NEW YORK STATE | Office of Addiction Services and Supports

KATHY HOCHUL
Governor

CHINAZO CUNNINGHAM, MD
Commissioner

Expanding Access to Medication for Addiction Treatment in Skilled Nursing Facilities in New York State

January 12, 2023

Who we are…

Kelly S. Ramsey, MD, MPH, MA, FACP, DFASAM
Chief of Medical Services
Kelly.Ramsey@oasas.ny.gov

Pamela Mund, MD
Associate Chief of Addiction Medicine
Pamela.Mund@oasas.ny.gov

Pat Lincourt, LCSW
Associate Commissioner
Division of Addiction Treatment and Recovery (ATAR)
Pat.Lincourt@oasas.ny.gov

Lesley Puryear, LMSW
NYS Opioid Treatment Authority (SOTA) and Bureau Director, Adult Treatment Services, ATAR
Lesley.Puryear@oasas.ny.gov

Celyn Ng, M-Pharm, MPH
Project Manager, Bureau of Adult Treatment Services, ATAR
Celyn.Ng@oasas.ny.gov

Financial Disclosures

Dr. Ramsey has no relevant financial disclosures.

Dr. Mund has no relevant financial disclosures.

Pat Lincourt has no relevant financial disclosures.

Lesley Puryear has no relevant financial disclosures.

Celyn Ng has no relevant financial disclosures.

Agenda

1. Introduction and Overview: NYS Office of Addiction Services and Supports (OASAS)
2. Medications to treat OUD and AUD
3. What is an OTP?
4. Working Through Barriers and Increasing Access to MOUD
5. Reducing Stigma

Learning Objectives

- Develop an understanding of medications for opioid use disorder (OUD) and alcohol use disorder (AUD) including common myths and misconceptions about their use.
- Learn about coordinating care for older adults with a substance use disorder with a focus on opioid use and medications for opioid use disorder.
- Combatting stigma and existing barriers to care coordination.

OASAS: Overview

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OASAS. Every Step of the Way.

OASAS
What we do:

IMPROVE LIVES
BY LEADING A COMPREHENSIVE SYSTEM OF ADDICTION SERVICES:

Prevention, Treatment, Harm Reduction and Recovery

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OASAS
What we do:

OASAS oversees one of the nation's largest substance use disorder systems of care with approximately 1,700 prevention, treatment and recovery programs serving over 680,000 individuals per year. This includes the direct operation of 12 Addiction Treatment Centers where our doctors, nurses, and clinical staff provide inpatient and residential services to approximately 8,000 individuals per year. OASAS is the single designated state agency responsible for the coordination of state-federal relations in the area of addiction services.

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NYS OASAS *New* Division of Harm Reduction

2022 SOTS Address: OASAS Division of Harm Reduction

- To make a push toward ending the opioid epidemic, the State will expand and enhance a public health-style program coordinated by NYS DOH and the Office of Addiction Services and Supports (OASAS) that includes harm-reduction services, health monitoring, and evidence-based community interventions. Programs will include established initiatives such as expanded access to sterile syringes, naloxone, buprenorphine, and other medications used to treat opioid use.
- The State will also create a Division of Harm Reduction within OASAS to embed harm reduction principles and strategies across the OASAS system of care. This new division, in collaboration with the DOH's Office of Drug User Health, will implement harm-reduction initiatives that will include:
  - Expanding naloxone and buprenorphine access by mandating pharmacies to maintain a stock of these medications;
  - Investing in fentanyl test strips, opioid overdose prevention kits, safety kits, and resources to prevent individuals from overdosing while alone;
  - Developing a public awareness campaign to prevent overdose deaths in public settings;
  - Creating and implementing a medication for addiction treatment program for uninsured and underinsured individuals;
  - Expanding access to sterile syringes by allowing emergency departments and health departments to provide syringes to individuals who present with signs and symptoms of injection drug use.

