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Maximizing Access to Buprenorphine (MOUD) through Telehealth Team Treatment in a Private Practice

Wednesday, August 3

12:00 - 1:00 pm

Edwin C. Chapman, MD | DACS Consultant

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District Addiction Consultation Service

DACS provides support to primary care and specialty prescribers in addressing the needs of their patients with substance use disorders and chronic pain management.

All Services are FREE

- Phone consultation for clinical questions provided by expert addiction medicine specialists
- Education and training opportunities related to substance use disorders and chronic pain management
- Assistance in the identification of substance use and behavioral health resources and referrals that meet the needs of the patients in your community

Funding for DACS is provided by The District of Columbia Government, DC Health, Health Regulation and Licensing Administration (HRLA), Pharmaceutical Control Division (PCD). DACS is administered by the University of Maryland School of Medicine staff and faculty.

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Financial Disclosure:

Dr. Edwin Chapman, faculty for this activity, has no relevant financial relationship(s) with ineligible companies to disclose. None of the planners for this activity have financial relationships to disclose.

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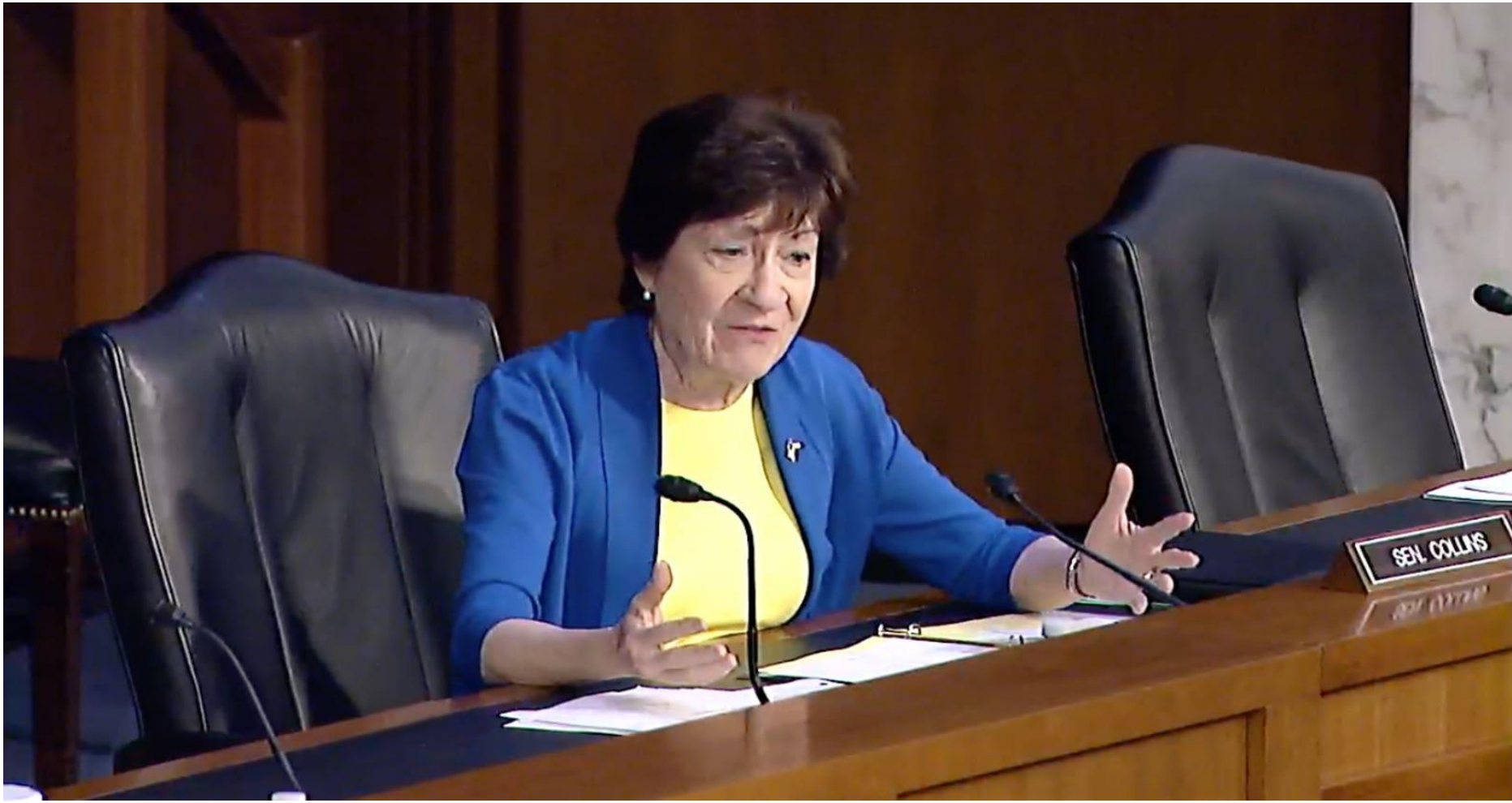
Feds Must Do More to Fight Fentanyl, Senators Say
— "What we're doing is not working," said Sen. Susan Collins

by Joyce Frieden, Washington Editor, MedPage Today July 26, 2022



WASHINGTON -- The federal government is not doing enough to lessen the fentanyl overdose crisis, Sen. Susan Collins (R-Maine) said Tuesday.

"We have to face the very unpleasant truth that what we're doing is not working," Collins, a member of the Senate Committee on Health, Education, Labor, & Pensions (HELP), said at a hearing on "Fighting Fentanyl: The Federal Response to a Growing Crisis."

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Washington, DC
as a
“Tale of Two Healthcare Cities”

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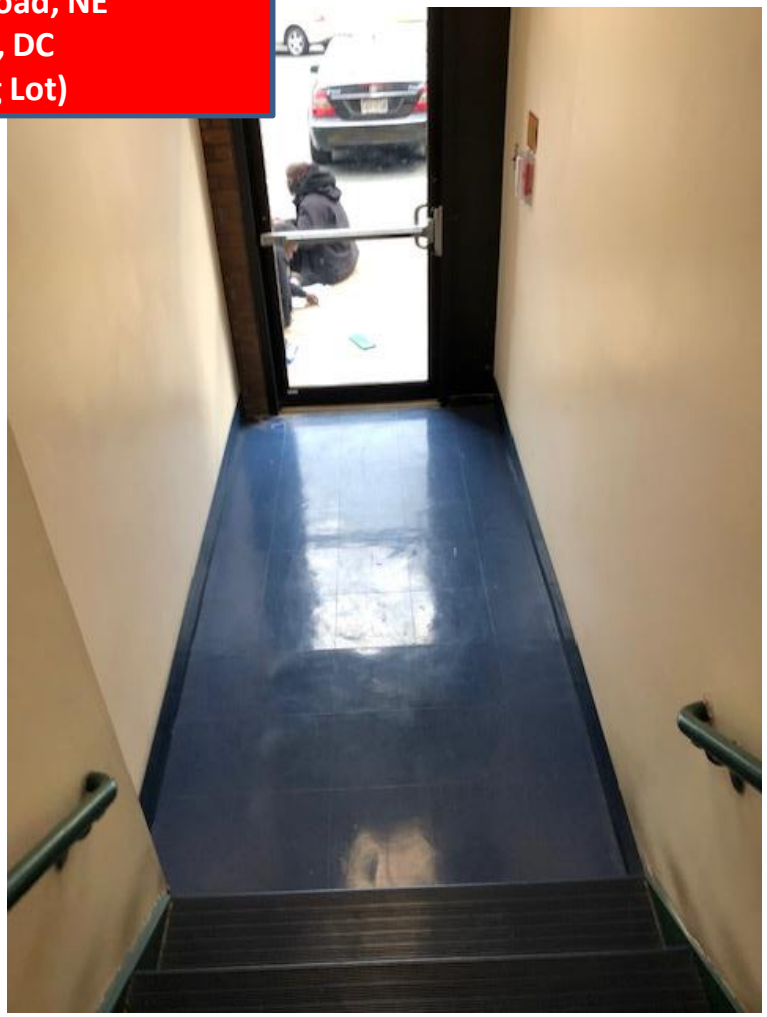

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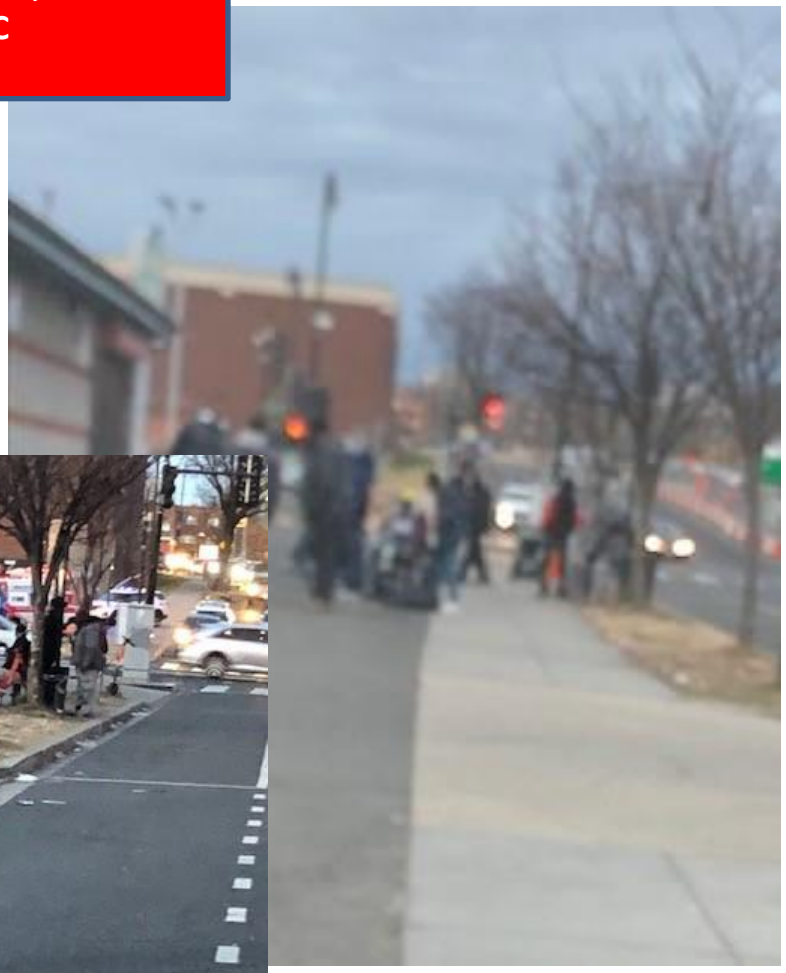

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Health Affairs

content.healthaffairs.org

doi: 10.1377/hlthaff.2015.0393

Health Aff January 2016 vol. 35 no. 1 20–27

Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving Into Supportive Housing

Bill J. Wright[1,*], Keri B. Vartanian[2], Hsin-Fang Li[3], Natalie Royal[4] and Jennifer K. Matson[5]

Author Affiliations

*Corresponding author

Abstract

The provision of supportive housing is often recognized as important public policy, but it also plays a role in health care reform. Health care costs for the homeless reflect both their medical complexity and psychosocial risk factors. Supportive housing attempts
along with on-site integrate
mixture of survey and adm
formerly homeless people w
Oregon between 2010 and
significantly lower overall h
moved into supportive hous
reductions in emergency and

The Washington Post

Democracy Dies in Darkness

No room on the street: D.C. orders homeless out of underpass in fast-developing neighborhood

By **Joe Heim** and **Justin Wm. Moyer**

Jan. 10, 2020 at 5:41 p.m. EST

Williamson/The

SOCIAL DETERMINANTS of HEALTH:
SAFE HOUSING *IS* GOOD MEDICINE

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"Only 10-20% of what determines how long you live happens in the hospital… 80-90% is determined by the neighborhood where you are born and where you happen to be living."

February 2016

Edwin C. Chapman, Sr., MD, DABIM, FASAM
301 538-1362
echap1647@aol.com

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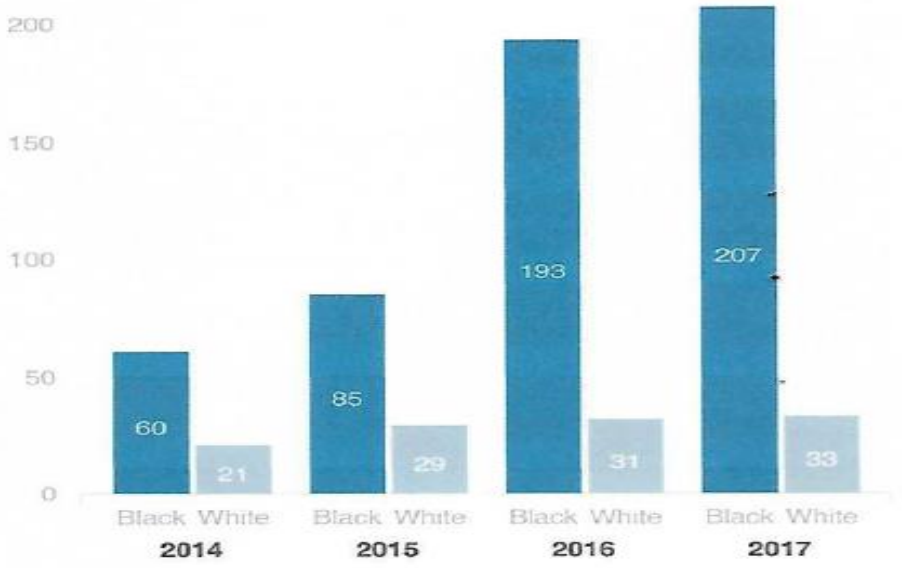
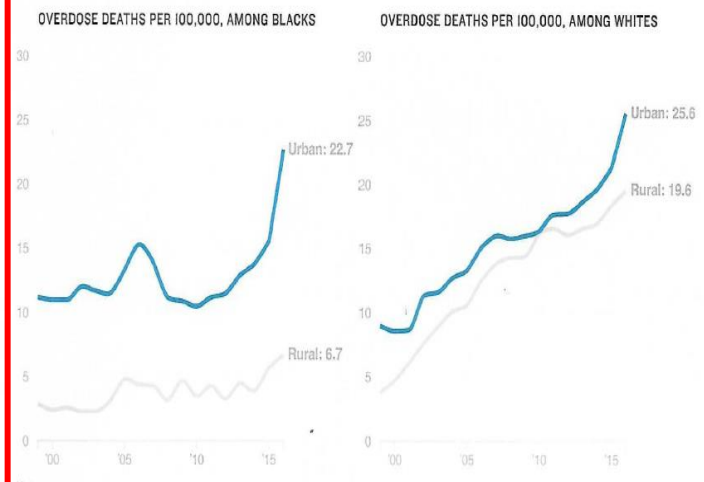
More Than 80 Percent Of D.C. Opioid Deaths Are Among Blacks

The number of opioid overdose deaths among blacks in D.C. more than tripled between 2014 and 2017.



Source: District of Columbia Office of the Chief Medical Examiner
Credit: Katie Park/NPR

Blacks In Urban Areas Have Seen Sharpest Rise In Drug Death Rate



Notes

Rate shown is age-adjusted among non-Hispanic blacks and whites. "Urban" refers to counties in large central metropolitan areas. "Rural" refers to nonmetropolitan or micropolitan areas.

Source: Centers for Disease Control and Prevention
Credit: Katie Park/NPR

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CHAPMAN, MD, PC
Profile of Patients on Buprenorphine in 2015:

(1) Average Age - 52yrs
(2) 2/3 Male vs. Female
(3) Average years incarcerated - 10
(4) > 50% require mental health medication
(5) 10 - 12% HIV+
(6) 60 - 65% Hepatitis C+
(7) 90% Smoke
(8) 25-50% Homeless or Insecure Housing

LIFE EXPECTANCY CUT SHORT by 20-25 YEARS

Edwin C. Chapman, MD
Assistant Professor
Dept. of Behavioral Health
Howard University College of Medicine

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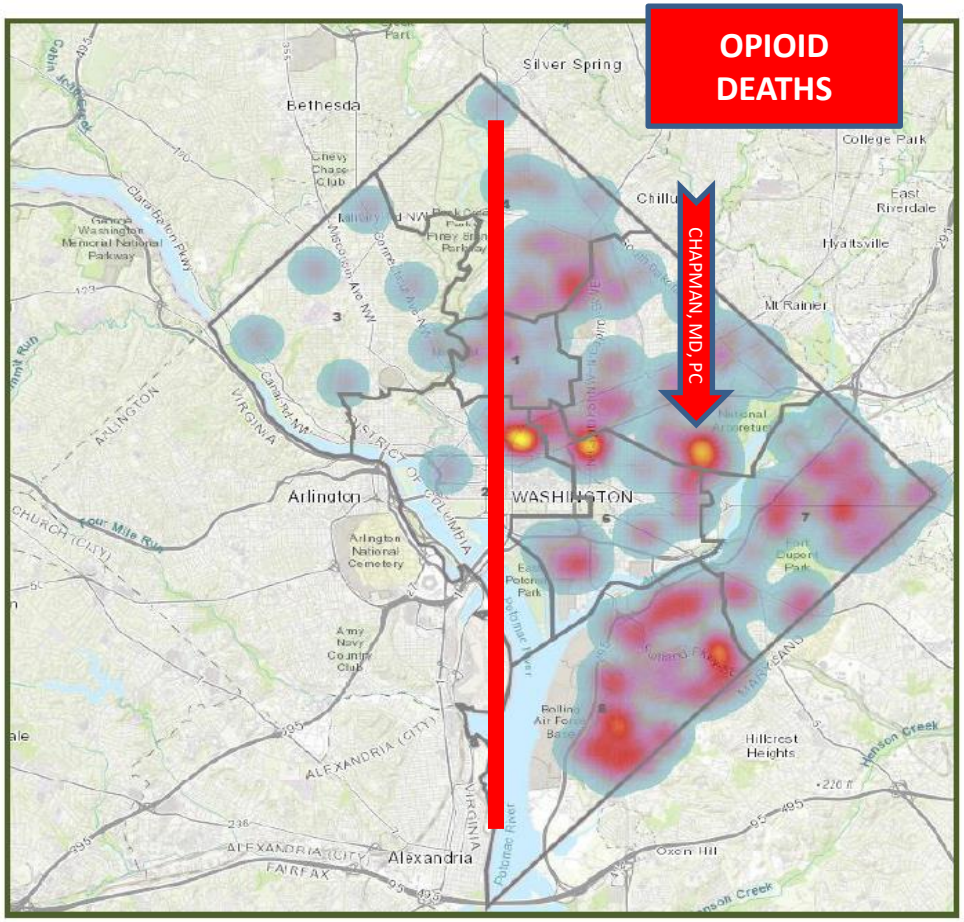
Map of Opioid Overdoses by Jurisdiction of Residence

The map below displays opioid overdoses in 2017 by jurisdiction of
opioid overdoses are prevalent in Wards 5, 6, 7 and 8. The map also

EAST END

OPIOID DEATHS



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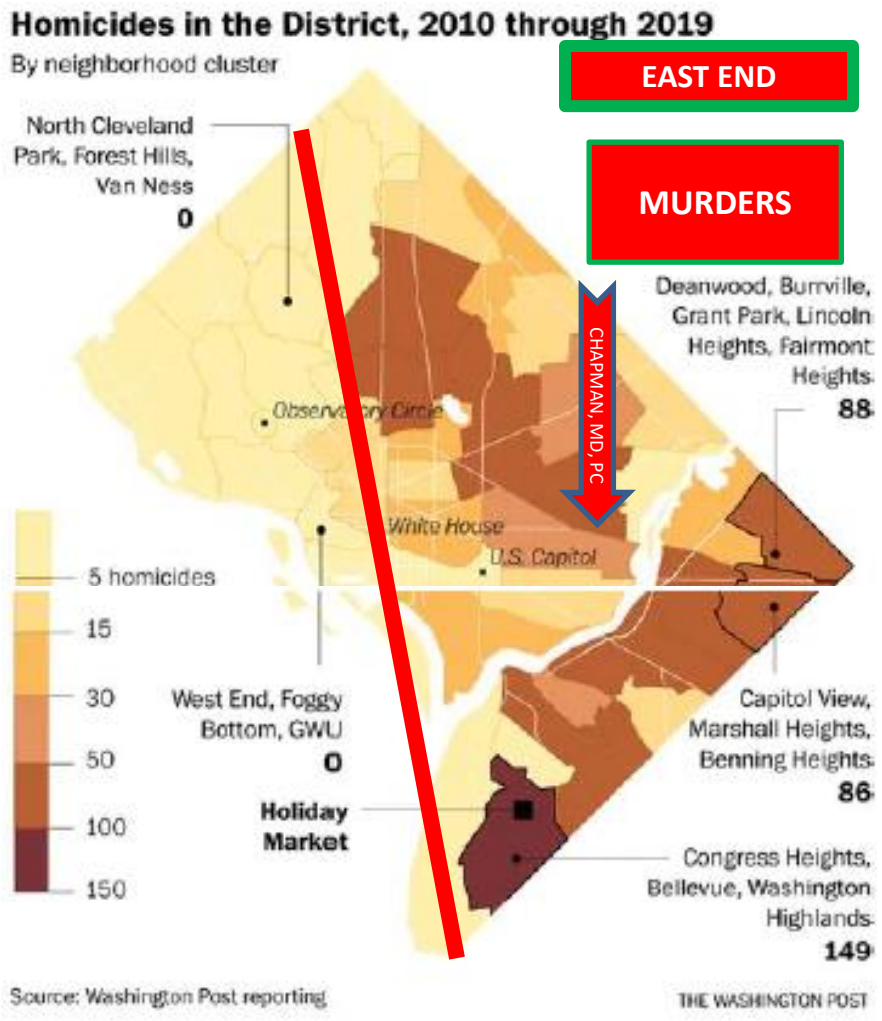

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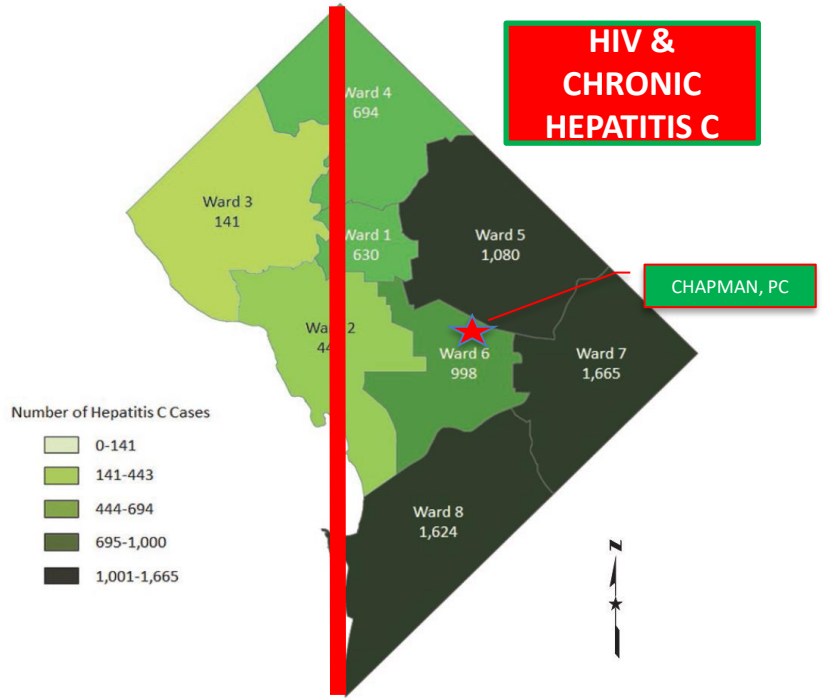
District of Columbia Department of Health

Map 7. Number of Newly Reported Chronic Hepatitis C Cases by Ward
District of Columbia, 2008-2012

EAST END

HIV & CHRONIC HEPATITIS C



- Address and ward information was available for 74% of newly reported chronic hepatitis C cases.
- Wards 7 had the highest number of newly reported chronic hepatitis C cases between 2008 and 2012 (n=1,665) followed by Wards 8 and 5.
- Ward 3 had the lowest number of newly reported chronic hepatitis C cases between 2008 and 2012 (n=141).
- There were 718 newly reported chronic hepatitis C cases between 2008 and 2012 among individuals reportedly incarcerated at the time of diagnosis, and 219 cases among individuals identified as homeless.

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Opioid Use Disorder as a Classic Example of "Medical Apartheid"

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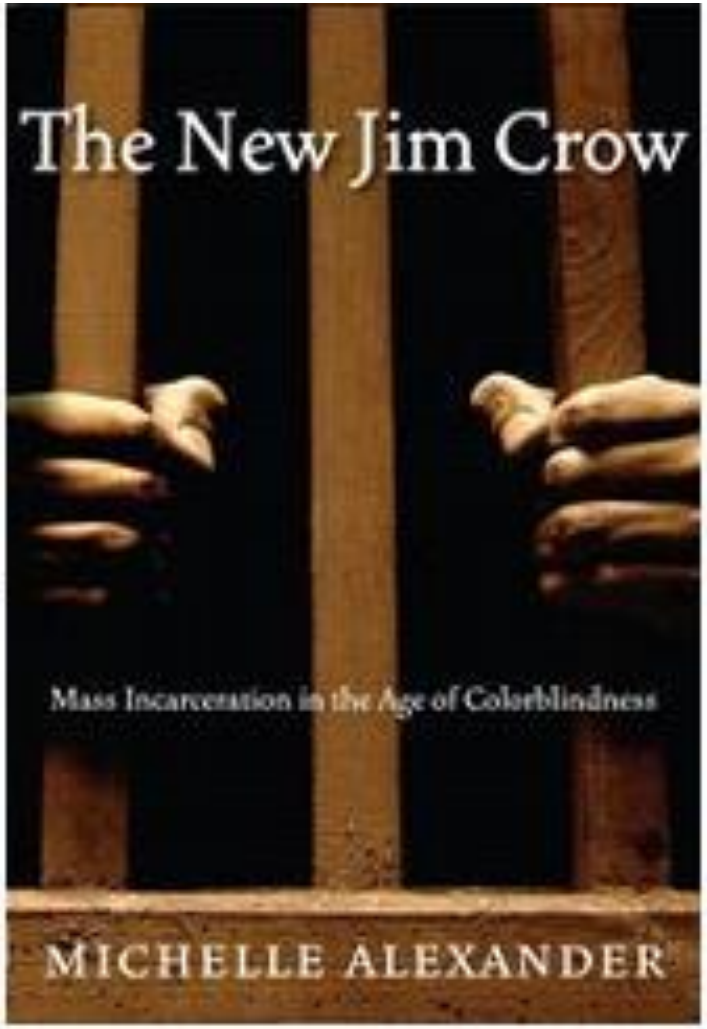
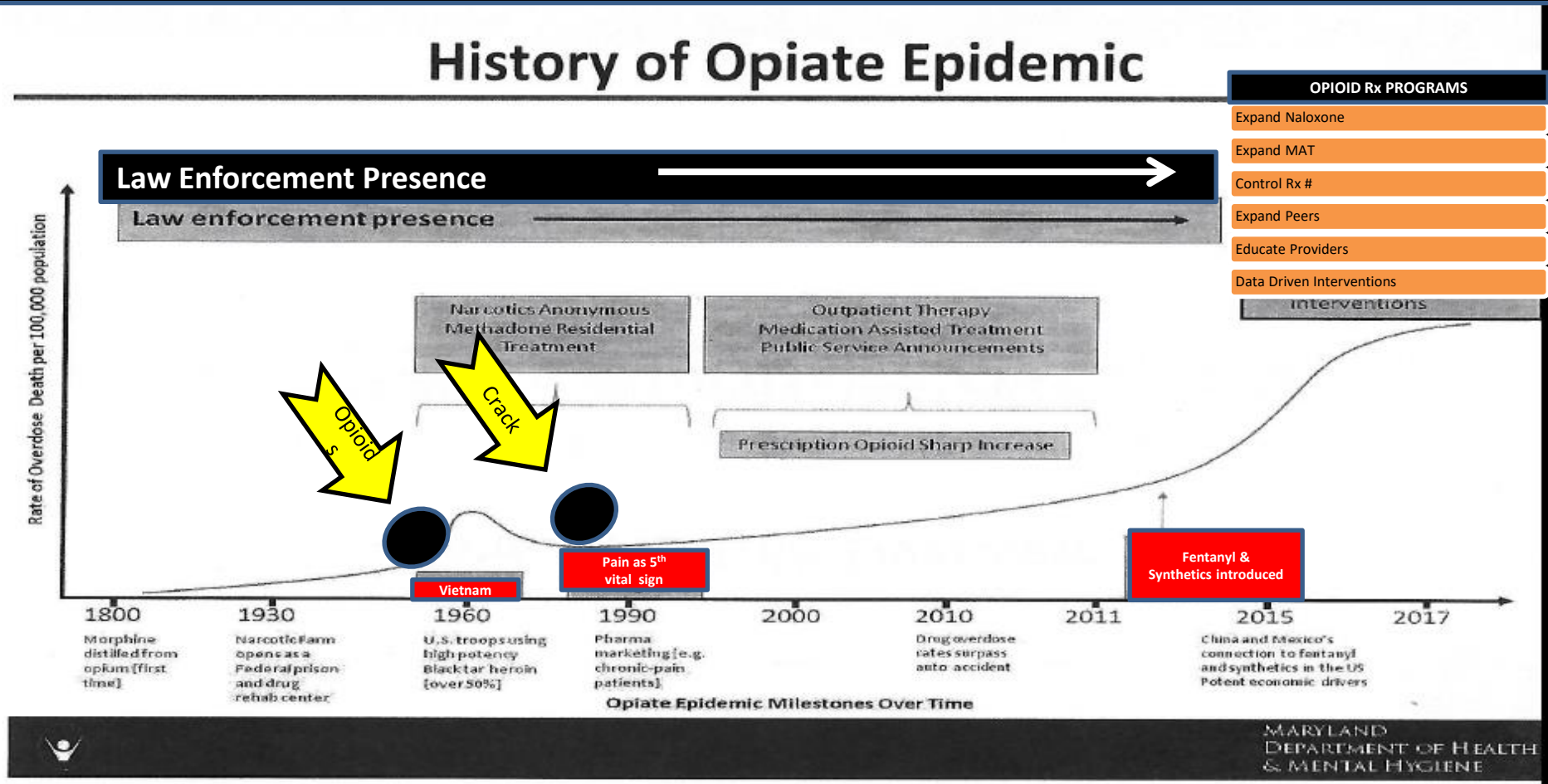


Here-to-fore, OPIOIDS & CRACK COCAINE WERE "MORAL" PROBLEMS in BLACK (URBAN) AMERICA…



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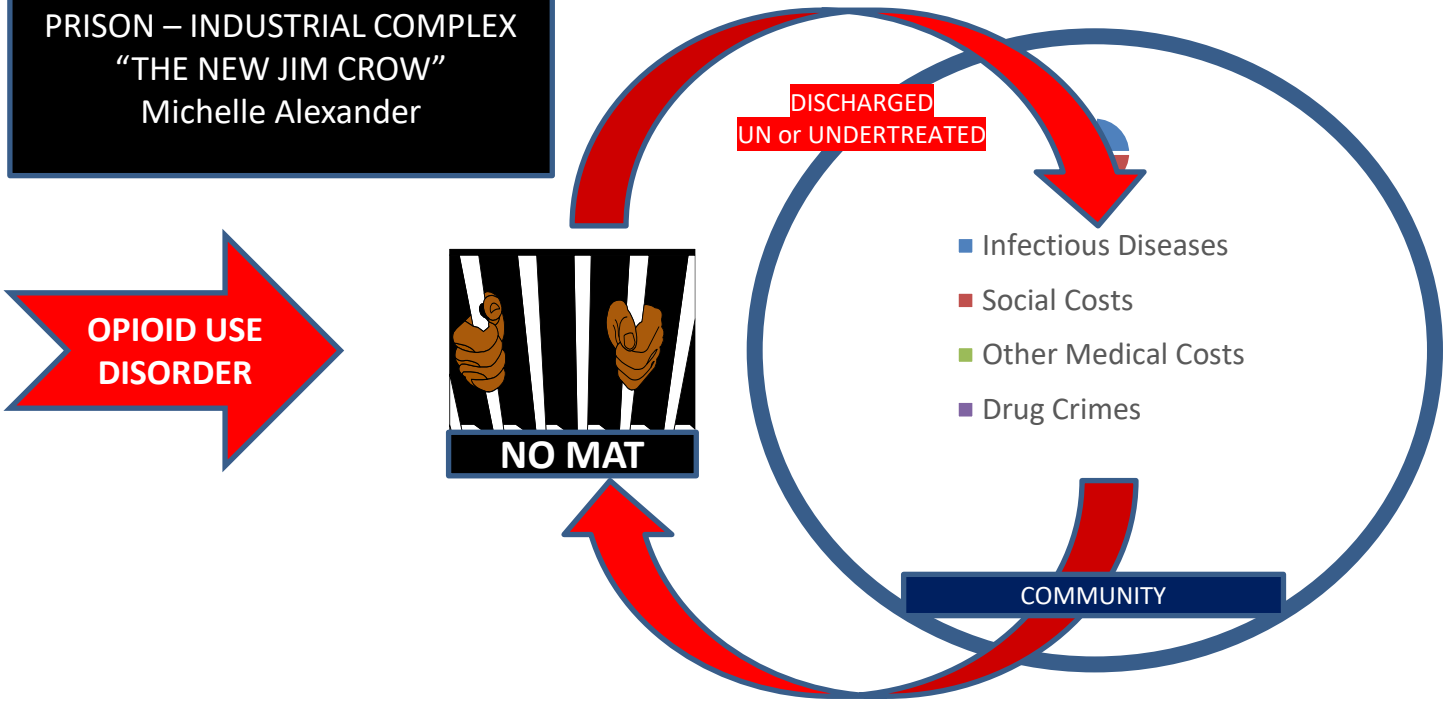
PRISON – INDUSTRIAL COMPLEX
"THE NEW JIM CROW"
Michelle Alexander



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TRUMP ADMINISTRATION'S "2016-2020" HEALTHCARE & OPIOID TREATMENT CONUNDRUM

TRUMP

"Lock'um Up!!

"Medication Treatment Simply Replaces 1 drug for another!!"

"STRUCTURAL INCOMPETENCY"
Dr. Helena Hansen
UCLA

"Able Bodied Should Work to Get Medicaid!!"

"Needle Exchange Encourages Drug Use !!"

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NMA Statement on the Medicaid Work Requirement

2017

Dear NMA Membership,

The Trump Administration is working swiftly to move forward with grant approval to allow states to impose work requirements on their Medicaid programs. Kentucky received approval to move forward today. Nine other states have similar waiver requests, and more approvals are expected. This is the first time in the Medicaid program's history that such a requirement has been allowed. The National Medical Association condemns the Trump Administration's approval of these cruel and inherently harmful requirements.

The Trump Administrations assumption that Medicaid work requirements are "a positive incentive for beneficiaries" are misguided and biased. A recent analysis of census data by the Kaiser Family Foundation reports that 60 percent of Medicaid's non-elderly adults already work and of those without a job, more than a third are ill or disabled, 30 percent are caring for young children, and 15 percent are in school. This action is an attack on the health and wellness of disabled and low-income Americans. Imposing such requirements could result in Medicaid enrollment denials or insurance coverage interruptions that ultimately, endanger the lives of people in need of medical care.

The National Medical Association will continue to challenge this and other policies proposed by th
fail to promote equal access to healthcare and endanger the lives of the patients that we serve.

Sincerely,
Doris Browne, MD, MPH
118th President of the National Medical Association

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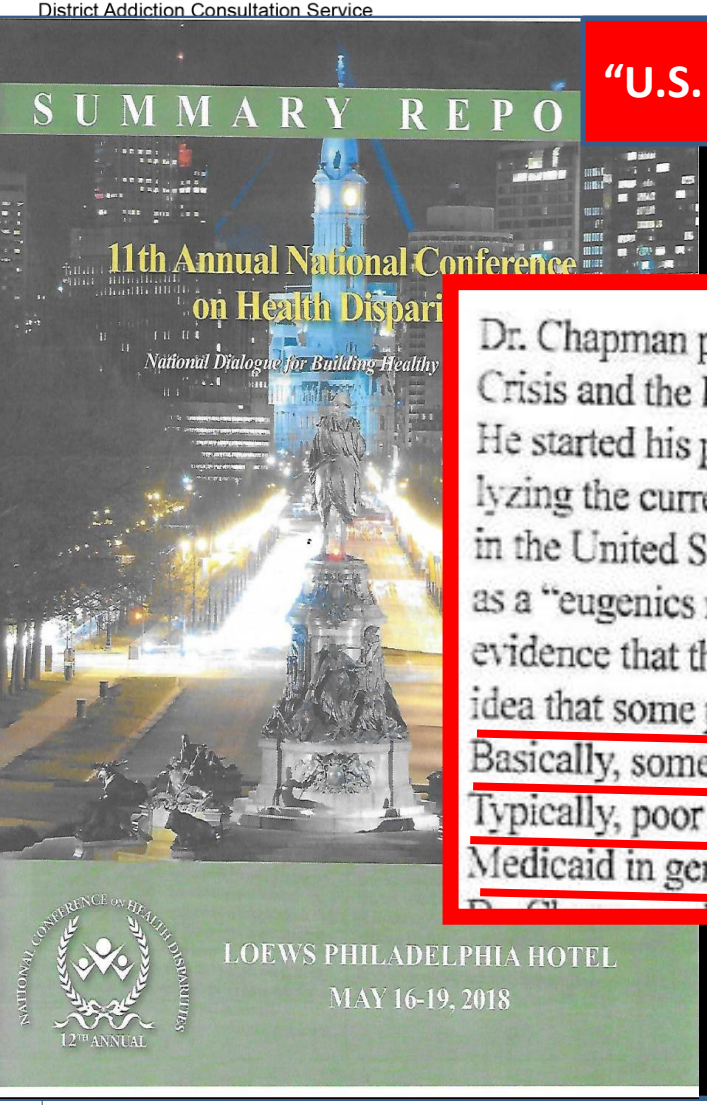

"U.S. Eugenics Healthcare Model"

Dr. Chapman presented "The Opioid Crisis and the Black Community." He started his presentation by analyzing the current state of health care in the United States. He referred to it as a "eugenics model." He provided evidence that the nation's health care system is based on the idea that some people deserve to get care and others do not. Basically, some lives are worthier of preserving than others. Typically, poor people, people of color and people who are on Medicaid in general, are considered to be undeserving of care.

Dr. Edwin Chapman

MAY 18, 2018

Panelists

Dr. Edwin C. Chapman, *Private Practice, Internist, Addiction Medicine, Washington, DC*

Dr. Edwin Chapman

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eral, are considered to be undeserving of care.
ed several states that are trying to exclude
dicaid and health care by implementing a work
Chapman noted that this "eugenics model"
national response to the opioid epidemic. Spe-
he opioid epidemic began to affect rural white
solution for African Americans who were
was to incarcerate them. Dr. Chapman also
s that showed that opioid overdoses, while
to be a "white problem," are rampant in the
n community due to PTSD, racism and other
ts, such as the lack of affordable housing,
e. Dr. Chapman concluded that the same
treatments and resources proposed to solve opioid overdoses in white communities should be extended to African-American communities. He cited the treatment models in France and Portugal as examples of how the United States could begin to solve the opioid epidemic.

