The Opioid Epidemic:

Saving Lives With Clinical Solutions and Policy Recommendations

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Officially announced by the Centers for Disease Control and Prevention (CDC) in 2011, the opioid crisis has maintained a protracted presence, with an alarming increase in the past few years. Several factors have exacerbated the U.S. opioid epidemic, including the economic and emotional toll from the COVID-19 pandemic, which increased stress-related drug use, disrupted recovery meetings and impaired vital supports for individuals at risk. In addition, the marked expansion of illicitly manufactured, potent synthetic opioids has flooded the U.S. with lethal counterfeit opioid pain pills, increasing the danger of non-prescribed opioids.

For years, clinicians have been working to reduce opioid prescribing and to provide patients with the most clinically appropriate treatment and guidance. However, they require additional community and legislative support. A systemic approach is required to address the opioid epidemic. This paper discusses some of the clinical treatment strategies and public policy options.

INTRODUCTION: Opioid Use, Abuse and Treatment in the United States

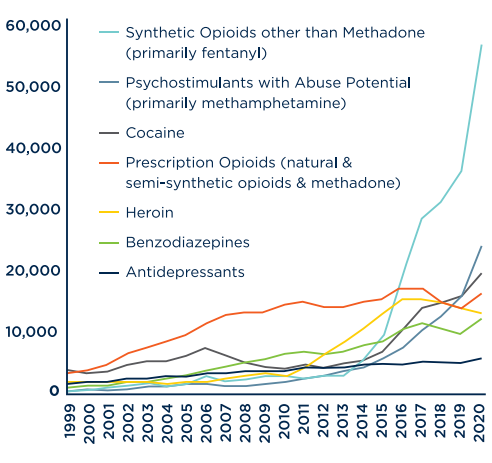
THE OPIOID EPIDEMIC IN AMERICA

More than 932,000 people in the U.S. have died from a drug overdose since 1999. In 2020, opioids were involved in 68,630 overdose deaths – nearly 75 percent of all drug overdose deaths.[1] The COVID-19 pandemic compounded the crisis. More than 100,000 people died of drug overdoses in the U.S. between April 2020 and April 2021. That figure, a record for any 12-month span, was 28.5 percent higher than the same period a year earlier. Synthetic opioids, primarily fentanyl and its analogues, were responsible for 64 percent of the April 2020 to April 2021 deaths. That figure was up from 49 percent the year before.[2]

Opioid abuse is linked to a rise in human immunodeficiency virus (HIV) and hepatitis C infections. In the small community of Austin, Indiana, 170 new HIV infections were linked to people misusing prescription opioid pain medications during a period of eight months.[3] From 2005 to 2014, the rate of emergency department (ED) visits due to opioid use rose from 89.1 to 177.7 per 100,000 population.[4] The number of pregnant women with opioid-related diagnoses documented at delivery rose 131 percent from 2010 to 2017, while the number of babies born with neonatal abstinence syndrome increased by 82 percent.[5]

NATIONAL DRUG-INVOLVED OVERDOSE DEATHS*

Number Among All Ages, 1999-2020



* Includes deaths with underlying causes of unintentional drug poisoning (X40-X44), suicide drug poisoning (X60-X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10-Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2020 on CDC WONDER Online Database, released 12/2021.

The CDC has estimated that prescription opioid misuse costs the U.S. economy $78.5 billion a year in higher healthcare and criminal justice costs, lost productivity and addiction treatment.[6] Productivity losses are likely to increase since Americans are dying younger and younger. According to Ohio State University researchers, about 3,300 adolescents ages 10 to 19 died of an unintentional drug overdose in the U.S. between 2015 and 2019, representing 187,078 years of life lost.[7] A bipartisan study conducted by the RAND Corporation and released by the Commission on Combating Synthetic Opioid Trafficking in February 2022 estimated the ongoing opioid epidemic costs the U.S. $1 trillion every year and is “a threat” to the nation’s security and global competitiveness.[8]

[1] U.S. Centers for Disease Control and Prevention. The Drug Overdose Epidemic: Behind the Numbers. Retrieved from https://www.cdc.gov/opioids/data/index.html.

[2] McPhillips D. (November 17, 2021). Drug Overdose Deaths Top 100,000 Annually for the First Time, Driven by Fentanyl, CDC Data Show. CNN. Retrieved from https://www.cnn.com/2021/11/17/health/drug-overdose-deaths-record-high/index.html.

[3] Conrad C., Bradley H.M., Broz D. (May 1, 2015). Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxymorphone — Indiana. Morbidity and Mortality Weekly. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6416a4.htm.

[4] Jackson G., M.S., Brown A., M.P.H., DeFrances C. Ph.D. (December 15, 2020). Opioid-involved Emergency Department Visits in the National Hospital Care Survey and the National Hospital Ambulatory Medical Care Survey. National Health Statistics Reports. Retrieved from https://www.cdc.gov/nchs/data/nhsr/nhsr149-508.pdf.

[5] Hirai A., Ph.D., Ko J., Ph.D., Owens P., Ph.D. (January 12, 2021). Neonatal Abstinence Syndrome and Maternal Opioid-Related Diagnoses in the US, 2010-2017. Journal of American Medicine. Retrieved from https://jamanetwork.com/journals/jama/fullarticle/2774834.