OASAS Division of Harm Reduction

- **Structure of Division: 3 Pillars**
  - Education/Technical Assistance/Resources
  - Regulations/Structure/ Culture
  - Special Projects
- **Incorporating the harm reduction principles** into each Bureau/Division within OASAS and across the OASAS system. It is not intended to be a stand-alone Division, but to assist in incorporating harm reduction principles across the agency and system.
- **Adding opportunities for assessment, education and training:** the Division will work on assessing where agency and provider staff are with their knowledge and understanding of harm reduction principles and work to address additional opportunities for education and training for our staff and our providers. This is an opportunity for growth within the OASAS system.
- **Approaching substance use from a person-first, respect for the individual preference of the patient approach:** this is like actions OASAS has taken to incorporate person-centered care and allowing an individual to define recovery for *them.* This is an opportunity to have programs engage individuals *wherever they are* on the continuum of use and regardless of what their current or ultimate goals are.
- **Collaborating with the NYC DHS:** OASAS Has worked closely with NYC DHS for years, on implementing and expanding substance use services in the shelter system. This gives the opportunity for an even closer collaboration as both this Division and DHS will be working on engaging individuals and keeping them alive, within the OASAS system and those who have not entered the OASAS system.

Understanding Harm Reduction: Guiding Principles

A non-judgmental approach	Focus on enhancing quality of life, not abstinence
Evidence-based, feasible, and cost-effective practices	Recognition of complex social factors
Acceptance of behavioral change (or any change for that matter) as any incremental process	Empowerment of people who use drugs in reducing potential harms of their substance use
Meaningful participation by people who currently use drugs, by people who previously used drugs, and stakeholders in shaping policies and practices around substance use	Commitment to defending universal human rights

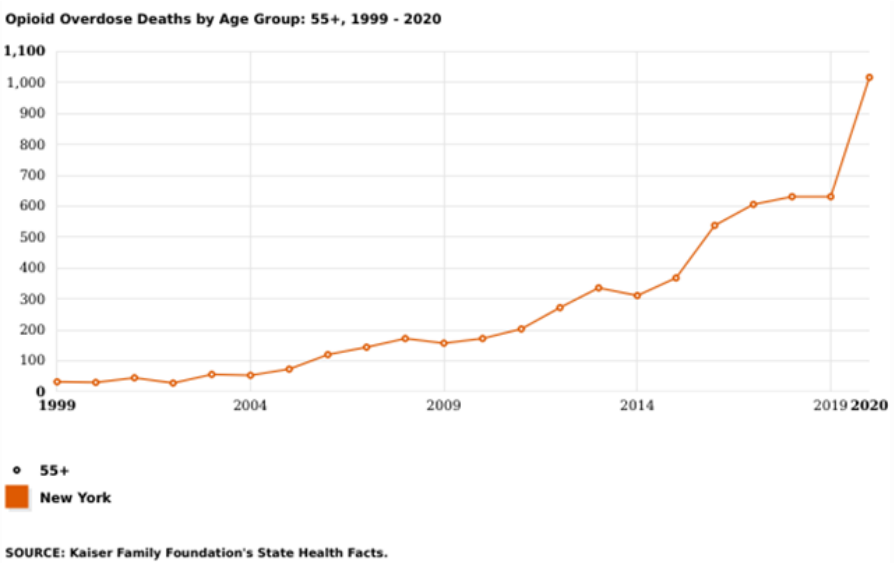
OASAS
Office of Justice, Equity, Diversity and Inclusion (JEDI):

In June 2022, OASAS established the Office of Justice, Equity, Diversity and Inclusion (JEDI) and appointed an Executive Equity Officer. This Office is tasked with examining policies, practices and developing goals using an equity lens and implementing change that is anti-racist, trauma informed, LGBTQ+ affirming and centered on the integration of equitable practices and the inclusion of all. We believe in the principles of equity, value the intersectionality of our staff and the people we serve and commit to collaborating and being guided by culturally specific community partners, dismantling oppressive systems, policies and practices, and instituting strategies that center on marginalized communities, especially black, indigenous and people of color (BIPOC).
OASAS commits to performing this work using a collaborative process, continuous engagement, assessment, evaluation and involvement of agency staff, providers, and communities that we serve.

Medications to Treat Opioid Use Disorder

Overdose Mortality

- Overdose deaths are rising, and, in 2021, the total number of overdoses topped 107,000.
- Older adults increasingly are represented among overdose deaths. In 1999, 5% of all opioid overdose deaths in NY were aged 55+. In 2020, 24% were 55+.
  - National data indicates that Black men aged 55+ have been impacted disproportionately by overdose.



