

# Low Barrier Access to MAT



## Today's Facilitator

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Department of Family Medicine



## In Conversation With



**County of Santa Cruz** *California*  
*Serving the Community ~ Working for the Future*

# Agenda

- Overview: Low Barrier Access to MAT and Medication First
- Speaker Introductions
  - Approach at Family Health Centers of San Diego
  - Approach at County of Santa Cruz
- Discussion
- Closing



# Overview



# Major Features of Buprenorphine

## **Partial agonist** at mu receptor

- Comparatively minimal respiratory suppression and no respiratory arrest when used as prescribed

## **Long acting**

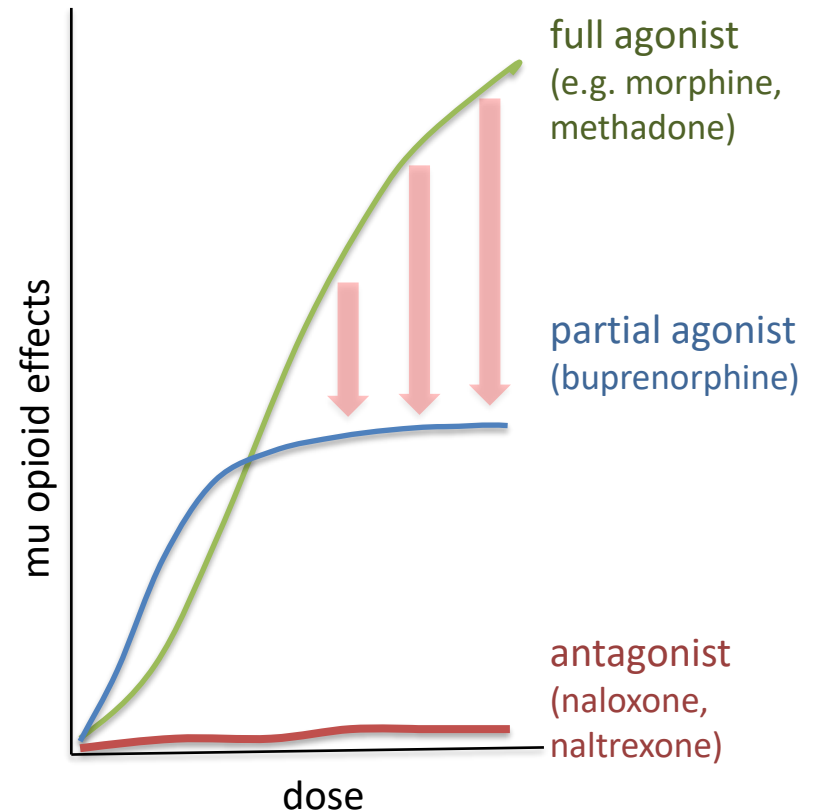
- Half-life ~ 24-36 Hours

## **High affinity** for mu receptor

- Blocks other opioids
- Displaces other opioids
  - Can precipitate withdrawal