[6] Florence C.S., Zhou C., Luo F., Xu L. (October 2016). The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. Med Care. Retrieved from https://pubmed.ncbi.nlm.nih.gov/27623005/.

[7] Hall O.T., Trimble C., Garcia S. (January 31, 2022). Unintentional Drug Overdose Mortality in Years of Life Lost Among Adolescents and Young People in the US from 2015 to 2019. Journal of American Medicine. Retrieved from https://jamanetwork.com/journals/jamapediatrics/fullarticle/2788490.

[8] Commission on Combating Synthetic Opioid Trafficking. (February 2022). Retrieved from https://www.rand.org/pubs/external_publications/EP68838.html.

What Is Opioid Use Disorder?

An opioid naïve patient refers to an individual who has not recently taken opioids (prescription or non-prescription) prior to receiving a treatment, procedure or surgery.[9] A patient who is **opioid tolerant** refers to an individual who is prescribed and regularly takes opioid-based medications. **Opioid dependence** occurs when an individual's body requires continued opioid use to prevent withdrawal.

Opioid Use Disorder (OUD) impacts approximately 3 million Americans.[10] People often believe that individuals with OUD can control opioid use by strong willpower and that they should be able to "just stop it." However, it is more complicated than that.

Opioid Use Disorder, also known as opioid addiction, starts in many ways but ultimately becomes a primary chronic disease of the brain that involves reward, motivation, memory and related circuitry. Dysfunction in these neurological circuits leads to biological, psychological, social and spiritual manifestations that are often criticized by society. Addiction is characterized by craving, inability to abstain from use, impairment in behavioral control and debilitating problems with one's behaviors.

Addiction can disrupt valuable interpersonal relationships, tear families apart and impact an individual's role in society. Without treatment or engagement in recovery activities, addiction is often progressive.

To confirm an OUD diagnosis, at least two of the following symptoms must be observed within a 12-month period:

- Opioids are taken in larger amounts or over a longer period than was intended
- A persistent desire or unsuccessful efforts to cut down or control opioid use
- A great deal of time is spent to obtain, use or recover from the effects of an opioid
- A craving or a strong desire or urge to use opioids
- Recurrent opioid use resulting in a failure to fulfill obligations at work, school or home
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids
- Social, occupational or recreational activities are given up or reduced because of opioid use
- Recurrent use in situations in which it is physically hazardous
- Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids
- Exhibits tolerance
- Exhibits withdrawal

Individuals who are opioid naïve, tolerant, dependent or diagnosed with OUD require a clinical management plan tailored to their unique needs.

[9] Lail S., Sequeira K., Lieu J., Dhalla I.A. Prescription of opioids for opioid-naive medical inpatients. Can J Hosp Pharm. 2014 Sep;67(5):337-42. doi: 10.4212/cjhp.v67i5.1387. PMID: 25364015; PMCID: PMC4214575.

[10] Azadfard M., Huecker M.R., Leaming J.M. Opioid Addiction. [Updated 2022 Apr 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK448203/.

TREATMENT: Specialty-Specific Tactics to Address the Opioid Epidemic

Envision clinicians have created best practices for the prevention and treatment of OUD across the medical group's various specialties. To this point, Envision clinicians have delivered evidence-based medications for opioid use disorder (MOUD) to their patients and published scholarly, peer-reviewed work proving MOUD's overwhelming success in reducing OUD mortality.[11] Historically, pharmacologic treatment for opioid use disorder was referred to as "Medication Assisted Treatment (MAT)," which combined medications with behavioral therapies. More recently, it has been determined that the mortality and morbidity treatment benefits are associated with medications alone or combined with behavioral interventions, and the term "MAT" was updated to "Medications for Opioid Use Disorder (MOUD)." MOUD plays a critical role in Envision clinicians' treatment of OUD.

EMERGENCY MEDICINE CARE

OUD treatment requires a comprehensive care approach and engagement from multiple clinical specialists, including but not limited to primary care physicians and pain specialists. **However, the ED serves as the U.S. healthcare system's safety net and is often the primary avenue through which many patients receive medical care — especially patients struggling with substance abuse.** As a result, emergency medicine clinicians are often the first to help care for patients suffering from OUD and can initiate MOUD. As Envision clinicians explained in the article referenced above, "ED-initiated buprenorphine treatment compared to brief, stabilizing interventions with outpatient referral significantly increased engagement with addiction treatment, reduced self-reported illicit opioid use and decreased use of inpatient addiction treatment services." Timely MOUD also improved "compliance compared to behavior therapy alone."[12]

Envision emergency medicine clinical leaders also have created, implemented, assessed and evolved our pain management policies and guidelines. They empower clinicians to address the growing opioid crisis in their clinical practice. Coupled with education and departmental implementation of alternative treatment programs, our clinicians and hospital partners have been working to reduce the number of opioid prescriptions in a way that is safe and clinically appropriate while setting patients up for long-term success. **In 2021, for example, 99 percent of patients who came to the ED with low back pain or a migraine received non-opioid pain therapy as the first line of treatment from Envision clinicians.**[13]

Our clinician-led ED policies typically include a standard approach to pain assessment, treatment guidelines and care coordination expectations and follow-up processes. These policies include patient and family education before, during and after ED treatment as well as educational handouts. Our pain policies also include the use of state-sponsored prescription drug monitoring programs, alternatives to opioid treatment guidelines, "no refill" policies and limitations on outpatient opioid prescriptions.

