have been summarized extensively in the policy literature and include:

- Screening for behavioral disorders using validated screening tools
- Team-based care with non-physician staff to support primary care physicians (PCPs) and co-manage treatment
- Shared information systems that facilitate coordination and communication cross providers
- Standardized use of evidence-based guidelines
- Systematic review and measurement of patient outcomes using registries and patient tracking tools
- Engagement with broader community services
- Individualized, person-centered care that incorporates family members and caregivers into the treatment plan

Tice et al., 2015
Are you Ready to Implement MAT Services in Integrated Care Settings?
Getting ready for implementation: MAT Implementation Checklist

Key areas of consideration before engaging in efforts to increase access to medication assisted treatment (MAT)

- Economic environment
- Treatment environment
- Workforce
- Regulatory barriers
- Cultural environment (attitudes, stigma)
The following series of questions can assist in determining organizational readiness to implement MAT, though there may be others depending on the design and make up of your organization. The questions are organized into five key sections:

- Organizational readiness
- Economic/regulatory readiness
- Workforce readiness
- Community readiness
- Patient and caregiver readiness
Directions for CIHS MAT Readiness Assessment Tool

Each section includes a series of considerations regarding areas to be considered before implementing a successful and sustainable MAT program.

Complete the tool by indicating whether the organization has:

- Not yet taken steps to investigate the question ("Not Ready")
- Begun the process ("In progress") or
- Has already addressed the question ("Ready")

Utilize these questions to guide the organization in determining next steps towards implementation.
## Organizational Readiness

<table>
<thead>
<tr>
<th>Question/Area of Consideration</th>
<th>Not Ready</th>
<th>In Progress</th>
<th>Ready</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your organizational leadership, including your board of directors, support the use of MAT?</td>
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</tr>
<tr>
<td>• Could they benefit from gaining further information about MAT?</td>
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<td></td>
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<tr>
<td>• Are there opportunities for sharing this information with your board?</td>
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<tr>
<td>Do you have data that would demonstrate the potential benefit to the people you serve of offering MAT, including information on comorbid conditions and medication use?</td>
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<tr>
<td>What MAT services will you offer (opioid use disorder, alcohol use disorder, smoking cessation)?</td>
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<tr>
<td>Who will you offer services to?</td>
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<tr>
<td>• All patients?</td>
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<td></td>
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<tr>
<td>• Those with comorbid mental health disorders? (see example below)</td>
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<tr>
<td>• Those with comorbid chronic medical conditions?</td>
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<tr>
<td>Do you have a plan to provide or connect patients to appropriate counseling and other behavioral health services?</td>
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<tr>
<td>How will you implement the most current guidelines for the use of MAT?</td>
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<tr>
<td>Do you have a quality assurance protocol for supporting and maintaining these new practices?</td>
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<tr>
<td>Does your infrastructure support requirements (e.g., appropriate clinical space, storage) for offering MAT services?</td>
<td></td>
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</tr>
<tr>
<td>Total (count)</td>
<td>54</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Economic/ Regulatory Readiness

<table>
<thead>
<tr>
<th>Question/Area of Consideration</th>
<th>Not Ready</th>
<th>In Progress</th>
<th>Ready</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do Medicaid and commercial insurers require for the use of MAT in your state?</td>
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<tr>
<td>• Are there limitations on who can prescribe MAT, the length of time patients can use MAT, and/or the type of formulations patients may receive?</td>
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</tr>
<tr>
<td>Do Medicaid formularies include all MAT formulations (e.g., injectable naltrexone, sublingual buprenorphine)?</td>
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</tr>
<tr>
<td>Does the state view the use of MAT as an evidence-based practice? (Some states require that clinicians follow evidence-based practices to be reimbursed under Medicaid and private insurance.)</td>
<td></td>
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<tr>
<td>Are you aware of the typical out-of-pocket cost for the medications, and are your patients able to afford these costs?</td>
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<tr>
<td>• If not, are you aware of ways you may be able to offset these costs for patients who need assistance?</td>
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<tr>
<td>Are clinicians eligible to receive Medicaid or commercial insurance reimbursement?</td>
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<tr>
<td>• Are they on preferred provider lists for commercial insurers and Medicaid managed care programs?</td>
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<tr>
<td>Will clinicians be reimbursed for clinical services required for MAT, such as physical examinations and laboratory tests?</td>
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<td></td>
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<tr>
<td>Total (count)</td>
<td></td>
<td></td>
<td>55</td>
</tr>
</tbody>
</table>
### Workforce Readiness