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Edwin C. Chapman, MD
Chief Medical Officer
Medical Home Development Group

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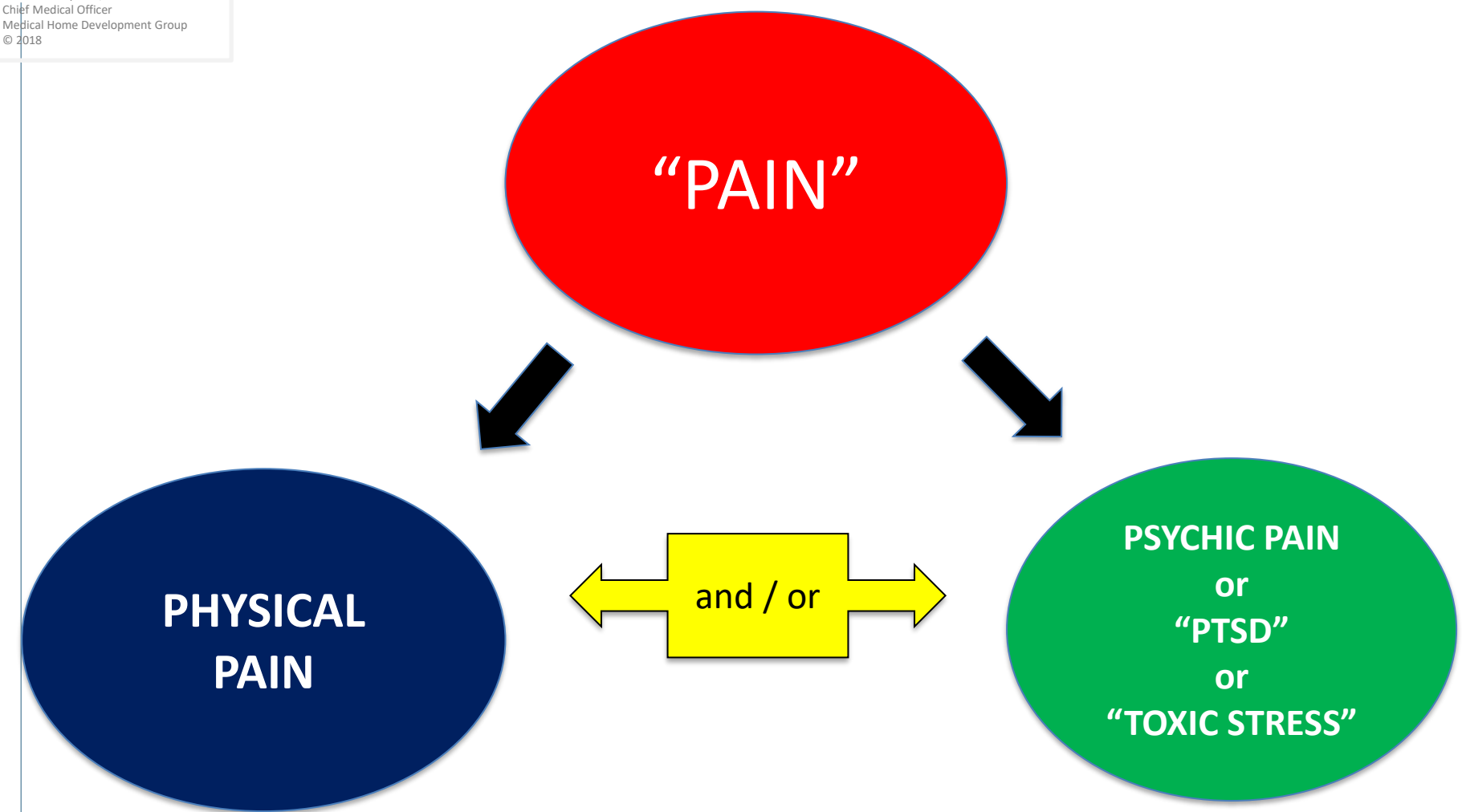

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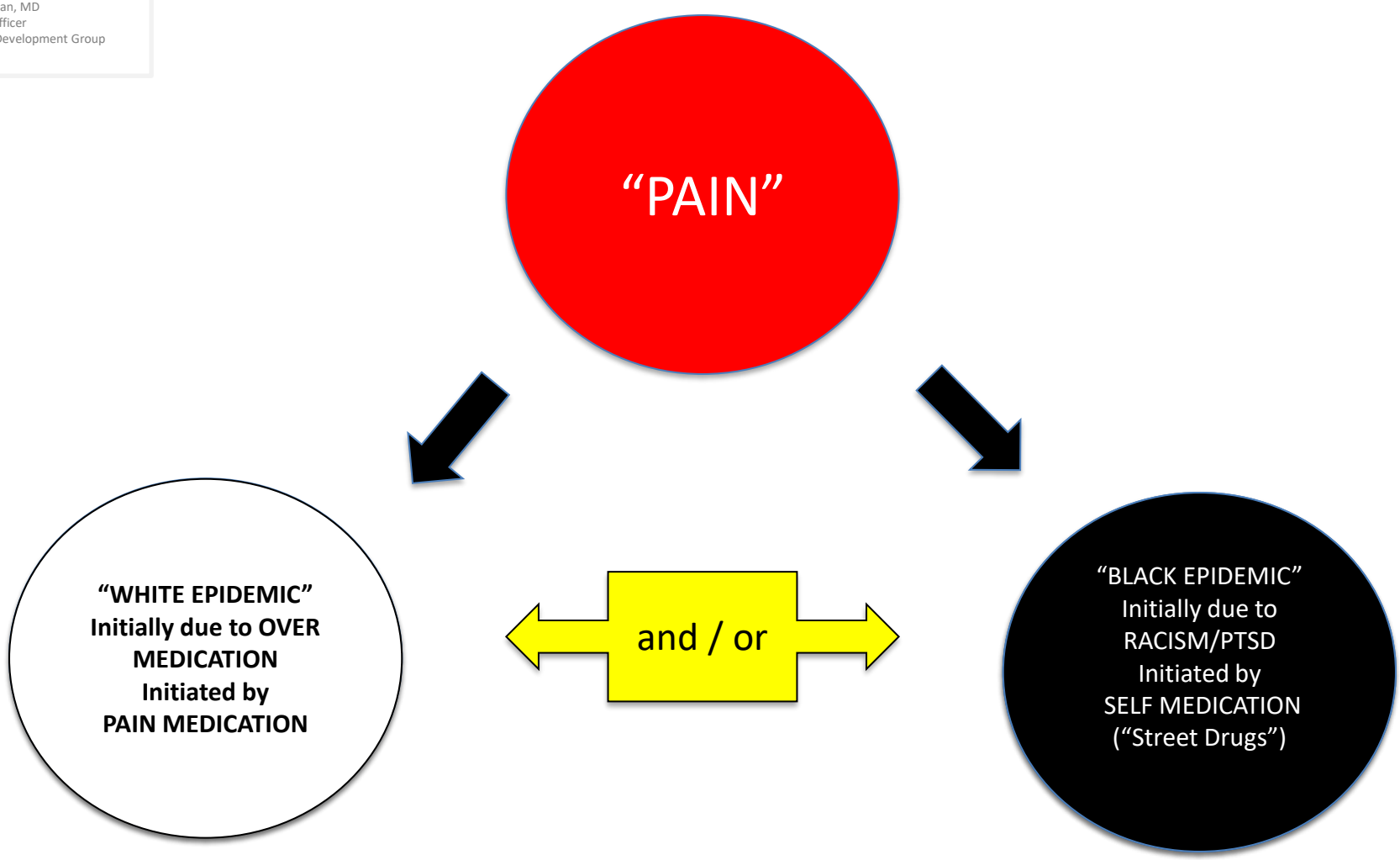

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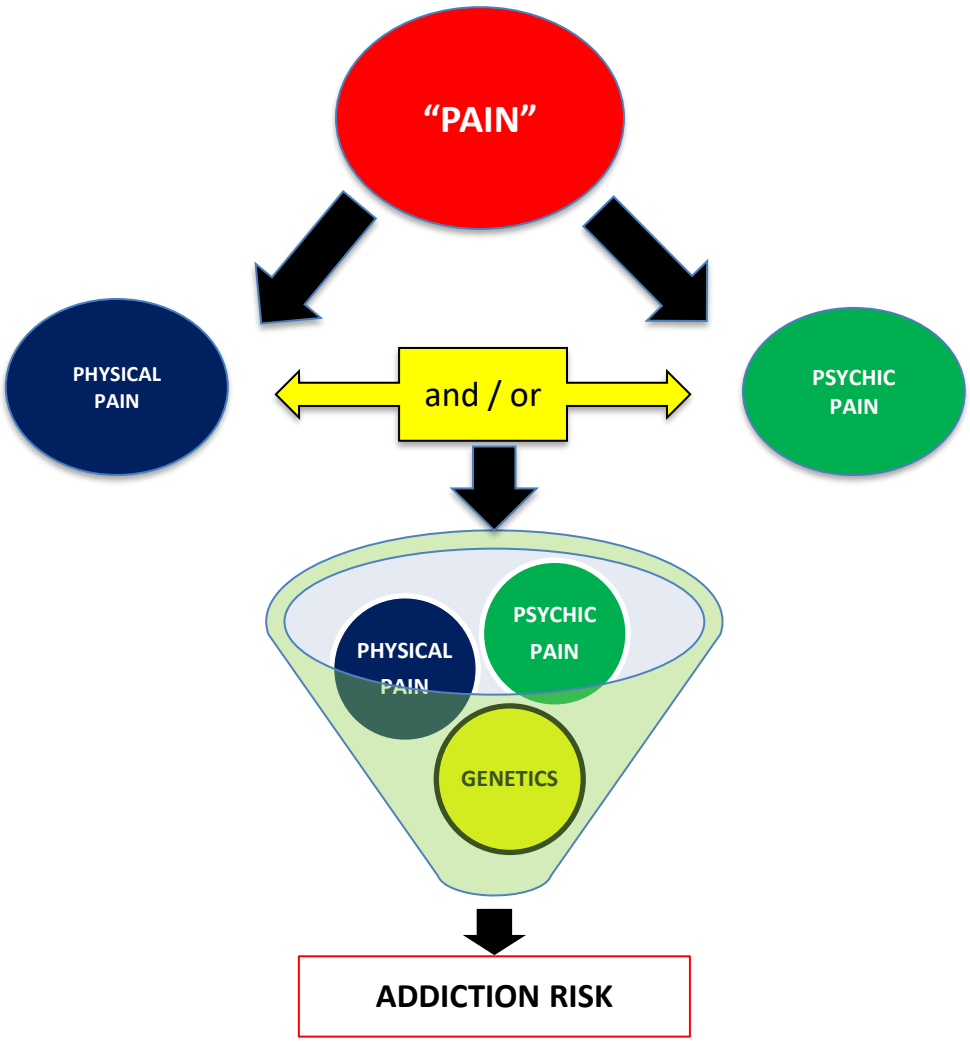

THE WHY FACTOR?

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OPIOIDS BECAME a "DISEASE" in WHITE (SUBURBAN and RURAL) AMERICA

Death rates are rising for middle-aged white Americans, while declining in other wealthy countries and among other races and ethnicities. The rise appears to be driven by suicide, drugs and alcohol abuse.

Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century Anne Case1 and Angus Deaton1 Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544 Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir

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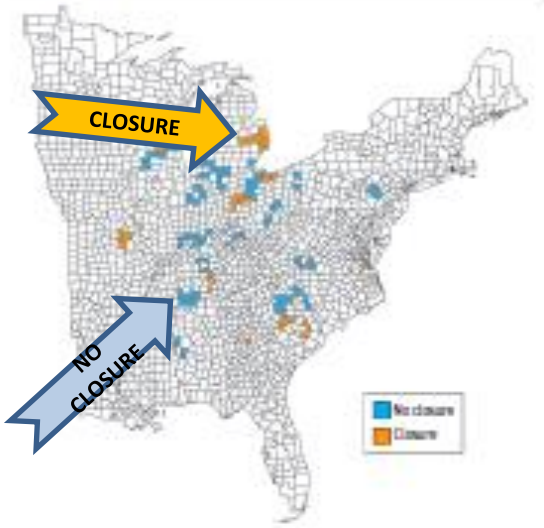
JAMA Internal Medicine | Original Investigation

Association Between Automotive Assembly Plant Closures and Opioid Overdose Mortality in the United States
A Difference-in-Differences Analysis

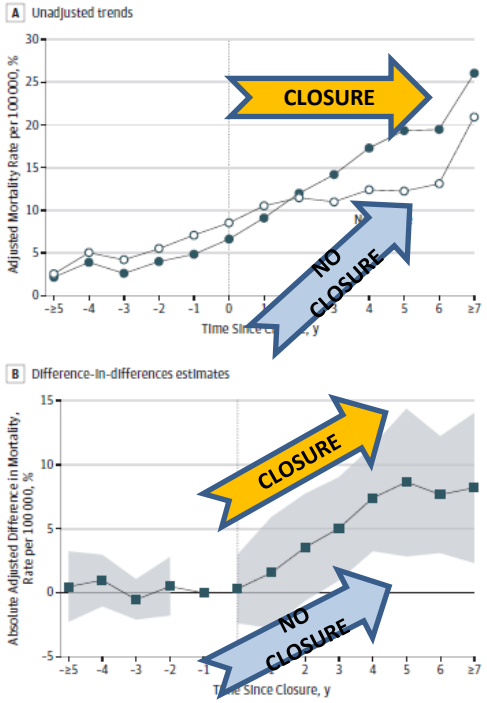
Ashwini S. Venkataramani, MD, PhD; Elizabeth F. Bair, MS; Rourke L. O'Brien, PhD; Alexander C. Tsai, MD, PhD

Figure 1. Sample Counties and Geographic Distribution of Automotive Assembly Plant Closures



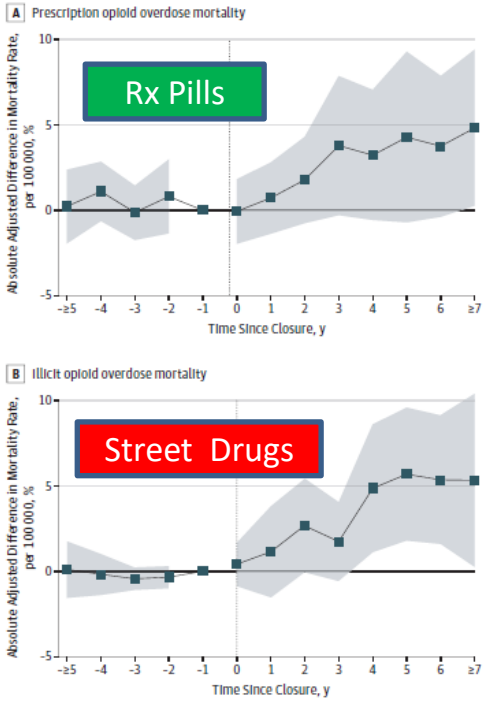
The 712 manufacturing counties that comprised the study sample were defined as those in which the percentages of employed residents working in manufacturing are in the top quintile nationwide. The 29 exposed manufacturing counties (Closure) were located in the 10 commuting zones in which an automotive assembly plant closure occurred between 1999 and 2016. The 83 unexposed manufacturing counties (No closure) were located in the 20 commuting zones in which automotive assembly plants in operation as of 1999 remained open throughout the duration of the study period.

Figure 2. Unadjusted Trends and Adjusted Difference-in-Differences Estimates of the Association Between Automotive Assembly Plant Closures and Opioid Overdose Mortality Rates



A, Unadjusted trends in county-level age-adjusted opioid overdose mortality rates among adults aged 18 to 65 years, separately for counties exposed and unexposed to automotive assembly plant closures. B, Adjusted difference-in-differences estimates (ie, the absolute adjusted difference between exposed and unexposed counties) for the same outcome (with the shaded areas representing 95% CIs) are plotted. In both panels, the x-axis represents the number of years relative to a plant closure, with event years 5 years or more years before exposure and 7 years or more years after combined into a single time point. The sample consisted of 2016 county-year observations, representing 29 exposed and 83 unexposed counties in 30 commuting zones followed from 1999 to 2016.

Figure 3. Difference-in-Differences Estimates of the Association Between Automotive Assembly Plant Closures and Prescription Opioid Overdose Mortality and Illicit Opioid Overdose Mortality



A, Prescription opioid overdose mortality. B, Illicit opioid overdose mortality. Models are identical to those presented in Figure 2B, except here the dependent variables are opioid overdose mortality per 100 000 individuals aged 18 to 65 years from prescription opioids and illicit opioids. See Figure 2 caption for further details.

100 000 (95% CI, 0.4-12.3; $P = .04$), while the estimated association for older non-Hispanic white women (35-65 years) was smaller in magnitude and not statistically significant. Estimates for nonwhite men and women were generally smaller

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JAMA Internal Medicine | Original Investigation

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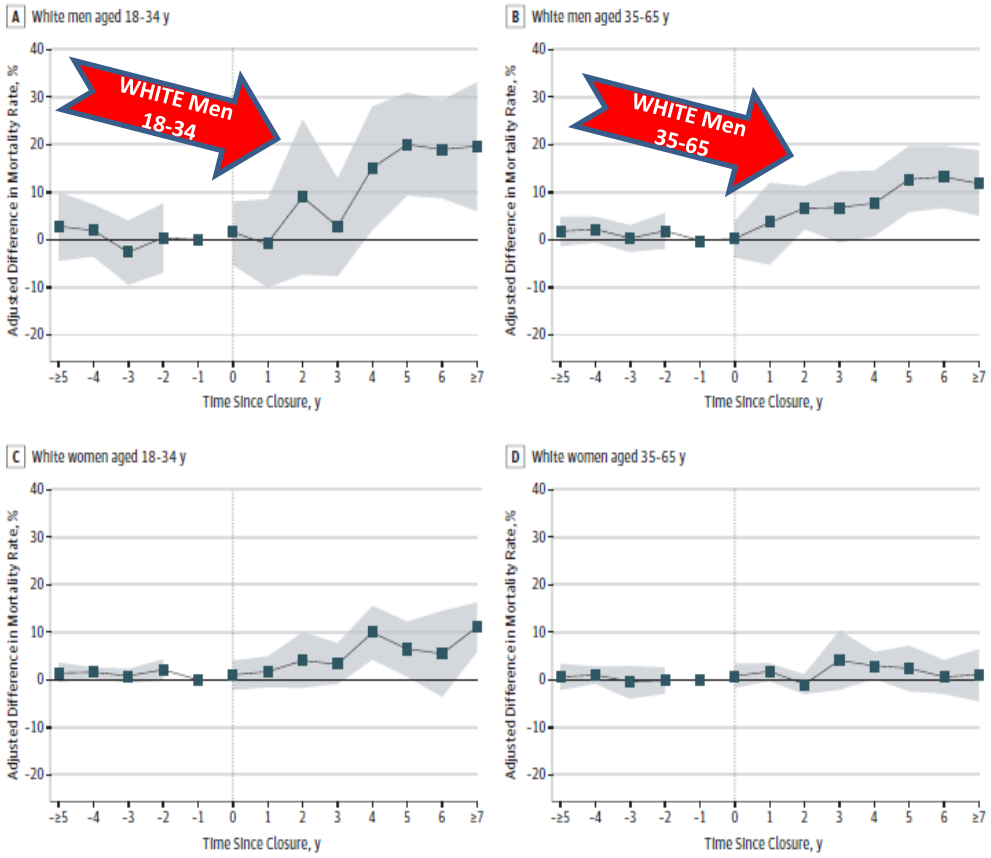
Ashwini S. Venkataramani, MD, PhD; Elizabeth F. Bair, MS; Rourke L. O'Brien, PhD; Alexander C. Tsai, MD, PhD

ties. The estimates imply that, 5 years after a plant closure, opioid overdose mortality rates were 85% higher, in relative terms, than what would have been expected had exposed counties followed the same outcome trends as unexposed counties. The burden of this increase in opioid overdose mortality was primarily borne by non-Hispanic white men.

Our findings illustrate the importance of declining economic opportunity as an underlying factor associated with the opioid overdose crisis. In particular, our findings, combined with a growing body of research demonstrating adverse associations between trade-related industrial decline and drug overdose mortality,[23,24] lend support to the view that the current opioid overdose crisis may be associated in part with the same structural changes to the US economy that have been responsible for worsening overall mortality among less-educated adults since the 1980s.[47,48] Declining economic opportunity is one hypothesized mechanism associated with these longer-term trends.[15,16,21,49] Given our study context, this argument

Figure 4. Difference-in-Differences Estimates for Opioid Overdose Mortality for Non-Hispanic White Adults, Stratified by Sex-Age Subgroups



A, White men aged 18 to 34 years. B, White men aged 35 to 65 years. C, White women aged 18 to 34 years. D, White women aged 35 to 65 years. Models are identical to those in Figure 2B except here the dependent variable is opioid overdose mortality for each listed sex-age subgroup among non-Hispanic white adults. See Figure 2 caption for further details.

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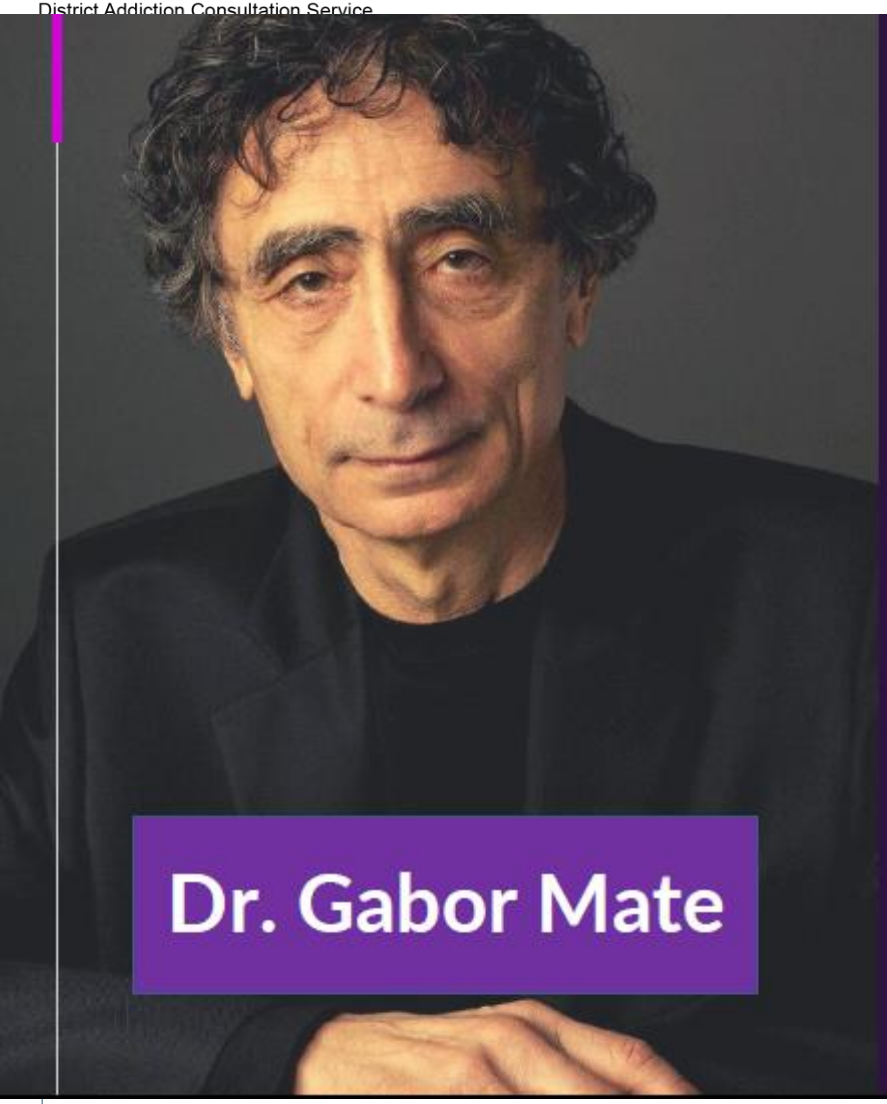

"Toxic Stress"

WRITINGS AND VIEWS

"A recurring theme in Maté's books is the impact of a person's childhood on their mental and physical health through neurological and psychological mechanisms, which he connects with the need for social change. In the book In the Realm of Hungry Ghosts, he proposes new approaches to treating addiction (e.g. safe injection sites) based on an understanding of the biological and socio-economic roots of addiction. He describes the significant role of "early adversity", i.e. stress, mistreatment, and particularly childhood abuse, in increasing susceptibility to addiction."

https://en.wikipedia.org/wiki/Gabor_Mate

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New Hampshire Mothers Struggling With Opioid Addiction Fight To Keep Their Children

Rachel Gotbaum June 2, 20188:37 AM ET

Jillian Broomstein starts to cry when she talks about the day her newborn son Jeremy was taken from her by New Hampshire's child welfare agency. He was 2 weeks old.

"They came into the house and said they would have to place him in foster care and I would get a call and we would set up visits," she says. "It was scary."

Broomstein, who was 26 at the time, had not used heroin for months and was on methadone treatment. The clinic social worker told her that since Jeremy would test positive for methadone when he was born, she would need to find safe housing or risk losing custody.

Neonatal Abstinence Syndrome (NAS)

Jillian Broomstein plays with her son.

Rachel Gotbaum/NPR

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The CHRONICLE of SOCIAL CHANGE

FINANCE REFORM · OPINION · SUBSTANCE ABUSE

On Child Welfare, an Insufficient Federal Response to the Opioid Epidemic

- by Angie Schwartz and Sean Hughes
- April 24, 2018 | Guest Writer

In 2012, following more than a decade of significant decline, the number of American children in foster care began rising. Between 2012 and 2016, the number of children in foster care nationally has increased by more than 10 percent. There is broad agreement that the ongoing opioid epidemic has been a primary contributor to those increases.

This 2016 photo of a grandmother and her boyfriend, overdosed in the front seat with her grandchild in the back, became symbolic of the need for stronger government response to the child welfare side of the opioid epidemic

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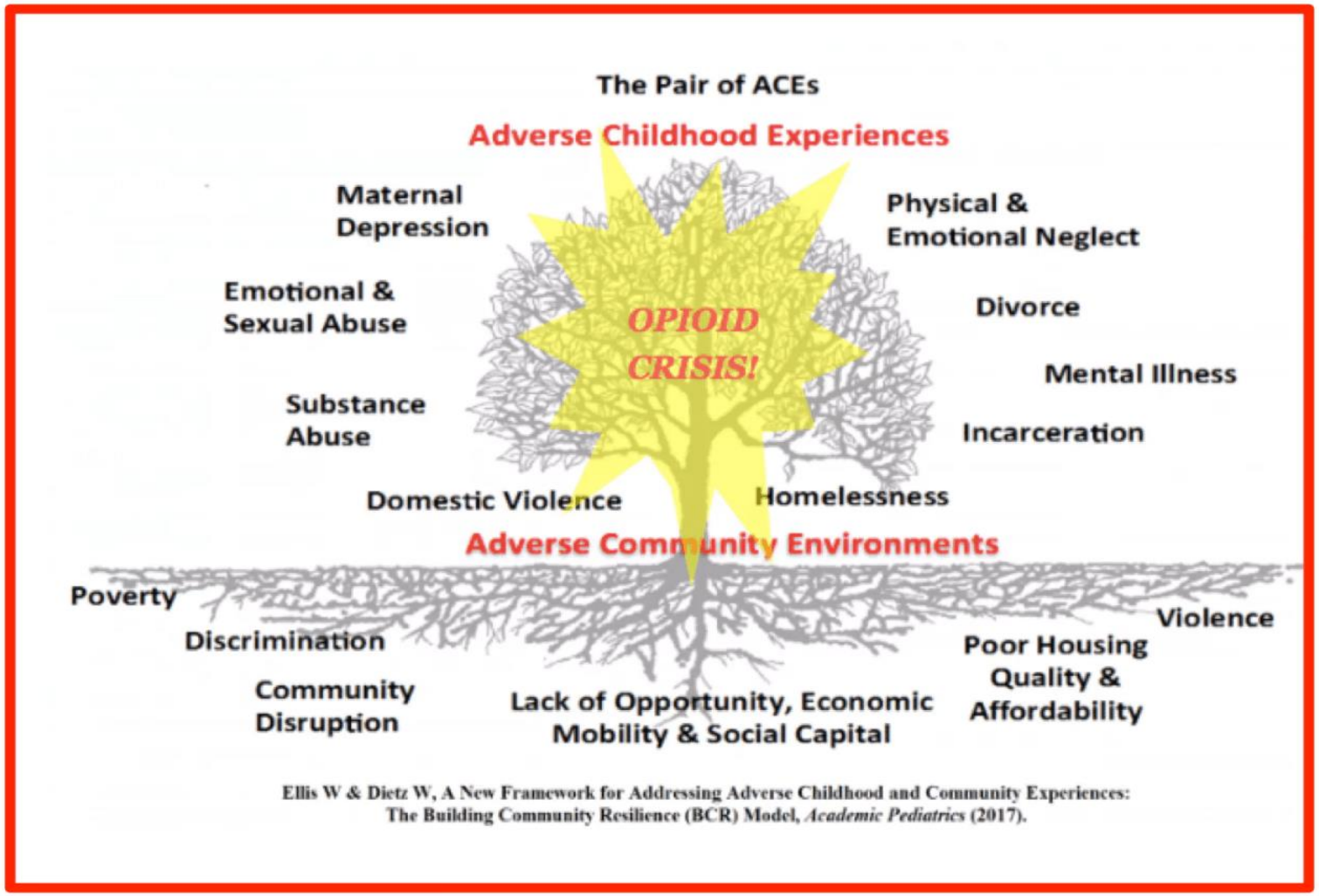
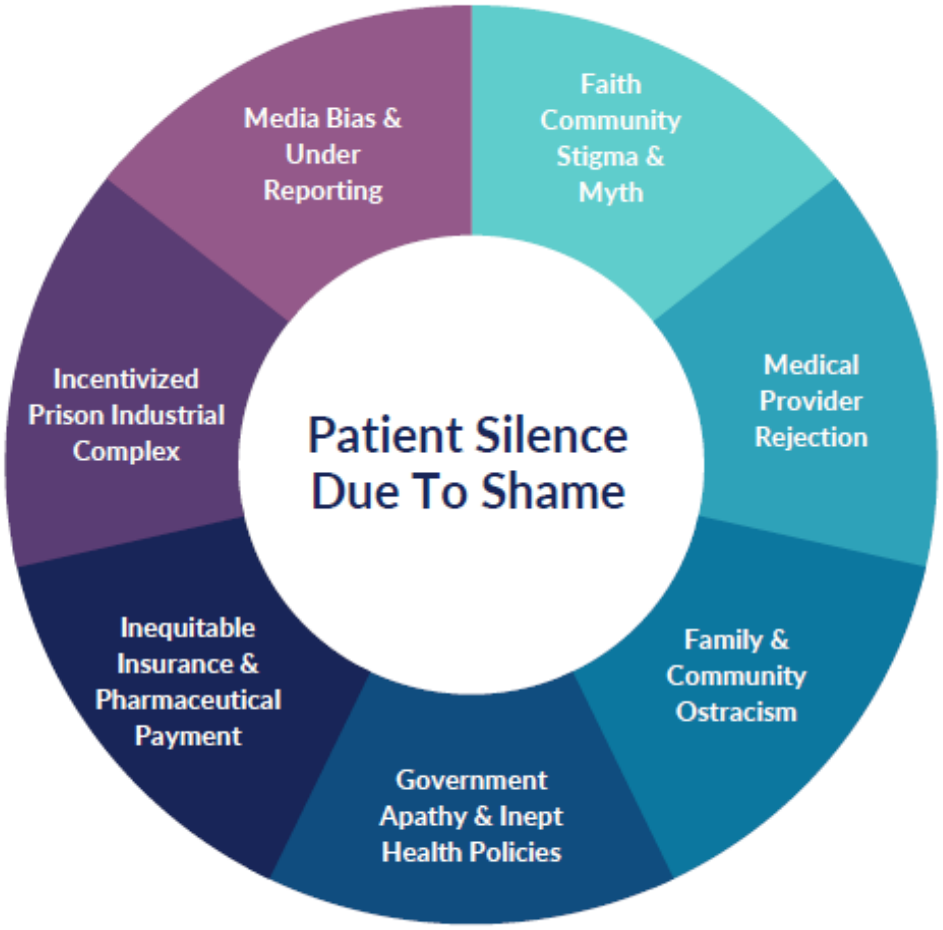


Ellis W & Dietz W, A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model, *Academic Pediatrics* (2017).

THE CYCLE OF DESPAIR



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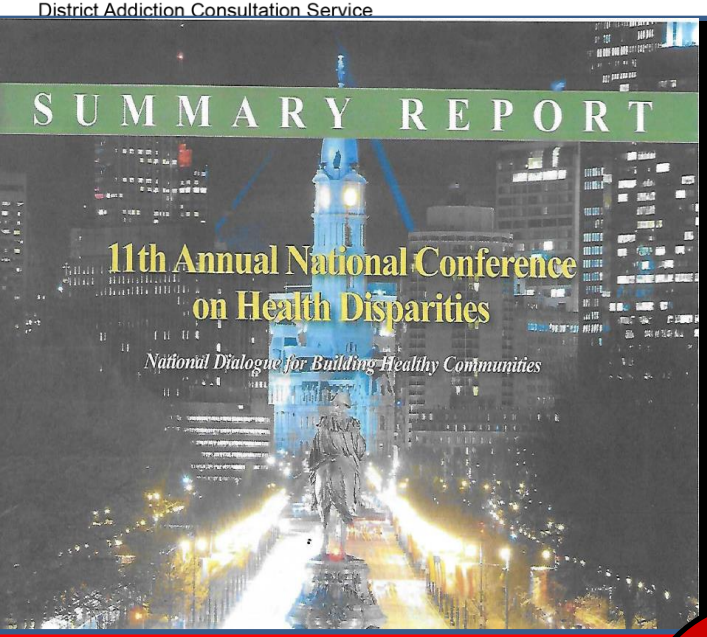

END

"Medical Apartheid" and "U.S. Eugenics Healthcare"

NATIONAL CONFERENCE ON HEALTH DISPARITIES 12TH ANNUAL

LOEWS PHILADELPHIA HOTEL

MAY 18, 2018

Panelists

Dr. Edwin C. Chapman, *Private Practice, Internist, Addiction Medicine, Washington, DC*

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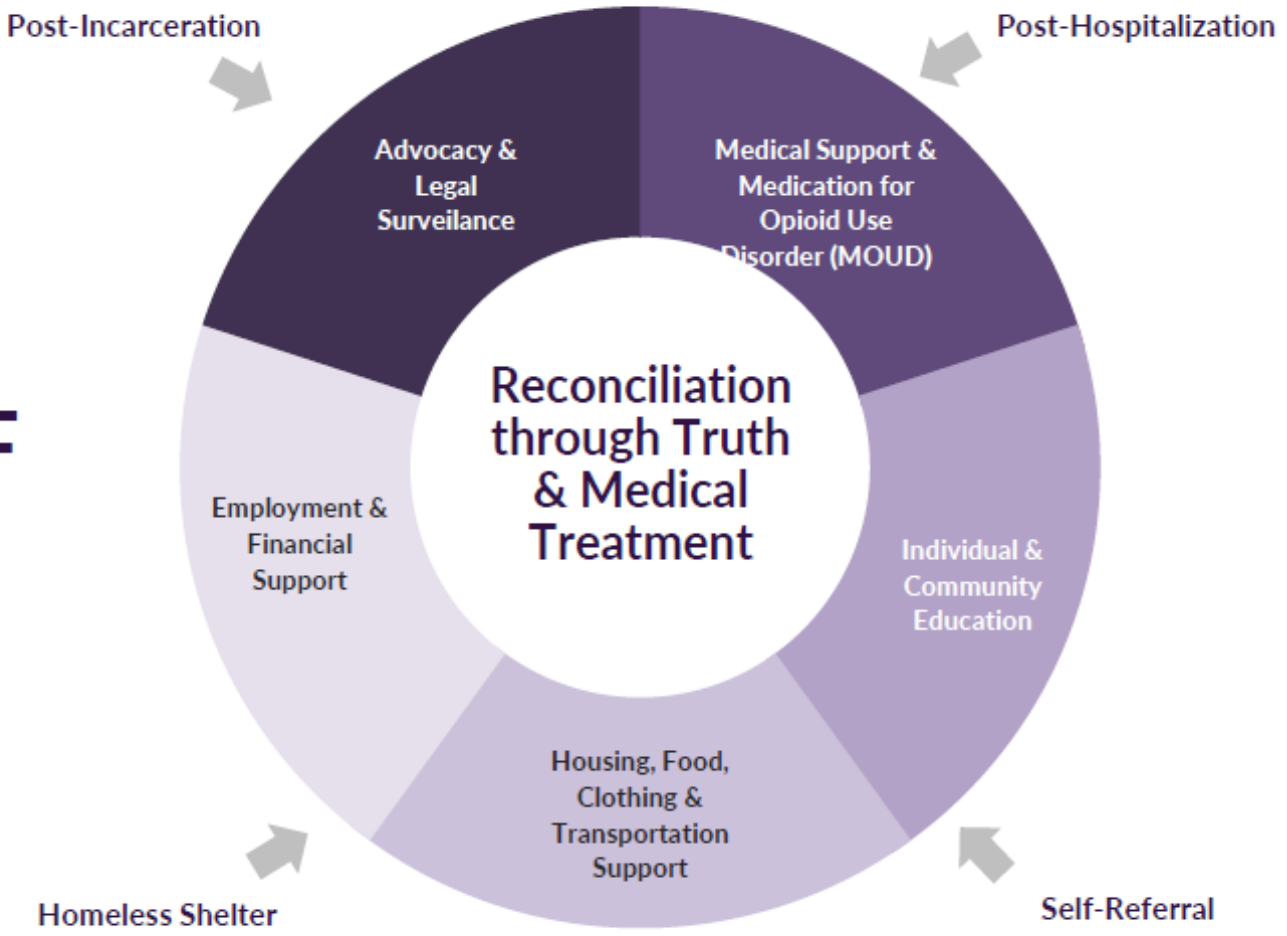
THE CYCLE OF REPAIR



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Cultural Competency and Legal Intervention as the "Antidote to Medical Apartheid"

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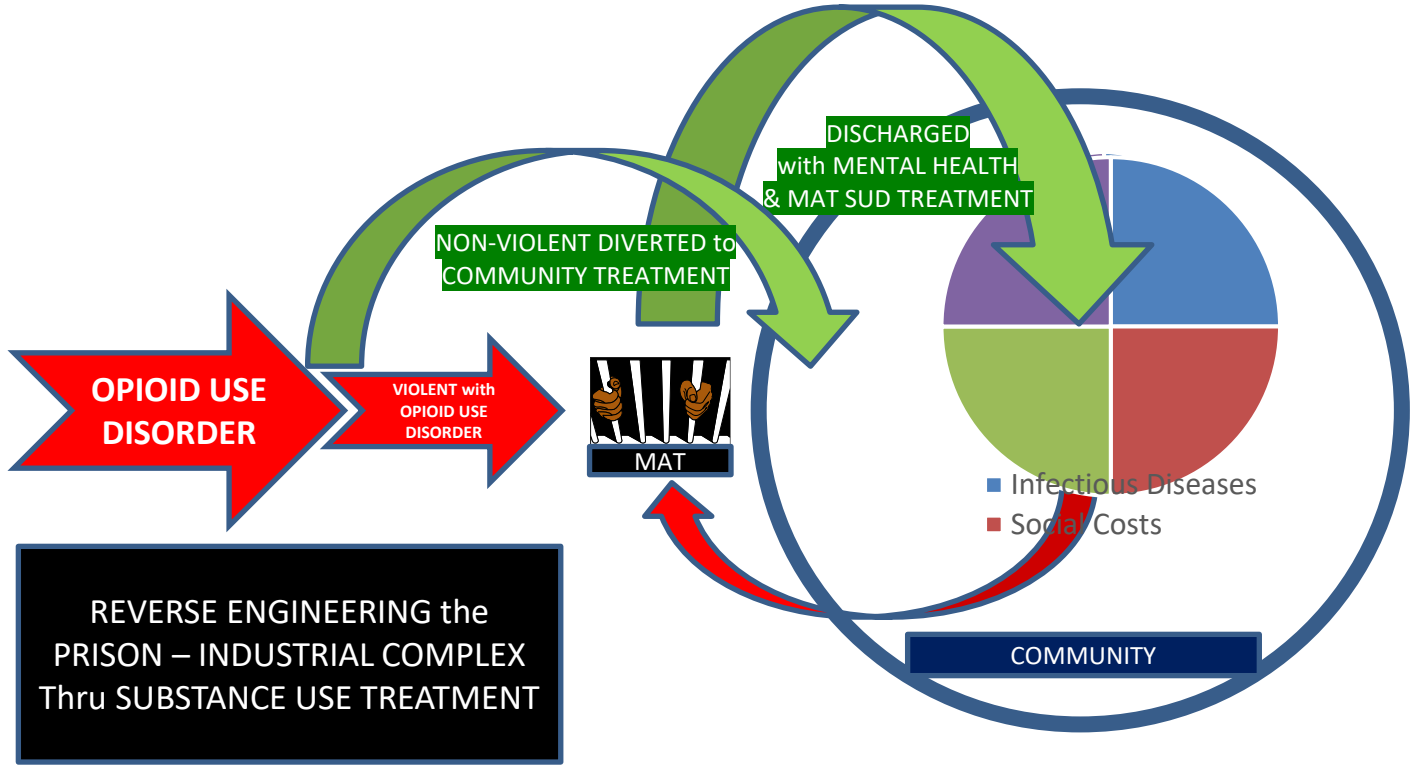

REVERSE ENGINEERING the
PRISON – INDUSTRIAL COMPLEX
Thru SUBSTANCE USE TREATMENT

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AFROCENTRIC "VILLAGE" HEALTH ECOSYSTEM of CARE for INTEGRATED and COLABORATIVE OPIOID TREATMENT

2013 – PRESENT
HOWARD UNIVERSITY
"URBAN HEALTH INITIATIVE"
for
COMPREHENSIVE OPIOID FAMILY CARE TREATMENT

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"Social Engineering" Pastors, Psychiatrists, Psychologists, Social Workers, Physicians, and Lay Persons
planning meeting on
"Black Mental Health in the DMV"
(District of Columbia, Maryland, and Virginia)

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Request for Applications (RFA)

RFA No. RM0 DCOR080819

Government of the District of Columbia
Department of Behavioral Health (DBH)

RFA Title: DC Opioid Response (DCOR) Faith-Based Recovery Month Grant

RFA Release Date: Friday, August 9, 2019

Application Submission Deadline:
Friday, August 23, 2019, 1:00 p.m. ET

Pre-Application Conference:
Tuesday, August 13, 2019

64 New York Avenue, NE, DBH Room 242
Washington, DC 20002
from
3:00pm – 4:00pm

1. Hosting Conversations on Opioid Awareness and Workshops to Understand the Signs and Symptoms of OUD

2. Promoting a Day of Recovery

3. Discussion of Treatment and Recovery Services

4. Training Community Members on Naloxone

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O'NEILL INSTITUTE LEGAL REQUIREMENTS for EQUITABLE INSURANCE COVERAGE:

"STRUCTURAL COMPETENCY"

(1) Universal Insurance Coverage with *NO WORK* or *COMMUNITY SERVICE* Requirement;

(2) Equitable Services Regardless of Neighborhood;

(3) Affordable Coverage;

(4 High Quality Services

(5) Cost Effective Care;

(6) Education, Transportation, Infrastructure, and Social Safety Net

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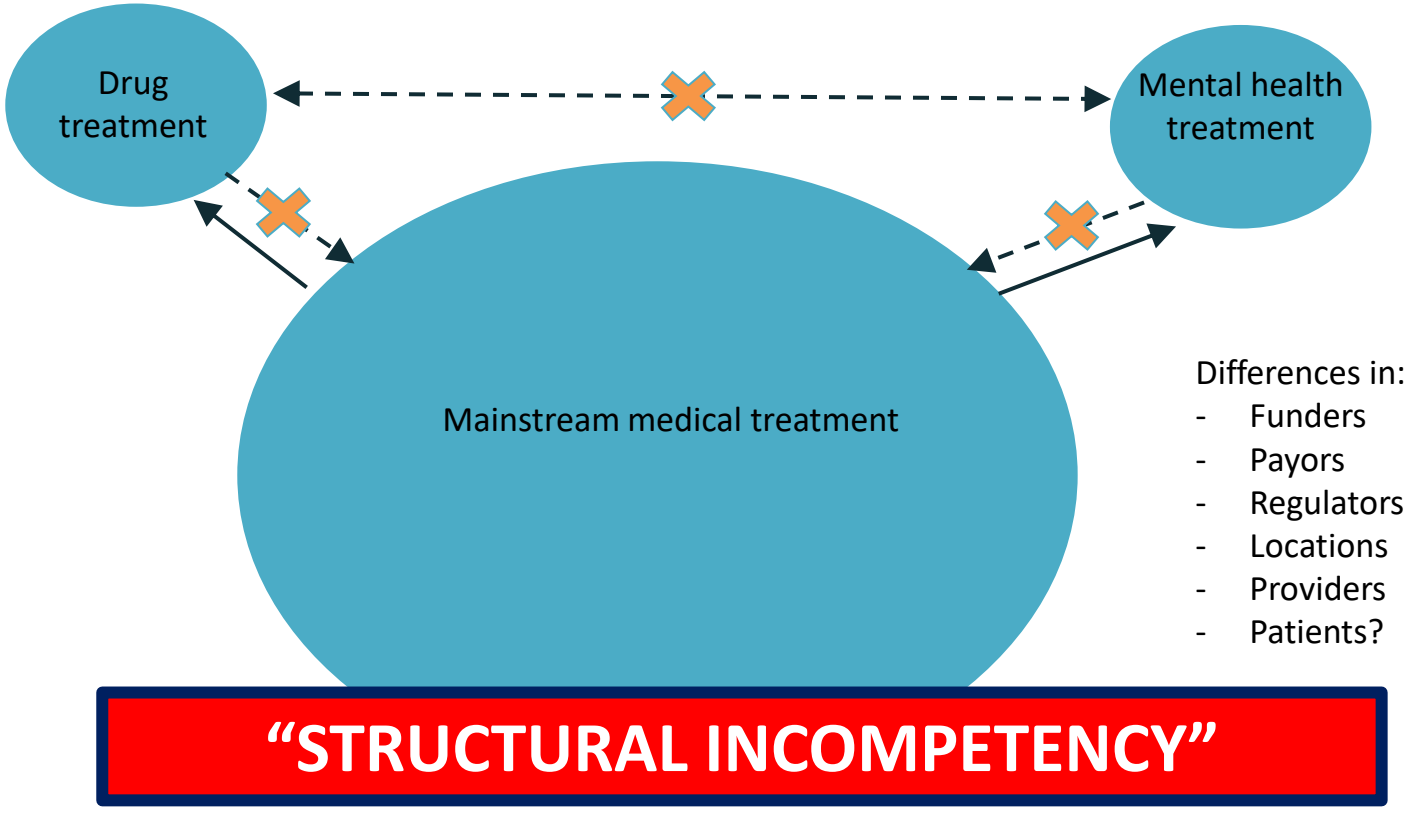
American health care system