[11] Logan G., Mirajkar A., Houck J., et al. (November 26, 2021). Physician-Perceived Barriers to Treating Opioid Use Disorder in the Emergency Department. Cureus. Retrieved from https://assets.cureus.com/uploads/original_article/pdf/73766/20211126-22221-1hqmrap.pdf.

[12] Hawk K., Hoppe J., Ketcham E., LaPietra A., Moulin A., Nelson L., Schwarz E., Shahid S., Stader D., Wilson MP., D'Onofrio G. Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department. Ann Emerg Med. 2021 Sep;78(3):434-442. doi: 10.1016/j.annemergmed.2021.04.023. Epub 2021 Jun 23. PMID: 34172303.

[13] Envision Healthcare. (April 14, 2022). Envision Healthcare 2021 Clinical Impact Report. Retrieved from https://www.envisionhealth.com/impact-report.

Other approaches include removing commonly abused opioids from ready availability, instituting ED team-based rounding and treatment planning and bedside patient education with nursing and other clinical support staff. A final effective method for patients includes a systematic, real-time identification of patients at risk of addiction with a thoughtful selection of appropriate pain control methods while ensuring patients receive referrals to outpatient programs for follow-up and treatment.

On an individual practice level, Envision clinicians are embracing educational opportunities to learn about their prescribing habits and how to improve based on clinical guidelines. Clinicians also work alongside partner hospitals and community organizations to develop comprehensive care plans for all patients, including pain patients. These efforts include supporting the maintenance of appropriate evaluation and treatment facilities for patients at risk for addiction and providing safe and timely follow-up for acute pain conditions with medical staff and hospitals.

PERIOPERATIVE MEDICINE, ANESTHESIA AND SURGICAL CARE

Nationally, more than 70 million patients undergo surgical procedures each year. About 80 percent experience postsurgical pain.[14] Guidelines for postoperative pain management increasingly recommend the use of multimodal analgesia, including regional anesthesia (RA), to reduce opioid prescriptions for post-operative pain. When ultrasound-guided regional anesthesia (UGRA) is used, longer block durations, faster onset times, improved block success and a reduced need for opioids are often achieved. UGRA also is associated with increased patient satisfaction and improved pain control.

In 2020, Envision partnered with industry leaders to develop innovative UGRA training programs. These highly successful programs, involving live clinician instructors and hands-on model scanning, have dramatically increased the number of patients receiving safe, effective opioid-sparing post-operative pain control.

In 2018, Envision clinicians at a Texas hospital implemented an opioid-sparing multimodal pain protocol that included UGRA. They have seen striking improvements in the safety, comfort and quality of care for surgical patients, along with substantial reductions in opioid usage and readmissions for pain control. The average length of stay for patients undergoing a range of procedures fell significantly, and within two years, the hospital achieved a 50 percent reduction in opioid use.[15]

Our clinicians' preoperative care approach includes a multispecialty assessment when warranted — pain, addiction, social work, physical therapy and occupational therapy and more. We have created a postoperative follow-up infrastructure that allows for tiered monitoring and support from multiple specialties as needed. These efforts provide immediate support to high-risk patients, help clinicians support low-risk patients who could drift into opioid misuse and allow for early identification of opioid misuse. Additionally, Envision perioperatists have developed best practices to care for surgical patients who are opioid-tolerant as well as those receiving chronic medical treatment with methadone and buprenorphine. **Our approach emphasizes human dignity and utilizes pragmatic guiding principles to minimize the disruptive effects of the perioperative experience for all surgical patients.**

[14] Adamson R., Lew I., Beyzarov E., et al. (July 2017). Clinical and Economic Implications of Postsurgical Use of Opioid Therapy. Hospital Pharmacy. Retrieved from https://journals.sagepub.com/doi/abs/10.1310/hpj4606-s4?journalCode=hpxa.

[15] Teamas R. (2020). Clinical and Financial Impact of an Opioid-Sparing Multimodal Pain Management Protocol. Anesthesiology News. Retrieved from https://www.anesthesiologynews.com/Review-Articles/Article/10-20/Clinical-and-Financial-Impact-Of-an-Opioid-Sparing-Multimodal-Pain-Management-Protocol/60793.

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Envision specialists also have adopted the American Society of Anesthesiologists strategies that include discussions about pain management expectations with patients and families and education on safe opioid use, storage and disposal as well as opioid misuse and abuse prevention following hospital discharge. With the recognition that certain opioid analgesics, such as remifentanil, may increase pain after exposure (opioid-induced hyperalgesia), our perioperatists have implemented best practices that limit its administration.