## **Slow dissociation** from mu receptor

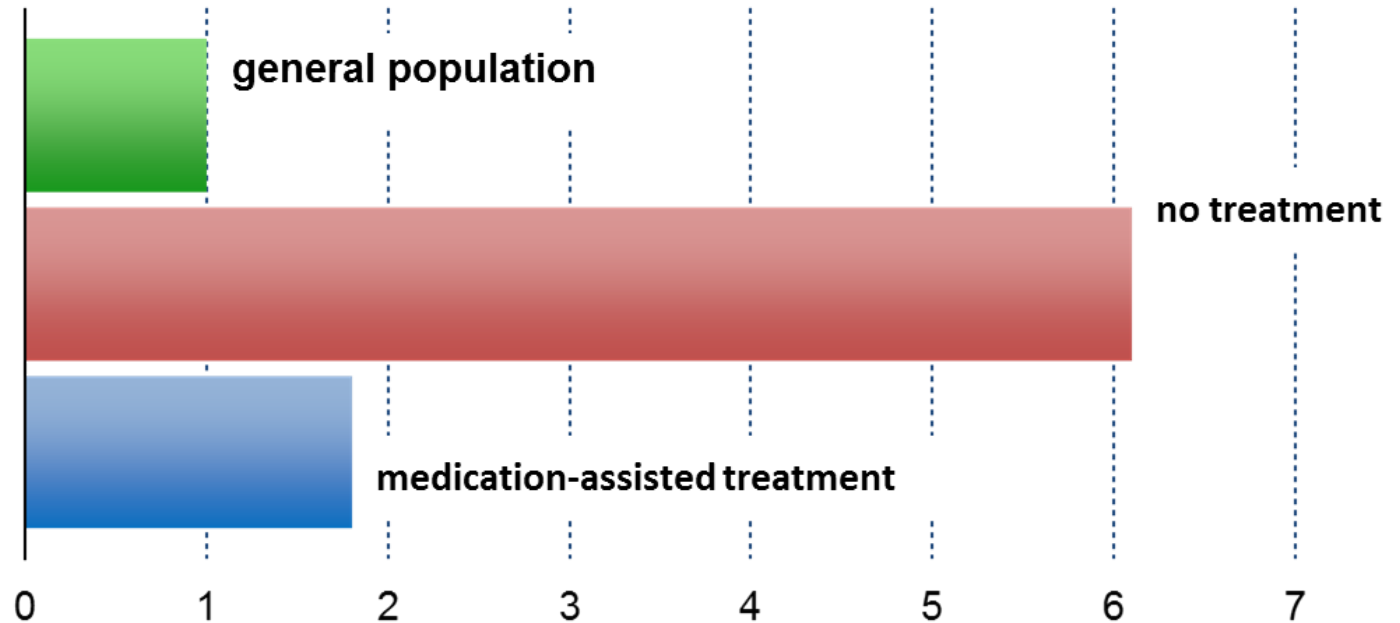
- Stays on receptor for a long time



SAMHSA, 2018  
Orman & Keating, 2009

# Benefits of MAT: Decreased Mortality

## Death rates:

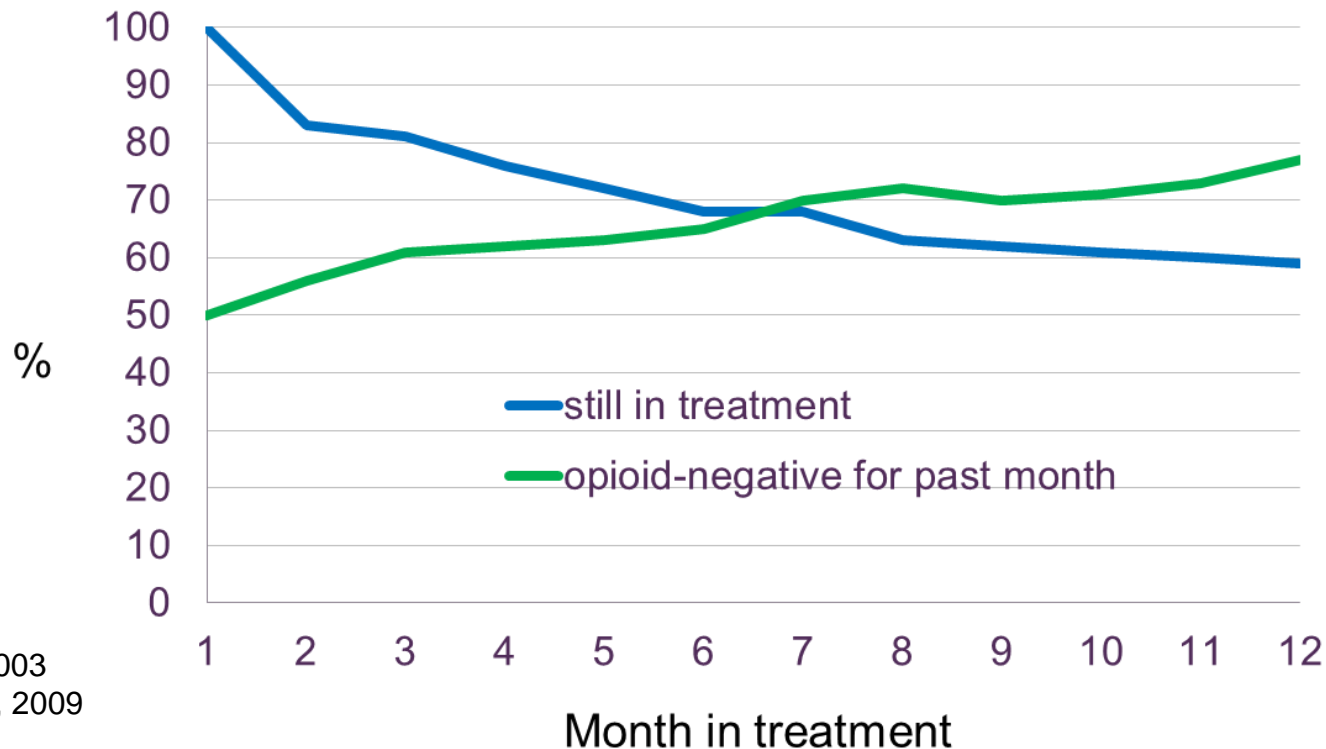


Dupouy et al., 2017  
Evans et al., 2015  
Sordo et al., 2017

Standardized Mortality Ratio

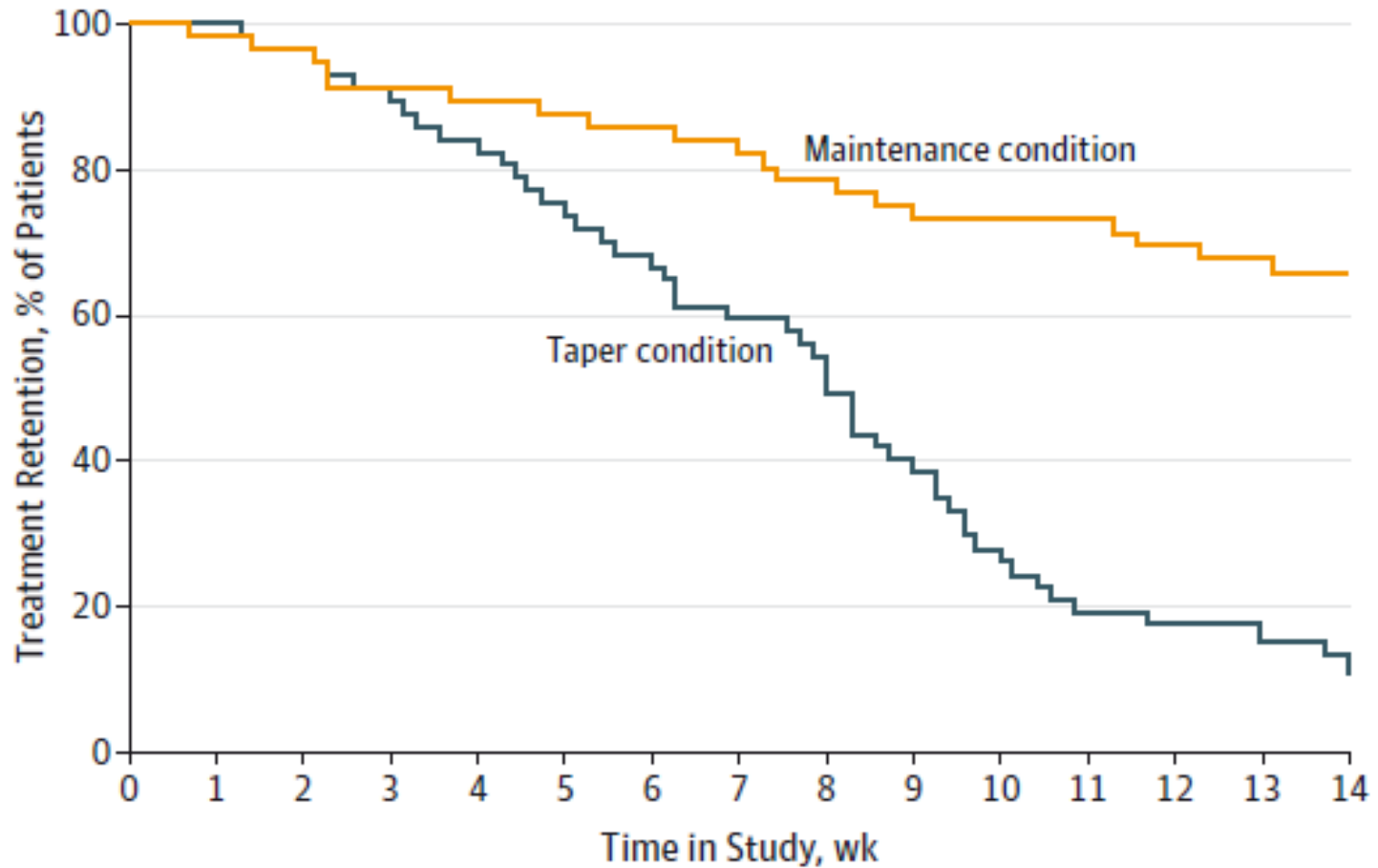
# Treatment Retention and Decreased Illicit Opioid Use on MAT