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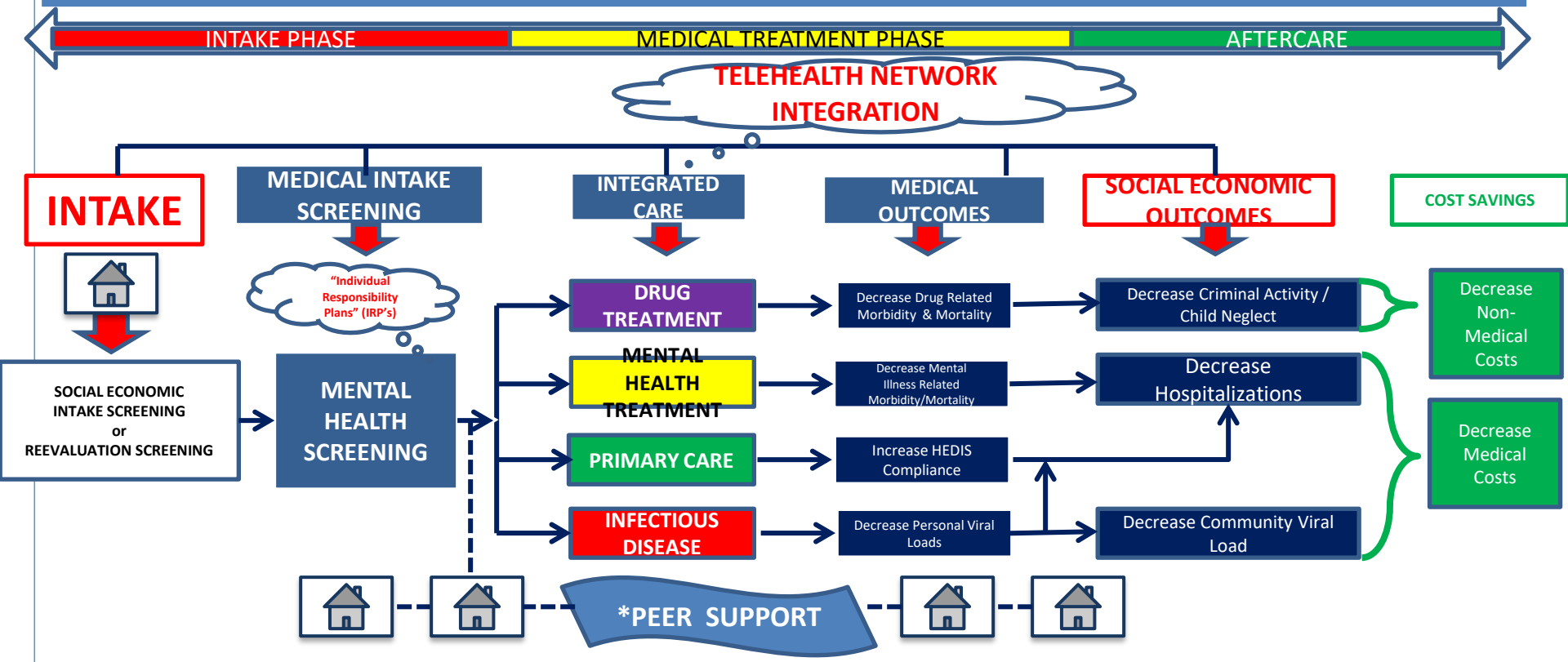
INTEGRATED TELEHEALTH OPIOID TREATMENT PATIENT FLOW : HIV, HEPATITIS C, MENTAL HEALTH, and SUBSTANCE ABUSE, and HEALTH HOMES DEMONSTRATION PROJECT



*LCHC = Leadership Council for Healthy Communities [Faith-based Organization / Multiple Churches in DC & Suburban Maryland]

Edwin C Chapman, MD
7/28/2021

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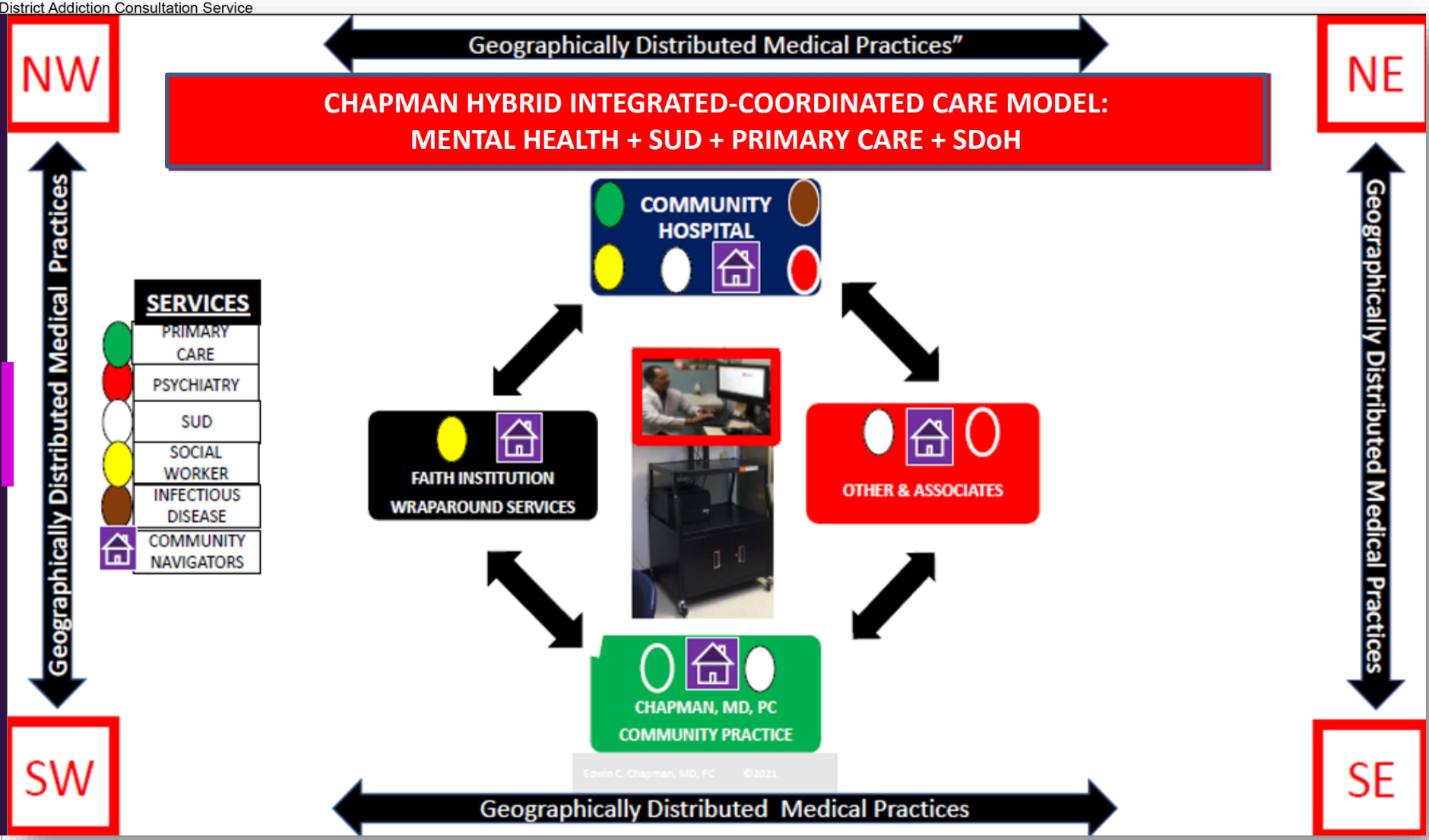

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ADDICTION PROFESSIONAL

DRIVING CLINICAL EXCELLENCE

Unlikely partners ignite innovative opioid treatment project in D.C.

November 16, 2015 by Gary A. Enos, Editor

November 16, 2015

An impoverished section of Washington, D.C., is serving as the laboratory for an innovative integrated care initiative featuring what could be characterized as unlikely partners. The driver of the Buprenorphine Integrated Care Delivery Project from Howard University's Urban Health Initiative is neither an addiction specialist nor a primary care doctor, but a urologist. The community-based medical practice that serves as the nexus of care under the initiative is run by a former methadone clinic medical director who now calls buprenorphine "the greatest drug I've ever used as a physician."

The conditions that have brought these partners together are the grossly underserved needs of the northeast Washington, D.C., community surrounding Edwin Chapman, M.D.'s medical practice. His treatment population has an average age of 52, an average 10-year history of incarceration, a 60% prevalence of hepatitis C (around 10% of the patients are HIV-positive), and a longtime history of opioid use (mainly heroin).

Chapman was finding that buprenorphine could quickly stabilize these multi-need patients and prepare them to work on the other challenges in their lives, but these individuals generally lacked access to comprehensive care that includes psychiatric support. At the same time, the urologist, Howard University professor Chiledum Ahaghotu, M.D., was looking for opportunities to design patient -centered care models and to leverage Howard's tradition of community partnership; Ahaghotu had begun working on his idea as a student in Brown University's Executive Master of Healthcare Leadership program.

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Is Telemedicine The Key To Making Addiction Treatment Work?

by Guest Post 03/07/2016 0 Comments

March 7, 2016

Editor's Note: D'Arcy Guerin Gue is a co-founder of Phoenix, with over 25 years of experience in executive leadership, strategic planning, IT services, knowledge leadership, and industry relations — with a special focus on patient engagement and federal compliance issues. She currently serves as the Director of Industry Relations at Phoenix Health Systems, a division of Medsphere Systems

Telehealth is one component in an innovative opioid treatment research project being conducted in Washington, DC. In a departure from the norm, the program is oriented around the practice of Edwin Chapman, MD, in partnership with Howard University's Urban Health Initiative.

In this impoverished corner of the nation's capital, Dr. Chapman's patients in the study average 52 years of age and 10 years of incarceration. About 60 percent live with hepatitis C, 10 percent are HIV positive and all are long-term users of opioids, primarily heroin.

Chapman's experience showed him that the opioid replacement buprenorphine effectively stabilized his patients' addiction issues enough that they could face other life challenges so long as they had access to comprehensive care, including psychiatric services. While access to the opioid replacement was available, care and counseling were not.

So Chapman and Howard Professor Chiledum Ahaghotu, M.D., worked together to create the Buprenorphine Integrated Care Delivery Project model.

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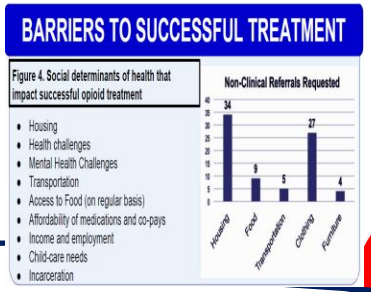
MEDICARE or MEDICAID BUPRENORPHINE OFFICE-BASED PROVIDER COMPLEX PATIENT TREATMENT SUPPORT NEEDS



SOCIAL WORKER/CARE COORDINATOR

PEER COACH

Social Determinants of Health

Complex Medical Issues

Criminal Justice Issues

Mental Health Issues

REMOTE or In-OFFICE PRIMARY CARE PROVIDER

REMOTE or IN-OFFICE PSYCHIATRIST and /or PSYCHOLOGIST

After prison, more punishment

Legal hurdles can make it impossible for the formerly incarcerated to obtain the jobs they've trained for

BY TRACY JAN

PROVIDENCE, R.I. — He had spent 17 of his 46 years behind bars, locked in a pattern of addiction and crime that led to 16 prison terms. Now, Moko Lincoln pushed a cart of cleaning supplies at the reentry house to which he had been paired in December, determined to provide for his grandchildren in a way he failed to do as a father.

"Keep on movin', don't stop," Lincoln sang, grooving to the British R&B group Soul II Soul on his headphones as he emptied trash cans and scrubbed toilets at Amos House. He passed a bulletin board plastered with hiring notices — a Rite cook, a warehouse worker, a landscaper — all good jobs for someone with a felony record, but not enough for him.

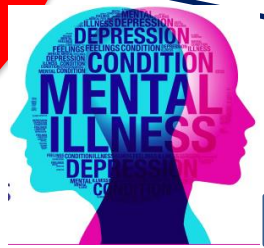
Lincoln, who is training to be a drug and alcohol counselor, wants those lost years to count for something more.

"I lived it," he said. "I understand it. My past is not a liability. It's an asset. I can help another person save their life."

Yet because regulations in Rhode Island and most other states exclude people with criminal backgrounds from many jobs, Lincoln's record, which includes sentences for robbery and assault, may well be held against him.

Across the country, more than 10,000 regulations restrict people with criminal records on access to

Moko Lincoln, 46, wants to be a licensed chemical dependency clinician, but his years in prison could work against him.



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INTEGRATED TELEHEALTH OPIOID TREATMENT PATIENT FLOW : HIV, HEPATITIS C, MENTAL HEALTH, and SUBSTANCE ABUSE, and HEALTH HOMES DEMONSTRATION PROJECT

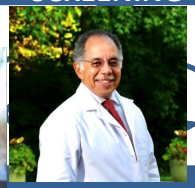
INTAKE PHASE | MEDICAL TREATMENT PHASE | AFTERCARE

TELEHEALTH NETWORK INTEGRATION

INTAKE

"Chronic Care Management" Team

MEDICAL INTAKE SCREENING



MENTAL HEALTH SCREENING

INTEGRATED CARE

- DRUG TREATMENT
- MENTAL HEALTH TREATMENT
- PRIMARY CARE
- INFECTIOUS DISEASE

MEDICAL OUTCOMES

- Decrease Drug Related Morbidity & Mortality
- Decrease Mental Illness Related Morbidity/Mortality
- Increase HEDIS Compliance
- Decrease Personal Viral Loads

SOCIAL ECONOMIC OUTCOMES

- Decrease Criminal Activity / Child Neglect
- Decrease Hospitalizations
- Decrease Community Viral Load

COST SAVINGS

- Decrease Non-Medical Costs
- Decrease Medical Costs

*PEER SUPPORT

*LCHC = Leadership Council for Healthy Communities [...anization / Multiple Churches in DC & Suburban Maryland]

Edwin C Chapman, MD
7/28/2013

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npr

NATIONAL

The Opioid Crisis Is Surging In Black, Urban Communities

March 8, 2018 · 5:00 AM ET

Heard on Morning Edition

MARISA PEÑALOZA

Listen · 3:50 Download

Transcript

March 2018

A man walks on Benning Road in Northeast Washington, D.C., in front of the Greater Northeast Medical Center, where Dr. Edwin Chapman works.

Claire Harbage/NPR

Larry and Evelyn Bing have been married for 22 years. Larry heard about Dr. Chapman on the streets from an addict friend

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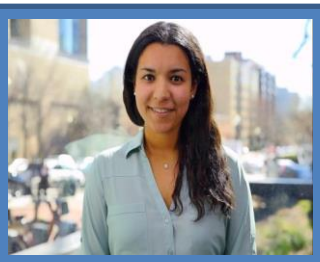
24/7 OPIOID TREATMENT TEAM

SOCIAL WORKER/CARE COORDINATOR



DYLAN OWENS

"African American Chronic Care Management" Team

Social Determinants of Health

Complex Medical Issues

DEBORAH Rodriguez-Gummo, RN

"African American Chronic Care Management" Team

REMOTE or In-OFFICE PRIMARY CARE PROVIDER

PEER COACHS

Criminal Justice Issues

Mental Health Issues

?

REMOTE or IN-OFFICE PSYCHIATRIST and /or PSYCHOLOGIST

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Impact of Fentanyl and Other Synthetic Opioids

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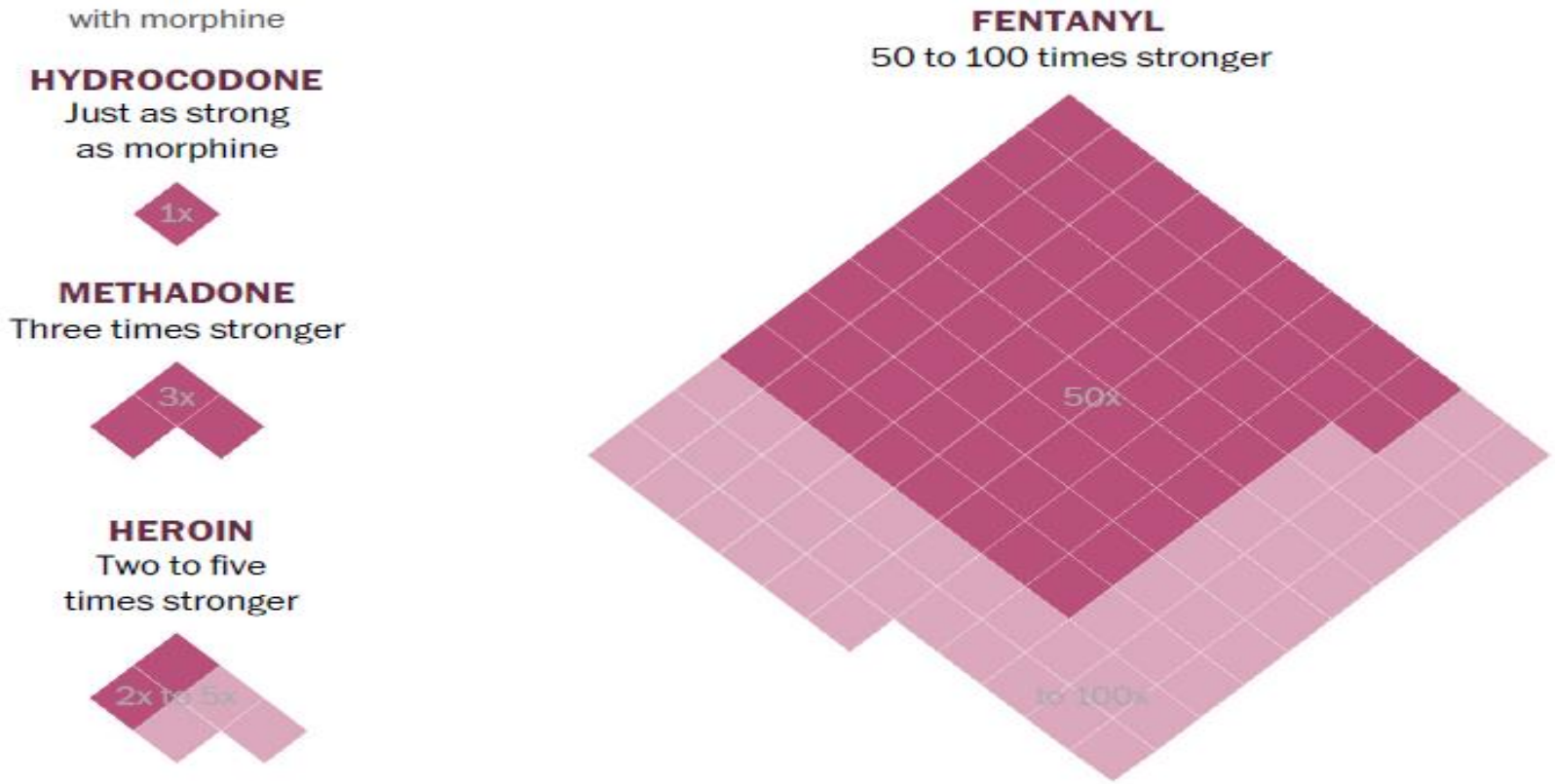

Sources: Centers for Disease Control and Prevention; Drug Enforcement Administration; National Institute on Drug Abuse, including congressional testimony; Maryland Poison Center at University of Maryland School of Pharmacy; Department of Justice Diversion Control Division; DanceSafe; and the Substance Abuse and Mental Health Services Administration

CHRIS ALCANTARA AND DAN KEATING/THE WASHINGTON POST

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Centers for Disease Control and Prevention

Emergency Preparedness and Response

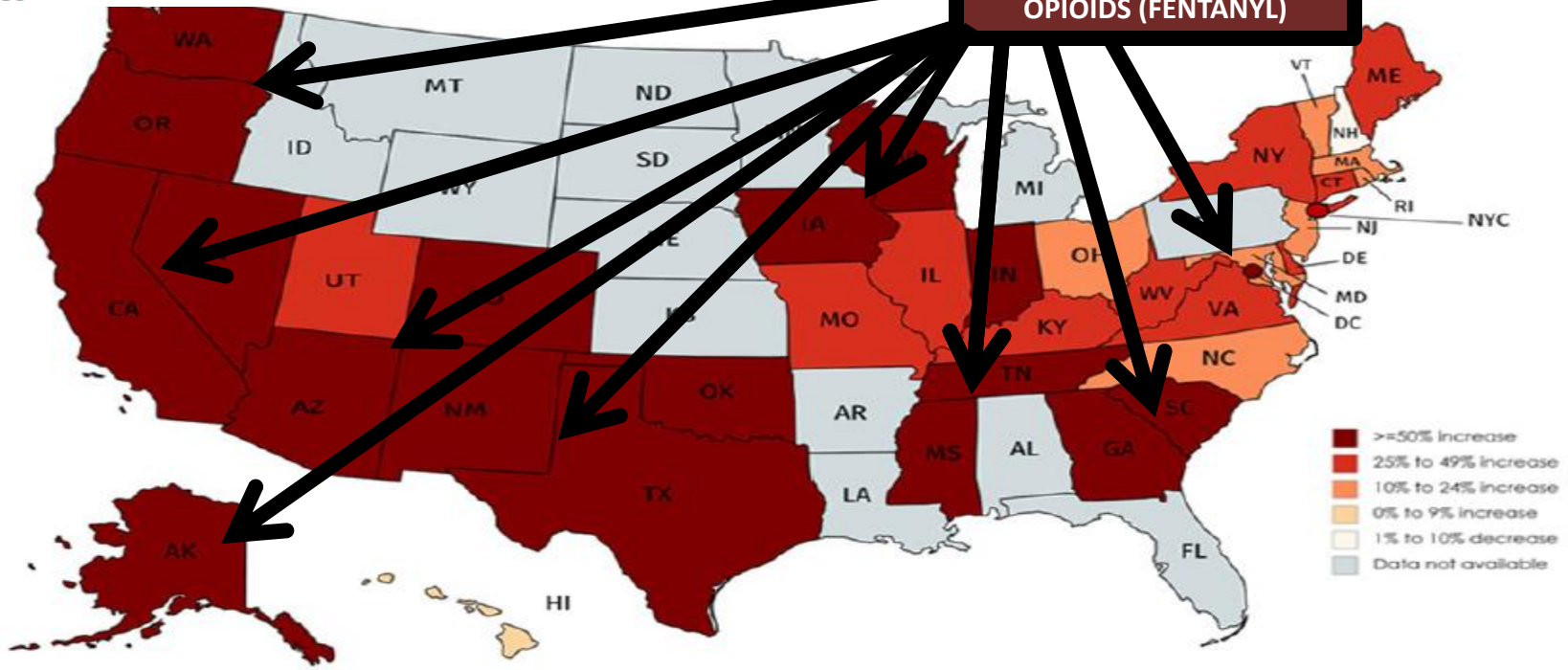
Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID–19 Pandemic

HAN HEALTH ALERT NETWORK

This is an official CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
December 17, 2020, 8:00 AM ET
CDCHAN-00438

➢50% INCREASE in OVERDOSE DEATHS DUE to SYNTHETIC OPIOIDS (FENTANYL)



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This photo provided by the U.S. Drug Enforcement Administration's Phoenix Division shows some of the 30,000 fentanyl pills the agency seized in one of its bigger busts, in Tempe, Ariz., in August, 2017.

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PNAS | RESEARCH ARTICLE | MEDICAL SCIENCES SOCIAL SCIENCES | OPEN ACCESS

Modeling the evolution of the US opioid crisis for national policy development

Tse Yang Lim[a,b], Erin J. Stringfellow[c], Celia A. Stafford[c,d], Catherine DiGennaro[c], Jack B. Homer[a,e], Wayne Wakeland[f], Sara L. Eggers[b], Reza Kazemi[b], Lukas Glos[b], Emily G. Ewing[b], Calvin B. Bannister[b], Keith Humphreys[g,h], Douglas C. Throckmorton[i], and Mohammad S. Jalali[a,c,1]

Edited by Andrea Bertozzi, University of California, Los Angeles, CA; received August 26, 2021; accepted March 16, 2022

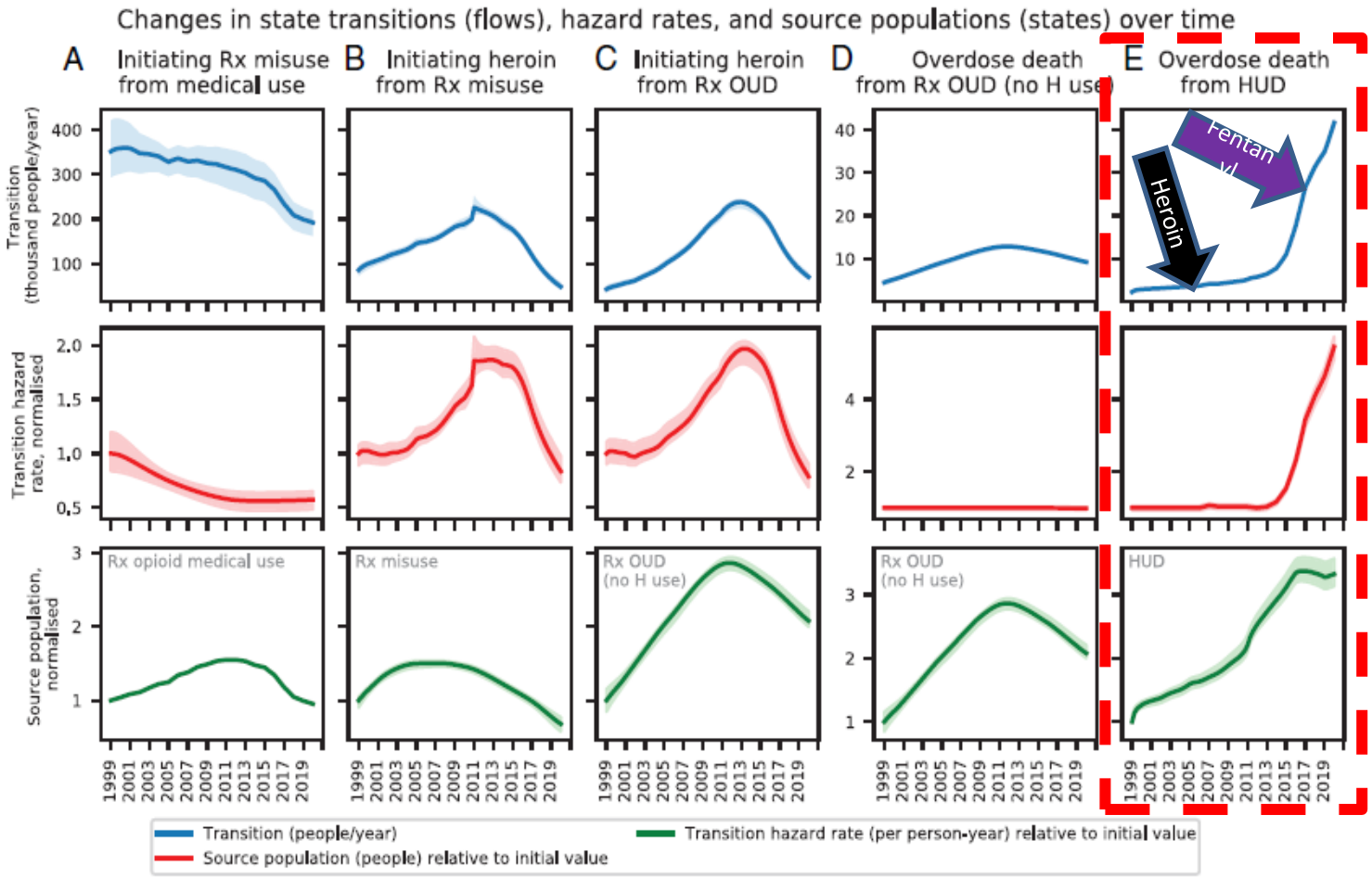

Fig. 3. (*A–E*) Changes in key transitions (flows) over time (*Top*, blue), distinguishing effects of changes in transition hazard rates (*Middle*, red), and source populations (*Bottom*, green). Bands are 95% CrIs. Source populations and hazard rates are normalized to their initial values. HUD, heroin use disorder; Rx, prescription opioid; Rx OUD, prescription opioid use disorder.

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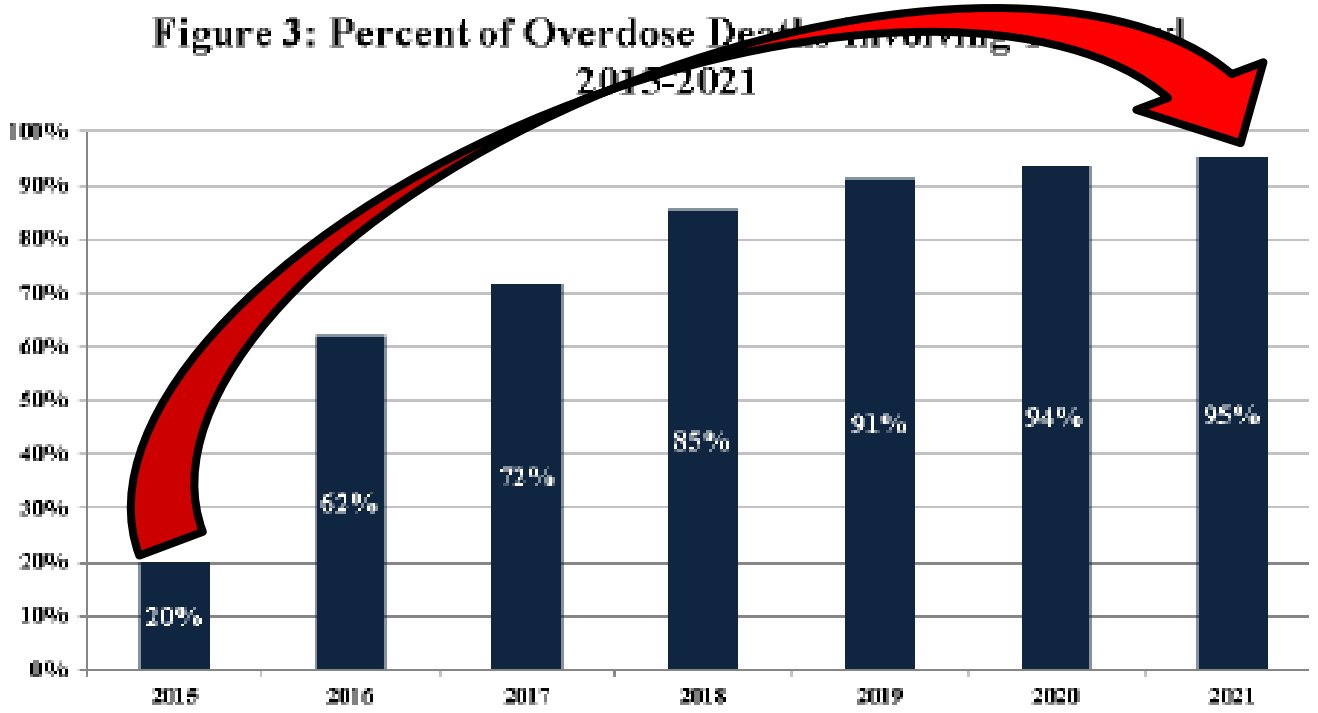
GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
401 E Street, SW – 6th Floor
Washington, DC 20024

WE ARE WASHINGTON DC

Opioid-related Fatal Overdoses: January 1, 2016 to December 31, 2021

Report Date: March 16, 2022

Figure 3: Percent of Overdose Deaths Involving [illegible] 2015-2021



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Racialization of Agonist (Methadone) vs. Partial Agonist (Buprenorphine) Medication for Opioid Use Disorder

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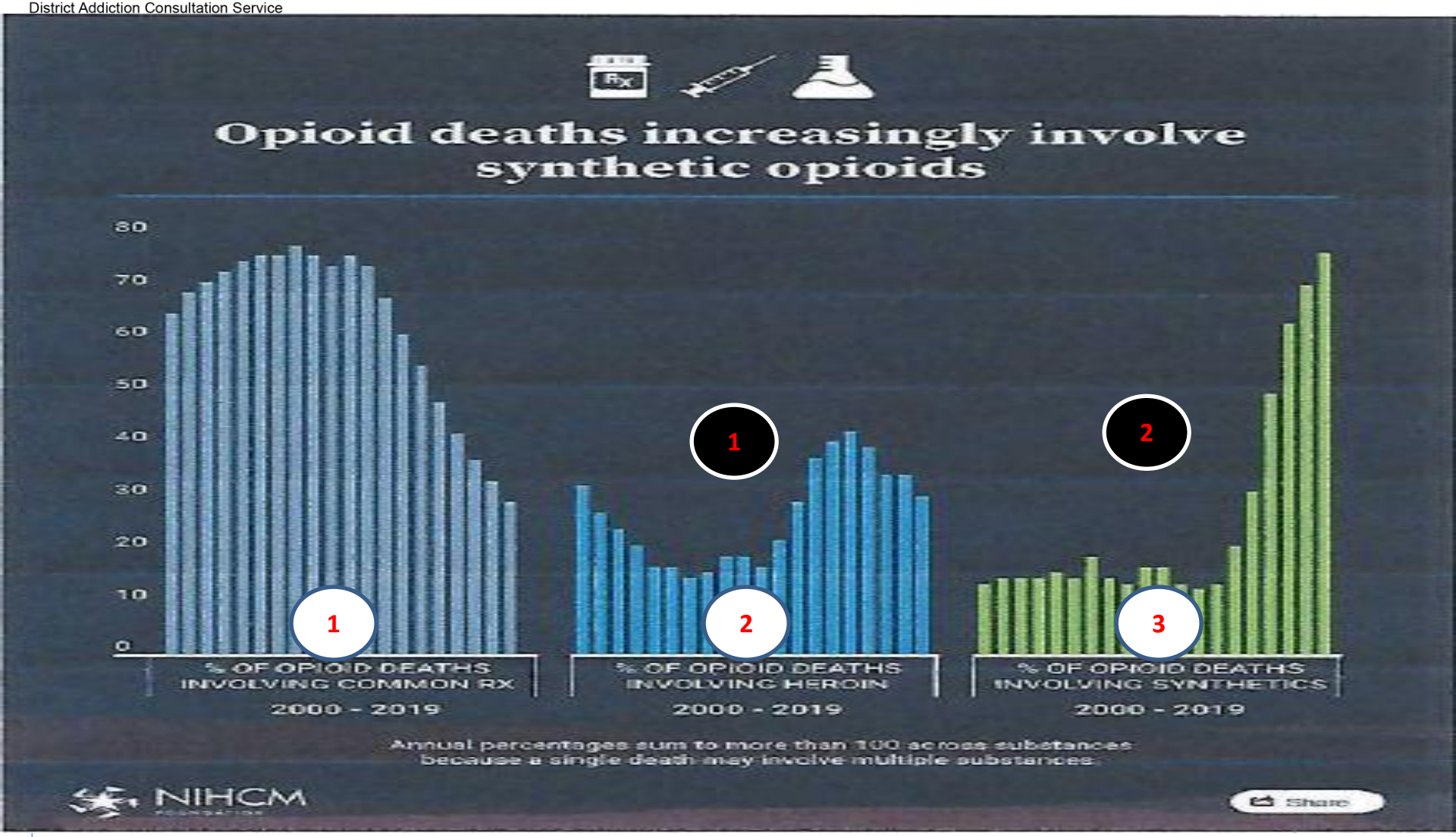

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52nd

POLICY & SCIENCE PLENARY SESSION

Saturday, April 24, 2021 | 10:00 am – 11:30 am ET | Virtual and On-Demand

Advancing Racial Justice & Structural Competency in Addiction Medicine

This plenary session, moderated by ASAM Board Member, Anika Alvanzo, MD, MS, FACP, DFASAM, will feature addiction and policy experts who will explore how racism influences addiction prevalence, access to evidence-based treatment, treatment outcomes, research and drug policies, with a specific focus on Black Americans. Speakers will provide guidance on how healthcare professionals who treat addiction can identify racism and promote structural competency in their practices and beyond. These talks will be followed by a panel discussion on how racism affects addiction treatment practices for people who use drugs, and steps that panelists have taken to promote structural competency as part of patient care and advocacy.

Edwin C. Chapman, MD, FASAM

Helena Hansen, MD, PhD

Tracie Gardner

Edwin C. Chapman, MD, FASAM – Internal Medicine and Addiction Medicine Specialist, *Howard University Hospital*

Dr. Chapman has practiced in Washington, DC for over 40 years specializing in Internal Medicine and Addiction Medicine. He will present information on how racism influences addiction prevalence, access to evidence-based treatment, treatment outcomes, and research.

Helena Hansen, MD, PhD – Professor and Chair, Research Theme in Translational Social Science and Health Equity, David Geffen School of Medicine, *UCLA*

Dr. Hansen recently co-authored a book titled "Structural Competency in Mental Health and Medicine: A Case-Based Approach to Treating the Social Determinants of Health." Dr. Hansen will provide a high-level, conceptual overview of structural competency and provide guidance on how healthcare professionals who treat addiction can adopt a structural competency framework and apply it to practice.

Tracie Gardner – Vice President of Policy Advocacy, *Legal Action Center*

Tracie Gardner has worked more than 30 years in the public health, public policy, and not-for-profit fields as a policy advocate, trainer, and lobbyist. To better inform healthcare professionals who treat addiction, Ms. Gardner will speak about the impact of racism on people of color who use drugs from the perspective of a seasoned policy professional and a Black woman in recovery.

POLICY & SCIENCE PLENARY SCHEDULE

10:00 am ET **Welcome to the Policy & Science Plenary**
Anika Alvanzo, MD, MS, FACP, DFASAM

10:10 am ET **Acknowledgement of Public Policy Award Recipients**
The Honorable Lori Trahan (D-MA) and the Honorable David McKinley (R- WV)

10:20 am ET **Distinguished Presentations**
Edwin C. Chapman, MD, FASAM
Helena Hansen, MD, PhD
Tracie Gardner

11:05 am ET **Panel Discussion with Distinguished Presenters**
Moderated by Anika Alvanzo, MD, MS, FACP, DFASAM

11:30 am ET **Closing Remarks & Adjourn**
Anika Alvanzo, MD, MS, FACP, DFASAM

SESSION MODERATOR

Anika Alvanzo, MD, MS, FACP, DFASAM
Board Member, *American Society of Addiction Medicine*
Eastern Region Medical Director, *Pyramid Healthcare*

Published in final edited form as:

Biosocieties. 2017 June ; 12(2): 217–238. doi:10.1057/biosoc.2015.46.

White opioids: Pharmaceutical race and the war on drugs that wasn't

Julie Netherland[a] and **Helena Hansen**[b,c,*]

[a]Drug Policy Alliance, 330 Seventh Avenue, New York, NY 10001, USA.

[b]Departments of Anthropology and Psychiatry, New York University, New York, NY 10003, USA.

[c]Nathan Kline Institute for Psychiatric Research, 140 Old Orangeburg Road, Orangeburg, NY10962, USA.

Abstract

The US 'War on Drugs' has had a profound role in reinforcing racial hierarchies. Although Black Americans are no more likely than Whites to use illicit drugs, they are 6–10 times more likely to be incarcerated for drug offenses. Meanwhile, a very different system for responding to the drug use of Whites has emerged. This article uses the recent history of White opioids – the synthetic opiates such as OxyContin® that gained notoriety starting in the 1990s in connection with epidemic prescription medication abuse among White, suburban and rural Americans and Suboxone® that came on the market as an addiction treatment in the 2000s – to show how American drug policy is racialized, using the lesser known lens of decriminalized White drugs. Examining four 'technologies of whiteness' (neuroscience, pharmaceutical technology, legislative innovation and marketing), we trace a separate system for categorizing and disciplining drug use among Whites. This less examined 'White drug war' has carved out a less punitive, clinical realm for Whites where their drug use is decriminalized, treated primarily as a biomedical disease, and where their whiteness is preserved, leaving intact more punitive systems that govern the drug use of people of color.