<table>
<thead>
<tr>
<th>Question/Area of Consideration</th>
<th>Not Ready</th>
<th>In Progress</th>
<th>Ready</th>
</tr>
</thead>
</table>
| **How do current employees view MAT?**  
  - How supportive are they?  
  - Do they need education to understand the benefits of adding a medication to current substance use disorder treatments? | | | |
| **Are there attitudinal barriers to the use of MAT in your state and community? If so, what are they?** | | | |
| **Does your agency have an appropriately trained team (physician, PA, nurse practitioner, nurse, care coordinator, and behavioral health specialist) to administer medication and the associated behavioral health services?** | | | |
| **How will you access prescribers?**  
  - Will the prescribers be internal or contracted?  
  - Full- or part-time?  
  - How will you train them?  
  - How will you retain them in the practice? | | | |
| **What are the state regulations required to implement a MAT program, particularly scope of practice and necessary certifications? (For instance, some states require that physicians conduct the clinical assessment rather than nurses or social workers.)** | | | |
| **How will you provide on-going training and supervision to your staff?** | | | |
| **Total (count)** | | | 56 |
### Community Readiness

<table>
<thead>
<tr>
<th>Question/Area of Consideration</th>
<th>Not Ready</th>
<th>In Progress</th>
<th>Ready</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will you work with consumer groups and advocates to increase demand for and knowledge of MAT in the substance use disorder community?</td>
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<tr>
<td>What other treatment programs in your region and state currently provide MAT?</td>
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<tr>
<td>• How well do clinicians in your area accept the “medical model” of treatment for substance use disorders?</td>
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<tr>
<td>Do you have relationships with other organizations that can provide additional treatment supports and resources?</td>
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<tr>
<td>• Are you able to contract with any of these other providers as a referral resource?</td>
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<tr>
<td>Is your organization a member of any group or association that supports the use of medications (e.g., primary care associations)?</td>
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<tr>
<td>Are state and local legislators aware of the evidence behind MAT?</td>
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<tr>
<td>• If not, how will you educate them?</td>
<td></td>
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</tr>
<tr>
<td>• How will you work with legislators to advocate for and improve the financing and regulatory environment for implementation of MAT?</td>
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<td></td>
</tr>
</tbody>
</table>

Total (count)
### Patient/Caregiver Readiness

<table>
<thead>
<tr>
<th>Question/Area of Consideration</th>
<th>Not Ready</th>
<th>In Progress</th>
<th>Ready</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there patient/caregiver barriers to the use of MAT? (These may include attitudinal barriers,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>out-of-pocket costs, difficulties with transportation to appointments, and difficulty with the side</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>effects of taking the medication.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Who will provide leadership to develop and implement plans to overcome these barriers?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do you assess patient and caregiver knowledge or understanding of substance use disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and MAT?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How will you educate patients and caregivers about the risks and benefits of MAT and its place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>within the treatment continuum?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do you assess a patient’s support network?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Are you aware of the options for mutual support groups in your community?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a mechanism for you to receive feedback from patients/caregivers regarding the quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of your services?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total (count) 58
What’s Next? Move from Readiness to Action

Take a look at where your responses fall in each section. Your responses should give you a clear picture of where you have knowledge gaps and point out potential barriers to success. Depending on what gaps you’ve identified, your next step may be to share further information with staff or your agency leadership or form a plan to educate community members and leaders.


• Knudsen HK, Abraham AJ, Oser CB. Barriers to the implementation of medication-assisted treatment for substance use disorders: the importance of funding policies and medical infrastructure. Eval Program Plann. 2011;34(4):375-381.