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Evidence-Based Strategies for Preventing Opioid Overdose

1. Targeted Naloxone Distribution
2. **Medications for opioid use disorder (MOUD)**
3. Academic Detailing
4. **Eliminating Prior-Authorization Requirements for MOUD**
5. Screening for Fentanyl in Routine Clinical Toxicology Testing
6. 911 Good Samaritan Laws
7. Naloxone Distribution in Treatment Centers and Criminal Justice Settings
8. **MOUD in Criminal Justice Settings and Upon Release**
9. **Initiating Buprenorphine-based MOUD in Emergency Departments**
10. Syringe Services Programs

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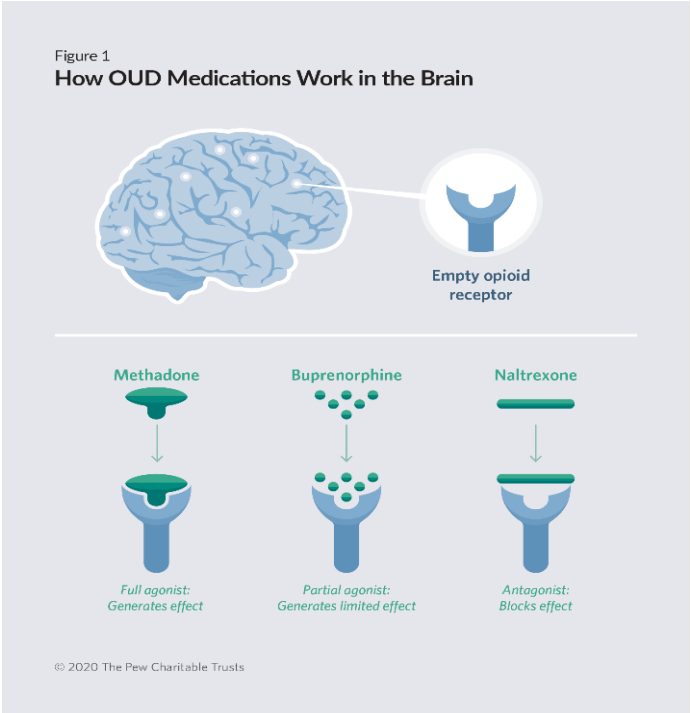
Medications for Opioid Use Disorder

- Medication for opioid use disorder (MOUD) is an evidence-based, life-saving treatment that utilizes FDA approved medications to treat opioid use disorder.
- These three FDA approved medications are:
  - Methadone: opioid full agonist; must be dispensed from an opioid treatment program (OTP); associated with decreased opioid mortality and all-cause mortality
  - Buprenorphine: opioid partial agonist; Schedule III drug; has required a DEA "X" waiver to prescribe; associated with decreased opioid mortality and all-cause mortality
  - Naltrexone: opioid antagonist; not a controlled substance; not associated with decreased mortality



Goals for MOUD

- Decrease risk for fatal and nonfatal overdoses
- Eliminate opioid withdrawal syndrome (OWS)
- Decrease opioid cravings
- Increase patient functionality
- Normalize brain anatomy and physiology
- Decrease transmission/acquisition of viral infections (Hepatitis B Virus, Hepatitis C Virus, HIV) and infection complications (abscesses, cellulitis, endocarditis)
- Increase retention in care
- Decrease use of other opioids

Dispelling Myths and Misconceptions About MOUD

- *Myth: "MOUD just trades one addiction for another"*
- *Fact:* Both buprenorphine and methadone do cause physical dependence to an opioid; however, physical dependence does not equal addiction or a use disorder; OUD is characterized by a compulsion to use opioids with associated behaviors which lead to dysfunction in the PWUD's life; buprenorphine and methadone allow people to stabilize, by occupying the mu opioid receptors to keep opioid withdrawal symptoms at bay and control opioid cravings, allowing a person to regain functionality in their life

