Delivering Whole Person Care

Improving Outcomes in Opioid Use Disorder Treatment

With Dr. Andrew Kolodny

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Dr. Andrew Kolodny’s primary area of focus is the prescription opioid and heroin crisis devastating families and communities across the country. He also serves as vice president of federal affairs for Physicians for Responsible Opioid Prescribing, an organization with a mission to reduce morbidity and mortality caused by overprescribing of opioid analgesics.

Dr. Kolodny served as chief medical officer for Phoenix House, a national nonprofit addiction treatment agency. He began his career working for the New York City Department of Health and Mental Hygiene in the Office of the Executive Deputy Commissioner. For New York City, he helped develop and implement multiple programs to improve the health of New Yorkers and save lives, including citywide buprenorphine programs, naloxone overdose prevention programs and emergency room-based screening, brief intervention and referral to treatment (SBIRT) programs for drug and alcohol misuse.
How Social Determinants of Health Impact the Opioid Crisis

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All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

Mortality by cause, white non-Hispanics ages 45–54

Deaths of Despair or Drug Problems?
Christopher J. Ruhm
NBER Working Paper No. 24188
January 2018
JEL No. E32,J12,J18,J11

ABSTRACT

The United States is in the midst of a fatal drug epidemic. This study uses data from the Multiple Cause of Death Files to examine the extent to which increases in county-level drug mortality rates from 1999-2015 are due to “deaths of despair”, measured here by deterioration in medium-run economic conditions, or if they instead are more likely to reflect changes in the “drug environment” in ways that present differential risks to population subgroups. A primary finding is that counties experiencing relative economic decline did experience higher growth in drug mortality than those with more robust growth, but the relationship is weak and mostly explained by confounding factors. In the preferred estimates, changes in economic conditions account for less than one-tenth of the rise in drug and opioid-involved mortality rates. The contribution of economic factors is even less when accounting for plausible selection on unobservables, with even a small amount of remaining confounding factors being sufficient to entirely eliminate the relationship. These results suggest that the “deaths of despair” framing, while provocative, is unlikely to explain the main sources of the fatal drug epidemic and that efforts to improve economic conditions in distressed locations, while desirable for other reasons, are not likely to yield significant reductions in drug mortality. Conversely, the risk of drug deaths varies systematically over time across population subgroups in ways that are consistent with an important role for the public health environment related to the availability and cost of drugs. Put succinctly, the fatal overdose epidemic is likely to primarily reflect drug problems rather than deaths of despair.

Source: Ruhm CJ. Deaths of despair or drug problems? NBER working paper no. 24188, January 2018.
Where Have All the Workers Gone?
An Inquiry into the Decline of the U.S. Labor Force Participation Rate

ABSTRACT  The U.S. labor force participation rate has declined since 2007, primarily because of population aging and ongoing trends that preceded the Great Recession. The labor force participation rate has evolved differently, and for different reasons, across demographic groups. A rise in school enrollment has largely offset declining labor force participation for young workers since the 1990s. Labor force participation has been declining for prime age men for decades, and about half of prime age men who are not in the labor force may have a serious health condition that is a barrier to working. Nearly half of prime age men who are not in the labor force take pain medication on any given day; and in nearly two-thirds of these cases, they take prescription pain medication. Labor force participation has fallen more in U.S. counties where relatively more opioid pain medication is prescribed, causing the problem of depressed labor force participation and the opioid crisis to become intertwined.
U.S. National: Opioid-Related Hospital Use by Community-Level Income

Rate of Emergency Department (ED) Visits

Year


Rate of ED Visits per 100,000 Population in the Income Quartile

- Income quartile 1 (lowest)
- Income quartile 2 (2nd lowest)
- Income quartile 3 (2nd highest)
- Income quartile 4 (highest)

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2010-2017 (all available data as of 01/28/2020). Emergency department visits exclude those for patients admitted to the hospital.
National Drug-Involved Overdose Deaths by Specific Category—Number Among All Ages, 1999-2019

*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 1999-2019 on CDC WONDER Online Database, released 12/2020.*
Heroin treatment admissions: 2003-2013

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 01.23.15.
Death rates from overdoses of heroin or prescription opioid pain relievers (OPRs), by age group

Three Opioid-Addicted Cohorts

1. 20-40 y/o, disproportionately white, significant heroin use, opioid addiction began with Rx use (addicted after 1995)

2. 40 y/o & up, disproportionately white, mostly Rx opioids, opioid addiction began with Rx use (addicted after 1995)

3. 50 y/o & up, disproportionately non-white, mostly heroin users, opioid addiction began in teen years with heroin use (addicted before 1995)
Non-Hispanic Whites

Non-Hispanic Blacks

Opioid Overdose Death Rate per 100,000 (1999-2017)
From Fentanyl + No Heroin + Any Other Opioid

SOURCE: CDC WONDER
Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: United States

Source: National Center for Health Statistics
Growth and Level of the Synthetic Opioid OD Deaths, 2016

Growth and Level of the Synthetic Opioid OD Deaths, 2016

The District of Columbia had the fastest rate of increase in mortality from opioids in the country, more than tripling every year since 2013.