Web-based resources

SAMHSA's Providers’ Clinical Support System for Medication-assisted Treatment (PCSS-MAT)
Educates providers on the most effective medication-assisted treatments to serve patients in a variety of settings.
https://pcssmat.org/

Prescribers’ Clinical Support System for Opioid Therapies (PCSS-O)
A national training and mentoring project that provides a variety of no cost CME programs on the safe and effective prescribing of opioid medications in the treatment of pain and/or opioid addiction.
https://pcss-o.org/

SAMHSA Opioid Overdose Prevention Toolkit
This toolkit offers strategies to health care providers, communities, and local governments for developing practices and policies to help prevent opioid-related overdoses and deaths. Access reports for community members, prescribers, patients and families, and those recovering from opioid overdose.
https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/All-New-Products/SMA16-4742
Web-based resources (continued)

National Institute on Drug Abuse (NIDA)
Their mission is to advance science on the causes and consequences of drug use and addiction and to apply that knowledge to improve individual and public health.
https://www.drugabuse.gov/drugs-abuse/opioids/opioid-crisis
https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio

CDC Overdose Prevention Resources
Includes, the best ways to prevent opioid overdose deaths: improve opioid prescribing, reduce exposure to opioids, prevent misuse, and treat opioid use disorder.
https://www.cdc.gov/drugoverdose/prevention/index.html

SAMHSA Behavioral Health Treatment Services Locator
The Behavioral Health Treatment Services Locator, is a confidential and anonymous source of information for persons seeking treatment facilities in the U.S. or U.S. Territories for substance use, misuse, substance use disorder treatment and/or mental health problems.
https://findtreatment.samhsa.gov/
CoP FACULTY CONTACT INFORMATION

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202-684-7462
Upon completing the webinar:

• Please use the link below to provide your feedback about this virtual webinar
  https://www.surveymonkey.com/r/2018OpioidMATVCoPFeedback

• Submit any questions you have about this virtual webinar and TA requests to: Virtual CoP Facilitator, Victor Ramirez, vramirez@mayatech.com
Recordings & Slides

Recordings & Slides for the Opioid/MAT Virtual CoP webinars are available on the CIHS website:

Additional Questions

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gvaughn@mayatech.com

Victor Ramirez
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Additional Comments?
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or MAI-COC-TA@mayatech.com
Visit

www.integration.samhsa.gov

or e-mail

integration@thenationalcouncil.org

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https://www.surveymonkey.com/r/2018OpioidMATVCoPFeedback

SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on
America’s communities.

The mission of HRSA is to improve health and achieve health equity through access to quality
services, a skilled health workforce, and innovative programs.

integration.samhsa.gov
HIV & Opioid Use: Integrating Overdose Prevention & Harm Reduction
Making a Difference Part 3

Aaron Williams, M.A.
Senior Director, Training and Technical Assistance
SAMHSA-HRSA Center for Integrated Health Solutions

Created by Niki Miller, MS, CPS & Linda Frazier, M.A. R.N.
Advocates for Human Potential, Inc.
The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

Disclosure:
The presenter, Aaron Williams has no conflicts of interest or financial relationships to disclose.

The creators, Niki Miller and Linda Frazier have no conflicts of interest or financial relationships to disclose.
WELCOME to the third in a series of virtual CoP webinars

- This session is the third in a series of three thirty-minute CoP sessions that are ‘on-demand’ webinars
- After viewing, please follow the link to give your immediate feedback
- Any questions received will be answered by email or by a follow up TA request based on the session content
- This format is designed for maximum learning, on your own schedule
Aaron Williams serves as the Senior Director, Training and Technical Assistance for Substance Abuse, SAMHSA-HRSA Center for Integrated Health Solutions, at the National Council for Behavioral Health.

Mr. Williams has over fifteen years of experience in the field of behavioral health services with an emphasis on substance use disorder treatment, substance abuse prevention, workforce development, and the use and implementation of evidence-based-practices in clinical settings.
Integrating Overdose Prevention/Risk Reduction: Key Topics

- Social determinants and the opioid epidemic
- Intersecting epidemics: community case study
- Shifting demographics and risk factors
- Overdose prevention vs. emergency intervention and naloxone basics
- Integrating relevant harm/risk reduction principles and activities
- Crossing the low-threshold doorway
“The current situation threatens to become a perfect storm, with the opioid, HIV, and viral hepatitis epidemics intersecting in dangerous ways.”