- *Myth: "MOUD is only for the short term"*
- *Fact:* Research has consistently shown that people maintained on MOUD for longer durations have better long-term outcomes than those who are taken off MOUD; there is no evidence to support benefits from stopping MOUD

Dispelling Myths and Misconceptions About MOUD

- *Myth: "Providing MOUD will only disrupt and hinder a patient's recovery process"*
- *Fact:* MOUD has been shown to assist PWUD in recovery by improving quality of life, level of functioning, and the ability to handle stress; most importantly, MOUD reduces both opioid and all-cause mortality while PWUD begin their recovery process; PWUD are often more open to other supports (counseling, peers, etc.) for their recovery once stable on MOUD

- *Myth: "There isn't any proof that MOUD is better than abstinence"*
- *Fact:* MOUD is evidence-based and is the recommended course of treatment for OUD; AAAP, AMA, NIDA, SAMHSA, NIAAA, CDC, WHO, and many other professional organizations emphasize MOUD as first-line treatment for OUD

Medications to Treat Alcohol Use Disorder

Understanding the Patient's Perspective on Drinking Alcohol and Prescribe MAUD

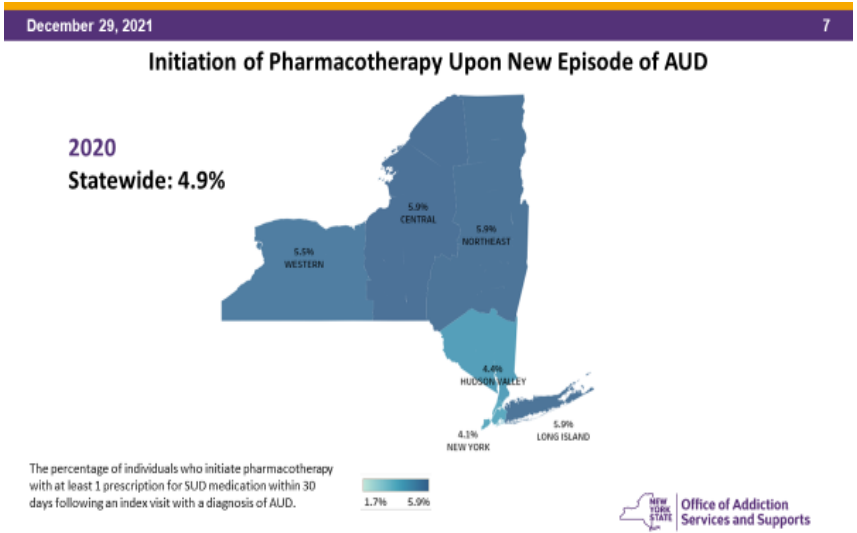
The Patient's Perspective on Drinking Alcohol

The Patient's Perspective on Drinking

39% Total Abstinence	"I want to quit using alcohol once and for all…
29% Controlled Drinking	"I want to use alcohol in a controlled manner…"
32% Conditional Abstinence	"I want to be abstinent for a period of time, after which I will make a new decision….."

4. DeMartini et al 2014

Underutilization of Medications for AUD (MAUD)



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Pharmacotherapy for AUD

- 3 FDA Approved Medications:
  - Disulfiram: approved in 1949; MOA: aldehyde dehydrogenase inhibitor
  - Naltrexone: oral formulation approved in 1994; (Vivitrol): depot injectable formulation approved in 2006; MOA: opioid receptor antagonist
  - Acamprosate: approved in 2004; MOA: NMDA/glutamate receptor antagonist

Inform Regarding Potential Harms from Alcohol Use: Estimated Deaths Attributable to Excessive Alcohol Use Among US Adults Aged 20 to 64 Years, 2015 to 2019