PAIN AND OUTPATIENT ADDICTION TREATMENT

The treatment of pain with traditional opioid medications, such as oxycodone, hydrocodone, fentanyl and others, was a prominent contributor to the first wave of the opioid crisis around 2010. Recent efforts to limit the prescribing of opioids as a means of reducing opioid use disorder in the pain setting are helpful, but data now shows that reducing opioids may confer significant risks. Safe and appropriate opioid de-prescribing is a highly individualized clinical challenge that requires extra support and attention to avoid precipitating OUD, mental health crises, suicide and other diseases of despair (such as alcohol use disorder). The utilization of multimodal techniques, including interventional treatment options, plays a key role in controlling chronic pain while minimizing the need for chronic opioid therapy. Our opioid reduction efforts are carefully applied, strongly supported and conform to the highest-quality recommendations to avoid exacerbating the opioid crisis.

Three medications are approved components of MOUD: buprenorphine, methadone and naltrexone. In recent years, the use of buprenorphine-containing products has risen significantly as a way to treat patients suffering from OUD and the management of chronic pain for patients not suffering from OUD. The primary rationale for prescribing buprenorphine to patients with a known or suspected history of OUD is to help manage the addiction aspect while decreasing the risk of an overdose death. As a semi-synthetic, partial opioid agonist, buprenorphine is associated with less euphoria, less physical dependence, lower abuse potential and a ceiling effect that enhances safety. It also has been proven to reduce opioid cravings and withdrawal symptoms and block some effects of co-administered opioids.

Buprenorphine plays a critical role in the management of opioid addiction. Envision clinicians have developed evidence-based, multispecialty guidance regarding the perioperative management of patients who are being treated for OUD, in-hospital management for admitted patients, coordination between specialists and postoperative management for both inpatient and outpatient scenarios. **Our guidance considers all facets of care, including the patient's physiological, psychological and social needs as well as addressing and optimizing social support and patient motivation.** While the guidance focuses on the peri-hospital management of buprenorphine, many of the same management principles will also apply to OUD patients managed on methadone and naltrexone.

HOSPITAL MEDICINE AND INPATIENT CARE

In a September 2018 report, the Office of the U.S. Surgeon General warned, "When healthcare is not well integrated and coordinated across systems, too many patients fall through the cracks..."[16] A high-quality handoff between clinicians sets the groundwork for a patient's inpatient care. Our hospital medicine clinicians identify patients at risk of oversedation and take precautionary measures to avoid complications. For patients on opioid medications, Envision hospitalists assist in safe weaning to oral formulations and, ideally, to non-opioid treatment plans. They also help identify patients at risk for addiction, facilitate rapid follow-up with appropriate treatment centers and play a crucial role in patient education.

We continue to embrace best practices offered by medical associations. The Society of Hospital Medicine's Reduce Adverse Drug Events related to Opioids (RADEO) guide offers protocols to help hospital medicine specialists implement safe opioid therapies. During the last several years, hospitalists have developed Patient and Family Advisory Councils through which patients and families can partner with the hospital healthcare team to address issues like opioid use and abuse inside and outside the hospital environment.

WOMEN'S AND CHILDREN'S CARE

An infant is born physically dependent on opioids every 15 minutes.[17] A multidisciplinary treatment plan should begin early in pregnancy and follow the infant throughout childhood and beyond. Our office-based perinatologists and hospital-based obstetricians start by performing routine screening studies to identify at-risk patients so they can be counseled, treated and referred, when appropriate, for specialized treatment.

Envision has created its "Heartbeat to Home" model of care to provide carefully guided support for high-risk moms and babies. This model instills trust through early identification and intervention as well as ongoing support to provide quality care that focuses on safety for the mother and the infant across the care continuum. We have used both the Finnigan Scoring System and the Eat-Sleep-Console Screening Tool to care for infants who have been born from moms on MOUD and from moms addicted to opioids. In the last 12 months, we have found that hospitals in our network who have the space to encourage moms to stay with their babies and use the Eat-Sleep-Console Screening Tool as a decision-making framework during their neonatal intensive care unit (NICU) course have an 18.3 percent lower number of days on medication and a 7.7 percent lower length of stay in the NICU. In addition to supporting the quality of treatment, this decreases the daily cost of care in the NICU and the overall cost of care for that patient. With an average daily cost of care for an infant with Neonatal Opioid Withdrawal Syndrome at $1,418, Envision has decreased healthcare costs by more than $500,000.[18]

HEARTBEAT *to* HOME

[16] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (September 2018). Facing Addiction in America: The Surgeon General's Spotlight on Opioids. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/OC_SpotlightOnOpioids.pdf.

[17] National Institutes of Health. Novel Technologies for Infants With Neonatal Opioid Withdrawal Syndrome. Retrieved from https://heal.nih.gov/news/stories/technologies-neonatal-opioid-withdrawal.

[18] Strahan A.E., Guy G.P., Bohm M., Frey M., Ko J.Y. Neonatal Abstinence Syndrome Incidence and Health Care Costs in the United States, 2016. JAMA Pediatr. 2020;174(2):200–202. doi:10.1001/jamapediatrics.2019.4791.

ADVOCACY: Partnering With Policymakers to Improve Patient Care

GROWING STIGMA SURROUNDING OPIOID USE

For years, as opioid-related overdoses gained attention, opioid use stigma increased. A 2019 survey found that 87 percent of Americans think patients are responsible for opioid misuse.[19]

Misconceptions about who is at fault can drive patients who need help further away from treatment. According to the American Hospital Association, the stigma surrounding OUD means fewer than 20 percent of patients have access to treatment.[20] The White House Office of National Drug Control Policy (ONDCP) has acknowledged that stigma represents an important barrier to addressing OUD. In a 2021 policy paper, ONDCP cited a study that indicated health professionals' negative attitudes toward patients with substance use disorders contribute to suboptimal care.[21]

Public policy has fed into this stigma.