What *is* the Opioid Crisis?
Drug overdose deaths jump in 2019 to nearly 71,000, a record high, CDC says
Primary non-heroin opiates/synthetics admission rates, by State
(per 100,000 population aged 12 and over)

1999
(range 1 - 50)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroine opiates/synthetics admission rates, by State
(per 100,000 population aged 12 and over)

2001
(range 1 – 71)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2003
(range 2 – 139)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2005
(range 0 – 214)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2007
(range 1 – 340)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Primary non-heroin opiates/synthetics admission rates, by State (per 100,000 population aged 12 and over)

2009 (range 1 – 379)

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10.
Rates of Opioid Sales, OD Deaths, and Treatment, 1999–2010

Rate

Opioid Sales KG/10,000

Opioid Deaths/100,000

Opioid Treatment Admissions/10,000

Year

OD Deaths/100,000
USA oxycodone consumption (mg/capita)
1980–2015

Sources: International Narcotics Control Board; World Health Organization population data
Controlling the epidemic: A Three-pronged Approach

• **Prevent** new cases of opioid addiction.

• **Treat** people who are already addicted.

• **Reduce supply** from pill mills and the black-market.
Comparison of Mortality Data from AIDS Case Reports and Death Certificates in Which HIV Disease Was Selected as the Underlying Cause of Death, United States, 1987–2006

*For comparison with data for 1999 and later years, data in the bottom (red) line for 1987–1998 were modified to account for ICD-10 rules instead of ICD-9 rules.
Buprenorphine Access Is Still Inadequate

The Supply of Buprenorphine Prescribers Across the U.S.\textsuperscript{13}

100% of these providers can prescribe opioids.

1.3 Million physicians, nurse practitioners, and physician assistants work in the U.S.

74,000 (5.7%) are waivered to prescribe buprenorphine.

Only 43,700 (3.4%) of the total provider population publicly disclose that they can prescribe buprenorphine.

SHATTERPROOF: STRONGER THAN ADDICTION

The required training varies between eight and 24 hours depending on prescriber type, and prescribers are restricted in the number of patients they are allowed to treat.
Buprenorphine Access Is Still Inadequate

**County-Level Waivered Prescriber Supply**

- The median buprenorphine capacity by county is 4 prescribers per 100,000 people.
- Thirty-nine percent (1,228) of counties do not have a waived buprenorphine prescriber, creating an access challenge for any of these counties’ 18 million residents.
  - Two-thirds (11.9 million) of these individuals live in rural areas.
  - One-third (6.1 million) of these individuals live in urban and suburban areas.
Impact of COVID-19 on the Opioid Crisis

• Increased rate of opioid OD death

• Ability to provide direct services and psychosocial support impeded

• Litigation against opioid industry slowed
OUD Increases COVID Risks

- Increased susceptibility to infection
  - Opioid-induced immunosuppression
  - Psychosocial factors (homelessness, treatment settings)

- Increased risk for complications
  - Opioid-induced immunosuppression
  - Respiratory depression from opioids
  - Other medical problems
OUD Increases COVID Risks

• Addictive disorder increases risk for COVID, with opioid use disorder followed by tobacco use disorder, having highest risk.

• Addictive disorder increases risk for death from COVID, with greatest risk in Black patients with OUD.

Treatment System Changes

• Feds relax Methadone rules on take-home doses and allow home deliveries.

• Buprenorphine home inductions

• Expansion of tele-medicine treatment

• Naloxone home deliveries
The acute clinical manifestations of COVID-19 are well characterized; however, its post-acute sequelae have not been comprehensively described. Here, we use the national healthcare databases of the US Department of Veterans Affairs to systematically and comprehensively identify 6-month incident sequelae including diagnoses, medication use, and laboratory abnormalities in 30-day survivors of COVID-19. We show that beyond the first 30 days of illness, people with COVID-19 exhibit higher risk of death and health resource utilization. Our high dimensional approach identifies incident sequelae in the respiratory system and several others including nervous system and neurocognitive disorders, mental health disorders, metabolic disorders, cardiovascular disorders, gastrointestinal disorders, malaise, fatigue, musculoskeletal pain, and anemia. We show increased incident use of several therapeutics including pain medications (opioids and non-opioids), antidepressants, anxiolytics, antihypertensives, and oral hypoglycemics and evidence of laboratory abnormalities in multiple organ systems. Analysis of an array of pre-specified outcomes reveals a risk gradient that increased across severity of the acute COVID-19 infection (non-hospitalized, hospitalized, admitted to intensive care). The findings show that beyond the acute illness, substantial burden of health loss — spanning pulmonary and several extrapulmonary organ systems — is experienced by COVID-19 survivors. The results provide a roadmap to inform health system planning and development of multidisciplinary care strategies to reduce chronic health loss among COVID-19 survivors.

Can We Learn From COVID-19?
Summary

• The U.S. is in the midst of a severe epidemic of opioid addiction and overdose deaths, which worsened during Covid.

• To bring the epidemic to an end:
  – We must prevent new cases of opioid addiction
  – We must improve access to treatment for people already addicted
Summary

• Social determinants are NOT a root cause of the opioid addiction epidemic.

• Social determinants of health impact opioid related morbidity and mortality.

• Addressing social determinants of health may improve outcomes in individuals suffering from OUD.
What’s next

MHA Opioid Stewardship Road Map Rollout
Thursday, Sept. 9, 12 - 1 p.m., CDT

Speaker panel
• Dr. Joseph Bianco, ambulatory quality leader, Essentia Health
• Dr. Ken Flowe, physician director, Carris Health Acute Care
• Dr. Bret Haake, chief medical officer and vice president of medical affairs, Regions Hospital;
• Dr. Alicia Gonzalez , emergency department medical director, Marian Regional Medical Center; regional director, CA Bridge Program

Register at www.mnhospitals.org and select upcoming events