- **Importance** Alcohol consumption is a leading preventable cause of death in the US, and death rates from fully alcohol-attributable causes (eg, alcoholic liver disease) have increased in the past decade, including among adults aged 20 to 64 years. However, a comprehensive assessment of alcohol-attributable deaths among this population, including from partially alcohol-attributable causes, is lacking.
- **Objective** To estimate the mean annual number of deaths from excessive alcohol use relative to total deaths among adults aged 20 to 64 years overall; by sex, age group, and state; and as a proportion of total deaths.
- **Design, Setting, and Participants** This population-based cross-sectional study of mean annual alcohol-attributable deaths among US residents between January 1, 2015, and December 31, 2019, used population-attributable fractions. Data were analyzed from January 6, 2021, to May 2, 2022.
- **Exposures** Mean daily alcohol consumption among the 2 089 287 respondents to the 2015-2019 Behavioral Risk Factor Surveillance System was adjusted using national per capita alcohol sales to correct for underreporting. Adjusted mean daily alcohol consumption prevalence estimates were applied to relative risks to generate alcohol-attributable fractions for chronic partially alcohol-attributable conditions. Alcohol-attributable fractions based on blood alcohol concentrations were used to assess acute partially alcohol-attributable deaths.
- **Main Outcomes and Measures** Alcohol-attributable deaths for 58 causes of death, as defined in the Centers for Disease Control and Prevention's Alcohol-Related Disease Impact application. Mortality data were from the National Vital Statistics System.
- **Results** During the 2015-2019 study period, of 694 660 mean deaths per year among adults aged 20 to 64 years (men: 432 575 [66.3%]; women: 262 085 [37.7%]), an estimated 12.9% (89 697 per year) were attributable to excessive alcohol consumption. This percentage was higher among men (15.0%) than women (9.4%). By state, alcohol-attributable deaths ranged from 9.3% of total deaths in Mississippi to 21.7% in New Mexico. Among adults aged 20 to 49 years, alcohol-attributable deaths (44 981 mean annual deaths) accounted for an estimated 20.3% of total deaths.
- **Conclusions And Relevance** **The findings of this cross-sectional study suggest that an estimated 1 in 8 total deaths among US adults aged 20 to 64 years were attributable to excessive alcohol use, including 1 in 5 deaths among adults aged 20 to 49 years.** The number of premature deaths could be reduced with increased implementation of evidenced-based, population-level alcohol policies, such as increasing alcohol taxes or regulating alcohol outlet density.

Alcohol-Related Deaths During the COVID-19 Pandemic

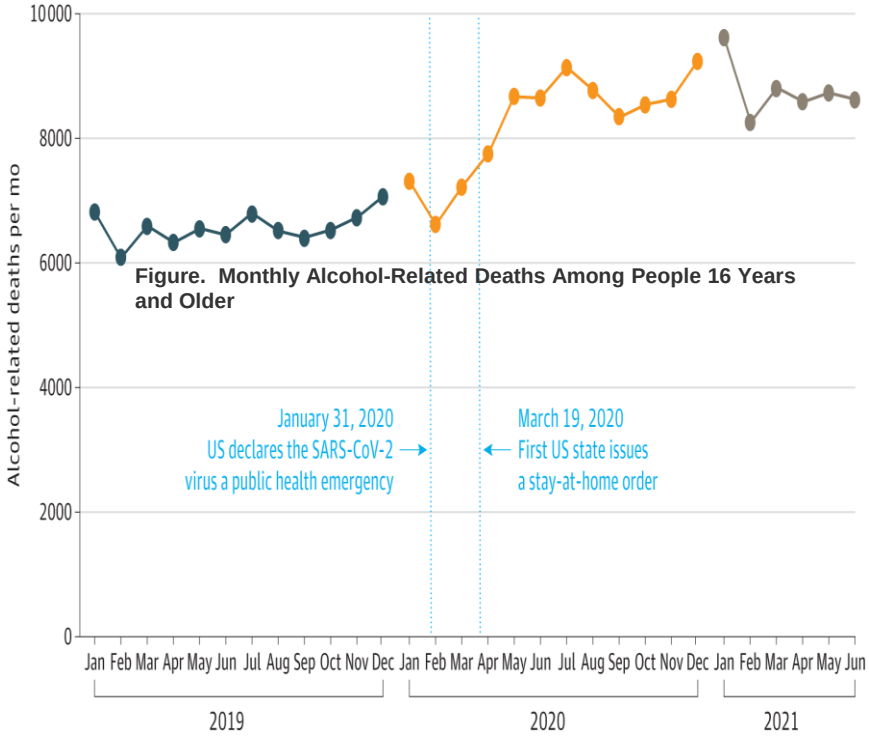

Figure. Monthly Alcohol-Related Deaths Among People 16 Years and Older

- The number of deaths involving alcohol increased between 2019 and 2020, from 78,927 to 99,017 [relative change, **25.5%**], as did the age-adjusted rate, from 27.3 to 34.4 per 100 000 [relative change, 25.9%].