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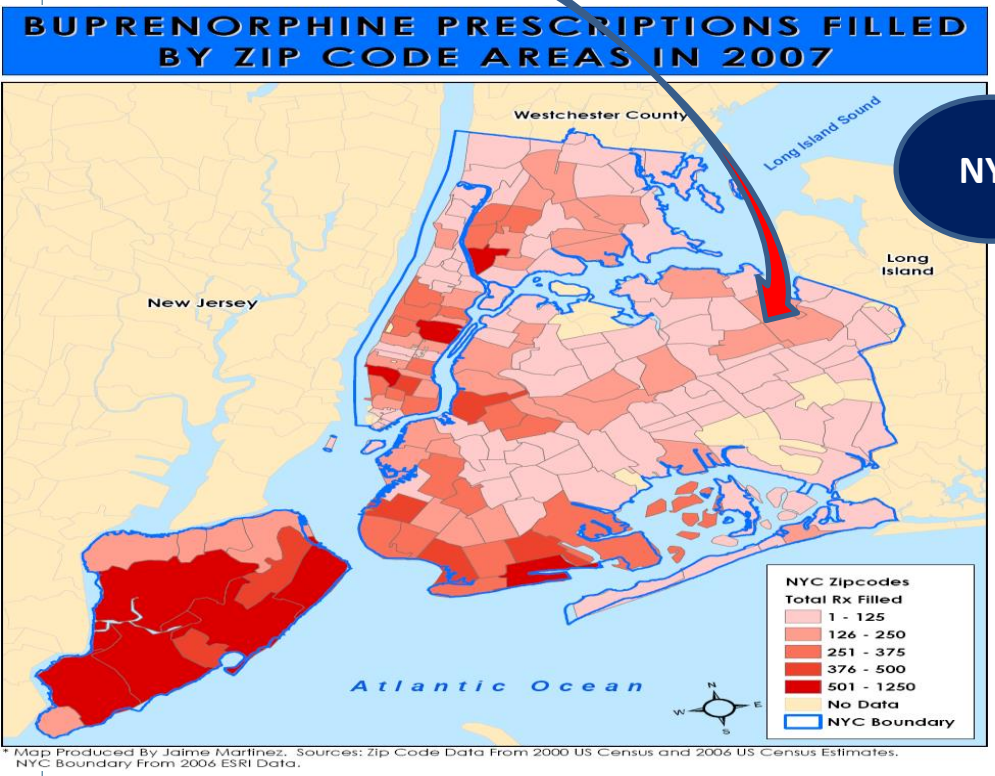
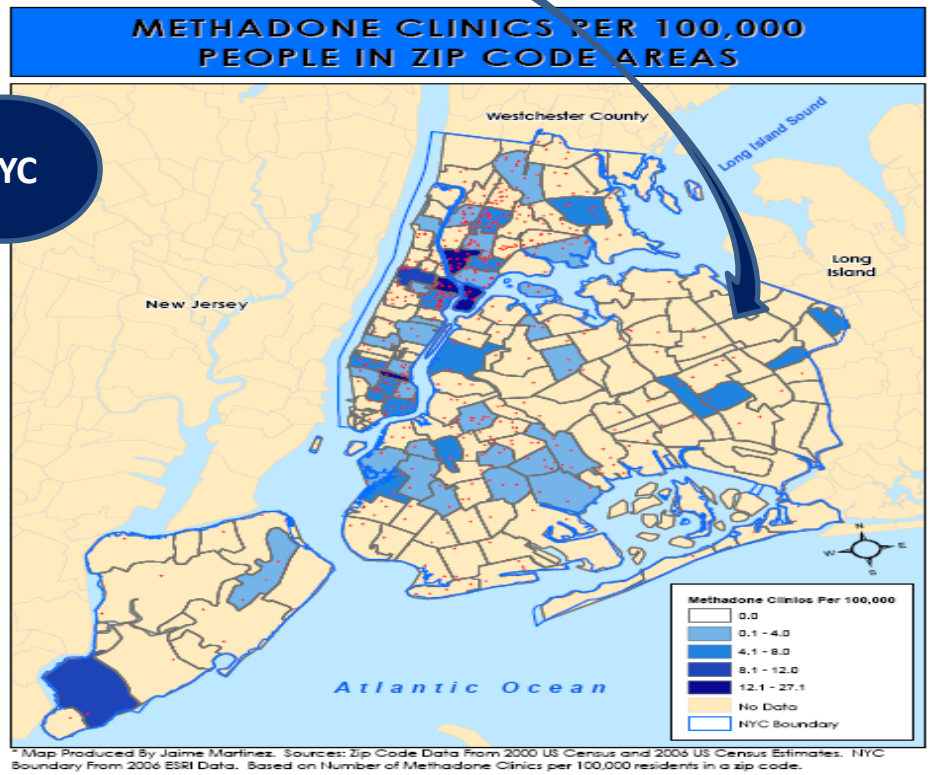
Buprenorphine treatment more accessible in high-income, non-minority neighborhoods



NYC



Hansen et al Drug Alcohol Depend 2016

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Table. Demographic Characteristics Associated With Buprenorphine Prescribing in Outpatient Care in the United States in 2004-2007 and 2012-2015

Variable	2004-2007 Visits Without Buprenorphine (n = 244 274), %[a]	2004-2007 Visits With Buprenorphine (n = 183), %[a]	2012-2015 Visits Without Buprenorphine (n = 204 527), %[a]	2012-2015 Visits With Buprenorphine (n = 718), %[a]	Adjusted OR (95% CI)[b]
Race/ethnicity[c]					
White	83.5	90.5	83.1	94.9	1.00
Black	11.5	6.5	10.6	2.7	0.23 (0.13-0.44)
Other	5.0	3.0	6.3	2.4	0.27 (0.08-0.90)
Payment method					
Private insurance	52				1.00
Medicare/Medicaid	35				1.16 (0.74-1.82)
Self-pay	4.5	37.8	4.5	39.6	12.27 (6.86-21.91)
Other or unknown	8.5	11.0	8.2	7.5	1.35 (0.78-2.35)
Sex					
Female	58.8	47.5	58.3	39.7	1.00
Male	41.2	52.5	41.7	60.3	2.22 (1.82-2.70)
Age, y					
<30	29.9	40.0	25.4	30.3	1.00
30-50	23.8	47.5	21.4	47.2	1.68 (1.33-2.12)
>50	46.3	12.5	53.2	22.4	0.38 (0.27-0.52)

BUPRENORPHINE MEDICATION DIVIDE

Abbreviation: OR, odds ratio.

[a] Analyses were completed using survey design elements accounting for visit weight, clustering, and stratification to generate nationally representative estimates.

[b] Adjusted odds ratios (AOR) were generated using logistic regression (1 = buprenorphine prescribed; 0 = no buprenorphine), including the variables reported in the Table. The AOR reflects the OR for buprenorphine treatment for a given visit characteristic during 2012 to 2015. The 2004 to 2007 visit characteristics are provided for comparison; they are not included in the logistic regression.

[c] White (Hispanic and non-Hispanic), black (Hispanic and non-Hispanic), and other (Asian, native Hawaiian/Pacific Islander, American Indian/Alaskan native, and multiple race, both Hispanic and non-Hispanic).

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Illustration by Jan Diehm / The Huffington Post

Dying To Be Free

2015

There's A Treatment For Heroin Addiction That Actually Works. Why Aren't We Using It?

By Jason Cherkis(http://www.huffingtonpost.com/jason-cherkis/)

JANUARY 28, 2015

State Medicaid Benefit:	Covers **methadone** as heroin treatment	Covers **naltrexone** as heroin treatment	Covers **buprenorphine** as heroin treatment	Requires **counseling** before buprenorphine prescription	Has **lifetime limit** on buprenorphine prescription	Has **daily dose limit** on buprenorphine
Alabama	✔	✔	✔	✘		
Alaska	✔	✔	✔	✘		24 mg
Arizona	✔	✔	✔	✘		
Arkansas	✘	?	✔	✔	24 months	
California	✔	✔	✔	✔		
Colorado	✘	✔	✔	✘		24 mg
Connecticut	✔	✔	✔	✘		
Delaware	✔	✔	✔	✔	12 months	16 mg
District of Columbia	✔	?	✔	✔		
Florida	✔	✔	✔	✔		
Georgia	✔	✔	✔	✘		16 mg
Hawaii	✔	?	✔	✘		
Idaho	✘	✔	✔	✘		24 mg
Illinois	✔	✔	✔	✔	12 months	16 mg
Indiana	✘	✔	✔	✔		
Iowa	✘	✔	✔	✔		16 mg
Kansas	✘	?	✔	✔		
Kentucky	✘	✔	✔	✔		24 mg
Louisiana	✘	✔	✔	✘		16 mg
Maine	✔	✔	✔	✔	24 months	
Maryland	✔	✔	✔	✔		32 mg
Massachusetts	✔	✔	✔	✘		24 mg
Michigan	✔	✔	✔	✔	12 months	24 mg
Minnesota	✔	✔	✔	✘		32 mg
Mississippi	✘	✔	✔	✘	24 months	8 mg
Missouri	✔	✔	✔	✔		
Montana	✘	✔	✔	✔	24 months	16 mg
Nebraska	✔	✔	✔	✘		

UNEVEN ACCESS TO ADDICTION TREATMENTS THROUGH MEDICAID

Despite the importance Medicaid places on providing access to health care, many states have inconsistent policies toward paying for medications used to treat opiate addiction. The American Society of Addiction Medicine surveyed each state's Medicaid program to determine which medications are covered and if any limitations exist. It found that many states' Medicaid programs either won't pay for drugs like methadone, place dosage limits on a patient's prescription for buprenorphine or require counseling that may be unobtainable.

State Medicaid Benefit:	Covers **methadone** as heroin treatment	Covers **naltrexone** as heroin treatment	Covers **buprenorphine** as heroin treatment	Requires **counseling** before buprenorphine prescription	Has **lifetime limit** on buprenorphine prescription	Has **daily dose limit** on buprenorphine
Nevada	✔	✔	✔	✔		16 mg
New Hampshire	✔	✔	✔	✔		24 mg
New Jersey	✔	?	✔	✘		32 mg
New Mexico	✔	✔	✔	✔		24 mg
New York	✔	✔	✔	✘		24 mg
North Carolina	✔	✔	✔	✘		24 mg
North Dakota	✘	✔	✔	✘		24 mg
Ohio	✔	✔	✔	✔		24 mg
Oklahoma	✘	✔	✔	✘		24 mg
Oregon	✔	✔	✔	✔		24 mg
Pennsylvania	✔	✔	✔	✔		16 mg
Rhode Island	✔	?	✔	✘		24 mg
South Carolina	✘	✔	✔	✔		16 mg
South Dakota	✘	✘	✔	✘		
Tennessee	✘	?	✔	✔		8 mg
Texas	✔	?	✔	✔		
Utah	✔	✔	✔	✔	36 months	24 mg
Vermont	✔	✔	✔	✔		16 mg
Virginia	✔	✔	✔	✔	24 months	16 mg
Washington	✔	✔	✔	✔	12 months	24 mg
West Virginia	✘	✔	✔	✔		16 mg
Wisconsin	✔	✔	✔	✘		
Wyoming	✘	✔	✔	✔	24 months	24 mg

Photos: Methadone from United States Department of Justice via Wikimedia Commons (http://commons.wikimedia.org/wiki/File:Methadone_40mg.jpg), Suboxone by Supertheman (http://commons.wikimedia.org/wiki/File:Suboxone.jpg), Naltrexone from Teva Pharmaceuticals (http://www.tevagenerics.com/default.aspx?pageid=3559&ProductNameControlledDrug=Naltrexone+HCl+Tablets%2C+USP&BrandName=ReVia%C2%AE+Tablets)

Source: The American Society of Addiction Medicine(http://www.asam.org/docs/advocacy/implications-for-Opioid-Addiction-Treatment)
Data collected via surveys completed by 37 states. Responses are left blank for states that did not respond to the survey, answer all survey questions or fully document Medicaid benefits on secondary sources such as websites.

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Prescription Opioid Addiction Treatment Study

The NIDA CTN Clinical Trial

R. Weiss, MD
Principal Investigator
Harvard Medical School, McLean Hospital

POATS

REFERENCES:

Weiss, et al. (2011). Adjunctive counseling during brief and extended buprenorphine-naloxone treatment for prescription opioid dependence: A 2-phase randomized controlled trial. *Archives of General Psychiatry,* *68*(12), 1238-46.

Weiss, et al. (2010). A multi-site, two-phase, Prescription Opioid Addiction Treatment Study (POATS): Rationale, design, and methodology. *Contemporary Clinical Trials, 31*(2), 189-99.

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Inclusion/Exclusion Study Criteria

Inclusion

- Informed Consent
- Age ≥ 18
- Birth control
- Able to meet study requirements
- Opioid Dependence
- Medical help for withdrawal
- Stable physical health
- Psychiatrically stable
- Locator Information
- Prior to inductions, COWS >8
- For pain, clearance to withdraw
- Methadone for pain <40mg/day

Exclusion

- Medical condition
- Allergy/sensitivity to meds
- Severe psychiatric condition
- Suicide risk in past 30 days
- ETOH/Sed/Stim dependence
- Clinical trial participant (30 d)
- Opioid maintenance tx (30 d)
- Pending legal issues
- Preg/lactating/no birth control
- Leaving local area during study
- LFT > 5x upper normal limit
- Surgery scheduled (6 m)
- Current SUD treatment

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Current participation in formal substance abuse treatment (other than self-help groups)

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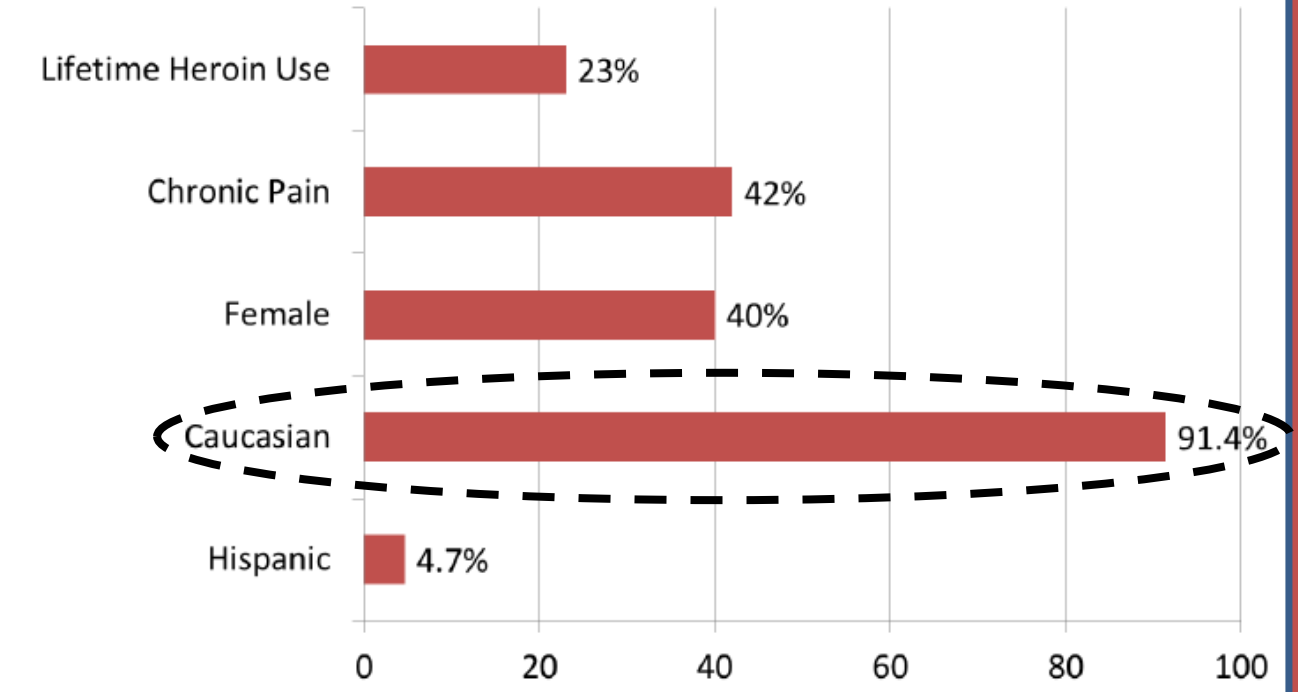
Baseline Stratification Factors and Sociodemographic Characteristics

Mean Age = 32.7 years

Mean Years Education = 13 years



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Buprenorphine Doses Prescribed

Phase 1	
8 mg	8%
12 mg	18%
16 mg	38%
20 mg	10%
24 mg	13%
32 mg	-
Other	13%

Phase 2	
8 mg	-
12 mg	14%
16 mg	27%
20 mg	14%
24 mg	16%
32 mg	11%
Other	18%

POATS

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2017

Addictive Behaviors Reports 6 (2017) 8–14

Contents lists available at ScienceDirect

Addictive Behaviors Reports

journal homepage: www.elsevier.com/locate/abrep

Commentary

Pharmacogenomics-guided policy in opioid use disorder (OUD) management: An ethnically-diverse case-based approach

Earl B. Ettienne[a,*], Edwin Chapman[b], Mary Maneno[a], Adaku Ofoegbu[a], Bradford Wilson[c], Beverlyn Settles-Reaves[d], Melissa Clarke[c], Georgia Dunston[c], Kevin Rosenblatt[e]

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[c] National Human Genome Center at How
[d] Howard University Department of Comm
[e] Consultative Genomics, PLLC, 5909 Wes

OUR FENTANYL SURVIVING (AA) PATIENTS DO BETTER ON BUPRENORPHINE 24 mgs – 32 mgs :
(1) Decrease Cravings, (2) Increased Negative Urines for Opioids, (3) Increased Retention in Care

ARTICLE INFO

Keywords:
Opioid use disorder
Opioid agonist treatment
Buprenorphine
Pharmacogenomics
Policy

Introduction: Opioid use disorder (OUD) is characterized by a problematic pattern of opioid use leading to clinically-significant impairment or distress. Opioid agonist treatment is an integral component of OUD management, and buprenorphine is often utilized in OUD management due to strong clinical evidence for efficacy. However, interindividual genetic differences in buprenorphine metabolism may result in variable treatment response, leaving some patients undertreated and at increased risk for relapse. Clinical pharmacogenomics studies the effect that inherited genetic variations have on drug response. Our objective is to demonstrate the impact of pharmacogenetic testing on OUD management outcomes.

Methods: We analyzed a patient who reported discomfort at daily buprenorphine dose of 24 mg, which was a mandated daily maximum by the pharmacy benefits manager. Regular urine screenings were conducted to detect the presence of unauthorized substances, and pharmacogenetic testing was used to determine the appropriate dose of buprenorphine for OUD management.

Results: At the 24 mg buprenorphine daily dose, the patient had multiple relapses with unauthorized substances. Pharmacogenetic testing revealed that the patient exhibited a cytochrome P450 3A4 ultrarapid metabolizer phenotype, which necessitated a higher
OUD management. The patient exhibite
dose recommendation compared to stan

Conclusion: Pharmacogenomic testing a
Collaboration by key stakeholders is esse
management.

HOWARD UNIVERSITY COLLEGE of PHARMACY

2019

R E S E A R C H P A P E R

Pharmacogenomics and OUD: Clinical Decision Support in an African American Cohort

Earl B. Ettienne, L.P.D., M.B.A., R.Ph., Adaku Ofoegbu, PharmD., Mary K. Maneno, Ph.D., Jayla Briggs, Ginikannwa Ezeude, PharmD., Simisola Williams, Casey Walker, Edwin Chapman, M.D.

Howard University IRB approval number: 18-MED-46.

Acknowledgements: We would like to acknowledge Dr. William Southerland, Dr. Anthony K. Wutoh, the Howard University Research Centers in Minority Institutions (RCMI) program and the District of Columbia Department of Healthcare

management. Clinical pharmacogenomics testing can elucidate these polymorphisms; however, a lack of real-world evidence for the use of pharmacogenomics in OUD management complicates the implementation process. We conducted a retrospective cohort study of 113 patients undergoing buprenorphine-based OUD management in Northeast Washington D.C. to determine if clinical pharmacogenomics testing for CYP3A4 and CYP3A5 would impact treatment outcomes. Data were collected from the electronic medical record (EMR) from December 30, 2015 to December 31, 2016. Study outcomes were based on presence of withdrawal symptoms, instances of unauthorized substances in urine drug tests (UDTs), and sublingual buprenorphine/naloxone (SBN) dose with standard-of-care (SOC) dosing versus pharmacogenomics (PGx)-based dosing. Pearson correlation tests, Wilcoxon signed rank tests, Wilcoxon rank sum tests, and one-way ANOVA tests were used. Linear and logistic regression analyses were used to assess predictors of withdrawal symptomatology. Kaplan-Meier survival analyses were used to assess time to first withdrawal. Our research suggests that patients with at least one copy of the CYP3A4*1B allele exhibit an accelerated rate of metabolism compared to the

pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of 11 symptoms occurring within a 12-month period.[1] Presently, OUD constitutes a significant public health burden as
ntinued to rise in the
ople that died of a drug
almost 400,000 people
any opioid, including
n 2017, the number of
overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illictly-manufactured fentanyl) was 6 times higher than in 1999 and approximately 130 Americans die of an opioid overdose every day.[2]

OUD is managed via both nonpharmacological and pharmacological approaches.[3–5] Nonpharmacological approaches employ cognitive behavioral therapy (CBT), such as 12-step programs, and pharmacological approaches employ the use of medication-assisted treatment (MAT) with methadone, buprenorphine (BUP), or extended-release intramuscular naltrexone (XR-NTX).[3–5] For the purposes of OUD management, methadone is made available through opioid treatment programs (OTPs) in methadone clinics, whereas BUP is available via office-based opioid treatment (OBOT) programs.[4]

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URBAN INSTITUTE

State Variation in Medicaid Prescriptions for Opioid Use Disorder from 2011 to 2018

Lisa Clemans-Cope, Victoria Lynch, Emma Winiski, and Marni Epstein

August 2019

VERMONT

- At 1,210 prescriptions for buprenorphine maintenance treatment per 1,000 Medicaid enrollees in 2018, Vermont's prescribing rate is 46 percent higher than the next highest rate. Though Vermont's higher rate likely relates to greater treatment needs than those of the nation overall, they also likely reflect increased OUD treatment capacity and coverage under the Medicaid expansion. Reportedly, 73 percent of Vermonters with OUD were in treatment in 2014, and by 2017, Vermont eliminated treatment wait lists in every county. Vermont's higher prescribing rate may also reflect higher dosing (e.g., 16 mg buprenorphine taken as two 8 mg tablets). Because growing evidence suggests higher doses of buprenorphine (e.g., 16–32 mg) are more efficacious than lower doses, Vermont's higher prescribing rate could reflect clinically effective dosing.

Foundation *for* Opioid Response Efforts

RUTGERS BIOMEDICAL AND HEALTH SCIENCES

04/28/21

Integrating MOUD into Primary Care: Medicaid Strategies for Improving Treatment Engagement and Outcomes and Reducing Disparities

Rutgers, The State University of New Jersey
New Jersey Division of Medical Assistance and Health Services
Virginia Department of Medical Assistance Services
Centers for Medicare and Medicaid Services (CMS)

Elimination of MOUD Prior Authorizations

NEW JERSEY

13

April 2019	• No prior authorization allowed for medications for treatment of opioid or alcohol use disorders; safety edits and formulary preferences may be utilized
April 2020	• Updated so only NJFC-defined safety edits can be applied; requires MCOs to provide coverage for all generic MAT medications, regardless of dosage form, for up to 32mg/day for oral buprenorphine

FORE

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Washington State Health Care Authority

Medication Treatment Guidelines for Substance Use Disorders (SUDs) - Transmucosal Buprenorphine

Medical policy no. 65.20.00.10-3 **Effective: November 1, 2019**

Related medical policies:

- **Sublocade (65.20.00.E5)**

WASHINGTON STATE

Dosage and quantity limits

Drug Name	Dose Limits
buprenorphine Hcl sublingual tablet	32 mg per day
buprenorphine/naloxone sublingual film (generic, Suboxone)	32 mg/8 mg per day
buprenorphine/naloxone sublingual tablet	32 mg/ 8mg per day
Zubsolv® sublingual tablet	22.8 mg/5.6mg per day

Policy: Transmucosal buprenorphine Medical Policy No. 65.20.00.10 *Last Updated 01/26/2021*

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Policies Should Promote Access to Buprenorphine for Opioid Use Disorder

1

State and federal leaders can eliminate barriers, boost treatment

The Pew Charitable Trusts May 24, 2021

States should also consider increasing dose limits on buprenorphine. The American Society of Addiction Medicine (ASAM) guidelines suggest that 24 milligrams should be the maximum daily dose; however, some state Medicaid programs, such as Tennessee's, still cap the dose at 16 milligrams per day.[32] No Medicaid program should limit buprenorphine dosage below clinical guidelines. States should consider exceeding the suggested 24-milligram maximum to account for higher doses that may be needed for patients with higher opioid tolerance, especially because fentanyl—a potent synthetic opioid—dominates the drug market.[33] For example, Washington state permits providers to prescribe 32 milligrams per day, with flexibility for higher doses with prior authorization.[34] Such flexible policies can help keep patients in treatment.[35]

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Policies Should Promote Access to Buprenorphine for Opioid Use Disorder

2

State and federal leaders can eliminate barriers, boost treatment

The Pew Charitable Trusts May 24, 2021

States should also consider separating counseling from medication in treatment payment bundles, as Maryland did in its opioid treatment programs.[41] Maryland rebundled payments to include managing the care plan, dosing, dispensing, and administering medication, drug screens, and coordination with other services; and individual and group counseling became separately billable services.[42] Additionally, because medication alone is an effective treatment, states should not require that facilities licensed to offer buprenorphine also furnish behavioral health services.[43] State can decouple these services through regulatory language; for example, while some states define "medication-assisted treatment" as medications in combination with behavioral therapies, New York defines it as treatment of a substance use disorder with medication alone.[44]

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Policies Should Promote Access to Buprenorphine for Opioid Use Disorder

3

State and federal leaders can eliminate barriers, boost treatment

The Pew Charitable Trusts May 24, 2021

Third, states should prohibit publicly funded treatment programs from discharging patients for continued illicit drug use. Patients in low-threshold buprenorphine treatment programs sometimes continue using illicit opioids or stimulants, especially those also experiencing homelessness or other issues.[45] Although some programs cite continued drug use as grounds for involuntary termination—a practice commonly called administrative discharge—evidence shows that it is safer for patients to continue prescribed medications for OUD than to be put at high risk for overdose by suddenly stopping treatment.[46] Federal guidelines recommend that programs avoid administrative discharge and instead re-evaluate patients if the current treatment plan proves ineffective.[47] Accordingly, regulators should explicitly prohibit the practice when licensing and certifying substance use treatment programs; for example, Maine's regulations for opioid treatment programs bar the use of administrative discharge "to discipline clients for minor infractions of program policy."[48]

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Making Addiction Treatment More Realistic And Pragmatic: The Perfect Should Not Be The Enemy Of The Good

Nora D. Volkow

JANUARY 3, 2022 10.1377/forefront.20211221.691862

While not using any drugs or alcohol poses the fewest health risks and is often necessary for sustained recovery, different people may need different options. Temporary returns to use after periods of abstinence are part of many recovery journeys, and it shouldn't be ruled out that some substance use or ongoing use of other substances even during treatment and recovery might be a way forward for some subset of individuals.

"HARM REDUCTION" !!

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Differences Between Popular Opioid Treatments

Methadone

Since 1972, methadone was regulated for addiction treatment. It has been considered the **gold standard for Medication-Assisted** Treatment (MAT) ever since.

Methadone is a full opioid agonist. It binds fully to mu-opioid receptors allowing its effects to be felt fully and increase as the dose increases.

Methadone is categorized as a Schedule II drug by the DEA, which means it is highly regulated and can only be dispensed at licensed clinics. Only after meeting strict federal and state requirements can they qualify for take-home medication but checks and balances remain in place to ensure the medication is being used safely and properly.

Buprenorphine

The Food and Drug Administration (FDA) approved it for use in Medication Assisted Treatment (MAT) in late 2002.

Buprenorphine is a partial mu-opioid agonist, so while it binds fully to receptors, it does not produce the same intensity of effect as methadone and other full agonists.

Buprenorphine's effects only increase up to a certain point. Once a certain dosage threshold is passed, the opioid effects plateau even when an individual takes more of the medication. This "ceiling effect" helps reduce the risk of misuse as well as side effects, which make it a safer option than methadone for people with a mild to moderate opioid use disorder. It is categorized as a Schedule III drug.

https://www.hcrcenters.com/blog/methadone-vs-buprenorphine-similarities-differences-hcrc/#:~:text=They're%20Both%20Opioids,opioid%20receptors%20in%20the%20brain.

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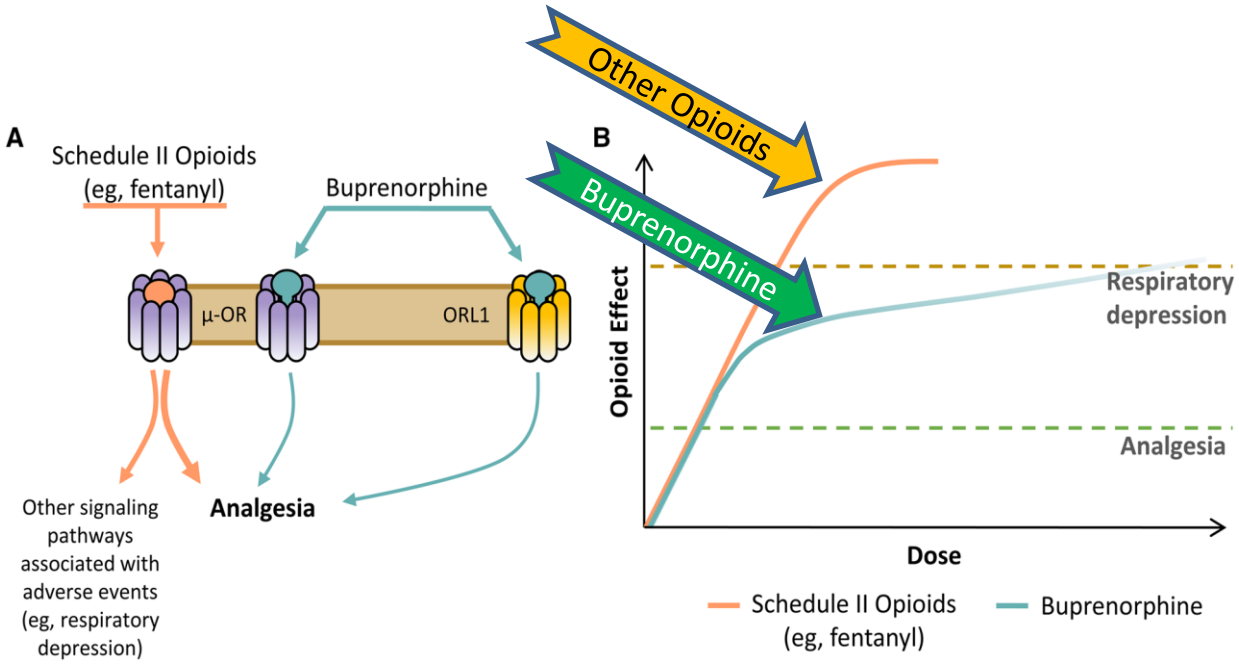

Pain Med, Volume 21, Issue 4, April 2020, Pages 714–723, https://doi.org/10.1093/pm/pnz356

OXFORD
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Differences Between Popular Opioid Treatments

- Methadone is less expensive.
- Methadone can be dispensed in a federally and state regulated, certified clinic.
- Patients have to often come for daily dosing, Patient of color are often referred to methadone clinics.
- Buprenorphine is more expensive than methadone.
- Buprenorphine can be prescribed in a private doctor's office by prescription up to one month.
- Buprenorphine is often less available to indigent patients and patients of color.

https://www.hcrcenters.com/blog/methadone-vs-buprenorphine-similarities-differences-hcrc/#:~:text=They're%20Both%20Opioids,opioid%20receptors%20in%20the%20brain.

Naseem Miller (17, May2021). "Racial disparities in opioid addiction treatment: a primer and research roundup." *The Journalist's Resource*. Harvard Kennedy School.

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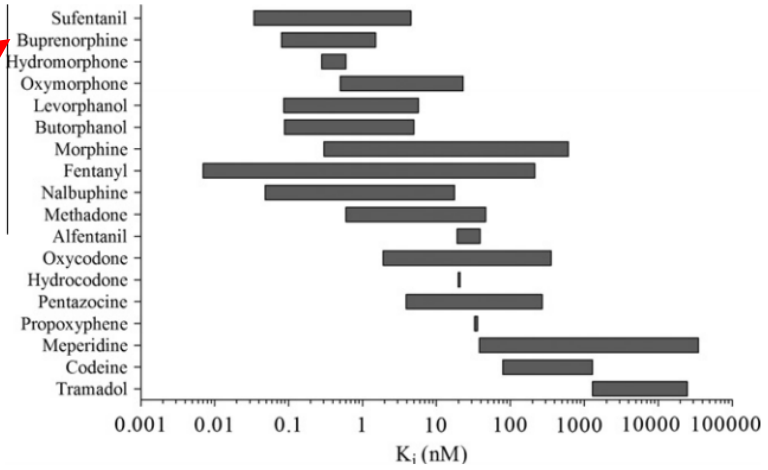
Drug	K_i (nM)	Drug	K_i (nM)	Drug	K_i (nM)
Tramadol	12,486	Hydrocodone	41.58	Butorphanol	0.7622
Codeine	734.2	Oxycodone	25.87	Levorphanol	0.4194
Meperidine	450.1	Diphenoxylate	12.37	Oxymorphone	0.4055
Propoxyphene	120.2	Alfentanil	7.391	Hydromorphone	0.3654
Pentazocine	117.8	Methadone	3.378	Buprenorphine	0.2157
		Nalbuphine	2.118	Sufentanil	0.1380
		Fentanyl	1.346		
		Morphine	1.168		

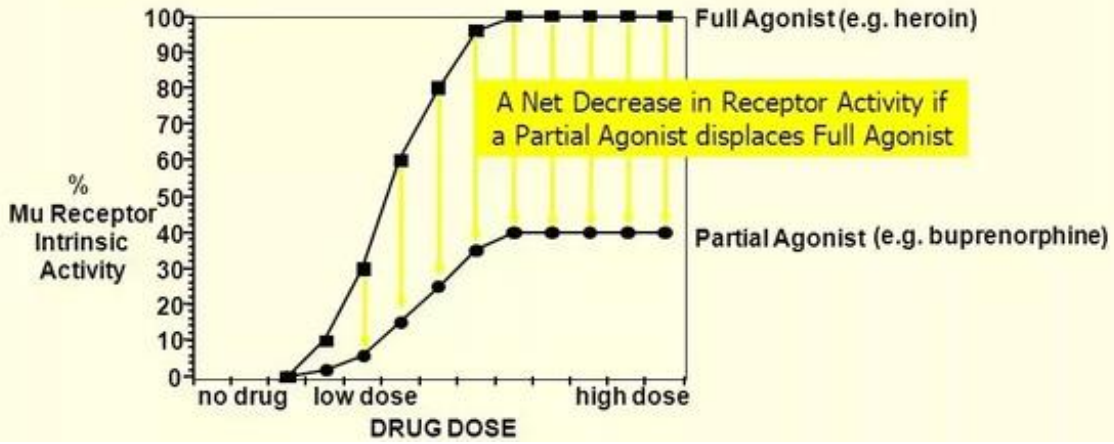


- **Buprenorphine has higher binding affinity than all the commonly used opioids**

Volpe DA et al. *Regulatory Toxicology and Pharmacology* 2011

Buprenorphine Precipitated Withdrawal

- Displaces a full agonist off the mu receptors
- Buprenorphine only partially activates receptors
- Net decrease in activation occurs and withdrawal develops (must be in withdrawal to start)



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Integrated Care for Opioid Use Disorder & Infectious Diseases

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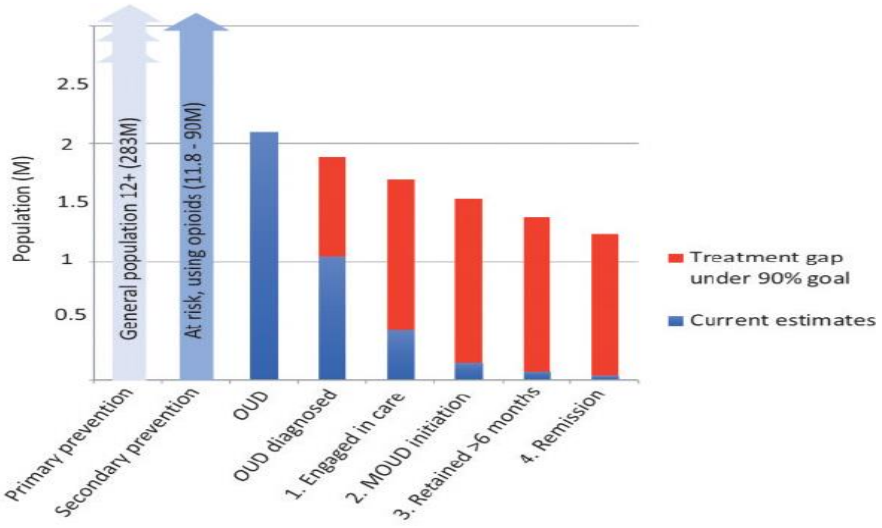
OUD and HIV Care Cascades

The Opioid Use Disorder (OUD) Care Cascade

(Challenges in opioid use disorder diagnosis, treatment, and retention in care)



The HIV Care Cascade

(Challenges in opioid use disorder diagnosis, treatment, and retention in care)

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COMMITTEE ON THE EXAMINATION OF THE INTEGRATION[redacted] INFECTIOUS DISEASE PREVENTION EFFORTS IN SELECT PROGRAMS

CARLOS DEL RIO *(Chair)*, Hubert Professor and Chair, Hubert Department[redacted] Global Health, Rollins School of Public Health, Emory University, and Professor of [redacted] University School of Medicine

JULIE A. BALDWIN, Director, Center for Health Equity Research, Northern Arizona University

EDWIN CHAPMAN, MD, Private Practice, Washington DC

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ROBIN P. NEWHOUSE, Distinguished Professor and Dean, Indiana Univ[redacted] Nursing

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Study Staff

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MISRAK DABI, Financial Business Partner

ROSE MARIE MARTINEZ, Study Director

BOX S-2
Barriers to Integration of Opioid Use Disorder and Infectious Disease Services

Prior Authorization Policies: State-level policies often require providers to obtain permission from insurers to prescribe buprenorphine (a Food and Drug Administration [FDA]-approved medication for opioid use disorder). Prior authorization prevents the timely, effective delivery of evidence-based care for opioid use disorder, thereby increasing the risk of infectious disease through continued drug use.

Drug Addiction Treatment Act (DATA) Waiver Requirement: Providers are required to apply for the ability to prescribe buprenorphine under the Drug Addiction Treatment Act (DATA) of 2000 (which amended the Controlled Substances Act) and also undergo mandatory training on prescribing practices. Once the DATA waiver is received, providers are limited to a certain number of patients they can treat with buprenorphine. This requirement decreases access to effective medications for opioid use disorder and increases the risk for infectious disease.

Lack of Data Integration and Sharing: Due to infrastructural difficulties and federal policies, medical care providers—including infectious disease providers—may not be able to access patients' information surrounding substance use and treatment, thereby inhibiting comprehensive care plans.

Inadequate Workforce and Training: There are several barriers to integration from a workforce perspective, including the geographic distribution and inadequate training of providers who can treat patients with opioid use disorder and infectious disease and restrictions about which providers can deliver certain kinds of care in certain settings.

Stigma: Self-stigma and societal stigma surrounding both opioid use disorder and infectious disease may prevent patients from seeking or accessing care, and provider stigma may inhibit a productive patient–provider relationship.

Payment and Financing Limitations: Services that are helpful to patients seeking integrated care for opioid use disorder and infectious disease (e.g., harm-reduction services, case management, telemedicine, and peer-recovery counselors) are difficult to obtain or sustain financially.

Same-Day Billing Restrictions: Some states do not allow providers to bill for a physical and a behavioral health visit in the same day, thereby requiring patients to return for care another day or forcing programs to provide care without the opportunity for reimbursement.

Limits on Harm-Reduction Services: Harm-reduction services serve as an entry point for further medical care, reduce the risk of infectious disease outbreaks, and allow for a culture of patient-centered care. Limiting these services, on the other hand, is a barrier to integrating opioid use disorder and infectious disease prevention and treatment.

Disconnect Between the Health and Criminal Justice Systems: Care for infectious diseases and opioid use disorder in criminal justice settings is fragmented and inconsistent; the process of maintaining coordinated care while patients enter and exit the criminal justice system is inadequate.

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Disconnect Between the Health and Criminal Justice Systems: Care for infectious diseases and opioid use disorder in criminal justice settings is fragmented and inconsistent; the process of maintaining coordinated care while patients enter and exit the criminal justice system is inadequate.

Opportunities to Improve Opioid Use Disorder and Infectious Disease Services

INTEGRATING RESPONSES TO A DUAL EPIDEMIC

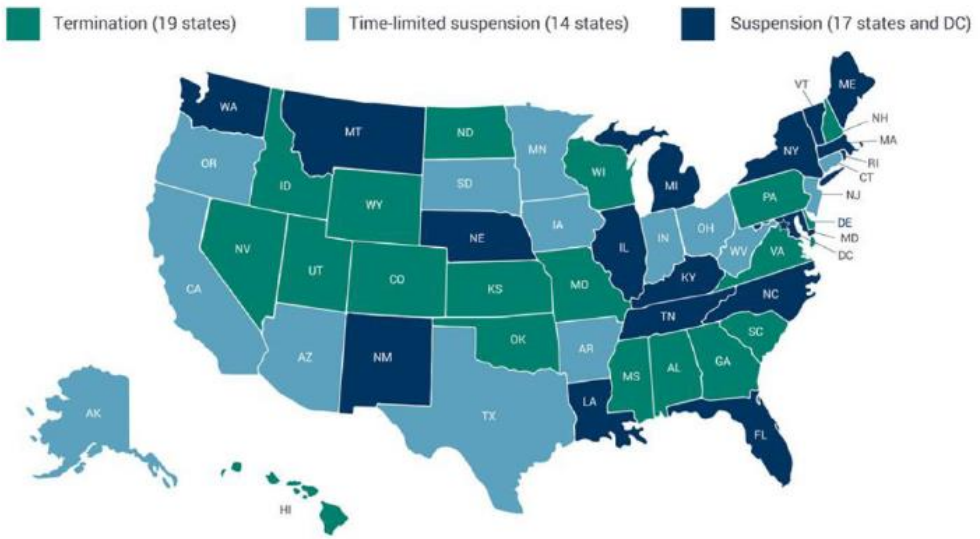

FIGURE 3-1 State policies on Medicaid enrollment during incarceration, 2018.
NOTES: Colorado and Hawaii recently passed laws to suspend rather than terminate Medicaid enrollment, and are in the process of implementing the law. Some states specify that suspension policies apply to specific prisons and jails. (MACPAC, 2018a).
SOURCES: MACPAC, 2018a; adapted from data from Kaiser Family Foundation (2019) and Families USA (2019).