- Richard Wolitski,
  Director, Office of HIV/AIDS and Infectious Disease Policy

Assessing the Evidence: What We Know About Opioid Overdose and Use Trends

- Nationally, overdose deaths from prescription opioids were higher among Whites, American Indians and Alaska Natives as compared to Blacks and Hispanics in 2016.¹
- Less is known about race/ethnicity regarding overdose deaths due to illicit opioids, but we know fatality rates can vary by up to six-fold across geographic regions.²
- Early epidemic: dominated by abuse of pharmaceutical opioids, but the proportion of deaths involving illicit opioids is trending upward, from 40 percent in 2013 to 60 percent in 2016.³

¹ CDC (2017)
² U.S. Department of Justice DEA. (2017)
³ CDC. National Center for Health Statistics. (2017)
Assessing the Evidence: What We Know About Opioid Overdose and Use Trends

- Nationally, for 2016, opioid overdose deaths from illicit use of prescription opioids were higher among whites, American Indians and Alaska Natives as compared to blacks and Hispanics. [https://www.cdc.gov/drugoverdose/data/overdose.html](https://www.cdc.gov/drugoverdose/data/overdose.html)

- Less is known specifically about race/ethnicity regarding overdose deaths due to other illicit opioids, however, it is known that fatality rates can vary by up to six-fold across geographic regions. [https://www.dea.gov/docs/DIR-040-17_2017-NDTA.pdf](https://www.dea.gov/docs/DIR-040-17_2017-NDTA.pdf)

- Early epidemic: while dominated by misuse of pharmaceutical opioids, the proportion of deaths involving other illicit opioids is trending upward as well, from 40 percent in 2013 to 60 percent in 2016. [https://www.cdc.gov/nchs/products/databriefs/db294.html](https://www.cdc.gov/nchs/products/databriefs/db294.html)
Assessing the Evidence: What We Know About Opioid Overdose Fatality Rates

*CDC Provisional Drug Overdose Death Counts. (2016)
**Krogstad, J. M. (2015, October 21)
***CDC. 2016 Gun Deaths (2018)
In the late 1990’s in the U.S., pharmaceutical opioids began to penetrate much more than in the prior six decades of illicit opioid trafficking, making previously unaffected areas, highly vulnerable.

Substance misuse multiplies a person’s risk of HIV infection via shared drug injecting equipment and via unprotected sex with infected partners; it can impact HIV/AIDS outcomes.

CDC HIV and Substance Use in the United States (2018)
Profiles of Risk

Demographic characteristics

- Age 49-64 (decreasing)
- Male
- White, American Indian/Alaska Native
- Past criminal justice involvement
- Military Veteran
- Medicaid/Medicare beneficiary
- Has been prescribed opioid analgesics
- Has a diagnosis of mental illness
- Rural, Midwest or Northeast
- Prior overdose event
- Chronic pain/chronic health conditions (includes HIV/AIDS)

Dynamic factors (modifiable)

- Concurrent alcohol use
- Using benzodiazepines or other sedatives
- Using alone/behind locked doors
- Injection drug use (IDU)
- Needing help injecting
- Using in public places/housing instability
- Recent treatment or detox episode
- Recently discontinued MAT
- Recently released from custody
- Relapsing after a period of recovery
Demographics are shifting as deaths from increasingly potent illicit opioids are on the rise...

- Latest analyses of fatal and non-fatal overdose suggest urban areas are becoming more vulnerable than rural. ¹

- Stereotypes about drug use among minorities are usually not based on factual information. Historic illicit drug use and binge drinking rates tend to be lower than for Whites. ²,³

- However, minority communities may have limited access to services; incarceration rates (especially for drug crimes) are much higher. ⁴

---

1 Agency for Healthcare Research and Quality. (2017)
2 Substance Abuse and Mental Health Services Administration. (2016)
3 McCabe, S. E., et al. (2007)
Demographics are shifting as deaths from increasingly potent illicit opioids are on the rise... (Cont.)

- Individuals recently released from custody are at up to 129 times the risk of drug overdose fatality as compared with the general population.  