- The number of deaths with an underlying cause of alcohol-associated liver diseases increased from 24,106 to 29,504 (22.4%) and the number of deaths with an underlying cause of alcohol-related mental health and behavioral disorders increased from 11,261 to 15,211 (35.1%). **Opioid overdose deaths involving alcohol as a contributing cause increased from 8,503 to 11,969 (40.8%).** Deaths in which alcohol contributed to overdoses specifically on synthetic opioids other than methadone (e.g., fentanyl and fentanyl analogues) increased from 6,302 to 10,032 (59.2%).

- Alcohol-related deaths accounted for 2.8% of all deaths in 2019 and 3.0% in 2020.

Opioid Treatment Programs (OTPs)

What is an OTP?

- OASAS-certified sites where methadone and other approved medications are administered to treat opioid use disorder
- A physician serves as Medical Director and other medical and nursing staff assess each individual and approve the plan of care. Clinical staff provide individual, family, and group treatment.
- Patients are prescribed and dispensed medication for addiction treatment which is expected to be long term medication management of a chronic medical condition. Many patients are provided treatment over a lifetime like management for other chronic conditions such as diabetes mellitus or hypertension.

Services Available in an OTP

- Medication for substance use disorder, including opioid use disorder and alcohol use disorder, and medication management via dispensing (nursing, not pharmacy)
  - ❑ Methadone
  - ❑ Buprenorphine (sublingual or buccal)
  - ❑ XR buprenorphine (injectable)
  - ❑ XR naltrexone (injectable)
  - ❑ Acamprosate
  - ❑ Disulfiram
- Individual sessions
- Group sessions
- Mental health services
- Care coordination

Services Available in an OTP (Continued)

- Medical evaluation by medical staff
- Take-home medication
- Health care for physical conditions for patients without primary care
- Treatment of co-occurring disorders (substance use disorder and mental health conditions)
- Staffing can include physicians, physician assistants, nurse practitioners, possibly psychiatrists, PNPs, RNs, LPNs, possibly social workers, CASACs, CASAC-Ts, counselors, peers

Care Coordination, Barriers, & Potential Solutions

Example of Barriers: Scenario 1

Lisa is a 70-year-old individual who has recently been admitted to the hospital following a fall at her apartment while carrying her groceries. Lisa has a history of opioid use disorder but is not currently in treatment. While at the hospital, she experiences opioid withdrawal. A physician at the hospital begins methadone treatment. After 2 weeks, a plan was developed to discharge Lisa to a subacute rehabilitation facility to aid in her recovery following the fall. However, Lisa's discharge was delayed as she is not registered with an opioid treatment program (OTP). Further coordination was needed to admit Lisa to an OTP close to the subacute rehabilitation facility.

Example of Barriers: Scenario 2

Matt is 67 years-old and had been in an opioid treatment program (OTP), receiving methadone for his opioid use disorder (OUD). He has been going to his program for the past 10 years and is making great progress with many aspects of his life. Recently, Matt suffered a stroke and is no longer able to go to his OTP as frequently. With appropriate approvals put in place, Matt assigned his daughter as a designated other to pick up his methadone from the OTP on his behalf while he regains strength and mobility.

Barriers

- Regulatory differences between buprenorphine and methadone from a medication initiation point of view
- Ability to obtain methadone for the treatment of opioid use disorder only from an OTP
- Regulatory requirement for daily dosing
- Mobility challenges and co-occurring disorders
- Additional coordination
- inability to identify a designated other
- Nursing administration/medication storage
- Lack of education
- Stigma

Potential Solutions

- Existing, extended take-home flexibilities
- Designated other
- Telehealth (audiovisual or audio only) initiations for buprenorphine
- Coordination with Medicaid transportation
- Medication delivery service
- Mobile medication units (MMUs)
- Potential forthcoming Federal regulatory changes