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The VICIOUS CYCLE of INCARCERATION with NO MAT TREATMENT

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Release from Prison — A High Risk of Death for Former Inmates

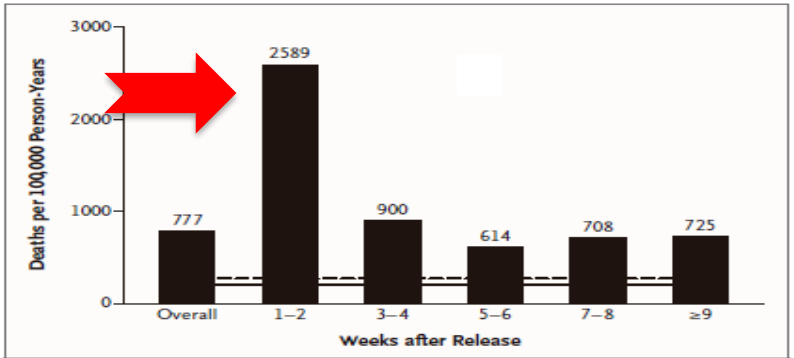

Figure 1. Mortality Rates among Former Inmates of the Washington State Department of Corrections during the Study Follow-up (Overall) and According to 2-Week Periods after Release from Prison.

The dashed line represents the adjusted mortality rate for residents of the State of Washington (223 deaths per 100,000 person-years), and the solid line represents the crude mortality rate among inmates of the state prison system during incarceration (201 deaths per 100,000 inmate person-years).

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Opioid Watch

Nonprofit News from The Opioid Research Institute

How Rhode Island Cut Opioid Overdose Deaths; Slashed Those of Recently Released Inmates 60%

March 16, 2018

Josiah Rich, MD, at the Rhode Island Department of Corrections in Cranston.

QUICK TAKEAWAY:

- **Rhode Island's new medication-assisted treatment (MAT) program for inmates slashed their overdose death rates upon release by 60%.**
- **The program's impact was so dramatic that it largely accounted for a 12.3% drop in statewide overdose deaths during the period studied.**
- **Key to the program's success was seamless transition to community MAT upon release.**
- **Without treatment, 40% of those who died did not make it through their first month of liberty.**
- **For inmates released during the first six months of 2017, 89% of overdose deaths were caused by fentanyl.**

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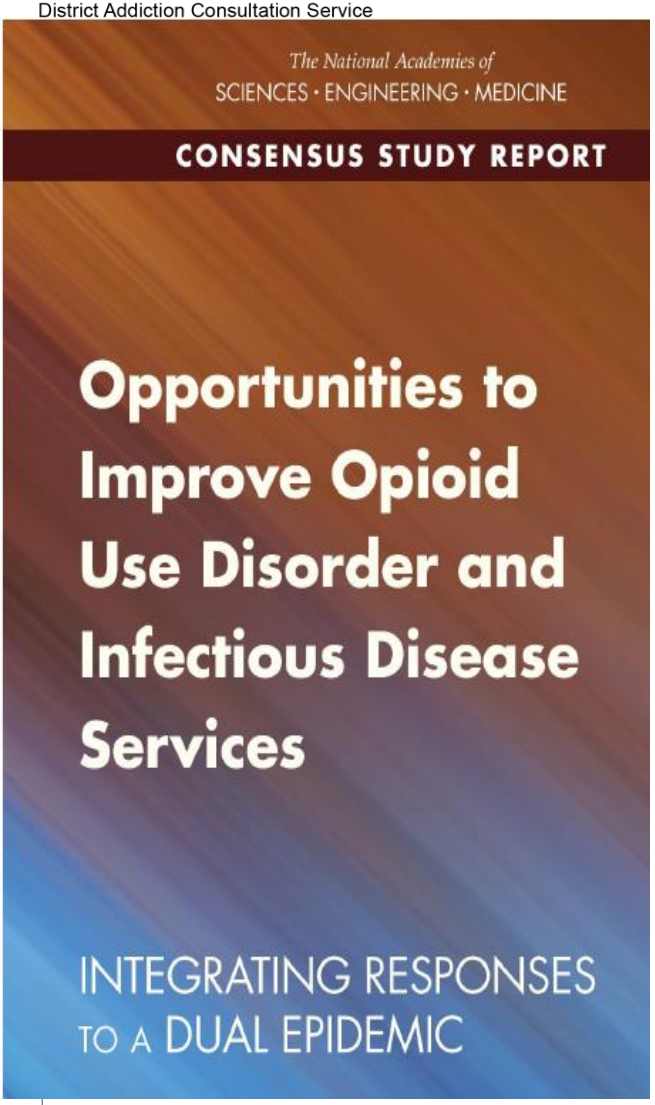

COMMITTEE ON THE EXAMINATION OF THE INTEGRATION OF OPIOID AND INFECTIOUS DISEASE PREVENTION EFFORTS IN SELECT PROGRAMS

CARLOS DEL RIO (*Chair*), Hubert Professor and Chair, Hubert Department of Global Health, Rollins School of Public Health, Emory University, and Professor of Medicine, Emory University School of Medicine

JULIE A. BALDWIN, Director, Center for Health Equity Research, Northern Arizona University

EDWIN CHAPMAN, MD, Private Practice, Washington, DC

HANNAH COOPER, Chair, Substance Use Disorders, Rollins School of Public Health, Emory University

DAVID GUSTAFSON, Professor Emeritus, Industrial and Systems Engineering, University of Wisconsin–Madison

HOLLY HAGAN, Professor and Codirector, Center for Drug Use and HIV/HCV R… York University College of Global Public Health

ROBIN P. NEWHOUSE, Distinguished Professor and Dean, Indiana University School of Nursing

JOSIAH "JODY" D. RICH, Professor of Medicine and Epidemiology, Brown University

SANDRA SPRINGER, Associate Professor of Medicine, Yale School of Medicine

DAVID L. THOMAS, Chief, Division of Infectious Diseases, Johns Hopkins University School of Medicine

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ELLEN F. EATON, Assistant Professor of Infectious Diseases, Department of Medicine, University of Alabama–Birmingham

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ROSE MARIE MARTINEZ, Study Director

BOX S-2
Barriers to Integration of Opioid Use Disorder and Infectious Disease Services

Prior Authorization Policies: State-level policies often require providers to obtain permission from insurers to prescribe buprenorphine (a Food and Drug Administration [FDA]-approved medication for opioid use disorder). Prior authorization prevents the timely, effective delivery of evidence-based care for opioid use disorder, thereby increasing the risk of infectious disease through continued drug use.

Drug Addiction Treatment Act (DATA) Waiver Requirement: Providers are required to apply for the ability to prescribe buprenorphine under the Drug Addiction Treatment Act (DATA) of 2000 (which amended the Controlled Substances Act) and also undergo mandatory training on prescribing practices. Once the DATA waiver is received, providers are limited to a certain number of patients they can treat with buprenorphine. This requirement decreases access to effective medications for opioid use disorder and increases the risk for infectious disease.

Lack of Data Integration and Sharing: Due to infrastructural difficulties and federal policies, medical care providers—including infectious disease providers—may not be able to access patients' information surrounding substance use and treatment, thereby inhibiting comprehensive care plans.

Inadequate Workforce and Training: There are several barriers to integration from a workforce perspective, including the geographic distribution and inadequate training of providers who can treat patients with opioid use disorder and infectious disease and restrictions about which providers can deliver certain kinds of care in certain settings.

Stigma: Self-stigma and societal stigma surrounding both opioid use disorder and infectious disease may prevent patients from seeking or accessing care, and provider stigma may inhibit a productive patient–provider relationship.

Payment and Financing Limitations: Services that are helpful to patients seeking integrated care for opioid use disorder and infectious disease (e.g., harm-reduction services, case management, telemedicine, and peer-recovery counselors) are difficult to obtain or sustain financially.

Same-Day Billing Restrictions: Some states do not allow providers to bill for a physical and a behavioral health visit in the same day, thereby requiring patients to return for care another day or forcing programs to provide care without the opportunity for reimbursement.

Limits on Harm-Reduction Services: Harm-reduction services serve as an entry point for further medical care, reduce the risk of infectious disease outbreaks, and allow for a culture of patient-centered care. Limiting these services, on the other hand, is a barrier to integrating opioid use disorder and infectious disease prevention and treatment.

Disconnect Between the Health and Criminal Justice Systems: Care for infectious diseases and opioid use disorder in criminal justice settings is fragmented and inconsistent; the process of maintaining coordinated care while patients enter and exit the criminal justice system is inadequate.

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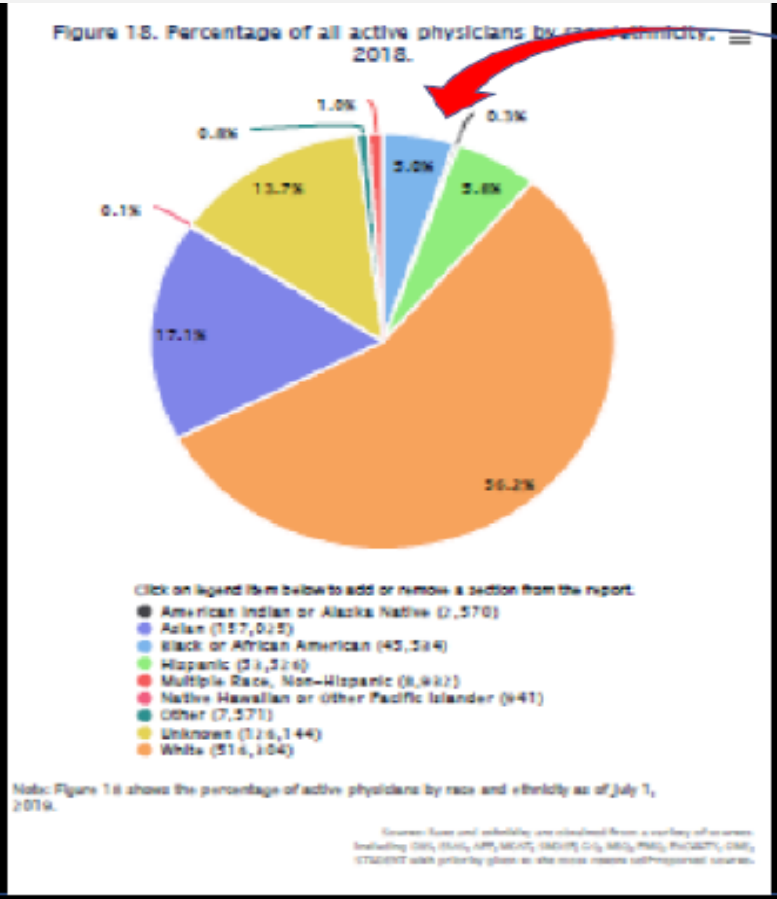
ONLY 6% of NURSES Are AFRICAN AMERICAN



ONLY 5% Of PHYSICIANS Are AFRICAN AMERICAN

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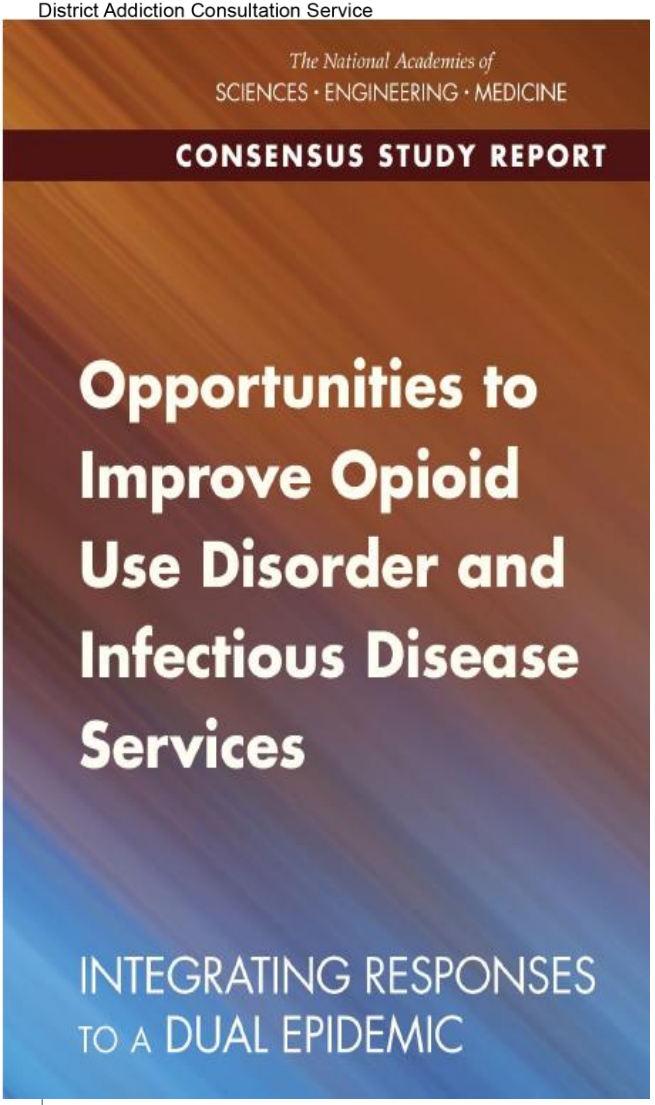

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Treatment Challenges for Opioid Use Disorder "In the Age of COVID"

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PNAS RESEARCH ARTICLE | MEDICAL SCIENCES SOCIAL SCIENCES OPEN ACCESS

Modeling the evolution of the US opioid crisis for national policy development

Tse Yang Lim[a,b], Erin J. Stringfellow[c], Celia A. Stafford[c,d], Catherine DiGennaro[c], Jack B. Homer[a,e], Wayne Wakeland[f], Sara L. Eggers[b], Reza Kazemi[b], Lukas Glos[b], Emily G. Ewing[b], Calvin B. Bannister[b], Keith Humphreys[g,h], Douglas C. Throckmorton[b], and Mohammad S. Jalali[a,c,1]

Edited by Andrea Bertozzi, University of California, Los Angeles, CA; received August 26, 2021; accepted March 16, 2022

Table 1. Exogenous input time series showing 2020 data values and assumptions for ETC, optimistic, and pessimistic cases

EXAMPLE: District of Columbia

Exogenous input	Source	2020 value	2032 Assumed value†		
			ETC	Optimistic	Pessimistic
Fentanyl penetration	NFLIS	56.2%	80.7%	69.8%	99.5%
Naloxone kits distributed	IQVIA, various*	2.30 million	3.60 million	4.22 million	2.94 million
Heroin price index (1999 = 1)	UNODC, STRIDE	0.49	0.49	0.58	0.40
Buprenorphine-waivered treatment providers	Various*	94,200	178,300	224,900	134,500
Methadone maintenance treatment capacity‡	N-SSATS	360,000	646,000	765,000	528,000
Vivitrol treatment capacity‡	IQVIA	32,900	45,800	52,700	39,900
Patients receiving opioid analgesic prescription	IQVIA	41.3 million	28.4 million	22.3 million	35.1 million
Prescriptions per person	IQVIA	3.49	3.31	3.01	3.50
Average days per prescription	IQVIA	24.4	26.8	24.0	28.0
Average opioid MME per day	IQVIA	31.3	23.6	20.2	28.0
ADF fraction of prescribed opioids (percent of MME)	IQVIA	4.9%	3.1%	3.1%	3.1%

MME, morphine milligram equivalent; NFLIS, National Forensic Laboratory Information System; N-SSATS, National Survey of Substance Abuse Treatment Services; STRIDE, System to Retrieve Information on Drug Evidence; UNODC, United Nations Office on Drugs and Crime.

*See *SI Appendix*, section S3 for details on input data derivations.

†Broadly, the optimistic scenario assumes stronger trends (1.5× ETC) in naloxone distribution, MOUD treatment capacity, and downward-trending aspects of prescribing, and weaker trends (0.5× ETC) in fentanyl penetration and upward-trending aspects of prescribing; vice-versa for the pessimistic scenario.

‡MMT/Vivitrol capacity are calculated based on treatment utilization data from listed sources (*SI Appendix*, section S3).

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RESEARCH ARTICLE

OPEN ACCESS

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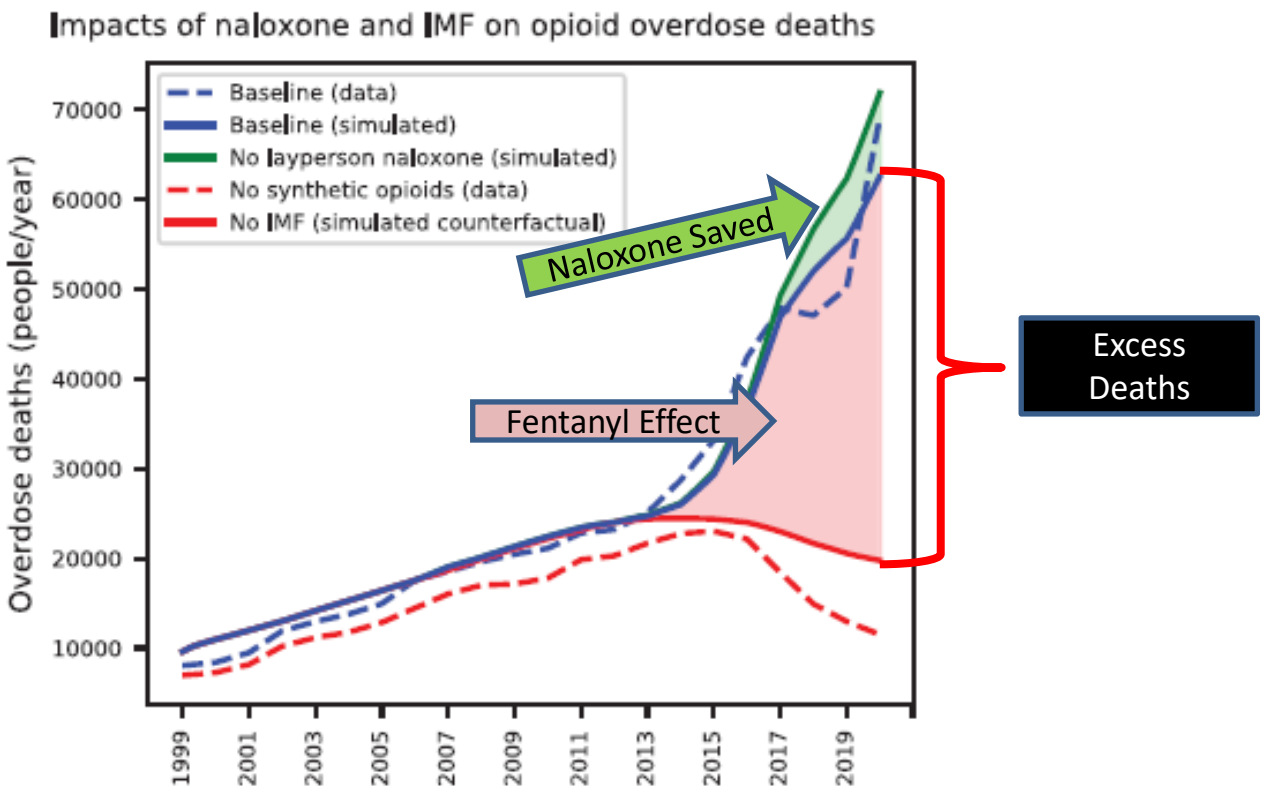

Fig. 4. Comparison of impact of naloxone distribution and IMF on opioid overdose mortality, showing total deaths averted due to layperson naloxone (green shading), and excess deaths due to IMF (red shading). Dashed lines are observed data. Simulated deaths absent IMF (red, solid) are higher than reported deaths not involving synthetic opioids (red, dashed): in earlier years, due to prescription fentanyl, and in later years, due to attenuated risk response in the counterfactual absence of IMF.

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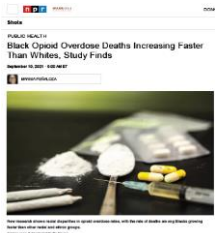
PUBLIC HEALTH

Black Opioid Overdose Deaths Increasing Faster Than Whites, Study Finds

September 10, 2021 · 5:00 AM ET

Pre-Covid 2018-2019
September 10, 2021



MARISA PEÑALOZA

A study published Thursday reveals a growing racial disparity in opioid overdose death rates. Deaths among African Americans are growing faster than whites across the country. The study authors call for an "antiracist public health approach" to address the crisis in Black communities.

The study, conducted in partnership with the National Institute on Drug Abuse at the National Institutes of Health, analyzed overdose data and death certificates from four states: Kentucky, Ohio, Massachusetts and New York. It found that the rate of opioid deaths among Blacks increased by 38% from 2018 to 2019, while rates for other racial and ethnic groups did not rise.

Chapman knows too well the problems faced by the African American population when it comes to drug addiction and treatment, "beginning with the fact that our epidemic was ignored for the most part, followed by insurance barriers and access to treatment," he says.

"Our population was always treated as a moral, criminal problem, which means that the patients that we're treating in the African-American community have that added burden," he says.

From his experience in his clinic, he says he's found it is more complex to treat Black patients, because you need additional resources, like help navigating the health care system, counseling and help finding housing or a job.

Chapman says Black communities also have a "provider access problem." He notes that relatively few addiction treatment specialists focus their practice on treating Black patients. "Then there is the stigma within the provider community about treating these patients because they're always perceived as being criminally inclined or not desirable as a patient," he says.

Conversely, Chapman adds, "there's the shame and stigma that the patients carry, so the patients don't seek treatment."

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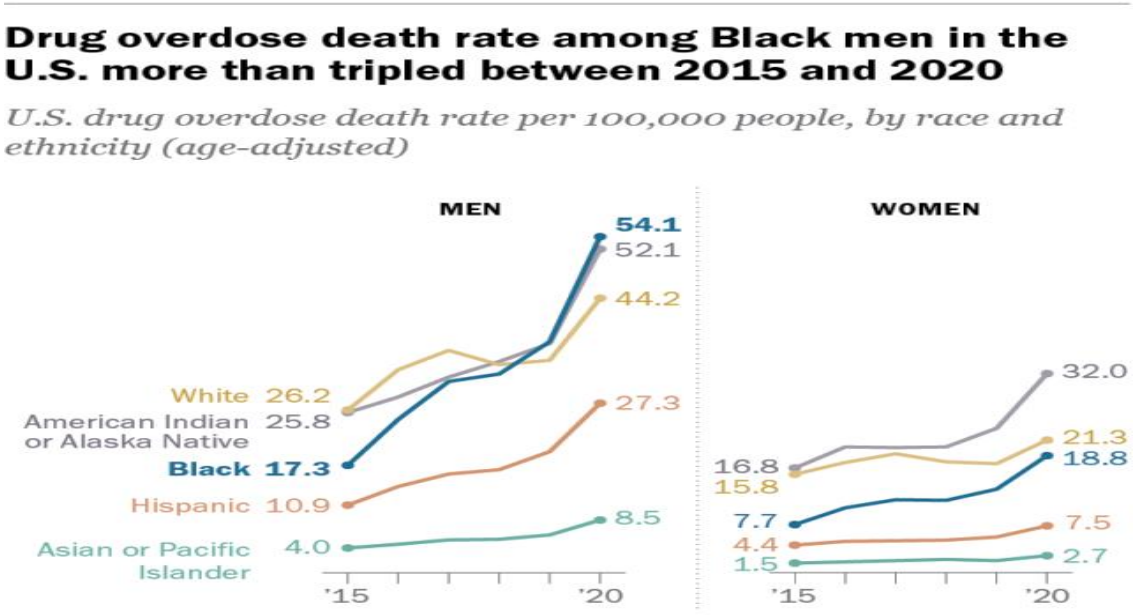
Drug Overdose Disparities



Synthetic opioids, like Fentanyl, are affecting opioid death rates among Black people more severely than other populations.

https://www.pewresearch.org/fact-tank/2022/01/19/recent-surge-in-u-s-drug-overdose-deaths-has-hit-black-men-the-hardest/

Mental Health Disparities: Diverse Populations – American Psychiatric Association 2017

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JAMA Network | Open

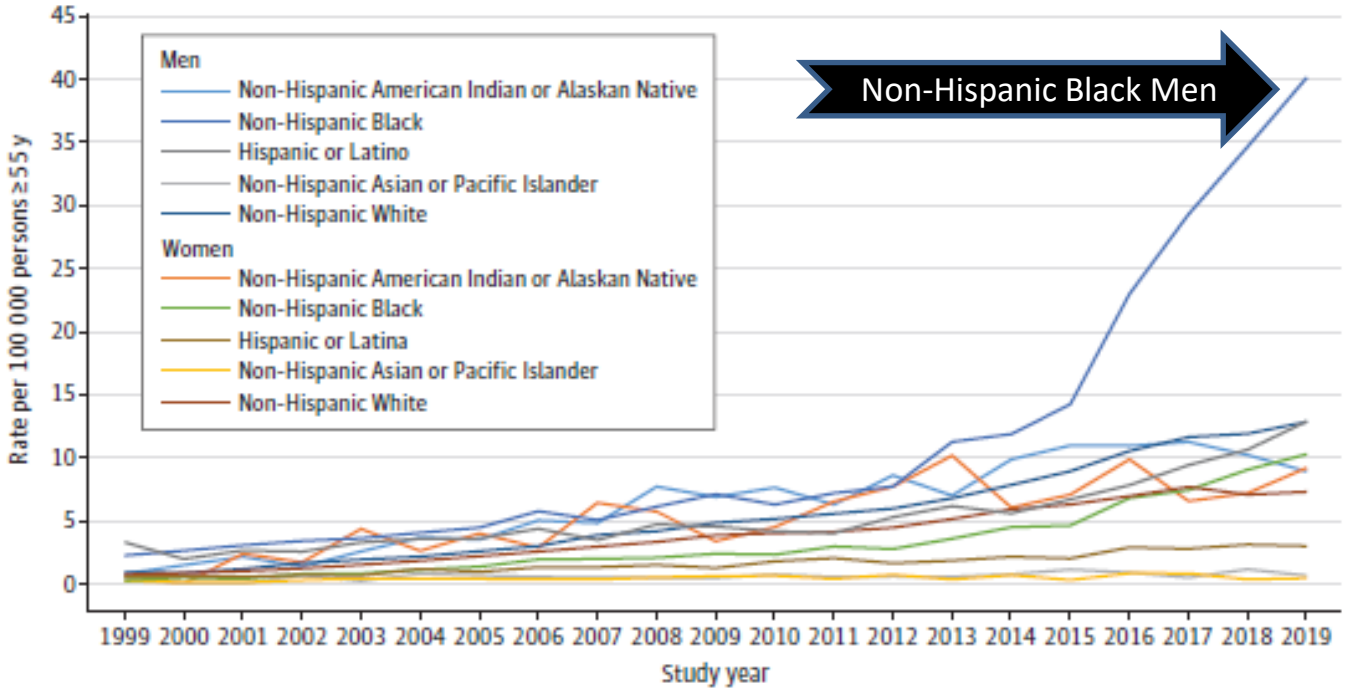
Original Investigation | Substance Use and Addiction

Disparities by Sex and Race and Ethnicity in Death Ra... Among Adults 55 Years or Older, 1999 to 2019

Maryann Mason, PhD; Rebekah Soliman; Howard S. Kim, MD, MS; Lori Ann Post, PhD

Pre-Covid 2018-2019
September 10, 2021

Figure 2. Rates of Opioid Overdose Deaths per 100 000 Persons 55 Years and Older by Sex and by Race and Ethnicity, 1999 to 2019



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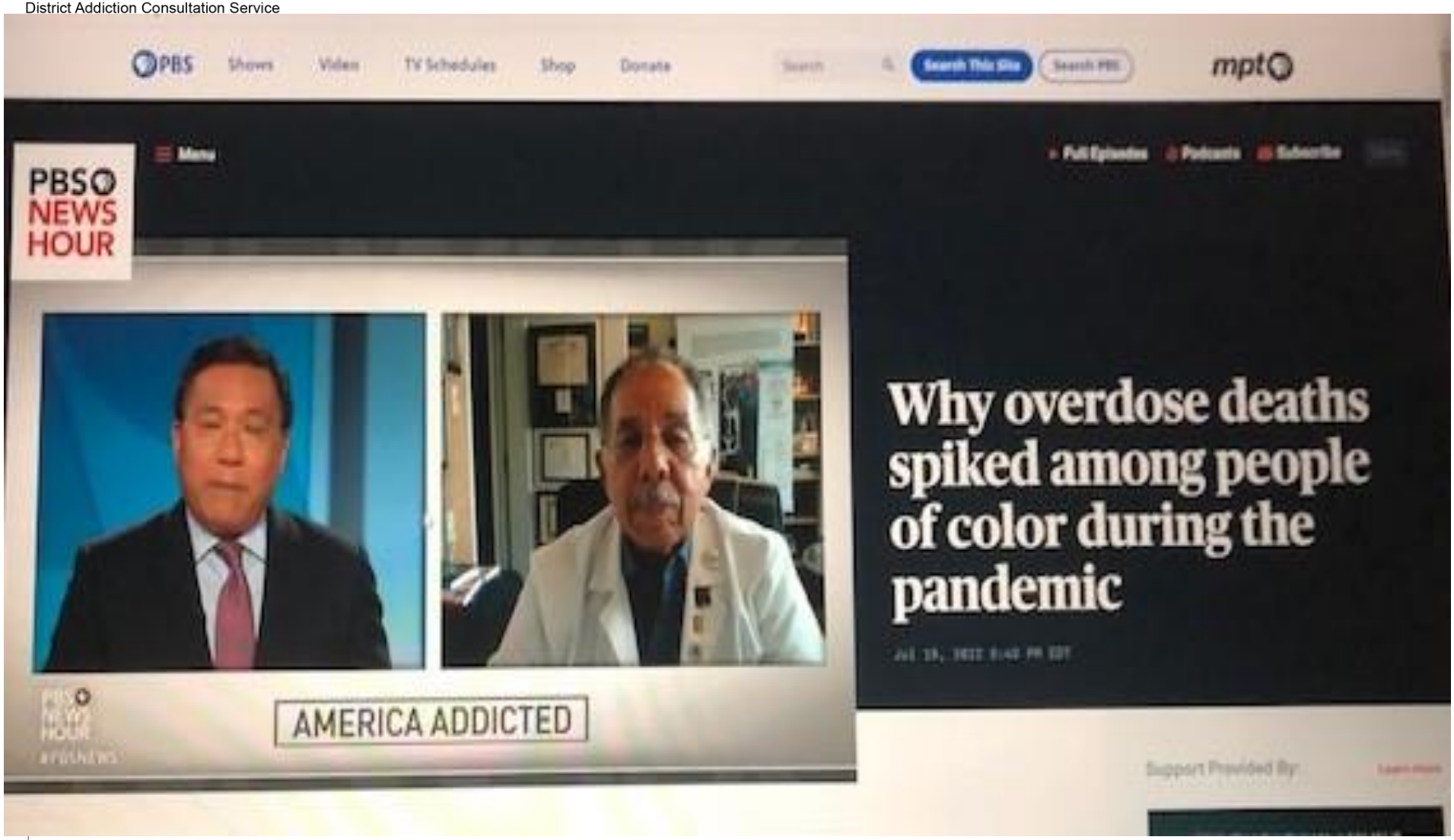

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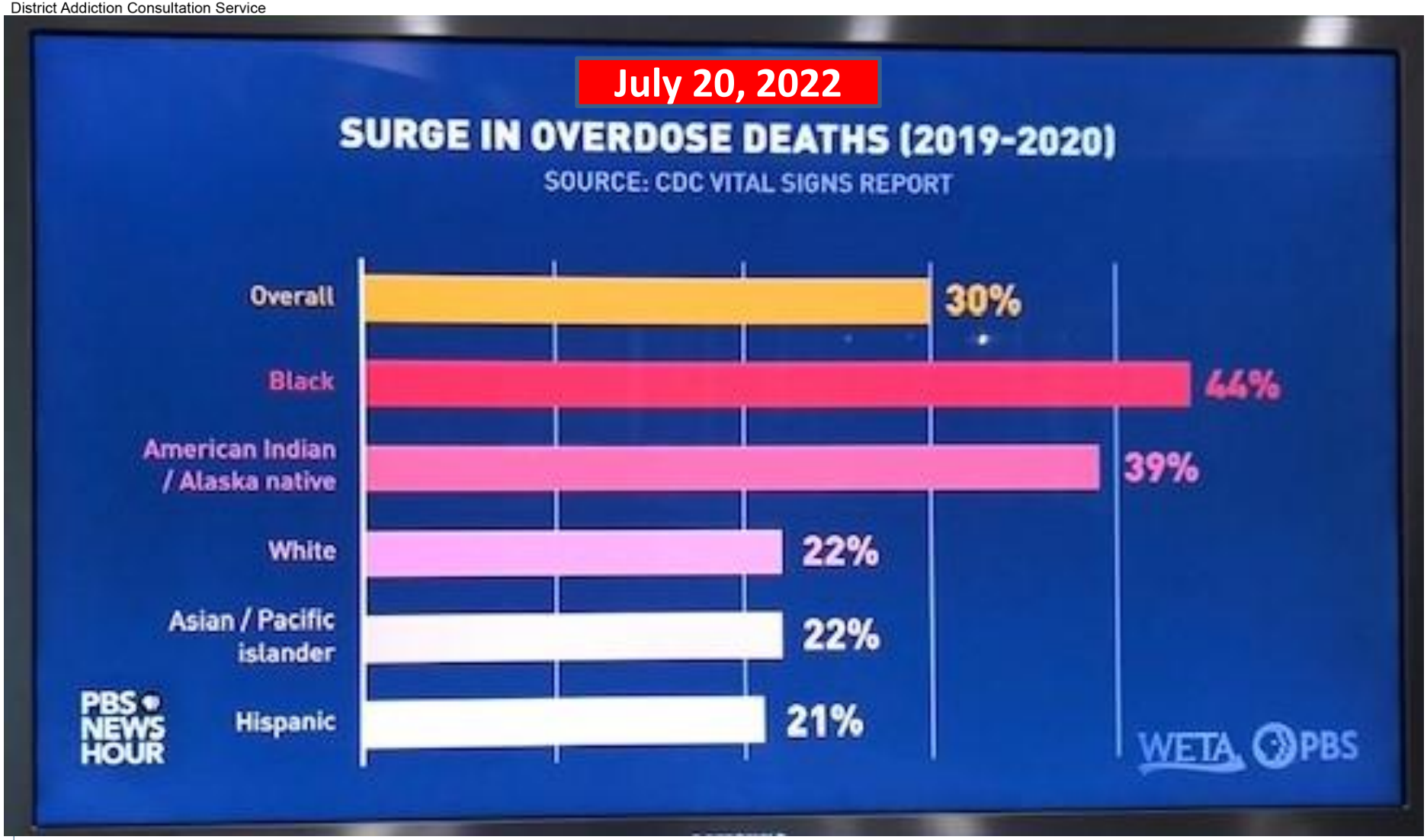

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1. Disproportionate increases among Black, AI/AN persons

- Relative rate increases in drug overdose deaths highest among **Black (44%)** and **AI/AN (39%)** persons, followed by **White persons (22%)** from 2019-2020.
- Death rates (overdose deaths/100 000 population) among **Black men aged ≥65 yrs** were nearly **6-times** as high as those among **White men of the same age** in 2019 **(35.7 vs 6.2)**, increasing to nearly **7-times** as high in 2020 **(52.6 vs 7.7)**.
- Rate among **AI/AN women aged 25-44** yrs increased to **nearly twice** that of **White women of the same age** in 2020.
- **Largest relative increase in overdose death rate (2019-2020):** AI/AN women aged 25–44 years (88%).

AI/AN, non-Hispanic American Indian or Alaska Native

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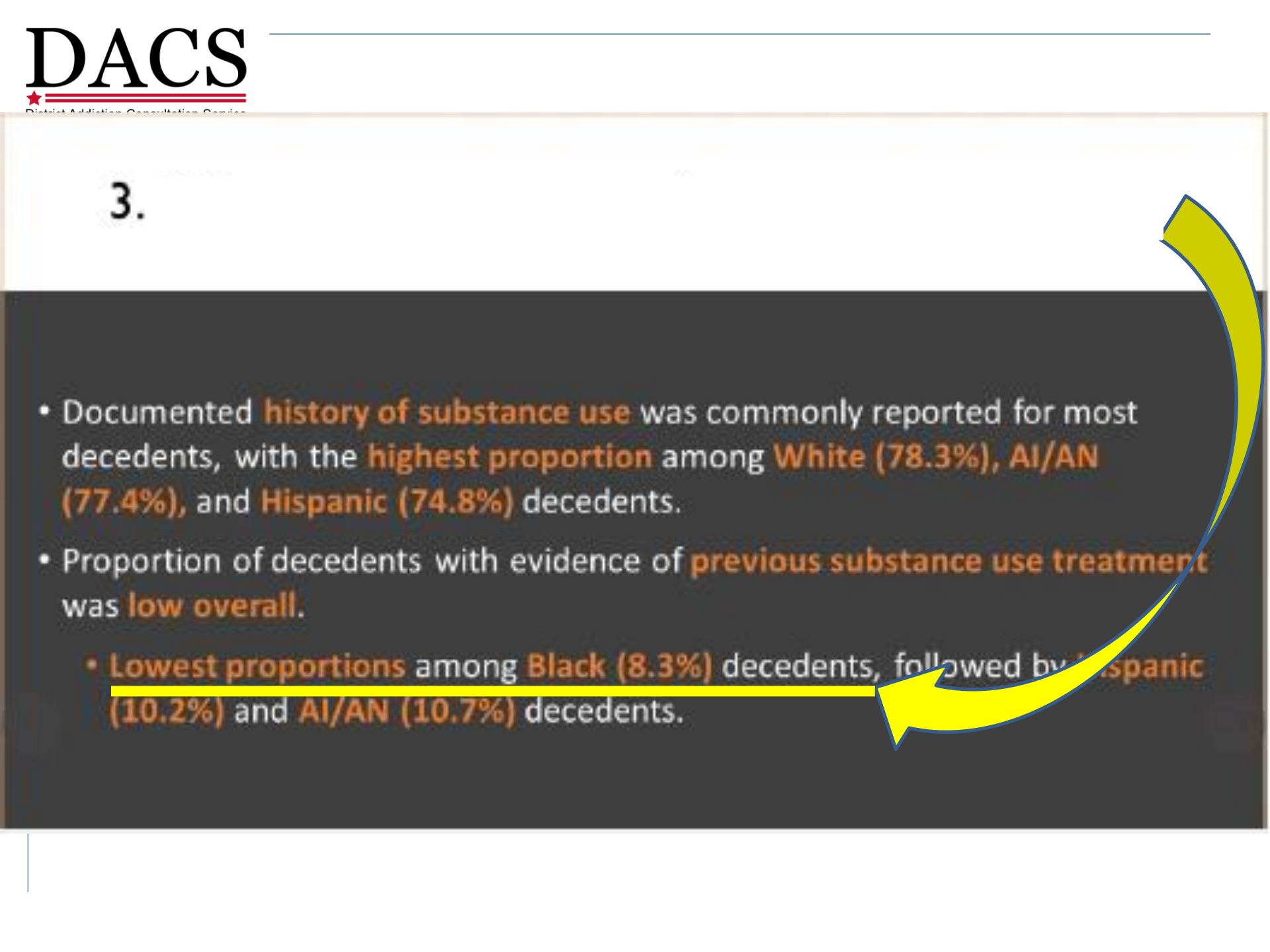
2. Greater disparities in overdose deaths in counties with more income inequality

Death rates (overdose deaths/100 000 population) **increased with rising county-level income inequality**, particularly among **Black persons**, among whom the overdose death rate was **more than twice as high** in areas with the **highest income inequality** (46.5/100 000) as in areas with the **lowest income inequality** (19.3/100 000).

3.

- Documented **history of substance use** was commonly reported for most decedents, with the **highest proportion** among **White (78.3%)**, **AI/AN (77.4%)**, and **Hispanic (74.8%)** decedents.
- Proportion of decedents with evidence of **previous substance use treatment** was **low overall**.
  - **Lowest proportions** among **Black (8.3%)** decedents, followed by **Hispanic (10.2%)** and **AI/AN (10.7%)** decedents.



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4. Drug overdose death rates were higher in areas with a higher potential capacity for opioid treatment and mental health treatment; varied by race and ethnicity

- **Among Black individuals**, drug overdose rate in 2020 in counties with the **highest mental health provider availability (46.7)** was **>2.5-times** as high as that in areas with the **lowest rate** of mental health providers **(17.2)**.