- Native American/Alaska Natives are among the hardest hit by the opioid epidemic. 

5 Binswanger, I. A., et al. (2007)
6 U.S. Department of Justice, DEA (2017)
### Geography: Overdose Demographics Vary Widely

Six states report higher opioid overdose fatality rates among Blacks than Whites.

One state reports higher fatality rates among Hispanics than Whites.

<table>
<thead>
<tr>
<th>State</th>
<th>2016 US Overall Rates/ per 100,000</th>
<th>Opioid Overdose Fatality Rate: 13.3</th>
<th>Whites: 17.5</th>
<th>Blacks: 10.3</th>
<th>Hispanics: 6.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington DC</td>
<td>38.8</td>
<td>7.4</td>
<td>49.4</td>
<td>No data</td>
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<tr>
<td>Illinois</td>
<td>18.9</td>
<td>16.2</td>
<td>23.5</td>
<td>9.5</td>
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<tr>
<td>Minnesota</td>
<td>12.5</td>
<td>7.3</td>
<td>13.2</td>
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<tr>
<td>Missouri</td>
<td>23.6</td>
<td>15.2</td>
<td>27.4</td>
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<td></td>
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<tr>
<td>West Virginia</td>
<td>52.0</td>
<td>44.3</td>
<td>46.5</td>
<td>No data</td>
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<tr>
<td>Wisconsin</td>
<td>15.8</td>
<td>16.1</td>
<td>23.5</td>
<td>12.9</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>17.5</td>
<td>15.0</td>
<td>No data</td>
<td>21.3</td>
<td></td>
</tr>
</tbody>
</table>

Fatality rate among Blacks exceeds overall national rate in: CT, KY, MA, MD, MI, NJ, OH

Fatality rate among Hispanics exceeds overall national rate in: CT, MA, NY, MI, WI, OH, RI

Kaiser Family Foundation. (2016)
Naloxone administered in an overdose emergency is a heroic, lifesaving measure, but not preventive — any more than defibrillators are preventive of heart attacks.
Naloxone Basics

- FDA approved - 1971 to reverse opioid overdoses; nasal formulation (Narcan) recently approved for community use.

- Short-acting opioid antagonist (blocker); half-life 30-90 can outlast blocking effect, resulting in death. Multiple naloxone dosing required in many regions.²

- Deaths from synthetic opioids up 88% from 2013 to 2016, according to the CDC; 426% increase in illicit opioid drugs seizures testing positive for fentanyl, according to the DEA.²

- Always call for EMS; get revived individuals to the hospital! Ensure clients, staff and bystanders trained in administration know these critical action steps, especially in high-risk geographic regions.

1 U.S. Department of Justice, DEA. (2017, October).
Many Components of Opioid Harm/Risk Reduction Initiatives

Reducing fatal outcome of overdose
- Supervised drug consumption
  Immediate first-aid in drug emergencies
- Take-home naloxone programmes
  Improved bystander response

Reducing risk of overdose
- Retention in opioid substitution treatment
  Reduce drug use and injecting
- Overdose risk assessments
  In treatment facilities and prisons
- Overdose awareness
  Knowledge of risk and safer use

Reducing vulnerability
- Outreach and low-threshold services
  Accessible services
- Enabling environment
  Removing barriers to service provision
- Empowerment of drug users
  Enabling drug users to protect themselves
- Public health approach
  Recognition of wider impact

European Monitoring Centre for Drugs and Drug Addiction. (n.d.)
Harm reduction topics page
Overdose Prevention/Risk Reduction: Options for Integrated HIV Care Settings

Harm and risk reduction /safer use education
• Patient education materials; repeat hierarchy of risk behaviors

Links to community public health/harm reduction resources
• National harm reduction/naloxone program locators; linkages with local programs

Information on MAT/opioid agonist therapy & naloxone coverage and access
• MAT shared decision making tool; treatment locators, local referrals and coverage guide

Naloxone provision/training - drug users & family members; info on local laws
• Handouts, guidelines about laws, program locators, local harm reduction/public health trainings

Overdose risk assessments/prevention planning and linkages
• Risk assessments, checklist, screening, safety planning tools