- Buprenorphine promotes retention, and those who remain in treatment become more likely over time to abstain from other opioids



Kakko et al, 2003  
Soeffing et al., 2009

# Treatment Retention and Buprenorphine Dosage

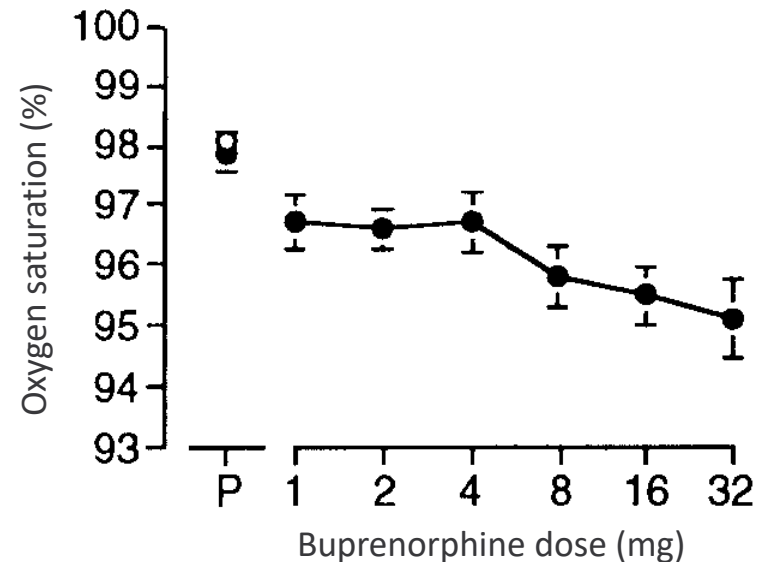
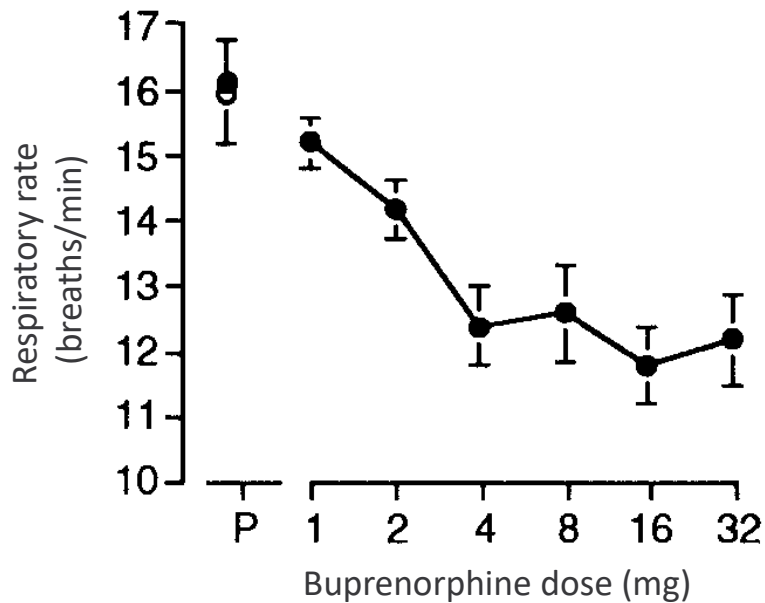