- Rates of opioid-involved deaths in 2020 among Black, AI/AN persons in **counties with at least 1 opioid treatment program** were more than twice those in counties without programs:
  - **Black:** 34.3 vs 16.6
  - **AI/AN:** 33.4 vs 16.2

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Understanding the Washington, DC Treatment Enigma

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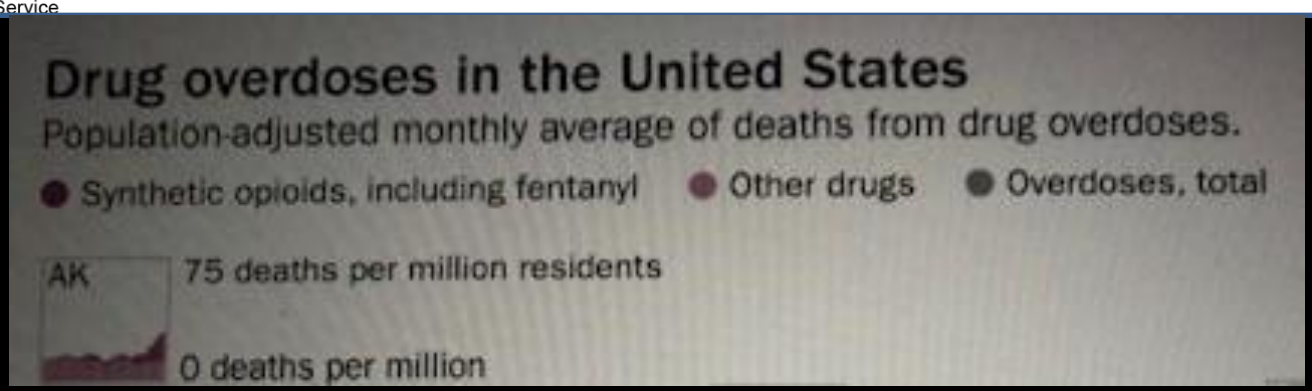

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Mental Health and Substance Use Report on Expenditures and Services

District of Columbia Department of Behavioral Health
Barbara J. Bazron, Ph.D., Director

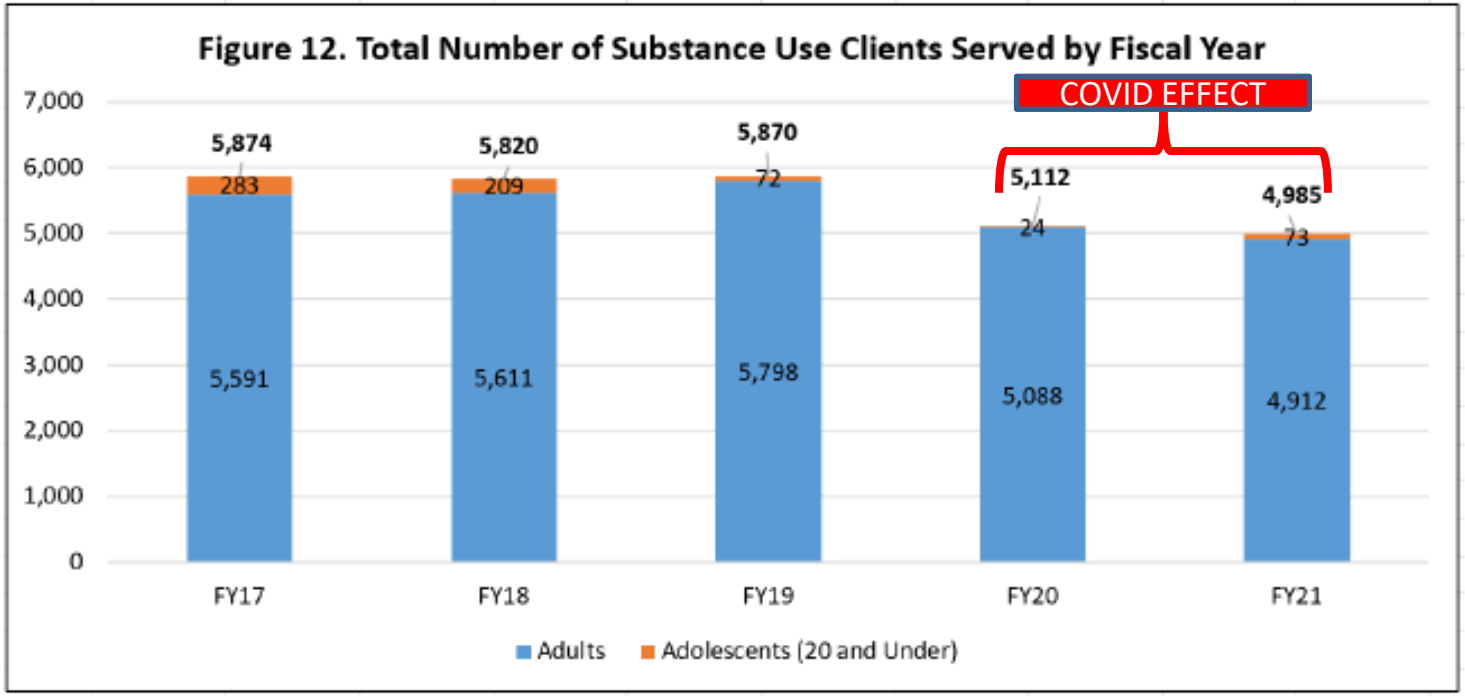

Figure 12 shows a decline in clients served between FY19 and FY20. The decline in FY20 appeared to be related to the public health emergency. There was a slight decline (2%) in FY21.

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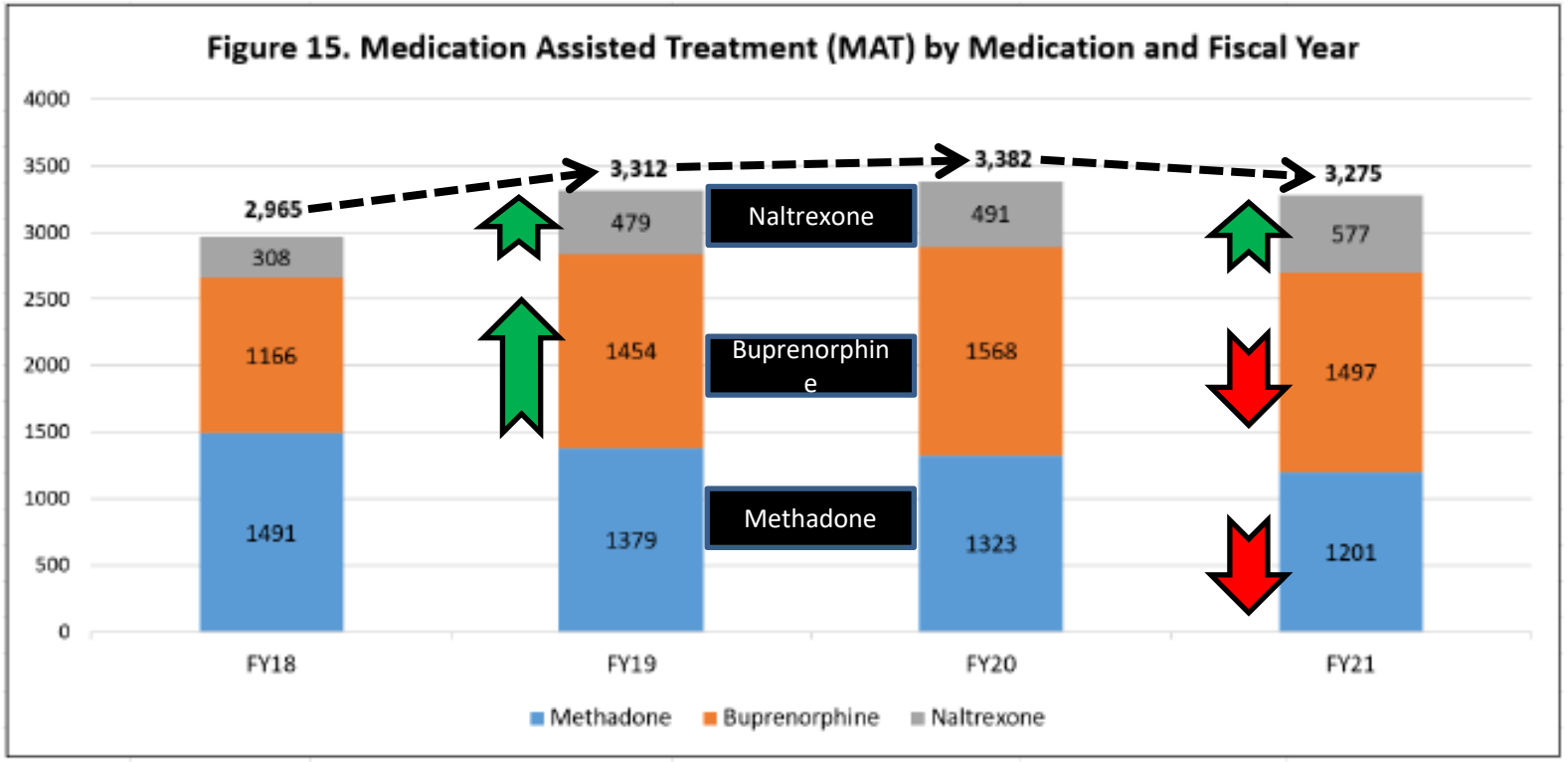

NOTE: Methadone is administered in Opioid Treatment Programs (OTPs), while Buprenorphine and Naltrexone are prescribed in primary care settings. DBH certifies the OTP providers, and the Department of Health Care Finance monitors prescribers of Buprenorphine and Naltrexone.

Figure 15 shows the total clients receiving MAT decreased by 3%, but Naltrexone use increased by 18%.

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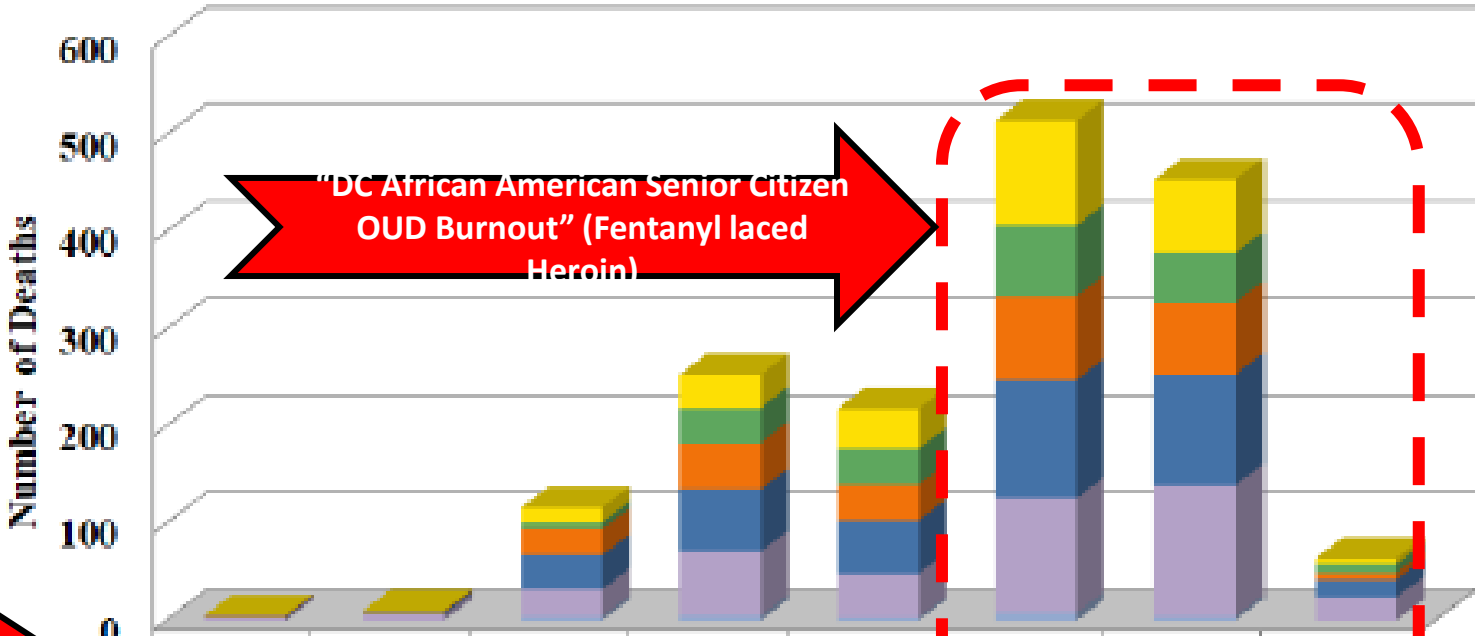
GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
[illegible], SW – 6th Floor
[illegible]gton, DC 20024

Opioid-related overdoses: January 1, 2017 to January 31, 2022

Fig. 5: Drug Overdoses due to Opioid Use by Age



	<16	16-19	20-29	30-39	40-49	50-59	60-69	70-79
[illegible]	0	1	15	34	41	108	76	6
[illegible]	0	0	7	36	37	73	51	9
201[illegible]		1	27	48	37	86	74	7
2020		2	35	64	55	122	114	18
2021	3	6	28	66	45	118	135	24

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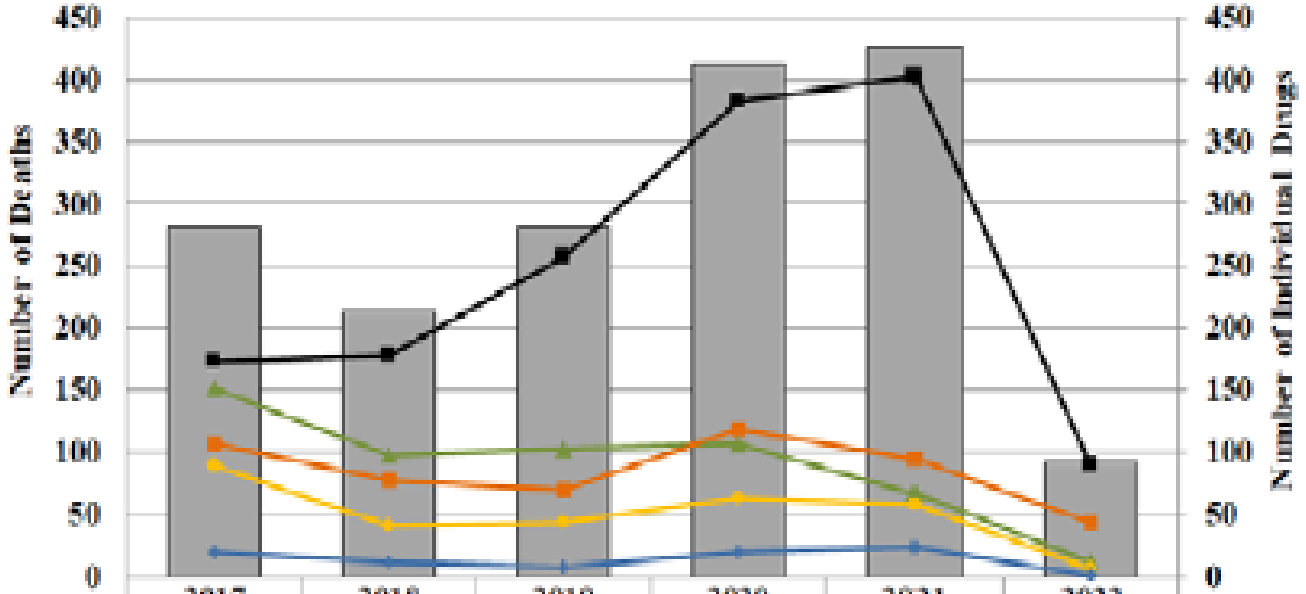
GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
401 E Street, SW – 6th Floor
Washington, DC 20024

Opioid-related Fatal Overdoses: January 1, 2017 to March 31, 2022

Report Date: June 17, 2022

Fig. 2: Total Number of Opioid Drugs Contributing to Drug Overdoses by Year (All Opioids)



	2017	2018	2019	2020	2021	2022
Number of Deaths	281	213	281	411	426	92
Heroin	151	97	102	106	67	11
Fentanyl	172	178	257	382	402	89
Fentanyl Analogs	107	78	69	119	95	43
Prescription Opioids	89	40	43	63	58	6
Other	20	12	7	19	24	1

3 Months

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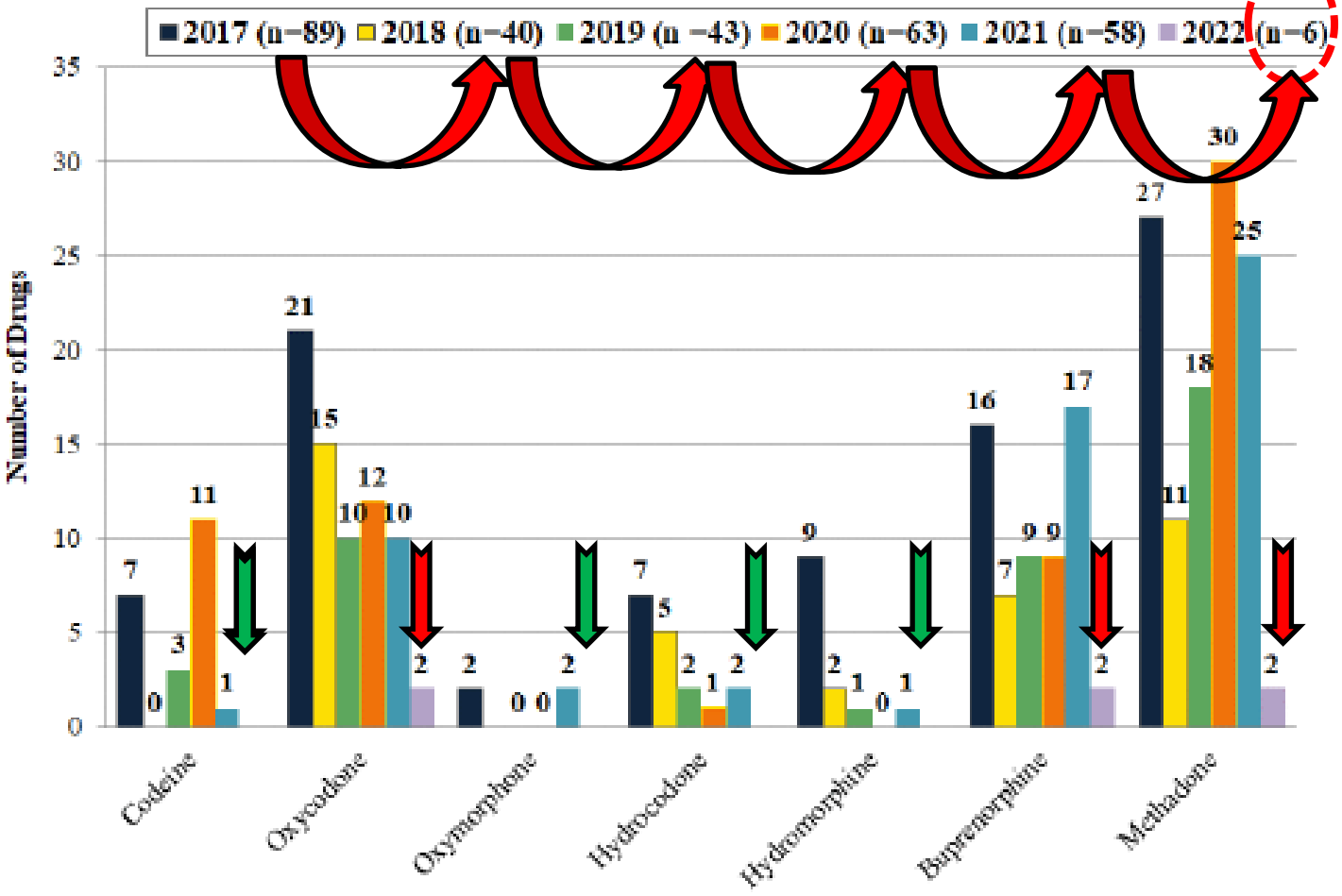
GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
401 E Street, SW – 6th Floor
Washington, DC 20024

Opioid-related Fatal Overdoses: January 1, 2017 to March 31, 2022

Report Date: June 17, 2022

Fig. 4: Number of Prescription Opioids Contributing to Drug Overdoses by Year (n=299)



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EPIGENETIC SUSCEPTIBILITY & BIOLOGICAL FOOTPRINT

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TREATMENT SAVES MONEY:
MEDICAL + CRIMINAL JUSTICE + SOCIAL JUSTICE

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$7,500

ANNUAL

BUPRENORPHINE

TREATMENT

The treatment cost of $7,529 per FTE patient estimated in the previous section includes $2,113 in opportunity cost, which accounts for transportation costs and forgone wages. The remaining treatment cost of $5,416 includes the cost of medication and physician visits. Because physicians set their own rates, there is no standard price of an office visit for buprenorphine treatment, so comprehensive data are not available.

SAVES MONEY

DEA estimates the total economic burden to be $75.7 billion ($82.14 billion USD in 2018).[35] Dividing this total economic burden by the number of patients, DEA estimates the annual economic burden of prescription opioid abuse is $42,000 per person (USD in 2018).

$42,000

UNTREATED ANNUAL MEDICAL COSTS

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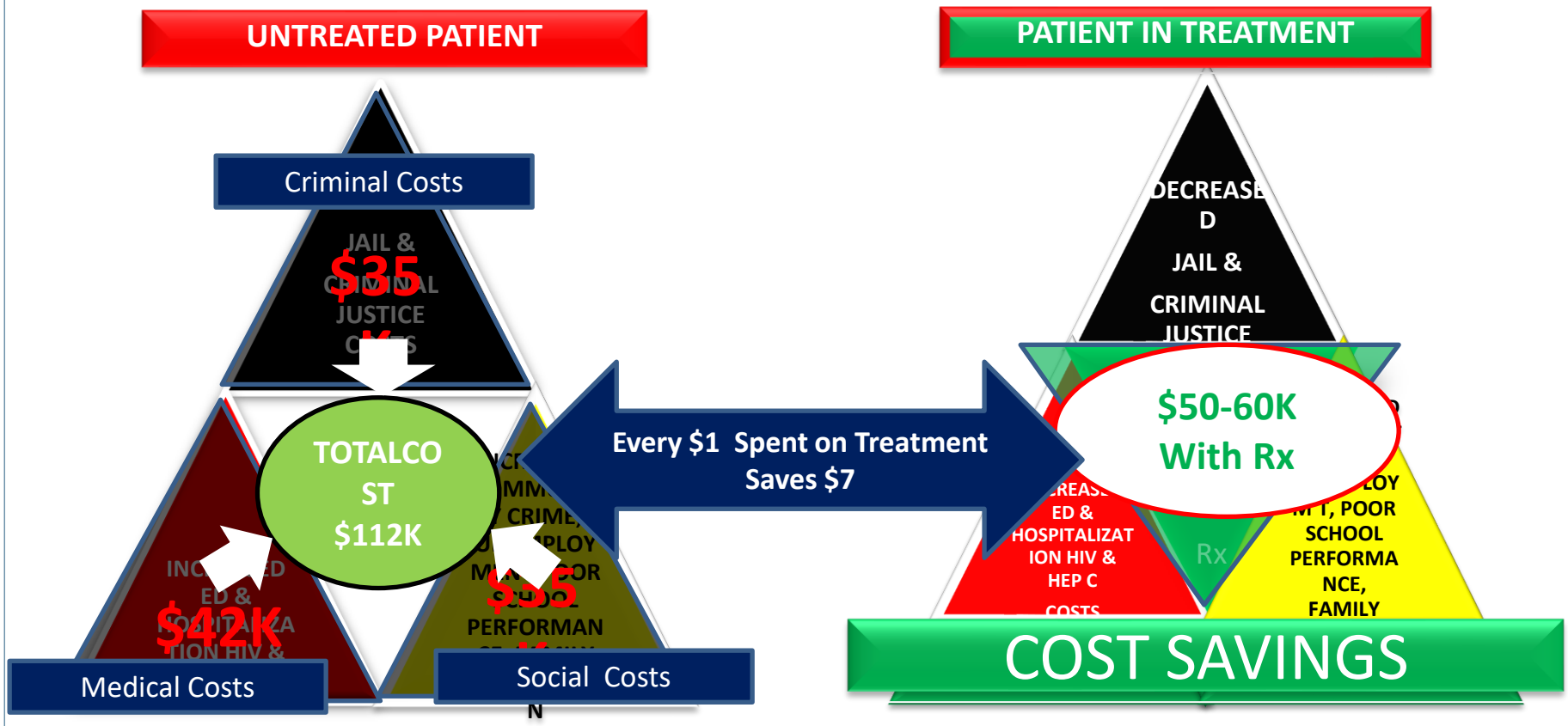
TOTAL IMPACT of an INDIVIDUAL PATIENT on COMMUNITY



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A WORLD VIEW of OPIOID USE DISORDER BEST PRACTICES with COMPARISON to the UNITED STATES: The GOOD , the BAD, and the UGLY

FOUR PHILOSOPHICAL KEYS to TREATMENT:

1. "Harm Reduction" – Clinical Treatment Modality
2. "Contingency Management" – Clinical Tool
3. "Loss Mitigation" – Financial Efficacy of Rx
4. "Retention in Treatment" – Outcomes Measure

Edwin C. Chapman, MD

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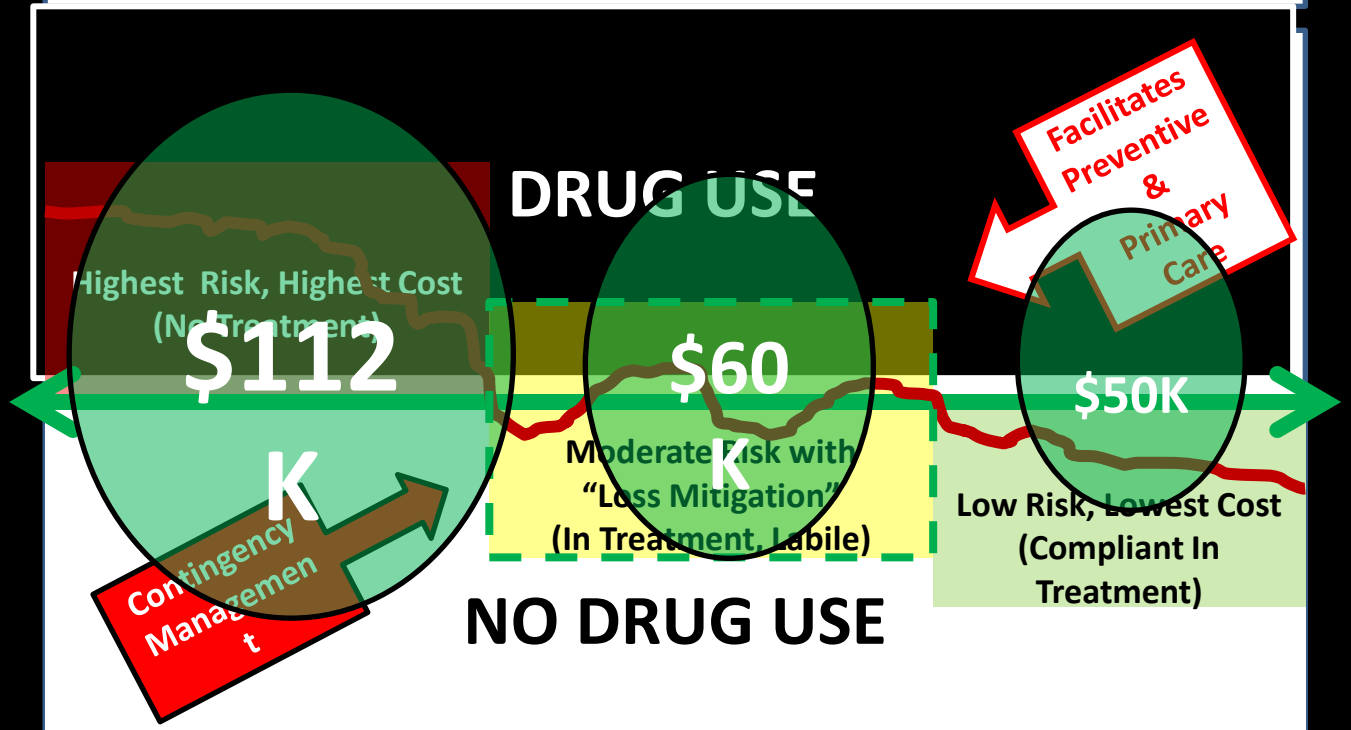
"HARM REDUCTION" & "LOSS MITIGATION"
thru
"CONTIGENCY MANAGEMENT" TREATMENT MODEL



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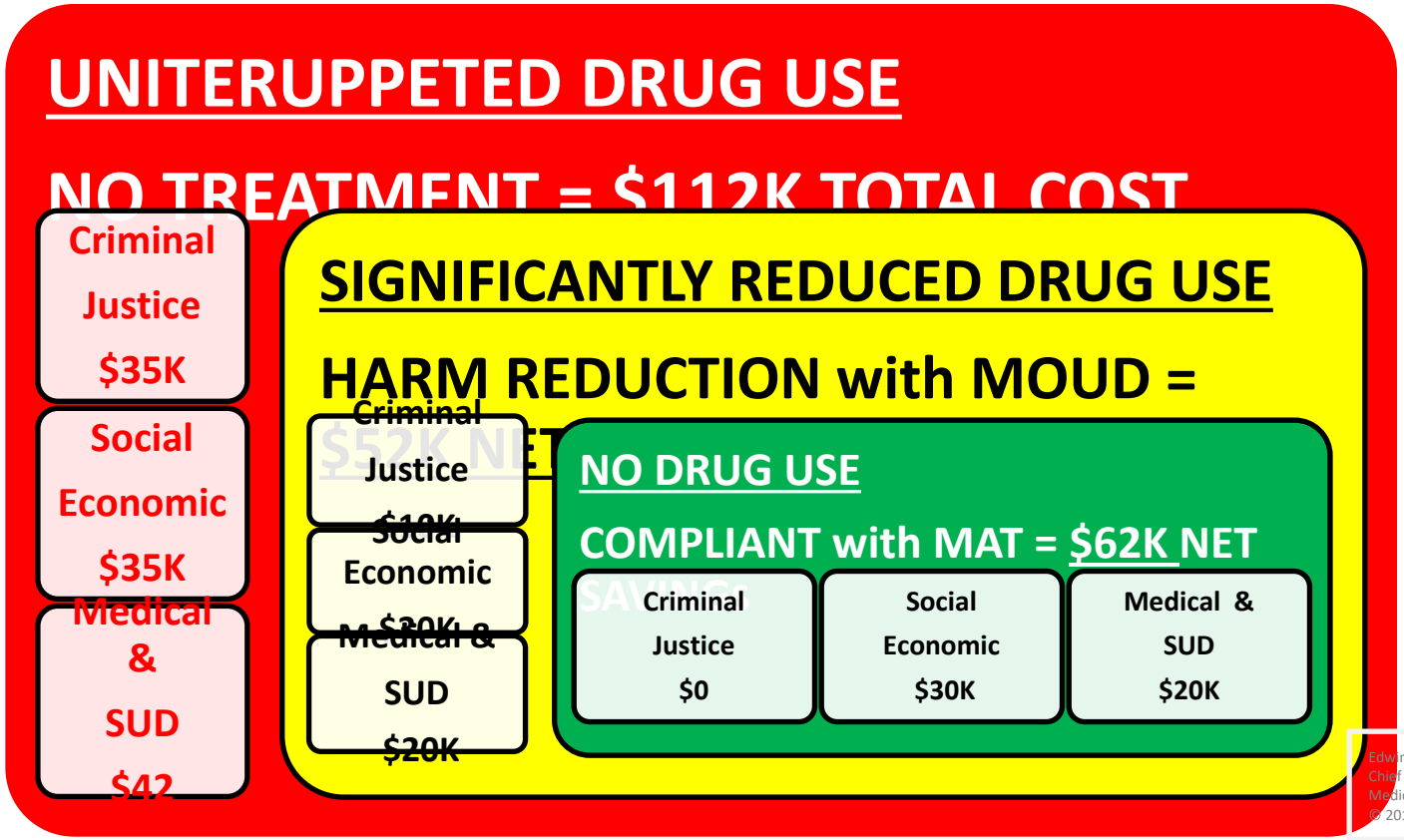
HARM REDUCTION-LOSS MITIGATION MODEL using MEDICATION for OPIOID USE DISORDER (MOUD)



Edwin C. Chapman, MD
Chief Medical Officer
Medical Home Development Group

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Current E & M Payment System as a Barrier to Comprehensive Opioid Treatment Care

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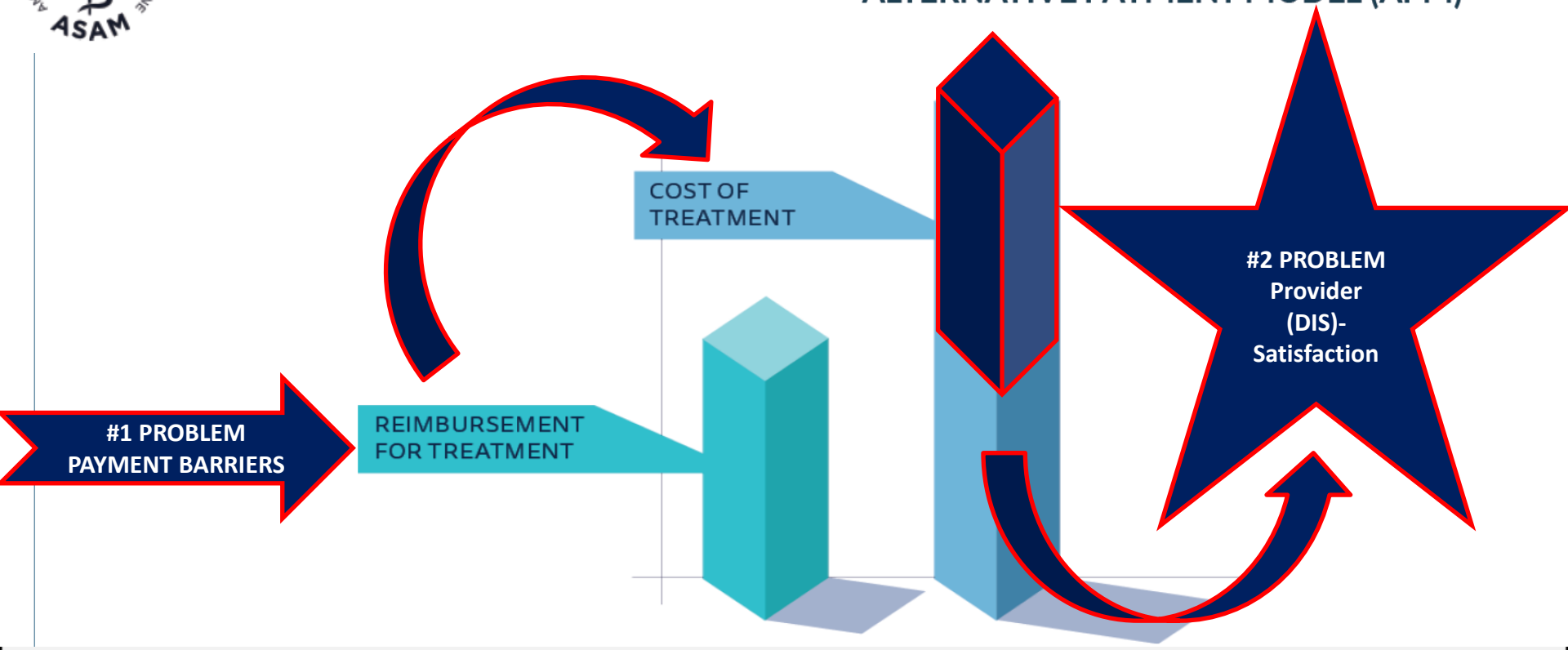
ASAM American Society of Addiction Medicine

PATIENT-CENTERED OPIOID TREATMENT (P-COAT)

ALTERNATIVE PAYMENT MODEL (APM)



Payment and Financing Limitations: Services that are helpful to patients seeking integrated care for opioid use disorder and infectious disease (e.g., harm-reduction services, case management, telemedicine, and peer-recovery counselors) are difficult to obtain or sustain financially.

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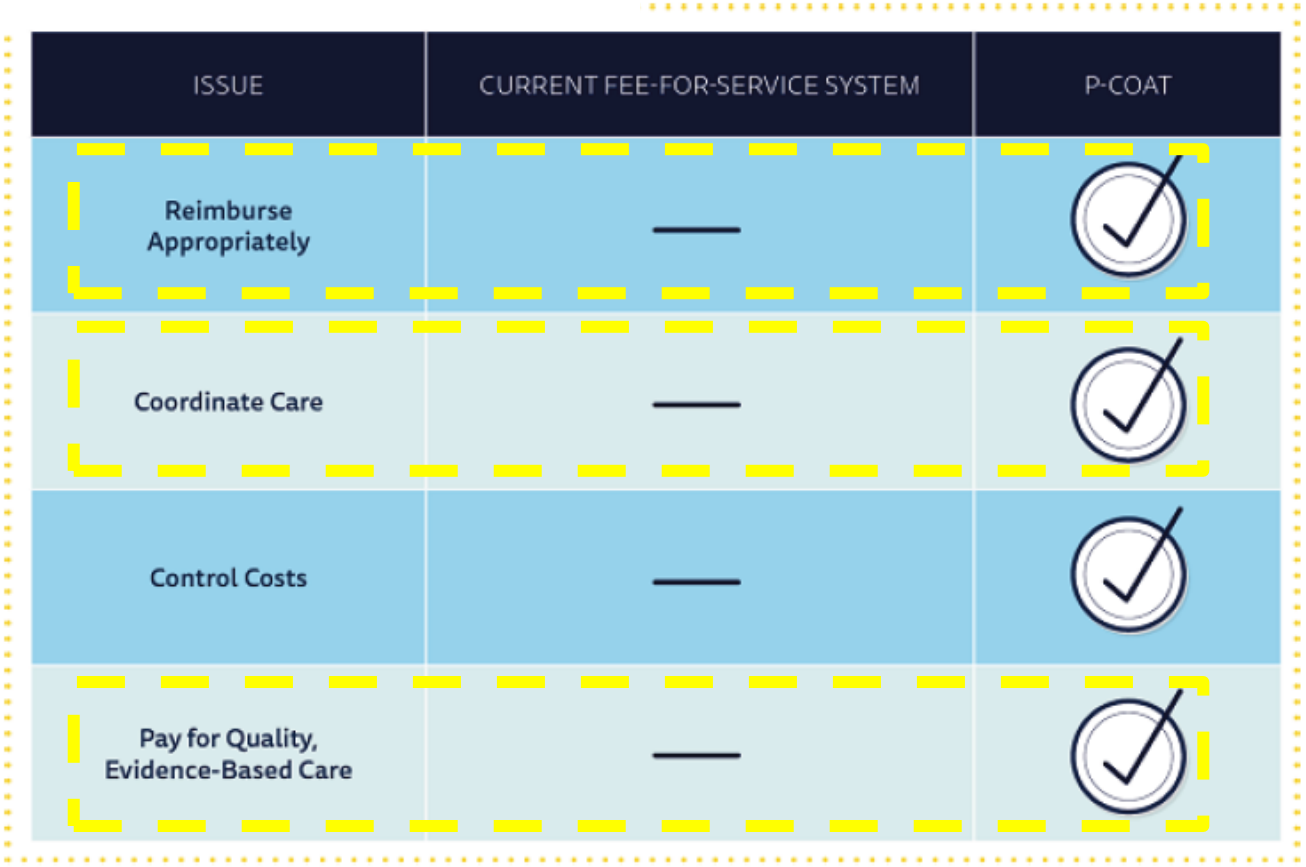
PATIENT-CENTERED OPIOID TREATMENT (P-COAT)

ALTERNATIVE PAYMENT MODEL (APM)



TYPICAL MCO

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PATIENT-CENTERED OPIOID TREATMENT (P-COAT)

ALTERNATIVE PAYMENT MODEL (APM)

INTEGRATED CARE DELIVERY

Coordinate Care

Contrary to the current system of care, patients treated by P-COAT providers would be expected to receive three types of coordinated outpatient services: • Office-based outpatient medical treatment using either buprenorphine or naltrexone; • Appropriate outpatient psychological and/or counseling therapy services; and • Appropriate coordination of services such as care management, social support, and other necessary medical services to treat the patient's condition. Some physician practices and provider organizations would be able to deliver all three services. However, many physician practices would only be able to provide medical treatment and care management services, and they would need to collaborate with addiction specialists or behavioral health organizations when available and feasible to ensure a patient can receive the full range of medical, psychological, and social support services in a coordinated manner. P-COAT is designed to accommodate multiple care settings involving integrated and coordinated care delivery. P-COAT accommodates an add-on for technology-based treatment and recovery tools.

COORDINATED CARE DELIVERY

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ASAM American Society of Addiction Medicine | PATIENT-CENTERED OPIOID ADDICTION TREATMENT (P-COAT)

Reasons for underutilization:

- Insufficient or limited insurance coverage for services related to treating substance use disorder (SUD)
- Shortage of physicians qualified to prescribe MAT
- Lack of access to addiction specialists

Some Problems with Current Payment Systems:

- Payments (E&M) for physicians and clinicians are generally insufficient to identify, diagnose and treat OUD
- Prior authorization requirements make it difficult to deliver timely, effective treatment
- Limited reimbursement for telemedicine
- Separate billing for medical and behavioral services related to OUD
- Limited payment for transportation and other non-medical social services needed to effectively treat patients

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ASAM American Society of Addiction Medicine | PATIENT-CENTERED OPIOID ADDICTION TREATMENT (P-COAT)

GOALS

- ✓ Provide appropriate financial support to physicians/clinicians to successfully treat OUD with MAT
- ✓ Encourage more PCPs to provide treatment with MAT
- ✓ Broaden coordinated delivery of medical/psychological/social model of treatment
- ✓ Reduce/eliminate spending on outpatient treatments that are ineffective/unnecessarily expensive
- ✓ Improve access to evidence-based outpatient care for patients being discharged from intensive levels of care
- ✓ Reduce spending on potentially avoidable emergency department visits and hospitalizations
- ✓ Increase the proportion of individuals with opioid addiction who are successfully treated
- ✓ Reduce deaths caused by opioid overdose and complications of opioid use
- ✓ Improve adherence to medications to treat opioid addiction

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CMS.gov
Centers for Medicare & Medicaid Services

EVALUTION & MANAGEMENT
E & M CODES

DO NOT ADDRESS
"Social Determinants of Health"

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American Society of Addiction Medicine
PATIENT-CENTERED OPIOID ADDICTION TREATMENT (P-COAT)

FULLY INCORPORATE

"Social Determinants of Health"
&
Advanced Payment for Associated Personnel

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CMS.gov
Centers for Medicare & Medicaid Services

Office-Based Opioid Use Disorder (OUD) Treatment Billing

In the CY 2020 Physician Fee Schedule final rule, CMS included new coding and payment for a monthly bundle of services for the treatment of OUD that includes:

- Overall management
- Care coordination
- Individual and group psychotherapy
- Substance use counseling
- Add-on code for additional counseling

This is a way for clinicians to bill for a group of services in the office setting similar to the services covered under the Opioid Treatment Program benefit for clinics. Clinicians providing these bundled services to Medicare patients should use these codes:

HCPCS Code for Office-Based OUD Treatment	Description
G2086	In the first calendar month: • Developed the treatment plan • Coordinated care • Provided at least 70 minutes of individual therapy and group therapy and counseling
G2087	In a subsequent calendar month: • Coordinated care • Provided at least 60 minutes of individual therapy and group therapy and counseling
G2088	• Coordinated care • Provided more than 120 minutes of therapy and counseling Note: Bill each additional 30 minutes separately and include the code for primary procedure

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UNDERSTANDING
"MEASUREMENT BASED CARE"
in
ADDICTION TREATMENT

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CPT *TIME or PROCESS* Based Care

(Evaluation & Management or E &M Billing)

vs.