Syringe service programs, local harm reduction coalitions
• National exchange locator; local harm reduction partners/health departments
Although development of overdose screening tools/protocols is in its infancy, according to the United Nations, detectable risk factors include:

- Injection drug use (IDU); extended history of addiction and IDU
- Prior opioid overdose incident (s)
- High levels of intoxication from alcohol and opioid use
- Poly drug use – especially opioids with alcohol, benzodiazepines or other sedatives
- History of co-occurring mental health problems, depression or suicidality
- Loss of tolerance after a period of incarceration, detoxification or treatment
- Co-morbid chronic health conditions including HIV/AIDS
- High risk using behaviors: sharing or using used equipment, needing help injecting
Overdose signs, symptoms and response

Respiratory Depression

May happen minutes or hours after ingestion.
In 3-5 minutes lack of oxygen can cause brain damage or death.

1. Try stimulation to get them to wake up
2. If non-responsive, begin rescue breathing
3. Call for help: 911
4. Recovery position: lay on side with knee bent, face turned to the side
5. Administer naloxone if you have it
6. Get them to the hospital

Harm Reduction Coalition. (n.d.). Overdose response–nasal naloxone
Administering Naloxone

1. Naloxone injection, solution (generic)
2. Naloxone nasal spray (Narcan)
3. Naloxone auto injector (similar to an EpiPen)
   • Non-scheduled prescription medication
   • Injection administered IM, SC, or IV
   • Sprayed in nose (higher concentration)
   • Wears off in 20-90 minutes
   • No effect if opioids are not present
   • Kits provided to lay people with two doses
   • Increasing multi-dosage requirements

Harm Reduction Coalition. (n.d.). Overdose response–nasal naloxone
1. Never use alone.
2. Never use behind a locked door—seconds count.
3. Never mix substances (including alcohol).
4. Know your source—use carefully when you don’t (a test shot or dose).
5. Be mindful of your tolerance—start low and go slow after periods of abstinence.
6. Locate overdose prevention emergency services near you.
7. Never share equipment, pipes, tie-offs, or water.
8. Have naloxone on hand.
9. Medication-Assisted Treatment (MAT) can help you stay alive and free.
10. If you use a syringe that has been used, rinse it twice with bleach, then water.

For those at high risk of relapse, presenting a hierarchy of risk behaviors can increase safety.
‘Opening Doorways to Hope’: Low Threshold Services

Low Threshold Model

- No commitment to abstinence required
- Immediate access to MAT
- Basic health and human needs
- Safety and street outreach
- Mobile and drop-in services
- Not permissible by US federal law – Syringes and supplies
- Trauma-informed
- Entry to services for many groups that can be harder-to-reach

The following remarks are provided by Katie Scott, an Associate with the Center for Integrated Health Solutions (CIHS)
Are you ready to implement overdose prevention and risk reduction in integrated care settings?

Legal Issues: two sets of relevant laws

Policy Surveillance Program at Temple University Law School: Law Atlas Project

- Search Good Samaritan Overdose Prevention laws by state
- Search Naloxone Overdose Prevention laws by state

SAMHSA – Overdose Prevention Toolkit
North American Syringe Exchange Network (NASEN)
- directory of programs by-state
Links and Resources
(see accompanying handout/materials for more)

SAMHSA Resources:
- State Opioid Treatment Authority Listing Opioid Treatment Program Locator
- FDA Approval of Narcan Nasal Spray Nov, 2015

Harm reduction and safety education resources:
- When the Seconds Count Card – American Society of Anesthesiologists /ONDCP
- Staying Alive on the Outside—Center for Prisoner Health and Human Rights 7-minute video
- Drug Overdose Prevention Education (DOPE) Project – Be a Lifesaver pamphlet

Treatment / Culturally responsive health information:
- Black and African American Communities and Mental Health
- Native American Behavioral Health Topics
- Hispanic/Latino Communities and Mental Health
- Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals
- One Sky Center-Resources for Native American/Alaska Native populations


Citations


Kaiser Family Foundation. (2016). Opioid overdose deaths by race/ethnicity. https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.


NIDA Community-Based Outreach Model: A Manual To Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users. National Institute on Drug Abuse, NIH Publication Number 00-4812.)
Citations

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