Infectious disease experts Mark Tyndall and Zoë Dodd have argued that policymakers' focus on criminalization **"puts the responsibility and blame for opioid use firmly on the individuals at risk."** That focus has reduced support for potential solutions like needle exchange programs, opioid substitution therapies and supervised injection sites. The authors said, **"In any other epidemic, such as an infectious outbreak, we would not even consider criminal enforcement as a response. Saving lives would be the priority."**[22]

Laws, regulations and government resources must augment and support clinicians' ability to care for patients. Programs implemented at the state level and around the globe indicate policies that prioritize preventing addiction, reducing overdose deaths and getting people into treatment are successful.

SUCCESSFUL EFFORTS ABROAD AND IN THE UNITED STATES

In the 1990s, Lisbon, Portugal, was known as the heroin capital of Europe. After years of prioritizing treatment over incarceration, Portugal now has one of the lowest rates of drug-related deaths in Europe. Prior to the COVID-19 pandemic, heroin use was cut in half,[23] making the country's drug mortality rate four times lower than the European average. The country's health districts deploy clinicians and addiction experts to visit drug users daily to identify their needs. Portugal relies heavily on methadone to treat OUD, which is another large-scale example of the importance of MOUD in treating patients with OUD.

[19] Stobbe M., Swanson E. (April 25, 2019). AP-NORC Poll: Many Blame Drug Firms for Opioid Crisis. The Associated Press. Retrieved from https://apnews.com/article/united-states-health-new-york-ap-top-news-us-news-103530ad684f4941999e99467121b5d6.

[20] American Hospital Association. Opioids and Stigma. Retrieved from https://www.aha.org/opioids-and-stigma.

[21] Executive Office of the President, Office of National Drug Control Policy. (April 1, 2021). The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One. Retrieved from https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf?fbclid=IwAR2TBk34U_XRqlqK_pAYnUd_9f7zY3IbCQI9KxI6S5eYeRJdFzI9B09hZ84.

[22] Tyndall M., M.D., Dodd Z., M.E.S. (August 2020). How Structural Violence, Prohibition, and Stigma Have Paralyzed North American Responses to Opioid Overdose. AMA Journal of Ethics Policy Forum. Retrieved from https://journalofethics.ama-assn.org/article/how-structural-violence-prohibition-and-stigma-have-paralyzed-north-american-responses-opioid/2020-08.

[23] Klobucista C. [Updated 2022 May 12]. The U.S. Opioid Epidemic. Council on Foreign Relations. Retrieved from https://www.cfr.org/backgrounder/us-opioid-epidemic.

A Portuguese patient recovering from heroin addiction said officials "treat us like sick people, not criminals."[24]

The Swiss government also has prioritized treatment over criminalization. Between 1991 and 2010, overdose deaths in the country were cut in half, HIV infections fell 65 percent and the number of new heroin users decreased by 80 percent. The country's model "is internationally recognized as a major step in redefining how to tackle narcotic drugs."[25]

In the United States, the National Academy for State Health Policy (NASHP) has evaluated policy approaches that state leaders have taken to address the opioid crisis. These efforts and their outcomes are shared below.[25]

Implementing prescription drug monitoring programs (PDMP). In 2011, Florida was one of the first states to establish a PDMP. In a decade, the state achieved a 69.3 percent reduction in the number of individuals shopping for multiple opioid prescriptions.[26]

Investing in harm reduction. Massachusetts trained more than 64,000 people to administer naloxone to prevent overdose, invested in first responder training, provided naloxone doses to community health centers and implemented a bulk-purchasing program that offered naloxone at a discount. As of 2019, approximately 12,000 overdoses had been prevented. Some advocates are now calling for naloxone to be offered without a prescription.[27]

Embracing MOUD. Virginia expanded MOUD access in 2017. Since then, treatment rates for individuals with opioid disorders have risen more than 70 percent. Rhode Island offers MOUD to incarcerated individuals, an innovation that led to a 60 percent reduction in post-incarceration opioid-related deaths.[28]

Connecting rural communities. States like New Mexico have linked clinical specialists with practitioners in rural areas, facilitating long-distance learning and peer-to-peer mentoring. New Mexico implemented this model in 2005 and now ranks fourth in the country in the number of clinicians able to deliver MAT services.[29]

Expanding Medicaid. States that expanded Medicaid have seen a significant increase in OUD treatment.[30] Between 2011 and 2018, for example, Medicaid prescriptions for buprenorphine maintenance treatment per 1,000 enrollees rose from 40 to 138 in states that expanded Medicaid. In non-expansion states, the rate increased from 16 to 41.[31]

[24] Brown C. How Europe's Heroin Capital Solved Its Overdose Crisis. CBC. Retrieved from https://www.cbc.ca/news2/interactives/portugal-heroin-decriminalization/.