24/7 *OUTCOMES MEASUREMENT*-Based Care

(P-COAT bundled billing)

"Fishing with a net versus fishing with a spear"

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INTEGRATED TELEHEALTH OPIOID TREATMENT PATIENT FLOW : HIV, HEPATITIS C, MENTAL HEALTH, and SUBSTANCE ABUSE, and HEALTH HOMES DEMONSTRATION PROJECT

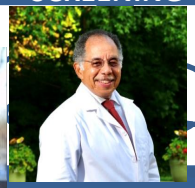
INTAKE PHASE | MEDICAL TREATMENT PHASE | AFTERCARE

TELEHEALTH NETWORK INTEGRATION

INTAKE

"Chronic Care Management" Team

MEDICAL INTAKE SCREENING



MENTAL HEALTH SCREENING

INTEGRATED CARE

- DRUG TREATMENT
- MENTAL HEALTH TREATMENT
- PRIMARY CARE
- INFECTIOUS DISEASE

MEDICAL OUTCOMES

- Decrease Drug Related Morbidity & Mortality
- Decrease Mental Illness Related Morbidity/Mortality
- Increase HEDIS Compliance
- Decrease Personal Viral Loads

SOCIAL ECONOMIC OUTCOMES

- Decrease Criminal Activity / Child Neglect
- Decrease Hospitalizations
- Decrease Community Viral Load

COST SAVINGS

- Decrease Non-Medical Costs
- Decrease Medical Costs

*PEER SUPPORT

*LCHC = Leadership Council for Healthy Communities [...nization / Multiple Churches in DC & Suburban Maryland]

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"I did not know that I suffered with the disease of diabetes" ...

"I did not know that I suffered with the disease of hypertension" ...

"I had hepatitis C and Medicaid did not want to pay for it" ....

"It took 5 times for the doctor that I was referred to by Dr. Chapman to get Medicaid to pay for it!!" ...

"Medicaid paid $90,000 for 3 months treatment and... I no longer have the hepatitis C virus" ...

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CHAPMAN, PC BUPRENORPHINE PATIENTS
LONGEST DRUG FREE PATIENT (2005-2022) NOW AGE 75

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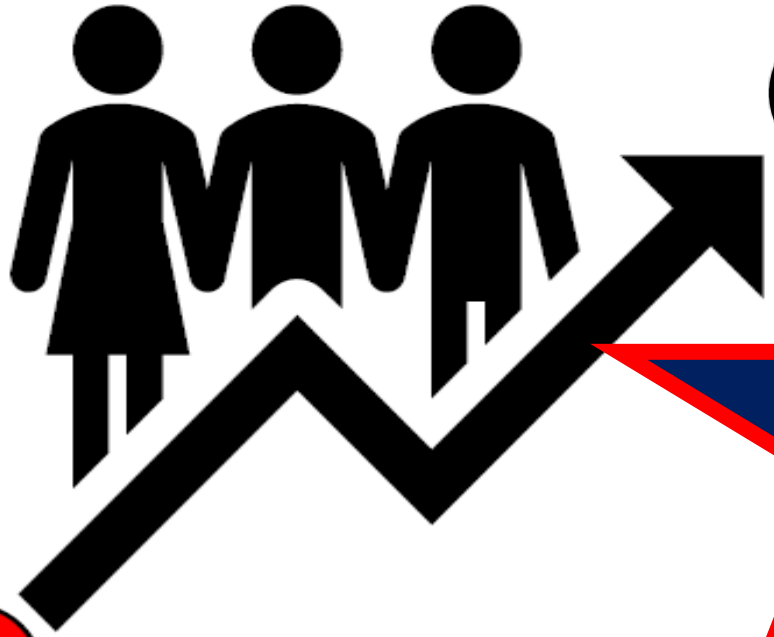
AVERAGE AGE CHAPMAN, PC BUPRENORPHINE PATIENTS INCREASED from 52 → 59 years (2014 -2020)



60

52

2014

2020

#1 GOAL
Improved Medical Outcomes

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OPIOID MEDICAL TREATMENT SAVES MONEY:
250 Patients x $7,500 /patient/year = $1,875,000 Annual Cost

(FED. REG. 11/2/2020) UNTREATED = $42,000 /patient/year

TREATMENT COST = $ 7,500 /patient/year

SAVINGS = $34,500/patient/year

X

TOTAL ANNUAL NET MEDICAL SAVINGS (250 patients) = **$8,500,000**

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CHAPMAN, PC BUPRENORPHINE PATIENTS
RETENTION IN TREATMENT

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INTEGRATED TELEHEALTH OPIOID TREATMENT PATIENT FLOW : HIV, HEPATITIS C, MENTAL HEALTH, and SUBSTANCE ABUSE, and HEALTH HOMES DEMONSTRATION PROJECT

INTAKE PHASE | MEDICAL TREATMENT PHASE | AFTERCARE

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"African American Chronic Care Management" Team

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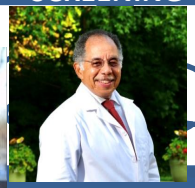

MENTAL HEALTH SCREENING

INTEGRATED CARE

- DRUG TREATMENT → Decrease Drug Related Morbidity & Mortality
- MENTAL HEALTH TREATMENT → Decrease Mental Illness Related Morbidity/Mortality
- PRIMARY CARE → Increase HEDIS Compliance
- INFECTIOUS DISEASE → Decrease Personal Viral Loads

MEDICAL OUTCOMES

SOCIAL ECONOMIC OUTCOMES

- Decrease Criminal Activity / Child Neglect
- Decrease Hospitalizations
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COST SAVINGS

- Decrease Non-Medical Costs
- Decrease Medical Costs

*PEER SUPPORT

*LCHC = Leadership Council for Healthy Communities [...nization / Multiple Churches in DC & Suburban Maryland]

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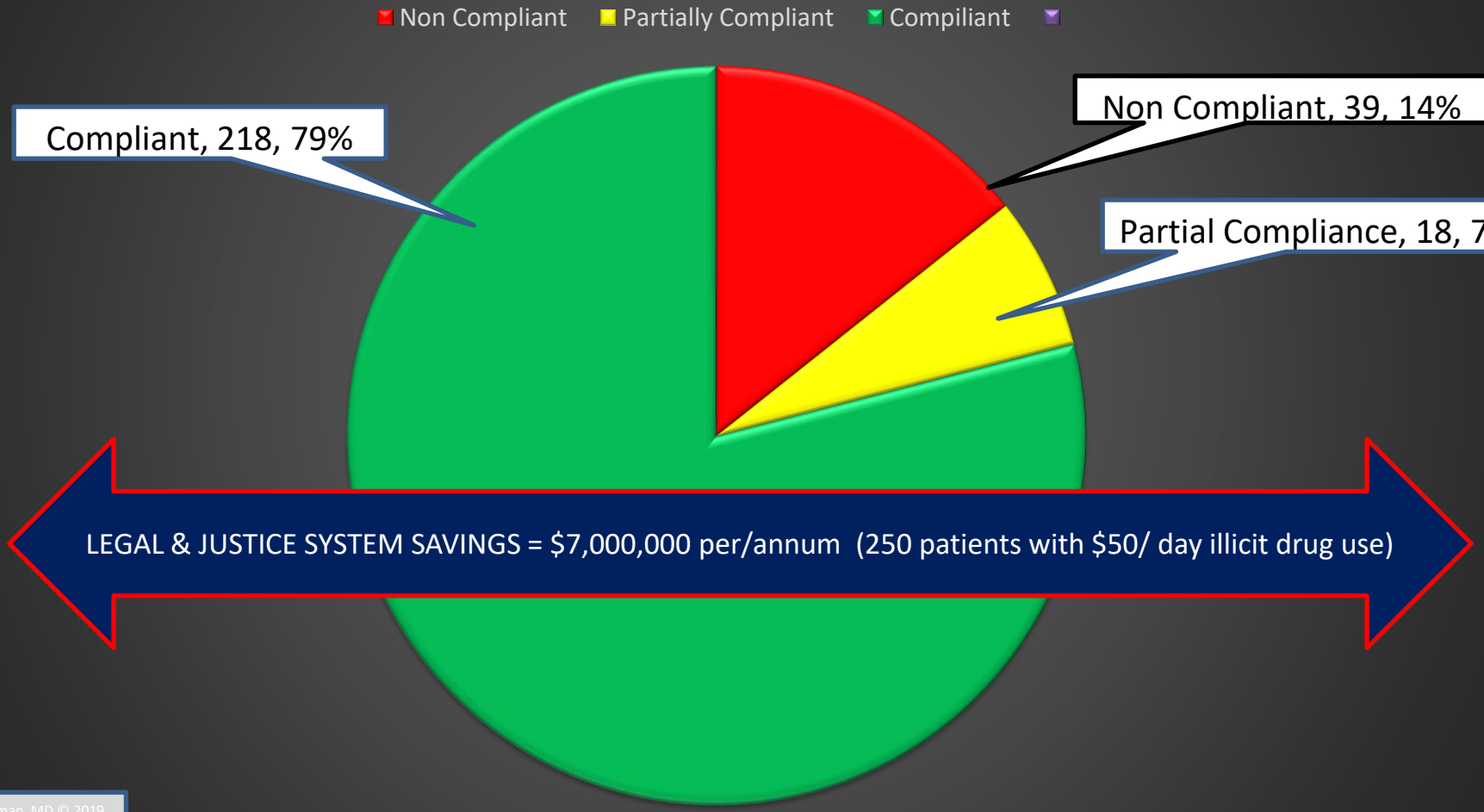
ILLICIT OPIOID & OTHER DRUG USE



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OPIOID TREATMENT JUSTICE SYSTEM SAVINGS

1. UNTREATED LEGAL COSTS = $35,000 /patient/year
2. TREATMENT (250 patients) x 80% SUCCESS RATE = 200

THEREFORE,

$35,000 x 200 = $7,000,000 in Criminal Justice Savings

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The High Price of the Opioid Crisis, 2021

Increasing access to treatment can reduce costs

DATA VISUALIZATION August 27, 2021 Topics: Health Care & U.S. Policy Projects: Substance Use Prevention and Treatment
Read time: 1 min

Untreated opioid use disorder (OUD), a chronic brain disease, has a serious cost to people, their families, and society because of increased health care spending, criminal justice issues, and lost productivity.

Each year, opioid overdose, misuse, and dependence account for:

$35 billion in health care costs[1]

Patients who experienced an opioid overdose accounted for $1.94 billion in annual hospital costs.[2]

$14.8 billion in criminal justice costs[3]

Each dollar invested in addiction treatment reduces drug-related crime, theft, and criminal justice costs by $4-$7.[4]

$92 billion in lost productivity[5]

The losses stem from premature death due to overdose, "productive hours" lost to OUD, and opioid-related incarceration.

Nearly 70,000 Americans died of an opioid overdose in 2020.[6] Improving access to evidence-based treatments for OUD has been associated with savings of $25,000 to $105,000 in lifetime costs per person.[7]

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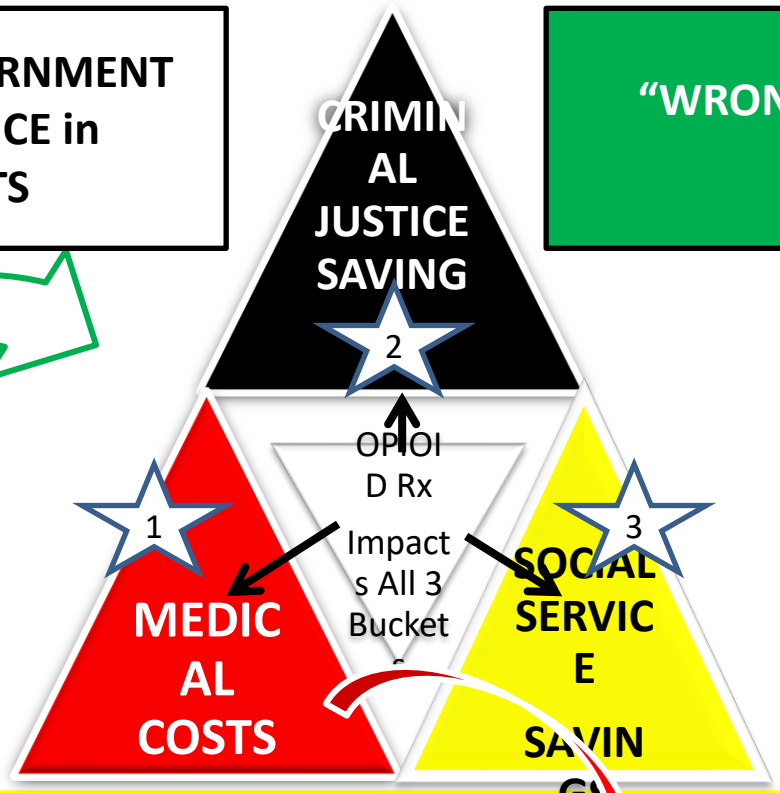
WHY OPIOID MOUD "GOVERNMENT CARVEOUT" MAKES SENCE in $ DOLLARS and CENTS

"WRONG POCKET SAVINGS": (Buckets 2 & 3)



If maintenance therapy is such a good deal, why don't we more readily provide it? One answer is that, though treatment works, its benefits are diffuse. A great deal of the cost of treatment would be borne by insurers and public health programs. But a great deal of the savings would be captured by society at large (through a reduction in crime, for example). As my colleague Keith Humphreys and co-authors wrote, "If, for example, one is held responsible to keep a hospital budget in balance, spending scarce funds on [substance use disorder] treatment does not become more attractive just because it saves money for the prison system."

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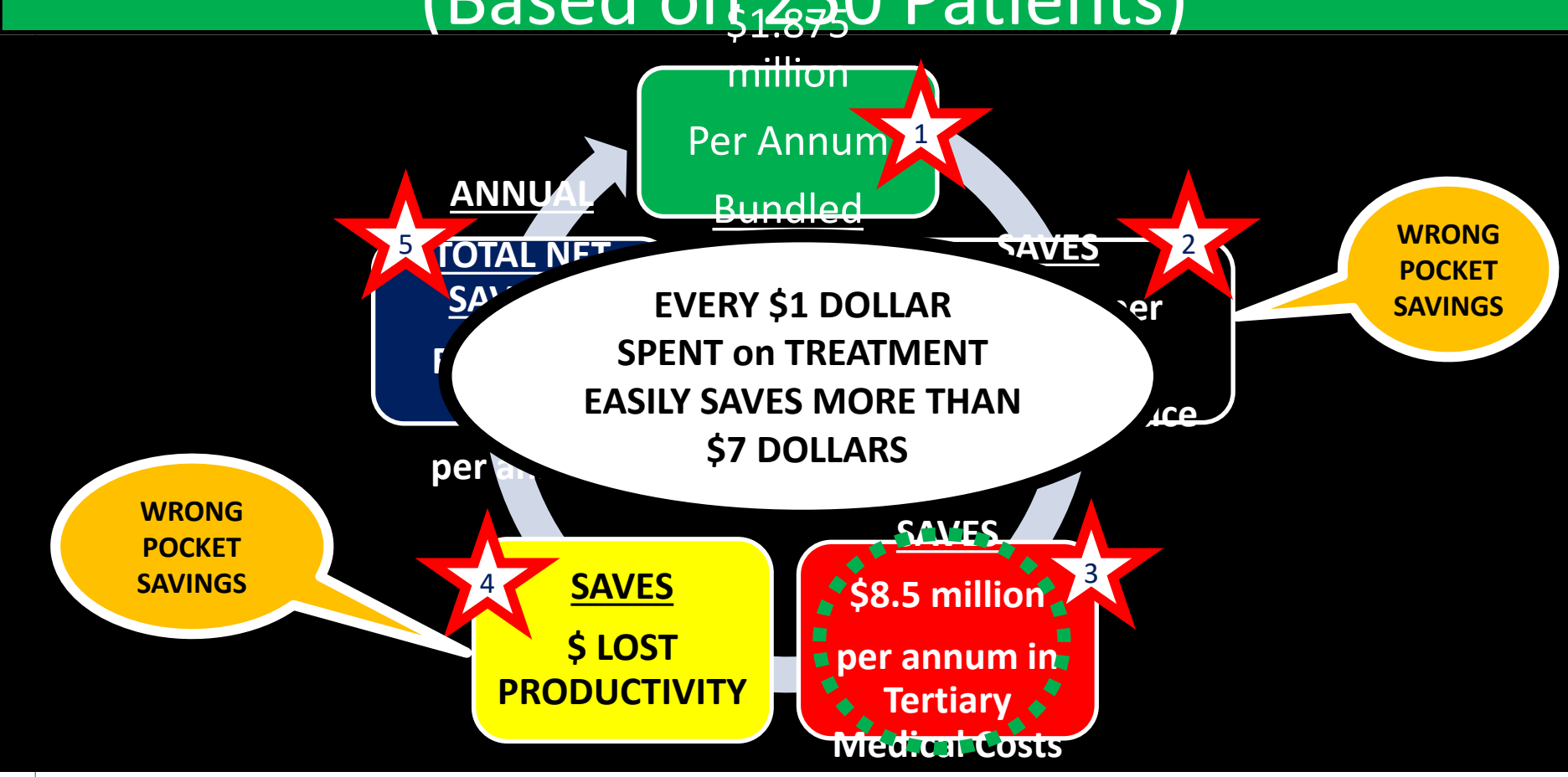
BUPRENORPHINE LOSS MITIGATION MODEL (Based on 250 Patients)



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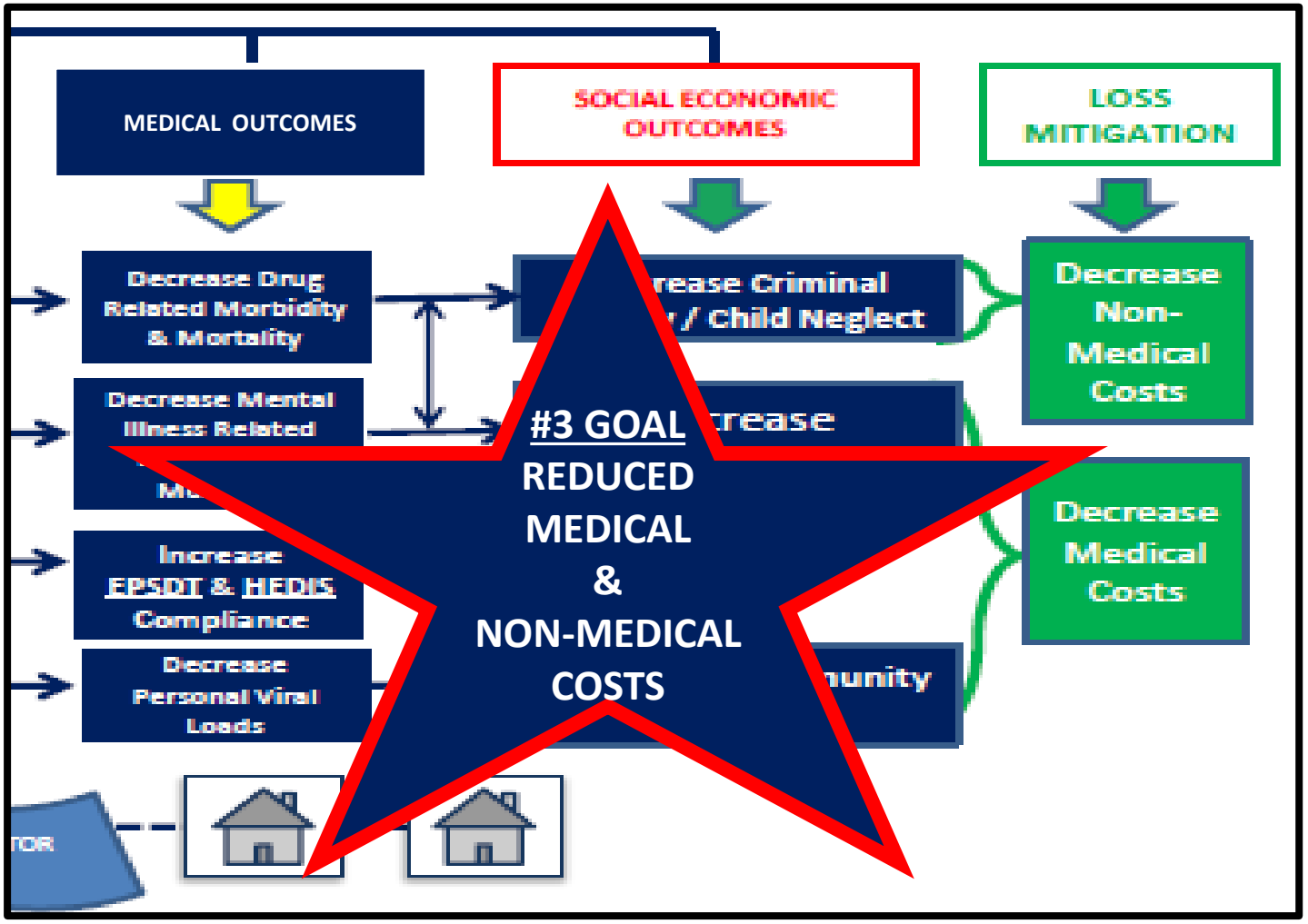

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CUMMULATIVE OUTCOMES MEASURES with *PROPOSED* BUNDLED per MEMBER per MONTH PAYMENTS

OPIOID TREATMENT

1. Retention in Care
2. Negative Opioid Toxicology
3. Overdose / ED Visits & Hospitalizations / OD Deaths

PRIMARY CARE
(in collaboration with

1. HEDIS Measures
2. HIV & Hepatitis Referral, Treatment, an
   Load Monitoring
3. Preventive Health Referrals and Trac
   (mammogram, colonoscopy, PSA, v
   etc.)

#4 GOAL
IMPROVED PROVIDER SATISFACTION

MENTAL HEALTH REFERRALS & TRACKING
(onsite via tele-health or at remote provider site)

NON-MEDICAL OUTCOMES MEASURES
elated Conviction / Incarceration
of Health (housing,
tation, food, clothing)
ster care, family reintegration,

PRIATE EDUCATION & EMPLOYMENT REFERRALS

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THERE ARE "ELEPHANTS" in OUR COMMUNITY !!!:

The 1999 "60 MINUTES STORY"

PEER COACH in *MY* OFFICE

HAS NEW CONDO

COMMUNITY MENTOR to MANY

CERTIFIED COUNSELOR & NARCAN TRAINER

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PHYSICIAN ADVOCACY to END PUBLIC POLICY BARRIERS

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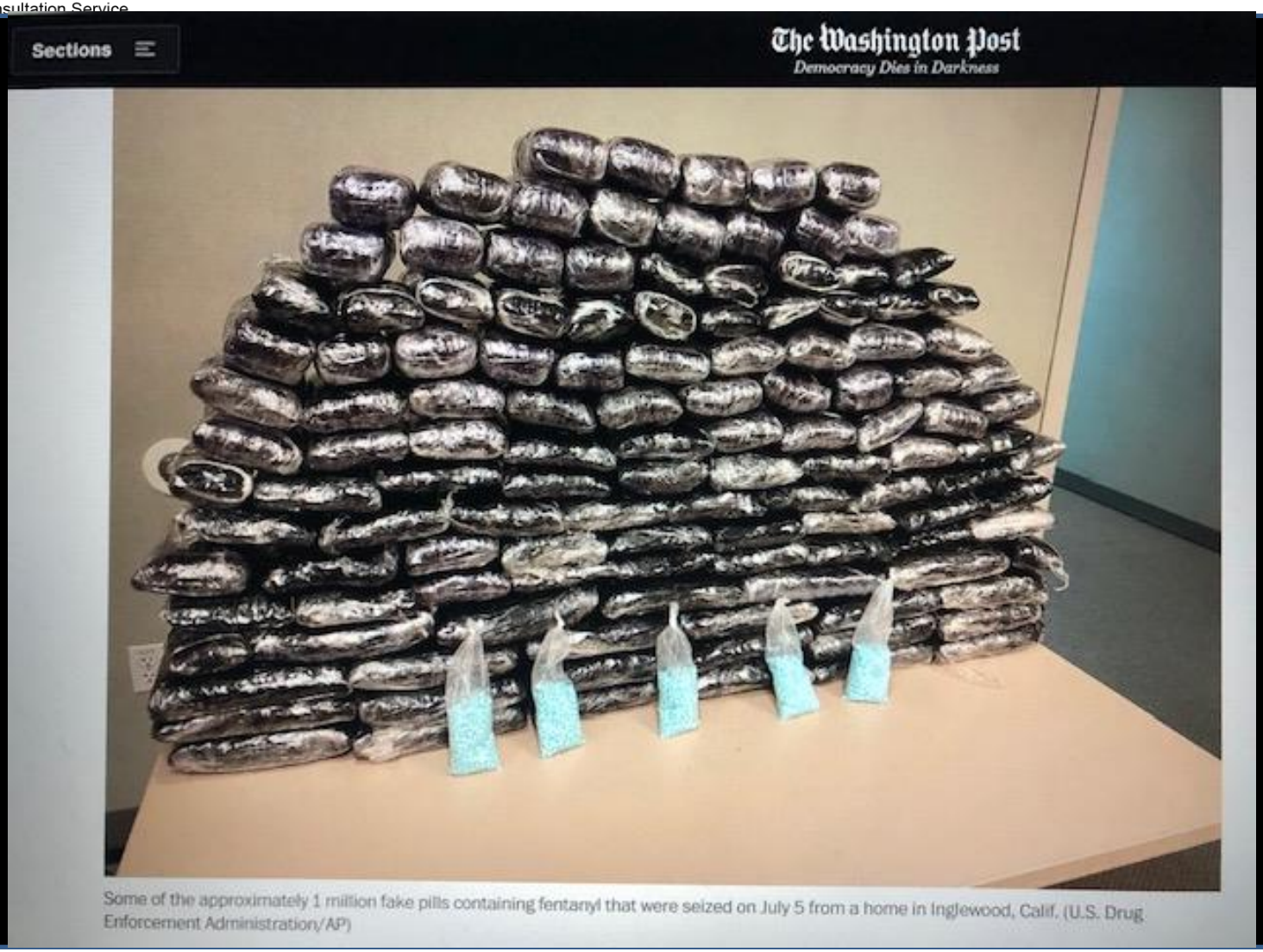

Some of the approximately 1 million fake pills containing fentanyl that were seized on July 5 from a home in Inglewood, Calif. (U.S. Drug Enforcement Administration/AP)

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Feds Must Do More to Fight Fentanyl, Senators Say — "What we're doing is not working," said Sen. Susan Collins

by Joyce Frieden, Washington Editor, MedPage Today July 26, 2022

Other committee Republicans also focused on drug interdiction at the border. **"We have to recognize that a policy at the border which has been feckless and ineffective ... not just allows people to come here who are illegal immigrants -- it allows drugs to come across as well," said Sen. Bill Cassidy, MD (R-La.).** "We've got to control that border. If there's a message I wish the administration to get, it's use your tools to control it."

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Feds Must Do More to Fight Fentanyl, Senators Say — "What we're doing is not working," said Sen. Susan Collins

by Joyce Frieden, Washington Editor, MedPage Today July 26, 2022

But Sen. Ben Ray Luján (D-N.M.) said it's not just borders that the government should look at when it comes to interdiction. "Don't forget about airports" and other ports of entry, he said. "The screening -- or lack thereof -- that is done at our ports should alarm all of us ... the United States must adopt 100% screening into the United States with commercial goods and with passenger traffic at all of our ports of entry. Only then will we start to understand how these cartels and other entities are throwing products at the problem. I hope that we can at least come together there and work together to get something done."

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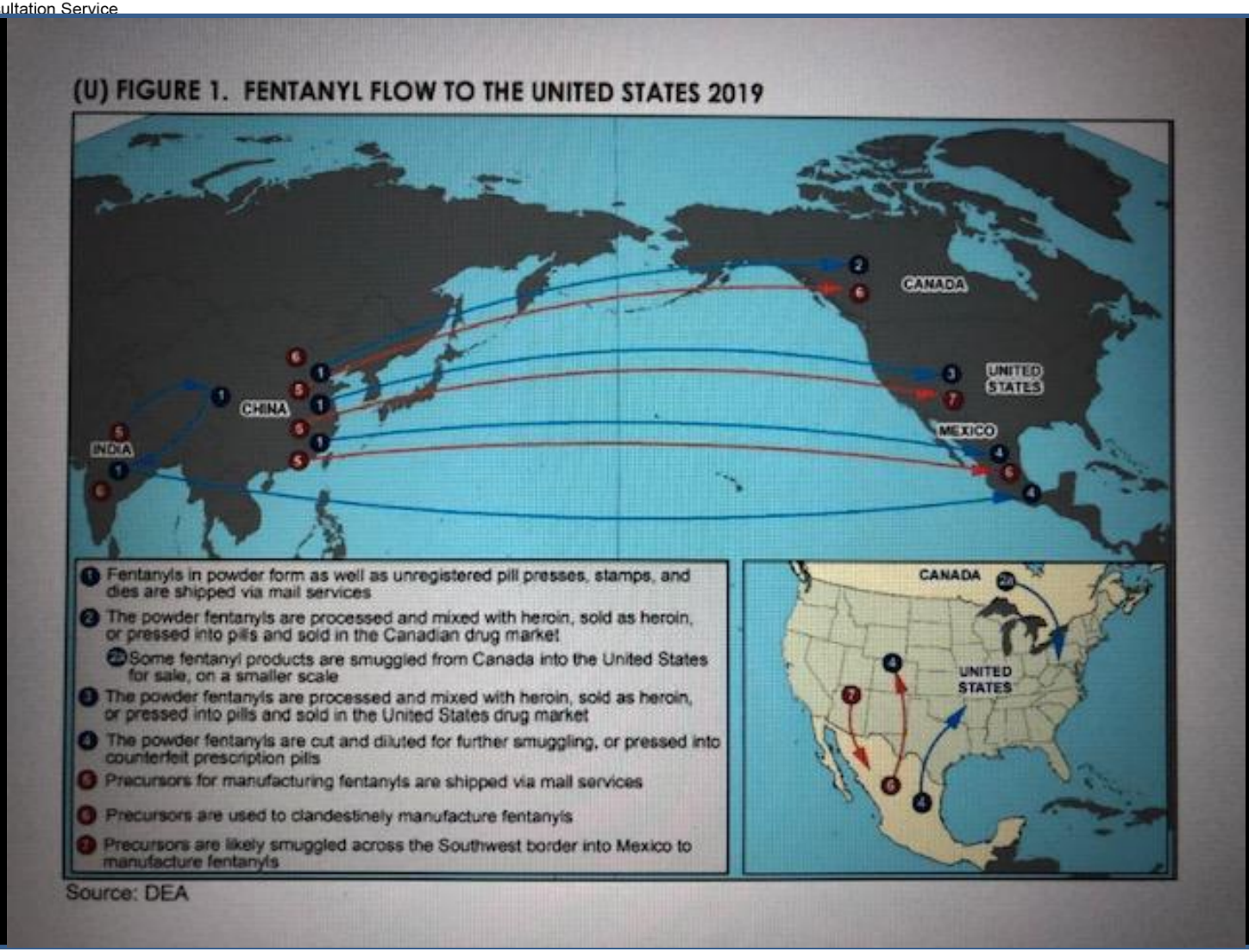

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THE FUTURE of TREATMENT?

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Feds Must Do More to Fight Fentanyl, Senators Say — "What we're doing is not working," said Sen. Susan Collins

by Joyce Frieden, Washington Editor, MedPage Today July 26, 2022

Luján also expressed concern about access to substance use disorder treatment, particularly for Native Americans. "According to the CDC, only about one in every 10 American Indian/Alaska Native and Hispanic people with substance use disorder reported receiving treatment," he said. **"About 70% of the 2 million folks across the country that are not getting any treatment are predominantly in rural and Native American communities, and in Hispanic communities, Black communities, and other communities of color as well.** I appreciate that there's more attention being brought to these issues, but again, what's been happening? The data shows where this is occurring, and there's still no response."

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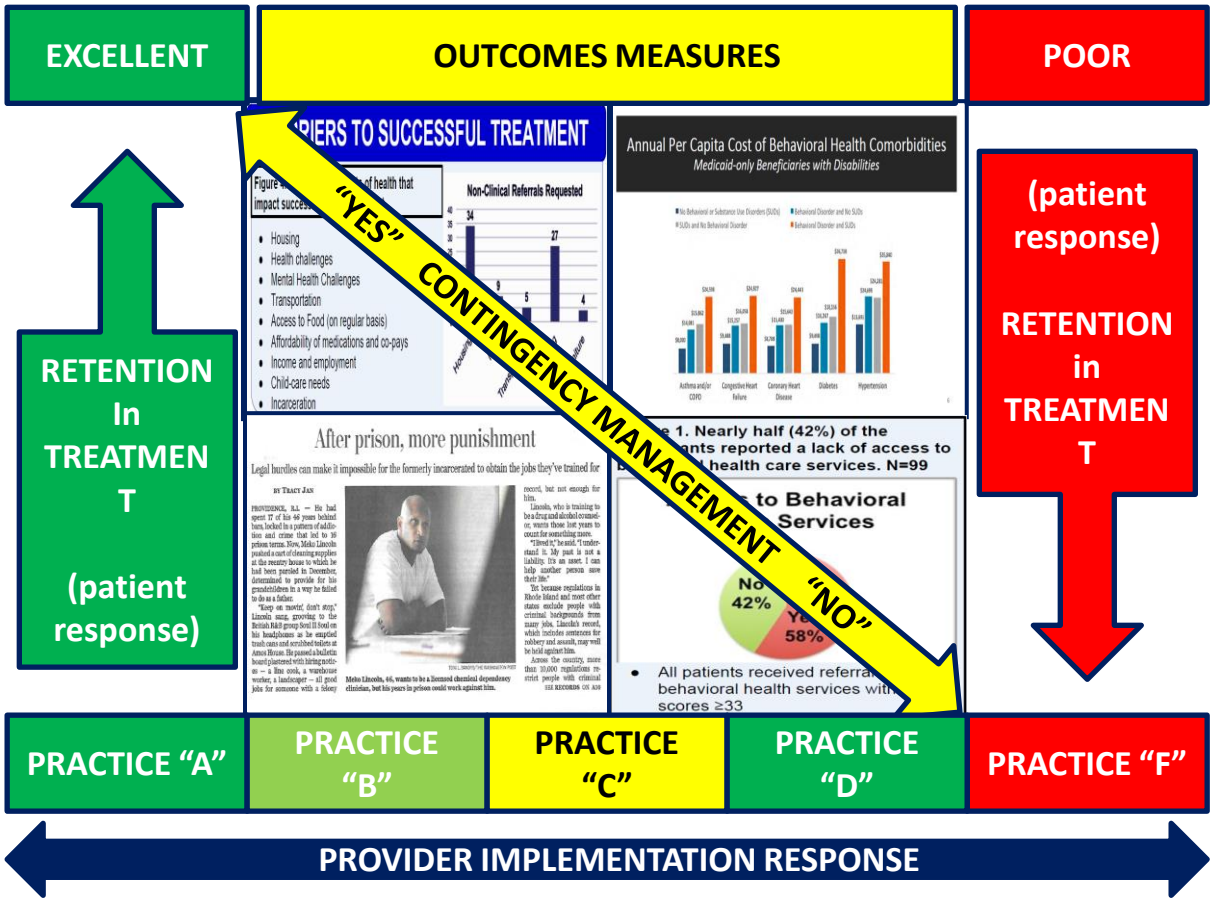
CMS OPIOID TREATMENT CARVEOUT with DIRECT PAYMENT to PROVIDER SYSTEM



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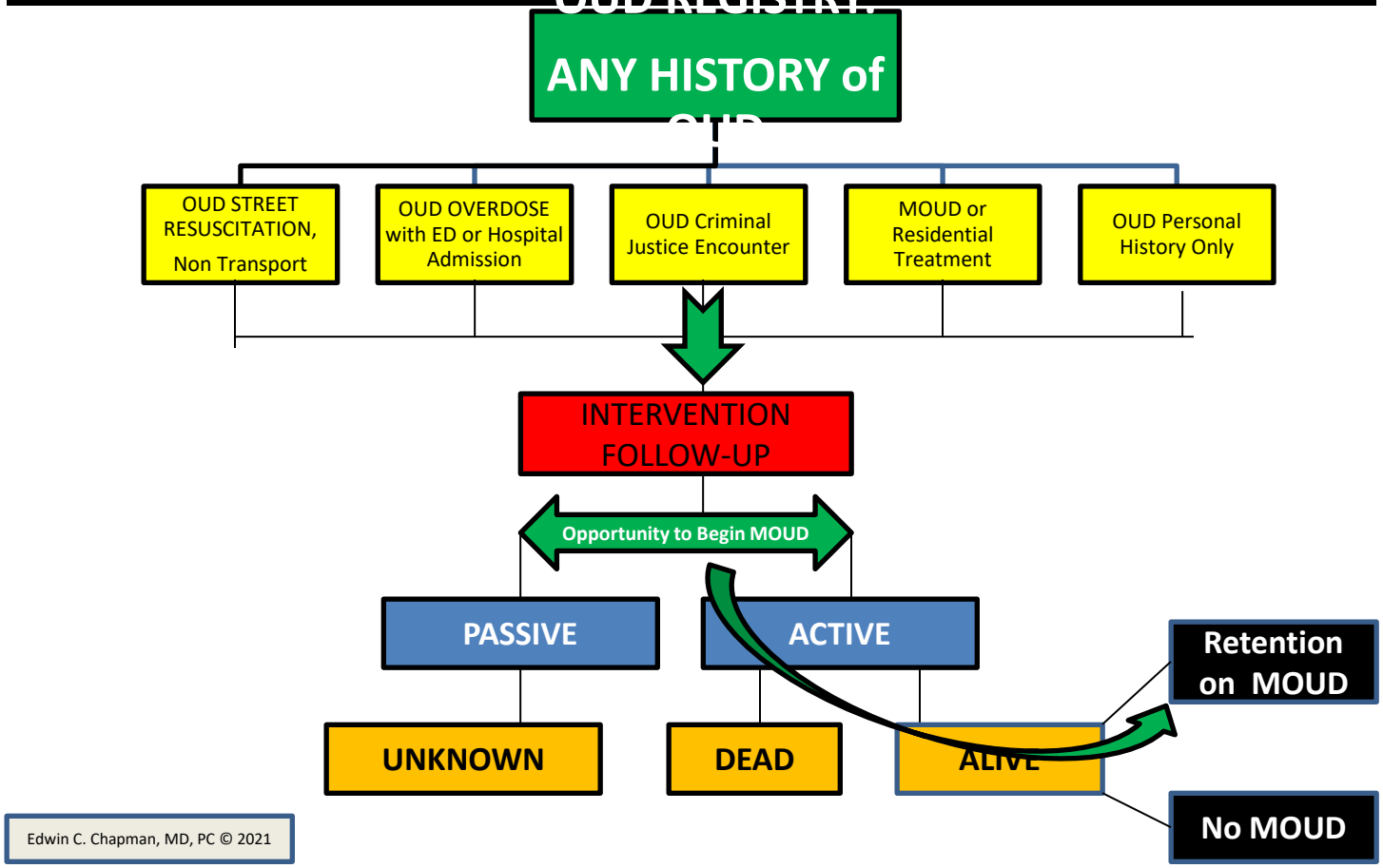
MOUD TREATMENT CASCADE



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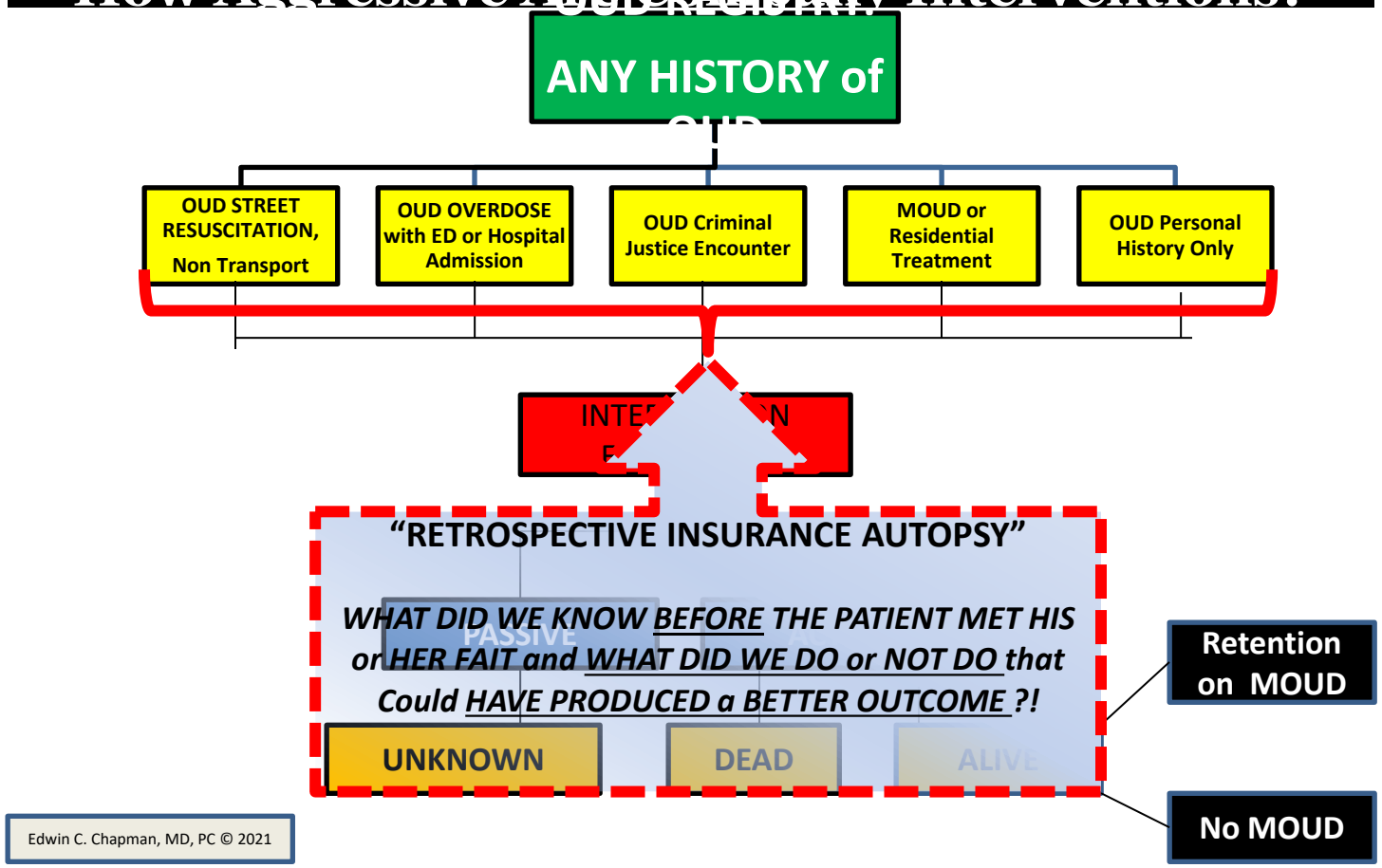
"RETROSPECTIVE INSURANCE AUTOPSY": If 98% of DC Residents Are Insured, How Aggressive Are Our Recovery Interventions?