Fiellin et al., 2014



# Buprenorphine Dosing: Safety

- Cognitive and psychomotor effects appear to be negligible.
- Respiratory rate slowed but has as a plateau effect in adults.



- Nearly all fatal poisonings involve multiple substances

# Buprenorphine and Benzodiazepines

- Benzodiazepines are present in most fatal poisonings involving buprenorphine

<b>Human studies</b>	Minimal effects on respiration when both are taken at therapeutic doses
<b>Animal studies</b>	May remove the protective “ceiling effect” and allow buprenorphine to produce fatal respiratory suppression in overdose

- Used as prescribed benzodiazepines in combination with buprenorphine have been associated with more accidental injuries, but not with other safety or treatment outcomes

# Changes in FDA Recommendations

08/2016	09/2017
<ul style="list-style-type: none"><li>▪ Boxed Warning for combined use of opioid medicines with benzodiazepines or other CNS Depressants (e.g. Alcohol)</li><li>▪ Risks of slowed or difficult breathing; Sedation; Death</li></ul>	<ul style="list-style-type: none"><li>▪ Buprenorphine and methadone should not be withheld from patients taking benzodiazepines or other drugs that depress the central nervous system (CNS).</li><li>▪ The combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks.</li><li>▪ Careful medication management by health care professionals can reduce these risks.</li></ul>

# Diversion of Buprenorphine

- Primary motivation for diverted buprenorphine use is the abatement of withdrawal symptoms.
- In survey studies ~6% of participants report injecting buprenorphine “to get high”
- Steps taken to minimize buprenorphine diversion and misuse must be careful not to undermine the positive patient and public health benefits gained from expanded treatment access.

Lofwall, M. R., & Walsh, S. L. (2014). A review of buprenorphine diversion and misuse: the current evidence base and experiences from around the world. *Journal of addiction medicine*, 8(5), 315.

<http://pubmed.ncbi.nlm.nih.gov/25221984>



Providers  
Clinical Support  
System

# Medication FIRST Model

- People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatments planning sessions;
- Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
- Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
- Pharmacotherapy is discontinued only if it is worsening the person's condition.

<http://www.nomodeaths.org/medication-first-implementation>

# Medication FIRST Model

- Medication *first does not mean* Medication *only*
- Medication is contingent upon the patient's benefit, not based upon a timeframe, patient's participation in counseling, an unexpectedly positive test result, etc.

<http://www.nomodeaths.org/medication-first-implementation>



In Opioid Use Disorder:  
Adding psychosocial support does  
not change the effectiveness of  
retention in treatment and opiate  
use during treatment.

Amato L, Minozzi S, Davoli M, Vecchi S. Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. Cochrane Database of Systematic Reviews 2011, Issue 10. Art. No.: CD004147. DOI: 10.1002/14651858.CD004147.pub4

# Questions?





# Family Health Centers of San Diego



Ernie Taimanglo, MC, CADC II  
Program Supervisor – BHI/SUD  
Services

# Santa Cruz County Health Services Agency



Danny Contreras, SUDCC III-CS  
Health Services Manager  
MAT Program

# Discussion



# Discussion

- What's getting in the way of providing low barrier access to medications?
- What has worked in your clinic in promoting low-barrier access?

- Join the conversation!
- Use the chat box or unmute (\*6) to share your experience

# Next Steps



The breakout room will close at 1:50 pm and you'll be automatically sent back to the main Zoom room (your line will be muted)



Please fill out the poll/survey.



Thank you!