[25] Wolf M., Herzig, M. (July 22, 2019). Inside Switzerland's Radical Drug Policy Innovation. Stanford Social Innovation Review. Retrieved from https://ssir.org/articles/entry/inside_switzerlands_radical_drug_policy_innovation.

[26] Scott R., Philip C., M.D., Poston R. (December 1, 2017). 2016-2017 Prescription Drug Monitoring Program Annual Report. "Electronic-Florida Online Reporting of Controlled Substances Evaluation." Florida Health. Retrieved from https://www.floridahealth.gov/statistics-and-data/e-forcse/funding/2017pdmpannualreport.pdf.

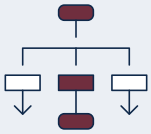
[27] Pattani A. (December 14, 2021). To Save Lives, Overdose Antidote Should Be Sold Over-The-Counter, Advocates Argue. National Public Radio. Retrieved from https://www.npr.org/sections/health-shots/2021/12/14/1063865914/to-save-lives-overdose-antidote-should-be-sold-over-the-counter-advocates-argue.

[28] Green T.C., Ph.D., Clarke J., M.D., Brinkley-Rubinstein L., Ph.D., et al. Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. JAMA Psychiatry. 2018;75(4):405–407. doi:10.1001/jamapsychiatry.2017.4614. Retrieved from https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2671411.

[29] Purington K. (February 4, 2019). Tackling the Opioid Crisis: What State Strategies Are Working? The National Academy for State Health Policy. Retrieved from https://www.nashp.org/tackling-the-opioid-crisis-what-state-strategies-are-working/.

[30] Purington K. (February 4, 2019). Tackling the Opioid Crisis: What State Strategies Are Working? National Academy for State Health Policy. Retrieved from https://www.nashp.org/tackling-the-opioid-crisis-what-state-strategies-are-working/.

[31] Meyer H. (August 22, 2019). Opioid Abuse Treatment Rates Far Higher in Medicaid Expansion States. Modern Healthcare. Retrieved from https://www.modernhealthcare.com/medicaid/opioid-abuse-treatment-rates-far-higher-medicaid-expansion-states.



EVIDENCE-BASED STRATEGIES THAT HAVE HELPED U.S. CITIES ADDRESS THE OPIOID EPIDEMIC INCLUDE THE FOLLOWING:

- ✓ Increasing access to medications for opioid use disorder and reducing barriers to treatment
- ✓ Expanding naloxone use
- ✓ Reducing opioid prescriptions while maintaining effective pain management
- ✓ Using contact with the criminal justice system as an opportunity for intervention
- ✓ Improving coordination between government agencies
- ✓ Creating safe-injection sites

The Pew Charitable Trusts. (May 10, 2018). A Combination of Approaches Helps Local Governments Tackle the Opioid Crisis. Retrieved from https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/05/a-combination-of-approaches-helps-local-governments-tackle-the-opioid-crisis.

PRIORITIZE PREVENTION AND TREATMENT AT THE FEDERAL LEVEL

In April 2021, the Biden-Harris Administration's White House ONDCP outlined a seven-point federal strategy to address the opioid crisis. The first pillar of the effort called for expanding access to evidence-based treatment.[32] To achieve that goal, Envision recommends that federal policymakers enact the following:

- **Make it easier for physicians to prescribe buprenorphine**
- **Reduce financial barriers to providers' use of MOUD**
- **Provide safe harbor to patients seeking treatment**
- **Reform patient privacy laws**
- **Expand access to virtual healthcare**

MAKE IT EASIER FOR PHYSICIANS TO PRESCRIBE BUPRENORPHINE

Under the previous administration, the U.S. Department of Health and Human Services (HHS) updated guidelines for buprenorphine administration. The new rules included broader exemptions from the X waiver, a congressionally mandated provision that requires clinicians to receive training before prescribing buprenorphine. As a bipartisan group of lawmakers noted, this requirement limits access to treatment. France's opioid overdose deaths fell 79 percent in a four-year period after making buprenorphine prescription possible without a waiver.[33]

[32] Executive Office of the President, Office of National Drug Control Policy. (April 1, 2021). The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One. Retrieved from https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf?fbclid=IwAR2TBk34U_XRqlqK_pAYnUd_9f7zY3IbCQI9KxI6S5eYeRJdFzl9B09hZ84.

[33] Adams K. (February 9, 2021). Lawmakers Urge White House to Abolish X-Waiver for Buprenorphine Prescription. Becker's Hospital Review. Retrieved from https://www.beckershospitalreview.com/pharmacy/lawmakers-urge-white-house-to-abolish-x-waiver-for-buprenorphine-prescription.html.

The Biden administration issued guidelines in April 2021. Those rules reduced paperwork requirements and added physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and certified nurse midwives to the list of clinicians who can prescribe buprenorphine.