Reducing Stigma

According to Johns Hopkins University School of Medicine's "Stigma of Addiction" online article, (2022):

"…Research demonstrates that **stigma damages the health and well-being of people with substance use disorder and interferes with the quality of care they receive in clinical settings**. Stigma towards people with substance use disorder can be seen at all levels of care within health care settings…"

Stigma of Addiction | Johns Hopkins Medicine

Stigma

Stigma in Health Care Settings

- Stigma includes attitudes, beliefs, behaviors, and structures at multiple levels (e.g., individuals, groups, organizations, systems) and can lead to prejudice or discrimination against people with mental health diagnoses and substance use disorders.
- Perpetuates stereotypes and assigns labels like dangerous, noncompliant or incapable of managing treatment, dirty, at fault, etc.
- Can be internalized to make people feel they are not deserving of being treated with dignity and respect
  - Fear, shame, and isolation
  - Feeling unwelcome, judged, or unworthy of seeking or receiving services
- Limits a person's ability or desire to access services
- Ultimately, stigma contributes to suboptimal (and sometimes traumatic) healthcare experiences and health outcomes

Stigma

Consider the Relationship of Stigma and Trauma

Realize that most people have experienced trauma

- Personal and/or generational/historical trauma
- People with a substance use disorder (SUD) are more likely to have experienced trauma, including trauma in healthcare or pharmacy settings

Recognize how trauma affects people

- Trauma impacts physical health; neurobiology; and cognitive, social, and emotional functioning
- Perceived “high-risk behaviors” can be a way of coping with trauma

Consider how past histories of trauma, violence, layers of disadvantage and stigma

- Consider how this may affect the way a person engages with providers and authority figures

Commit to not repeating trauma or creating more trauma (re-traumatizing)

What We Say and How We Say It Matters

The Real Stigma of Substance Use Disorders

In a study by the Recovery Research Institute, participants were asked how they felt about two people *"actively using drugs and alcohol."*

One person was referred to as a "substance abuser"

The other person as "having a substance use disorder"

No further information was given about these hypothetical individuals.

THE STUDY DISCOVERED THAT PARTICIPANTS FELT THE "SUBSTANCE ABUSER" WAS:

- less likely to benefit from treatment
- more likely to benefit from punishment
- more likely to be socially threatening
- more likely to be blamed for their substance related difficulties and less likely that their problem was the result of an innate dysfunction over which they had no control
- they were more able to control their substance use without help

- Words perpetuate stigma, especially when they imply fault or immorality
- Stigmatizing language in medical records or at the point of care not only affects how patients feel; it can also affect the care they receive for years to come by perpetuating bias among other providers or pharmacists
- Use person-centered language (e.g., patient with a substance use disorder)
- Use language that reflects an accurate, science-based understanding of SUD as a complex medical condition
  - Use clinically accurate, non-stigmatizing terminology
- Avoid moral judgments, assumptions, or subjective language

Best Practice to Avoid Use of Stigmatizing Language

BEST PRACTICES TO AVOID USING STIGMATIZING LANGUAGE

Don't Use	Do Use	Why
"addict" *"abuser"* *"junkie"*	*"person who uses heroin"* *"person with cocaine use disorder"*	*Using "person-first" language demonstrates that you value the person, and are not defining them by their drug use.*
"got clean"	*"no longer uses drugs"*	*"Clean," although a positive word, implies that when someone is using they are "dirty."*

https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/

Best Practice to Avoid Use of Stigmatizing Language

Deficits-Based	Strengths-Based
Addict	Person with a substance use disorder
Frequent Flyer	Utilizes services and supports when necessary
Hostile, Aggressive	Protective
Helpless/Hopeless	Unaware of capabilities/ opportunities
Mentally ill	Person with a mental illness
Lazy	Ambivalent, Working to build hope
Manipulative	Resourceful
Unfit parent	Person experiencing barriers to successful parenting
Resistant	Chooses not to, Isn't ready for, Not open to
Suffering with	Working to recover from; experiencing; living with
Abuses the system	Good self-advocate
Weaknesses	Barriers to change or needs

https://practicetransformation.umn.edu/clinical-tools/person-centered-language/

How Can You Help?

Questions?