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The Washington Post
By Phil Davis
December 10, 2019

With dozens of kids orphaned by the opioid crisis, this Md. county has a new outlook on trauma services

Ray Lynn, Cecil County heroin overdose coordinator since 2016, tracks overdoses and works with drug task forces to combat opioid abuse. (Amy Davis/Baltimore Sun)

But as gas prices rose in the mid-2000s, people weren't buying as many Chrysler Aspen and Dodge Durango SUVs produced in Newark. Chrysler announced in 2007 that it would close the plant. **General Motors closed its Newport, Del., automotive plant in 2009. "In the last 10, 15 years, all of that is gone," Lynn said. "There is no more jobs like that**.

By year's end, 89 people succumbed to fatal opioid-related overdoses, more than twice the previous year's total. It was that August when Lynn and school officials noticed a startling statistic: 33 children had been orphaned in just that month after at least one parent died of a drug overdose. "It was a surprise to everyone. I guess no one had ever put two and two together and realized the severity of the issue," Lynn said. "We had a classroom and a half of children, in one month, [who] lost a parent."
Since then, Lynn and other county officials have identified "well over" **100 children who have been orphaned by the opioid epidemic. He said he's already identified 50 children in 2019**.

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The Washington Post
By Phil Davis
December 10, 2019

…. "New outlook on trauma services"

Ray Lynn, Cecil County heroin overdose coordinator since 2016, tracks overdoses and works with drug task forces to combat opioid abuse. (Amy Davis/Baltimore Sun)

"We sort of built from the health department the **4 PILLARS of : (1) ENFORCEMENT, (2) TREATMENT, (3) RECOVERY, and (4) PREVENTION** to deal with this," he said. "And this sort of creates number **(5) SUPPORT SERVICES**." To pay for the overhaul, the county applied for a federal grant for young crime victims, intended to address children whose parents or guardians have overdosed. **The three-year, $639,000 grant has allowed the county to enter a public-private partnership that offers therapy for children and adults who have been exposed to overdoses. The partnership will "provide direct trauma therapy services to young crime victims in Cecil County at no cost to the family."** In addition, the county also provides training on how to identify and handle a child in trauma to various agencies and professionals, including health care workers, public safety personnel, educators and community service providers.

From April through September, 76 children and 41 adults have been referred for services.

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Opinion: She was paid to stay off drugs. Here's why this approach could help others.

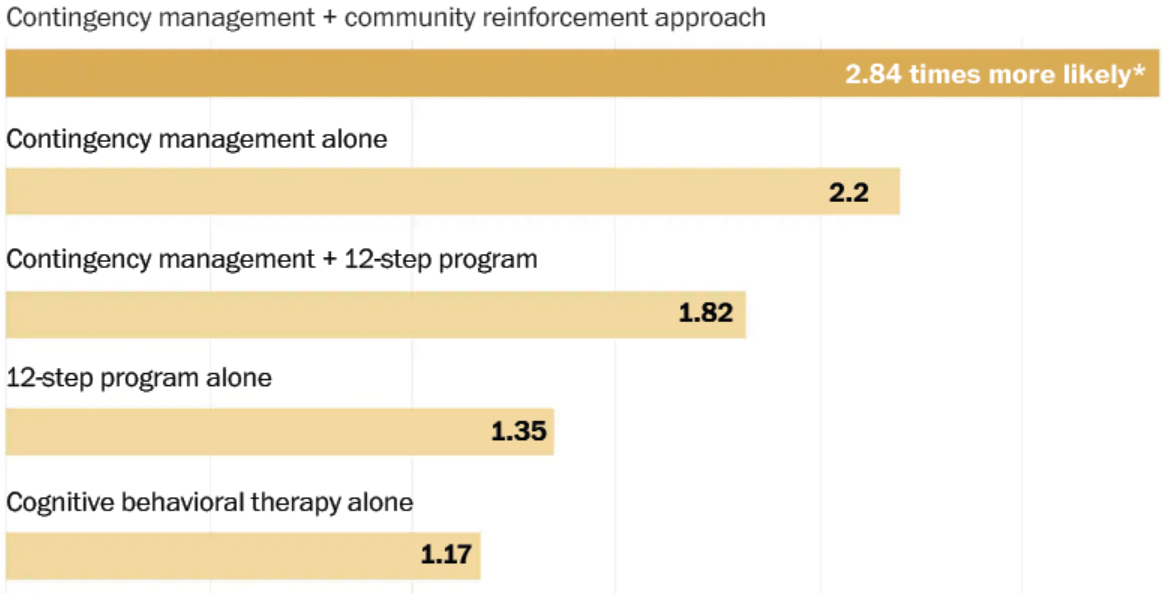
By Emefa Addo Agawu

Fellow, Post Opinions

March 31, 2022 at 9:15 a.m. EDT

Contingency management increased abstinence

People in contingency management programs were more likely to be abstinent at the end of the treatment than those in other programs.



* Compared with the control group.
Source: "Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction," De Crescenzo et al. (2018)

THE WASHINGTON POST

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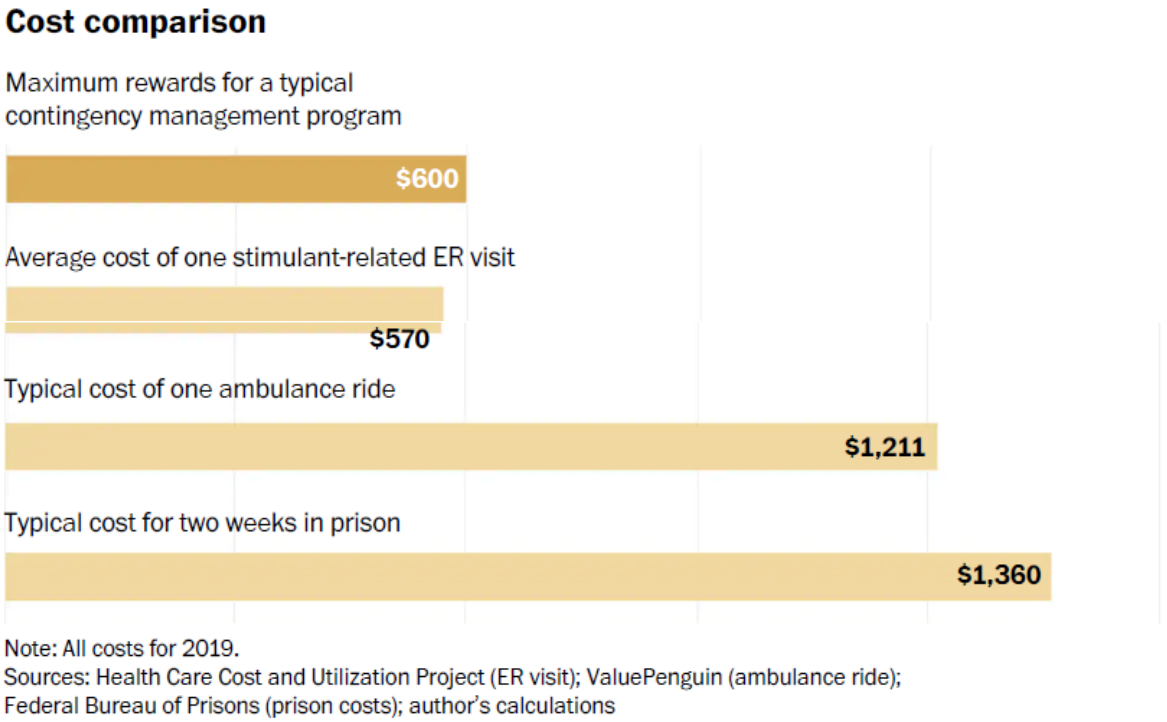

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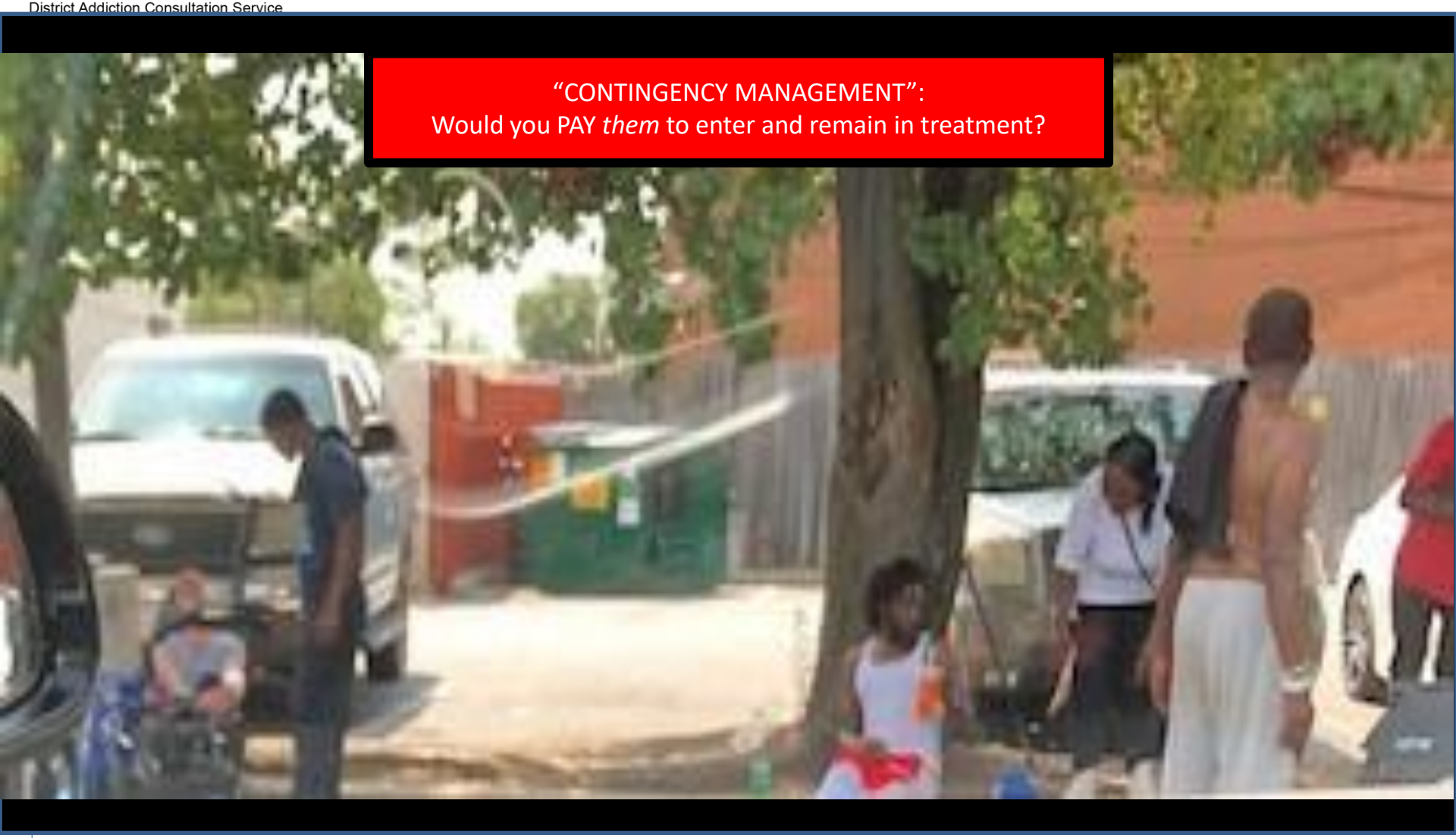

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OPIOID LITIGATION SUMMIT

MAXIMIZING THE IMPACT OF SETTLEMENTS TO ADDRESS THE OPIOID EPIDEMIC

EDWIN C. CHAPMAN, MD, DABIM, FASAM

MEMBER
National Academy of Medicine Committee on Examination of the Integration of Opioid and Infectious Diseases Prevention Efforts in Select Programs

PROFESSOR
Howard University School of Pharmacy and College of Medicine

Dr. Edwin C. Chapman has practiced in Washington, DC for over 45 years specializing in Internal Medicine and Addiction Medicine. Over the past 21 years, he has investigated the complex mix of addiction, undertreated mental illness, infectious diseases (AIDS & Hepatitis C), criminal behavior, and chronic diseases in which patients have 20-25 year shorter life expectancies. Dr. Chapman received his B.S. in 1969 and M.D. in 1973 from Howard University College of Medicine. He completed his internship and residency in

H. WESTLEY CLARK, MD, JD, MPH

DEAN'S EXECUTIVE PROFESSOR OF PUBLIC HEALTH
Santa Clara University

H. Westley Clark, MD, JD, MPH is currently the Dean's Executive Professor of Public Health at Santa Clara University in Santa Clara California. He is formerly the Director of the Center for Substance Abuse Treatment, SAMHSA, U.S. Department of Health and Human Service. Prior to his SAMHSA experience he was the Director of the Substance Use/PTSD Program and the San Francisco VA.

He contributed to the US Surgeon General's Report on Alcohol, Drug Abuse and Health as a Section Editor for Treatment. He is also on the Board of Directors of the Pacific Institute for Research and Evaluation. He is on the Board of Directors of the Foundation for Opioid Research Efforts. He is also on the National Advisory Board of Responsibility.Org.

He has received numerous awards for his contributions to the field of substance abuse treatment, including: the 2015 Lisa Mojer-Torres Award from Faces and Voices of Recovery, the 2015

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SEPTEMBER 24-25, 2021

OPIOID LITIGATION SUMMIT

MAXIMIZING THE IMPACT OF SETTLEMENTS TO ADDRESS THE OPIOID EPIDEMIC

DAY 1 | SEPTEMBER 24, 2021

WELCOME — 9:00AM-9:15AM

Professor Maria Glover, Georgetown University Law Center and **Susan Weinstein**, *President*, Legislative Analysis and Public Policy Association

PANEL 1 — 9:15AM-10:45AM

TOPIC: **STATE OF THE SETTLEMENTS, BELLWETHERS, AND SETTLEMENT DESIGN INNOVATIONS**

MODERATOR: **Professor Maria Glover**, Georgetown University Law Center

PANELISTS:
- **Professor Elizabeth Chamblee Burch**, University of Georgia School of Law
- **Mark Chalos**, *Managing Partner*, Lieff Cabraser Heimann & Bernstein LLP
- **Paul Geller**, *Managing Partner*, Robbins Geller Rudman & Dowd LLP
- **Professor Adam Levitin**, Georgetown University Law Center
- **Professor Sergio Campos**, University of Miami School of Law

PANEL 2 — 11:00AM-12:30PM

TOPIC: **HOW SETTLEMENT FUNDS CAN ACCELERATE ADDRESSING THE OVERDOSE CRISIS AND SPUR INNOVATION**

MODERATOR: **Chan Kemper**, *Senior Legislative Attorney*, Legislative Analysis and Public Policy Association

PANELISTS:
- **Dr. Miriam Delphin-Rittmon**, *Director*, Substance Abuse and Mental Health Services Administration
- **Robert Kent**, *General Counsel*, White House Office of National Drug Control Policy
- **Brandon George**, *Director*, Indiana Addiction Issues Coalition & *Vice President of Recovery Programs and Advocacy*, Mental Health America of Indiana

OPIOID LITIGATION SUMMIT

MAXIMIZING THE IMPACT OF SETTLEMENTS TO ADDRESS THE OPIOID EPIDEMIC

KEYNOTE — 12:30PM-1:00PM

Regina LaBelle, *Acting Director*, White House Office of National Drug Control Policy

INTERACTIVE VISIONING DISCUSSION — 1:00PM-2:00PM

MODERATORS: **Professor Maria Glover** and **Professor Shelly Weizman**, Georgetown University Law Center

PANEL 3 — 2:15PM-3:30PM

TOPIC: **OPERATIONALIZING SETTLEMENT DESIGN AND DISTRIBUTION IN A HETEROGENEOUS LANDSCAPE**

MODERATOR: **Beth Connolly**, *Project Director*, The Pew Charitable Trusts

PANELISTS:
- **Zachary Talbott**, *President and Chairman*, National Alliance for Medication Assisted Recovery & *President*, Talbott Legacy Center Maryville
- **Dr. Edwin Chapman**, *Member*, National Academy of Medicine Committee on Examination of the Integration of Opioid and Infectious Diseases Prevention Efforts in Select Programs & *Professor*, Howard University School of Pharmacy and College of Medicine
- **José Esquibel**, *Associate Director*, Colorado Consortium for Prescription Drug Abuse Prevention
- **Ariela Migdal**, *Of Counsel*, Kellogg Hansen Todd Figel & Frederick, PLLC

PANEL 4 — 3:30PM-4:45PM

TOPIC: **TOOLS AND INNOVATIONS AROUND SPENDING AND DISTRIBUTION**

MODERATOR: **Professor Jennifer Oliva**, Seton Hall University School of Law

PANELISTS:
- **Courtney Hunter**, *Vice President of State Policy*, Shatterproof
- **Professor Allan Brandt**, Harvard University
- **Michael Barnes**, *Chairman*, Center for US Policy
- **Professor Teddy Rave**, The University of Texas at Austin School of Law

CLOSING — 4:45PM-5:00PM

Professor Maria Glover and **Professor Shelly Weizman**, Georgetown University Law Center

OPIOID LITIGATION SUMMIT

MAXIMIZING THE IMPACT OF SETTLEMENTS TO ADDRESS THE OPIOID EPIDEMIC

DAY 2 | SEPTEMBER 25, 2021

WELCOME — 8:30AM-9:00AM

Professor Maria Glover, Georgetown University Law Center

PANEL 5 — 9:00AM-10:15AM

TOPIC: **ENSURING SUCCESS: QUALITY, TRANSPARENCY, OVERSIGHT, AND PRIVACY**

MODERATOR: **Dr. H. Westley Clark**, Santa Clara University

PANELISTS:
- **Dr. Josh Rising**, *Principal*, Rising Health Strategies
- **Professor Adam Zimmerman**, Loyola Law School at Loyola Marymount University
- **Professor Alexandra Lahav**, University of Connecticut School of Law

ROUNDTABLE DISCUSSION — 10:15AM-11:00AM

MODERATORS: **Beth Connolly**, *Project Director*, and **Dr. Alex Duncan**, *Senior Officer*, The Pew Charitable Trusts

PANEL 6 — 11:15AM-12:30PM

TOPIC: **BEYOND OPIATES: OPIATE SUMMIT AS FRAMEWORK FOR HEALTH CRISES IN LITIGATION**

MODERATOR: **Professor Alexandra Lahav**, University of Connecticut School of Law

PANELISTS:
- **Professor Oscar Cabrera**, Georgetown University Law Center
- **Professor Maria Glover**, Georgetown University Law Center
- **Professor Teddy Rave**, The University of Texas at Austin School of Law
- **Professor Jennifer Oliva**, Seton Hall University School of Law

CLOSING AND THANKS — 12:30PM-1:00PM

Professor Maria Glover and **Professor Shelly Weizman**, Georgetown University Law Center

O'NEILL INSTITUTE FOR NATIONAL & GLOBAL HEALTH LAW GEORGETOWN LAW | GEORGETOWN LAW | THE PEW CHARITABLE TRUSTS | LAPPA LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

This Summit is convened in partnership with the Legislative Analysis and Public Policy Association (LAPPA) and supported by Grant No. G1999ONDCP03A awarded by the Office of National Drug Control Policy, Executive Office of the President. Points of view or opinions expressed during this event do not necessarily represent the official position or policies of the Office of National Drug Control Policy or the United States Government.

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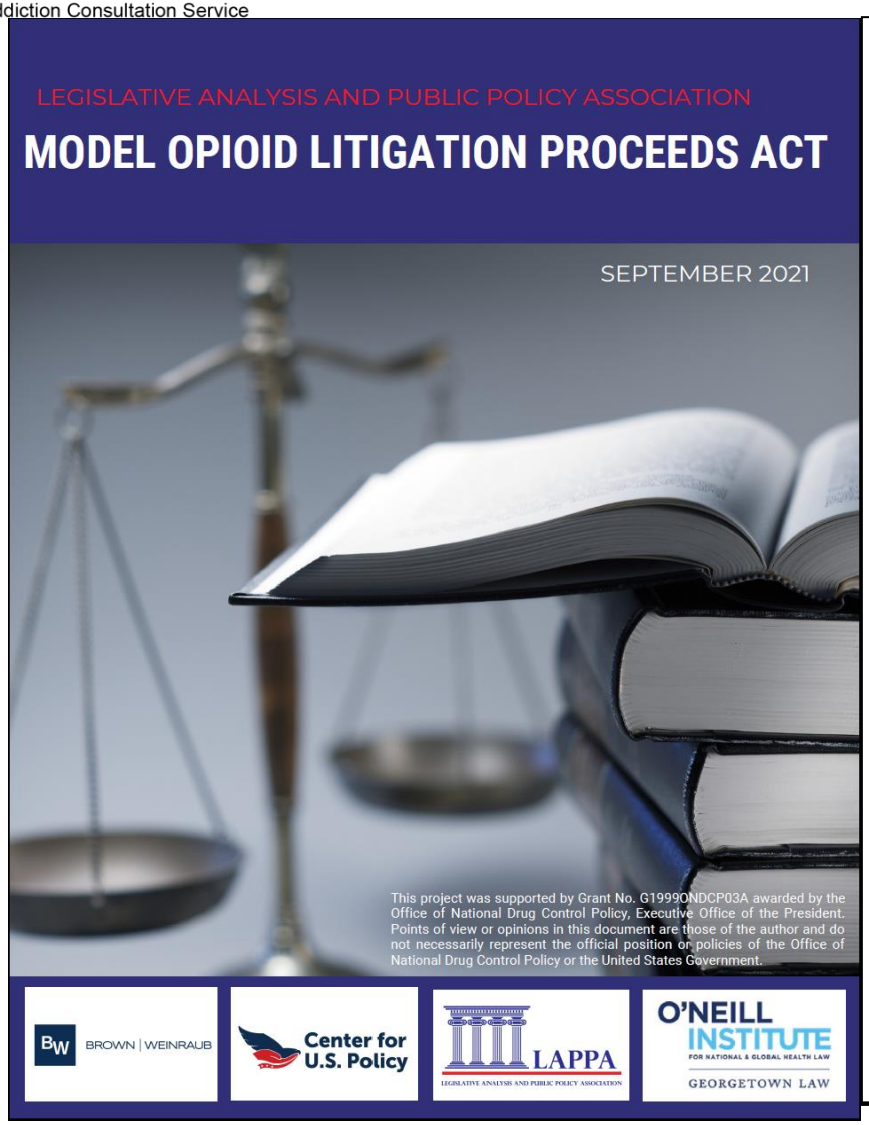

MODEL OPIOID LITIGATION PROCEEDS ACT

ACKNOWLEDGMENTS

The Legislative Analysis and Public Policy Association (LAPPA) is grateful to the Office of National Drug Control Policy, Executive Office of the President, for its support in funding, enabling, and contributing to this Model Act. LAPPA appreciates and acknowledges its invaluable partnership with the O'Neill Institute for National & Global Health Law at Georgetown University Law Center, the Center for U.S. Policy, and Brown & Weinraub, PLLC for their critical collaboration in helping to develop this model law.

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Additionally, this Model Act could not have been developed without the valuable input of the Model Opioid Litigation Proceeds Act working group. LAPPA wishes to thank its distinguished members, many of whom are listed below, for providing their expertise, guidance, and suggestions that contributed to the model's development.

Daniel Blaney-Koen, Esq.
American Medical Association

Kristina Bryant
National Center for State Courts

Beth Connolly
The Pew Charitable Trusts

Taleed El-Sabawi, Esq., PhD
Elon University School of Law

Jose Esquibel
Colo. Consortium for Prescr. Drug Abuse Prevention

Kristen Harper
Faces and Voices of Recovery

Courtney Hunter
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Legal Action Center

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Rising Health Strategies

Paul Samuels, Esq.
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Robert Valuck, PhD
University of Colorado School of Pharmacy

Lindsey Vuolo, Esq.
Partnership to End Addiction

The individuals and organizations that participated in the working group have not adopted, endorsed, or otherwise approved the contents of this document.

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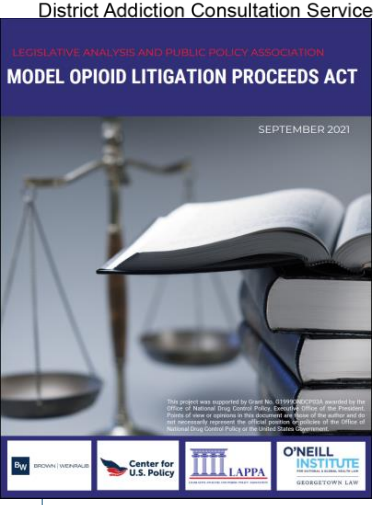

Commentary

According to 2018 data, an estimated 21.2 million Americans (or 1 in every 12 people) had a substance use disorder, of whom two million had opioid use disorder.[6] Yet, only a fraction of those with a substance use disorder (17 percent) received any form of treatment.[7] Common reasons for not receiving substance use treatment among people who perceived a need for treatment were as follows: not being ready to stop using (39.9 percent), not knowing where to go for treatment (23.8 percent), and having no health care coverage and not being able to afford the cost of treatment (20.9 percent).[8]

For all states, it will be important to take steps to ensure opioid litigation proceeds not duplicate or supplant services that Medicaid covers but to complement those services. Steps could include modeling the use of opioid litigation proceeds after the federal Ryan White HIV/AIDS Program, which provides HIV care and treatment services to low-income people with HIV who are uninsured or underserved.[24] All opioid litigation proceeds advisory councils should understand their state's Medicaid program so opioid litigation proceeds can complement Medicaid-covered services to improve the availability and quality of health care for people with substance use disorders, including when individuals may be especially vulnerable, such as during or after pregnancy, or upon release after incarceration.

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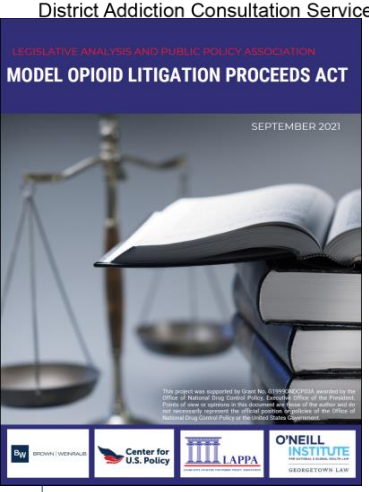

Opioid use disorder makes up only nine percent of substance use disorders in the United States. In addition, among people with opioid use disorder, polysubstance use is the norm, not the exception.[17] Alcohol use, for example, is responsible for more than 95,000 deaths in the U.S. per year.[18] Alcohol was involved in 15.5 percent of fatal heroin poisonings in 2017.[19] Therefore, to effectively address public health needs, prevention, treatment, recovery, and harm reduction services must be offered to all individuals who are at risk of, or have, a substance use disorder, including during and after pregnancy, rather than solely to those with an opioid use disorder. As such, this Act is drafted to ensure that settlement proceeds will be distributed to address opioid use disorder and other substance use disorders. The opioid litigation settlement proposal offered by major opioid distributors limited the use of proceeds to addressing opioid use disorders and co-occurring substance use and mental health disorders.[20] Under such an approach, services funded by settlement proceeds could be used to address stimulant use disorders, for example, only among people who also have opioid use disorders.

It is the intent of this Act to recognize that substance use disorder is a treatable condition from which individuals and families can recover. According to the 2019 National Survey of Drug Use and Health, among the 28.2 million adults in the U.S. in 2019 who perceived that they ever had a substance use problem, 75.5 percent (or 21.2 million people) considered themselves to be in recovery or to have recovered from their alcohol or other drug use problem.[21] A substantial, ongoing commitment from government is essential to support individuals, families, and communities in achieving long-term recovery and resilience.

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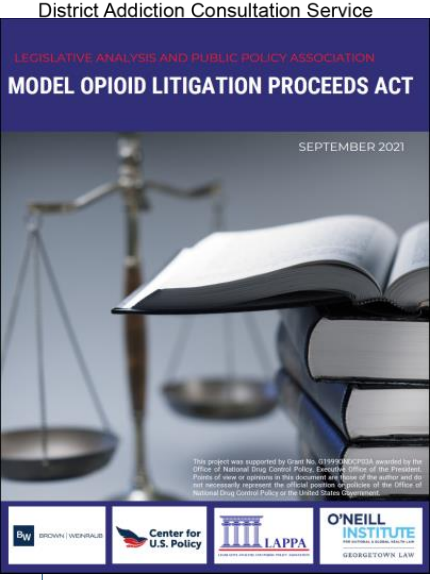

SECTION V. CREATION OF [OPIOID LITIGATION PROCEEDS] COUNCIL.

(a) Council established.—There is established an [Opioid Litigation Proceeds] Council.

(b) Purpose.—The purpose of the [Opioid Litigation Proceeds] Council is to ensure that proceeds received by this state pursuant to Section IV(b) of this Act are allocated and spent on [state] substance use disorder abatement infrastructure, programs, services, supports, and resources for prevention, treatment, recovery, and harm reduction; and to ensure robust public involvement, accountability, and transparency in allocating and accounting for the monies in the Fund.

(c) Appointment.—

(1) The Council shall be composed of [eleven (11] voting members and one non-voting ex-officio member. The [Secretary of Health] shall serve as the non-voting ex-officio member;

(2) Voting members must be residents of this state;

(3) A Council chair shall be appointed by the Governor;

(4) The Council shall be appointed as follows:

(A) [One (1)] by the Attorney General;

(B) [One (1)] by the [President] of the Senate;

(C) [One (1)] by the Speaker of the [House of Representatives];

(D) [Two (2)] by the [Association of Counties]; and

Agreement, OFF. OF ATT'Y GEN. JOSH SHAPIRO (July 2021), https://www.attorneygeneral.gov/wp-content/uploads/2021/07/2021-07-21-Final-Distributor-Settlement-Agreement.pdf; *Janssen Settlement Agreement*, OFF. OF ATT'Y GEN. & REPORTER HERBERT H. SLATERY III (July 2021), https://www.tn.gov/content/dam/tn/attorneygeneral/documents/foi/opioids-settlements/janssen-settlement.pdf.

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE ATTORNEY GENERAL

ATTORNEY GENERAL
KARL A. RACINE

July 14, 2022

The Honorable Phil Mendelson
Chairman, Council of the District of Columbia
John A. Wilson Building
1350 Pennsylvania Avenue, N.W., Suite 504
Washington, D.C. 20004

Dear Chairman Mendelson:

I write to transmit the "Opioid Litigation Proceeds Act of 2022" for consideration and enactment by the Council of the District of Columbia.

In recent years, the opioid epidemic has ravaged communities across the country. Sadly, the District has not escaped the epidemic or its tragic consequences. Indeed, the District has one of the highest opioid-overdose rates in the country, and it loses hundreds of residents each year to overdoses. The District has additionally endured the many other devastating effects that opioid abuse and addiction can have on individuals, families, and communities.

Over the last several years, my office has worked to hold the opioid industry accountable for its role in fueling the epidemic, and we recently reached landmark settlements with several of the companies involved. Under the settlement agreements that we have finalized thus far, the District will receive more than $49 million over the next 18 years. These settlement funds are primarily to be used to support efforts to curb the epidemic and mitigate its effects.

The proposed legislation sets forth the permissible uses of the settlement proceeds that will be deposited into a recently established Opioid Abatement Fund. The legislation also establishes mechanisms to assist the District in determining how best to use those proceeds consistent with the terms of the settlement agreements. More specifically, it establishes an Opioid Abatement Advisory Commission, which will make recommendations to the Mayor about how to use the funds to support evidence-based and evidence-informed opioid prevention, treatment, recovery, and harm-reduction programs. It also requires the Mayor to establish an Office of Opioid Abatement, which will, among other things, support the work of the Commission and oversee the grants process for opioid prevention, treatment, recovery, and harm-reduction programs.

I ask that the Council enact this legislation so that the District can begin using the settlement funds to help repair the damage done by the opioid epidemic.

If you have any questions, please contact me or Deputy Attorney General Emily Gunston at (202) 805-7638.

Sincerely,

Karl A. Racine
Attorney General for the District of Columbia

400 Sixth Street, N.W., Washington, D.C. 20001, (202) 727-3400, Fax (202) 730-0484

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-----Original Message-----
From: Kelly M. Corredor <kcorredor@asam.org>
To: EDWIN CHAPMAN <echap1647@aol.com>
Cc: Daniel Blaney-Koen <Daniel.Blaney-Koen@ama-assn.org>; Sandy.Marks@ama-assn.org <sandy.marks@ama-assn.org>
Sent: Thu, Jun 30, 2022 2:48 pm
Subject: FW: US House Labor-HHS Approps Update

June 30, 2022

Hi Dr. Chapman -

Today, the House Committee on Appropriations is holding its markup of the FY23 Labor, Health and Human Services, Education and Related Agencies (LHHS) appropriations bill.

The text of the draft bill can be found here and the draft report can be found here. Report excerpts which may be of particular interest to you are as follows:

Access to Buprenorphine.—The Committee is concerned by reports of patients not being able to fill buprenorphine prescriptions at pharmacies. The Committee requests a **briefing from CMS and OIG within 180 days of the date of enactment of this Act on the results of the current audits examining access to and use of medications for opioid use disorder (MOUD) and CMS's intended response.**

Utilization Management for MOUD.—The Committee recognizes that frontline medical provider experience and research increasingly indicate that individuals who take oral buprenorphine for opioid use disorder (OUD) may benefit from doses higher than 24mg. The population of individuals who may need higher doses of buprenorphine to prevent cravings is expected to increase as fentanyl continues to proliferate the illicit opioid market. **The Committee is aware that State Medicaid programs may have in place utilization management practices, including those that require a prior authorization before prescribing oral buprenorphine above 16mg or 24mg daily. The Committee requests that CMS examine State utilization management requirements related to oral buprenorphine, and whether such requirements unnecessarily delay access to treatment.**

Eliminating Racial Disparities in Overdose Deaths.—The Committee is concerned with the rising rates of overdose deaths in communities of color, specifically among Black people. These racial disparities are made worse by the fact that access to treatment is often dependent on race, income, geography, and insurance status, rather than individual preferences, or medical or psychiatric indicators and needs. **The Committee urges SAMHSA to scale programs in communities of color, including increased outreach capacity, to help eliminate racial disparities in overdose deaths and improve access to prevention and treatment services.**

Please let me know if you have any questions; wishing you a wonderful holiday weekend!

Kelly

Kelly M. Corredor
Chief Advocacy Officer
American Society of Addiction Medicine
Office: 301-547-4111
Cell: 904-657-6371
Pronouns: she/her

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The Washington Post *Democracy Dies in Darkness*

Patients and doctors who embraced telehealth during the pandemic fear it will become harder to access

le to share free access ×

September 15, 2021 at 12:00 p.m. EDT

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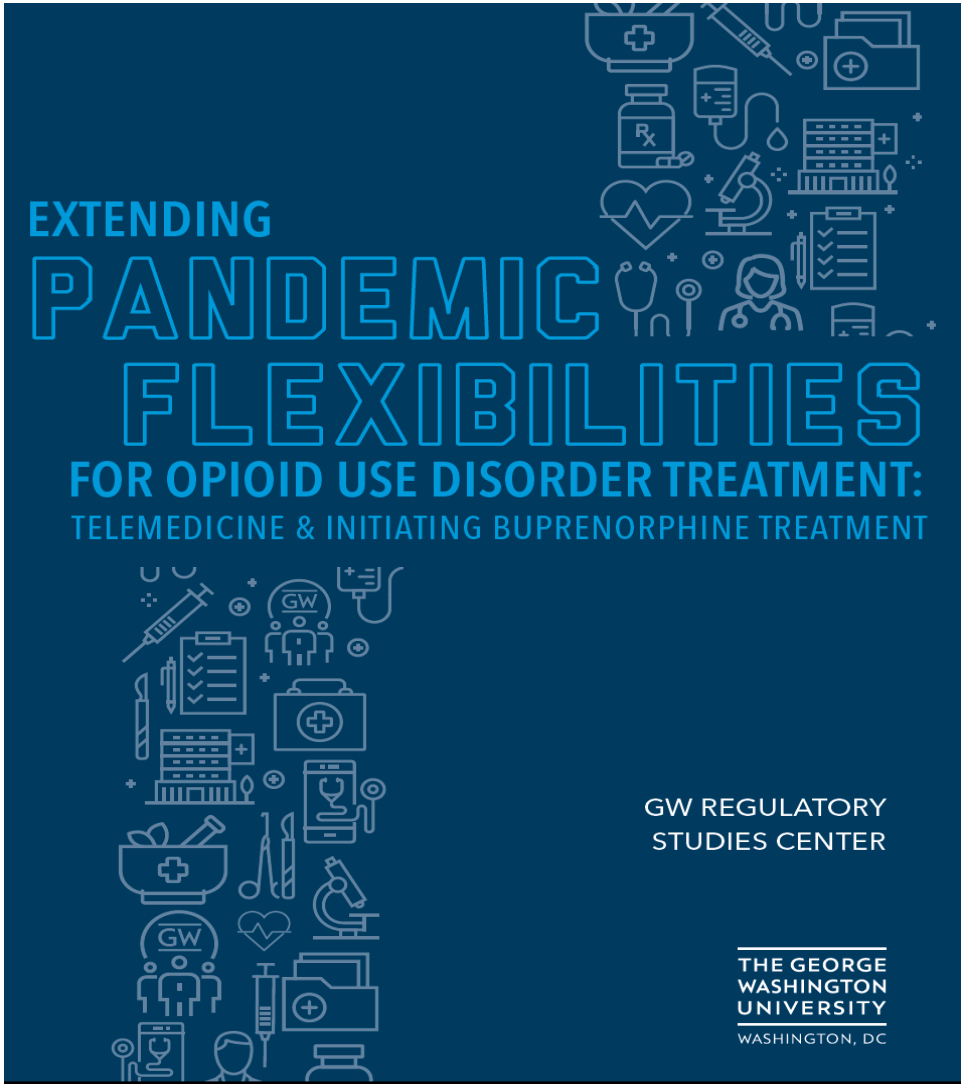
When the pandemic hit, the little health center on Vinalhaven, an island 15 miles off the coast of Maine, was prepared in ways many larger facilities were not. The Islands Community Medical Services had long been using telehealth to provide primary and behavioral care to its 1,500-strong year-round community, relying on grants to cover costs. As the public health emergency lifted many restrictions on virtual care, the clinic ramped up its offerings.

"We were able to pivot pretty quickly," said former operations director Christina R. Quinlan, describing a scramble to add specialized medical and social care.



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SUMMARY

The Future:

(1) **Overcoming STIGMA** – thru improved professional and community education

(2) **Overcoming Patient Barriers to Care** — According to the CDC report released on 7/19/2022, **only 1/12 African American OUD patients who die from opioid overdose have ever been in treatment**. How, then, does one encourage someone to enter treatment and/or remain in treatment?
(A) Contingency management - the future role of direct payment to patients for entering and remaining in treatment.
(B) Bounty payments - the potential role of direct payment to family, friends or associates for successfully bringing a new patient to treatment.

(3) **Overcoming Structural Barriers**:
(A) **Personnel** —
(i) If only 6% of social workers, 5% of physicians, 4% psychologists, and 2% of psychiatrists are African American, how can the community most effectively and efficiently expand services to an exponential increase in mental health and SUD needs?

(ii) Psychiatry & Psychology - Is there a potential role for NATIONAL CREDENTIALING and DIRECT PAYMENT from CMS as opposed to the current fragmented, disincentivized, private payer system?

(iii) What is the future of bundle payments for MOUD (MAT + Social Services + Psychiatrist/Psychologist + Peer Support)?

(B) Overcoming **Housing Regardless of Current Drug Use Status & Transportation**

(C) Overcoming **MOUD Dispensing Barriers** — Using "X-waivered provider / pharmacists collaborative agreements," can local pharmacies & pharmacists be the answer to reducing travel time and distance for MOUD access and dispensing?

(4) **Overcoming Regulatory Barriers** –
(A) **Training for Buprenorphine**
(B) Prior Authorizations for buprenorphine
(C) Same day billing for multiple services
(D) Data Sharing of Mental Health and Substance Use Disorder Records
(E) Disconnect between the Health and Criminal Justice Systems including MOUD in Jails and Prisons
(F) Buprenorphine provider / patient caps
(G) Buprenorphine dosing caps
(H) **Limits on Harm Reduction**

(5) TeleHealth -- How can we maintain, in perpetuity, the indispensable COVID proven role and value of this tool anyone, anywhere, anytime?

(6) **Revamping Payment** – Value based carveout measured and compensated based on "Retention in Care"
(A) ASAM-AMA Patient Centered Opioid Addiction Treatment (P-COAT)
(B) Alternative Bundled payments with monthly capitation

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QUESTIONS ?

"A Lawyer *(physician)* is a social engineer or a parasite on society"

Charles Hamilton Houston, JD
Howard University School of Law
Brown vs. Board of Education
(mentor to Thurgood Marshall)

Edwin C. Chapman, MD, DABIM, FASAM
Washington, DC
echap1647@aol.com

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District Addiction Consultation Service

DACS provides support to primary care and specialty prescribers in addressing the needs of their patients with substance use disorders and chronic pain management.

All Services are FREE

- Phone consultation for clinical questions provided by expert addiction medicine specialists
- Education and training opportunities related to substance use disorders and chronic pain management
- Assistance in the identification of substance use and behavioral health resources and referrals that meet the needs of the patients in your community

Funding for DACS is provided by The District of Columbia Government, DC Health, Health Regulation and Licensing Administration (HRLA), Pharmaceutical Control Division (PCD). DACS is administered by the University of Maryland School of Medicine staff and faculty.

1-866-337-DACS (3227) • www.DistrictACS.org

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Upcoming DACS Events:

- Overdose Awareness Day, 8/31/22 from 12-1pm
  - ***How to Save a Life: Evidence and Misconceptions About Medications for Opioid Use Disorder*** | Find out more and register here: bit.ly/3OWhycS

- 9/27/22 from 12-2pm: ***Opioid Use Disorder Treatment Integrated with Primary Care*** | Find out more and register here: bit.ly/3d7O26V