While the new guidelines are a step in the right direction, further action is needed. The federal government should consider the following:

- Eliminating the X waiver while improving training and education on substance use disorder (SUD) requirements for students and residents
- Requiring all clinicians to receive SUD training before receiving or renewing their Drug Enforcement Administration license to prescribe controlled drugs[34]

REDUCE FINANCIAL BARRIERS TO CLINICIANS' USE OF MOUD

Despite their success in treating OUD, methadone, buprenorphine and naltrexone are underutilized. Less than 35 percent of people with OUD received treatment in the previous year. In addition to the burdensome X waiver, insufficient reimbursement contributes to the fact that too few patients receive treatment.[35] Indeed, a 2020 Government Accountability Office (GAO) report explored how federal rules put clinicians "at financial risk."[36] A 2022 U.S. Department of Labor report concluded health plans and insurance companies also "are falling short of providing parity in mental health and substance-use disorder benefits."[37]

The federal government has taken steps in recent years to improve reimbursement policies, including launching four-year demonstration projects that will test whether a new care management fee and performance-based incentive for OUD treatment services can improve health outcomes.[38] These policies have had a profound effect in some states. In addition, University of Pennsylvania researchers have found a financial incentive "can dramatically increase the number" of ED physicians trained to prescribe overdose prevention medications. At the beginning of the study, only 6 percent of eligible physicians had the proper training to prescribe buprenorphine. After offering a training reimbursement and a $750 incentive, 89 percent of physicians were fully trained after six weeks.[39]

"For too long, insurance coverage was overly complex, hard to access, and discriminatory towards individuals with mental and substance use conditions. There was no recognition that mental health and substance use disorders are every bit as important as physical health and that going without effective treatment can be debilitating and even life threatening."

— U.S. Department of Health and Human Services

[34] Stringfellow E., Humphreys K., Jalali M. (April 22, 2021). Removing The X-Waiver Is One Small Step Toward Increasing Treatment of Opioid Use Disorder, but Great Leaps Are Needed. Health Affairs. Received from https://www.healthaffairs.org/do/10.1377/forefront.20210419.311749/full/.

[35] Polsky D., Ph.D., Sen A., Ph.D., Arsenault S., M.A. (July 16, 2020). Innovative Payment to Scale up Access to Medications for Opioid Use Disorder. The American Journal of Managed Care. Retrieved from https://www.ajmc.com/view/innovative-payment-to-scale-up-access-to-medications-for-opioid-use-disorder.

[36] Government Accountability Office. (January 2020). Opioid Use Disorder: Barriers to Medicaid Beneficiaries' Access to Treatment Medications. Retrieved from https://www.gao.gov/assets/gao-20-233.pdf.

[37] U.S. Department of Labor. (January 2022). Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage. Retrieved from https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

[38] Centers for Medicare and Medicaid Services. (April 8, 2021). CMS Selects Value in Opioid Use Disorder Treatment Demonstration Applicants. Retrieved from https://www.cms.gov/newsroom/press-releases/cms-selects-value-opioid-use-disorder-treatment-demonstration-applicants.

[39] Foster S., M.D., Lee K., M.D., Edwards C., M.D., et. al. (August 2020). Providing Incentive for Emergency Physician X-Waiver Training: An Evaluation of Program Success and Postintervention Buprenorphine Prescribing. Annals of Emergency Medicine. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0196064420301402?via%3Dihub.

Local, state and federal policymakers can remove financial barriers to clinicians' use of MAT by the following methods:

- Relaxing prior authorization requirements for initial prescriptions with Medicaid and commercial health insurers
- Amending state billing requirements and allowing treatments to be prescribed prior to a completed initial intake assessment
- Funding the initiation of OUD treatment through EDs using federal grants or state funds
- Evaluating Medicaid payment structures and state contracts with clinicians to ensure they can bill for medication treatment without concurrent counseling services
- Allowing Medicaid reimbursement for services that support patients in their treatment needs (e.g., social work, recovery coaching and peer and outreach work)
- Dedicating state and federal grant money to services that facilitate low-threshold prescribing (e.g., outreach, transportation and case management)

Federal policymakers also must prioritize funding in general and focus on cultural competency to reduce treatment gaps in underserved communities. President Biden's fiscal year 2023 budget calls for $11 billion in funding to address the opioid crisis, which is a start.[40]

PROVIDE SAFE HARBOR TO PATIENTS SEEKING TREATMENT

Removing fear and stigma while enhancing access to healthcare and housing will improve outcomes for patients struggling with OUD. In February 2022, the CDC took the important step of issuing draft updated guidelines for prescribing opioids that would give doctors more flexibility in prescribing opioids. Prior guidelines issued in 2016 often limited opioid prescriptions for acute pain. The new guidelines allow clinicians to come up with individualized patient plans and help reduce dosages with patient buy-in when it is safe.

The current stigma means pain practitioners are less inclined to keep OUD patients in their care, interfering with the retention — and potential treatment — of patients struggling with OUD. In addition, policy drivers, such as the CDC 2016 Opioid Guideline and state legislation, specifically call for the transfer of high-risk opioid patients to pain specialists. The notion that pain medicine is the ideal destination for high-risk opioid pain patients is held by many specialties. However, the majority of support for the treatment of OUD is directed at primary care. The CDC does not provide guidance for complex, specialized opioid care in pain medicine, further favoring discharge over treatment. The CDC should update its 2016 guidance for prescribing opioids for chronic pain to support the care of opioid patients within the specialty of pain medicine. The Pew Charitable Trusts also has recommended that federal and state programs prohibit discharge from publicly-funded OUD treatment programs of patients who continue to use substances.[41]

[40] The Pew Charitable Trusts. (May 24, 2021). Policies Should Promote Access to Buprenorphine for Opioid Use Disorder. Retrieved from https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/05/policies-should-promote-access-to-buprenorphine-for-opioid-use-disorder.

[41] The Pew Charitable Trusts. (May 24, 2021). Policies Should Promote Access to Buprenorphine for Opioid Use Disorder. Retrieved from https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/05/policies-should-promote-access-to-buprenorphine-for-opioid-use-disorder.

Good Samaritan Laws: Fear of criminal prosecution may keep individuals from calling emergency medical services when a friend or family member is experiencing an overdose. As of March 2021, 47 U.S. states and Washington, D.C., have enacted both Good Samaritan and naloxone access laws. These states are linked to lower rates of overdose deaths from opioids.[42]

Supportive Services: In August 2017, Ottawa Inner City Health's Managed Opioid Program began combining injectable opioid agonist treatment with supportive housing for people with severe OUD who were experiencing homelessness. Retention was 77 percent in the first year. Additionally, 45 percent of patients stopped non-prescribed opioid use, 96 percent were connected to behavioral health services and 31 percent had begun working in vocational programs.[43] According to a New York State Office of Alcoholism and Substance Abuse Services study, about half of homeless, mentally ill methadone patients who had housing were still adhering to their methadone treatment three years later. That number compared with only 20 percent without housing.[44]

The National Safety Council, a nonprofit national workplace safety advocate that has worked with employers to address opioid misuse among America's workforce, recommends the following:

- Law enforcement allows residents to turn in illicit substances without fear of retribution
- States and localities expand the use of specialty courts, including but not limited to drug courts and mental health courts, which prioritize treatment over incarceration
- First responders, including law enforcement, receive culturally sensitive and linguistically-appropriate crisis intervention services guidance and provide training for all first responders[45]

REFORM PATIENT PRIVACY LAWS

Current law impedes the continuum of care by preventing collaboration between clinicians. In July 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a final regulation to facilitate better care coordination while maintaining confidentiality protections. Additional reforms are needed, including those that perform the following:

- Ensure the consent requirements are simple and straightforward and impose no new administrative processes on patients, clinicians or health insurers
- Direct covered entities and business associates to disclose and redisclose data in accordance with HIPAA regulations
- Explore policy mechanisms for promoting the use of behavioral health data for care coordination purposes when state privacy laws may impose more stringent restrictions
- Ensure patient privacy rights are protected in accordance with the CARES Act and HIPAA
- Provide substance use disorder-related claims data to clinicians practicing in alternative payment models to help support their work in population health management[46]

[42] Government Accountability Office. (March 29, 2021). Drug Misuse: Most States Have Good Samaritan Laws and Research Indicates They May Have Positive Effects. Retrieved from https://www.gao.gov/products/gao-21-248.

[43] Harris M., Seliga R., Fairbairn N., et. al. (December 2021). Outcomes of Ottawa, Canada's Managed Opioid Program (MOP) Where Supervised Injectable Hydromorphone Was Paired with Assisted Housing. International Journal of Drug Policy. Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0955395921003054?dgcid=author.

[44] Appel P., Tsemberis S., Joseph H., et. al. (2012) Housing First for Severely Mentally Ill Homeless Methadone Patients. Journal of Addictive Diseases. Retrieved from https://pubmed.ncbi.nlm.nih.gov/22873188/.

[45] National Safety Council. (February 2020). A National Plan to Address Opioid Misuse. Retrieved from https://nsc-org-storage.azureedge.net/cms/nsc.org/media/site-media/docs/impairment/national-plan-opioid-misuse.pdf.

[46] The Partnership to Amend 42 CFR Part 2. Recommendations. Retrieved from https://www.helpendopioidcrisis.org.

EXPAND VIRTUAL HEALTHCARE

Keeping patients connected to MOUD and behavioral therapies is difficult under the best circumstances. Virtual healthcare, sometimes referred to as telehealth or telemedicine, can help. Clinicians who used virtual health for OUD patients during the COVID-19 pandemic reported increased access for their patients, particularly among historically underserved populations. Pew recommends local, state and federal lawmakers enact the following:

- Require health insurers to reimburse clinicians for all OUD services delivered virtually
- Set public and private reimbursement rates for virtual health-based OUD services on a par with in-person treatment
- Expand locations where patients can receive OUD treatment services via virtual health, including their homes
- Allow patients with Medicaid to access OUD treatment services by telephone
- Enable correctional institutions to use virtual health for OUD treatment services

States also should reform licensing standards to allow physicians licensed in other states to deliver virtual healthcare services in their states.

Conclusion

The U.S. opioid epidemic worsened during the COVID-19 pandemic despite the presence of effective prevention and treatment programs. Stigma, a focus on criminalizing substance abuse and constraints on access have kept OUD patients from getting the treatment they need. Working together, clinicians, health insurers and policymakers must continue to advance best practices for prevention. They also must change government and private sector laws, rules and regulations to enhance access to treatment. As a leading medical group in the U.S., Envision's clinicians are working within and across specialties to enhance the care of individuals with opioid use disorder.

[47] The Pew Charitable Trusts. (December 14, 2021). State Policy Changes Could Increase Access to Opioid Treatment via Telehealth. Retrieved from https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth.