Overdose Prevention Task Force – National Toolkit for Advocacy

Introduction

The Overdose Prevention Task Force (OPTF) was created in Spring 2019 in response to the rise in preventable overdose deaths across the nation. The OPTF focuses on six different public health initiatives that contribute to overdose deaths in our communities. These issues include Naloxone distribution, Harm Reduction, Stigma Reduction, Access to Care, Medication Assisted Treatment, and Recovery. The priorities and tactics guiding student action and advocacy are rooted in local and state laws, policies, and resources.

This toolkit was created to give medical students the tools to effectively advocate for systems changes within substance use treatment services and curriculum pertaining to substance use treatment services.

We hope you find this helpful in your advocacy journey.

Best,

Chrissa Karagiannis, OPTF Chair

Hannah Singleton, OPTF Vice Chair

Acknowledgements

This effort would not have been completed without the dedication and hard work of our current and past OPTF Chair and Regional Admins. The following students made significant contributions to the completion of the toolkit:

Chrissa Karagiannis, 2022-2023 OPTF Chair

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Pillar 1: Naloxone Distribution

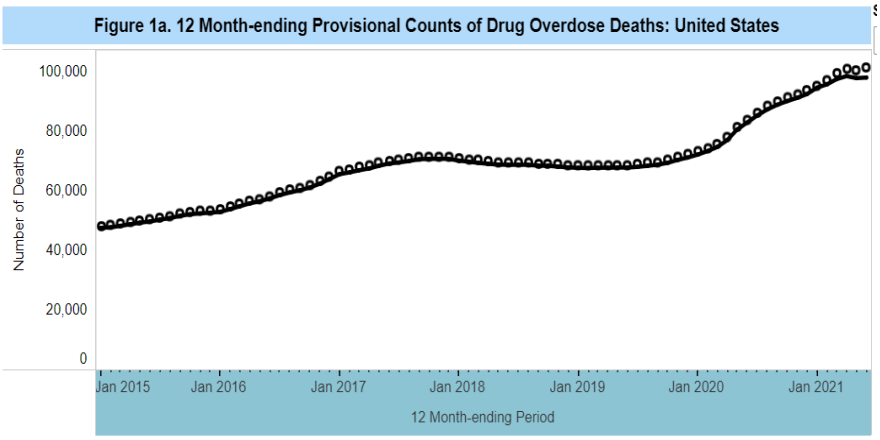
Problem Overview

What is an overdose?

Opioid overdoses occur secondary to excessive doses of opioids or a combination of opioids and other sedating drugs, resulting in slowing of respiration and inhibition of the medullary respiratory center from responding normally to the subsequent rise in CO_2. This leads to the development of inadequate respiration, decreased responsiveness and may lead to coma and death.[i]

Opioid overdose may also be referred to as **opioid poisoning**.

CDC's National Center for Health Statistics indicate that there were an estimated overdose deaths from opioids increased to **75,673 in the 12-month period ending in April 2021, up from 56,064 the year before**.[ii] There are projections of a further rise in overdose deaths in 2022.



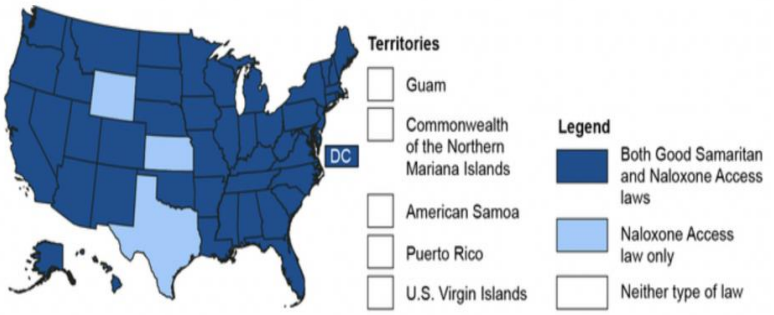
What is naloxone (brand name Narcan™)?

Naloxone is an opioid antagonist approved by the Food and Drug Administration (FDA) to rapidly reverse opioid-related overdose. It works by binding to opioid receptors and blocking the depressive effects on respiration by opioids such as heroin, morphine, fentanyl and oxycodone.[iii]

U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose: "Expanding the awareness and availability of this medication is a key part of the public health response to the opioid epidemic. Research shows that when naloxone and overdose education are available to community members, overdose deaths decrease in those communities. Therefore, increasing the availability and targeted distribution of naloxone is a critical component of our efforts to reduce opioid-related overdose deaths and, when combined with the availability of effective treatment, to ending the opioid epidemic."[iv]

Good Samaritan Laws: These are state laws stating that individuals who experience a drug overdose or persons who witness an overdose and seek help for the victim can no longer be prosecuted for possession of small amounts of drugs, paraphernalia, or underage drinking. It is important to know the laws in your state – [you can go to this document to learn more].

Figure: Jurisdictions with Good Samaritan and Naloxone Access Laws



Source: GAO analysis of jurisdiction laws. | GAO-21-248

The Need

Despite an increase in prescriptions for emergency opioid antagonists, **not enough of the medication is getting into the hands of those who need it most**.[v]

Key findings to naloxone availability:

- **Only one naloxone prescription** is dispensed for **every 70 high-dose opioid prescriptions** nationwide.
- Rural counties were nearly **3 times more likely to be a low-dispensing county** compared to metropolitan counties.
- Due to disparities in healthcare resources, there are **lower rates of access to naloxone** in lower socioeconomic areas, leading to overdose deaths **disproportionately affecting marginalized communities**.[vi]
- 48 jurisdictions currently carry Good Samaritan laws that serve to increase access to naloxone.[vii] Studies indicate that Good Samaritan laws contribute to a decrease in overdose deaths. However, Good Samaritan laws vary widely from state to state and may contribute to factors that affect a person's willingness to call 9-1-1.[viii]

Naloxone training and education for osteopathic medical students:

- Little data is available on the number of medical schools providing formalized overdose prevention training, and lack of education on naloxone may prevent access to treatment by providers.
- Barriers also exist in providing naloxone to third-party contacts of opiate users, despite the evidence that naloxone in the hands of bystanders reduces overdose deaths.[ix] One 2016 study on these barriers from medical students and providers towards naloxone as an opioid prevention strategy included: lack of knowledge or experience, medical community common practices and norms, insufficient provision of third-party education, physician and clinic scheduling practices, worry about insulting patients, and fear of being viewed as 'enabling' drug abuse[x]

Advocacy Tools: Call to Action

Medical students can reduce overdose deaths in our nation through advocacy efforts that address the opioid epidemic in their communities. The list of action items below is not comprehensive but serves as a guide to the myriad number of efforts students can make to affect change. Our suggestions are based on national guidelines[xi] and efforts and reviewed by leaders in addiction medicine policy in osteopathic medical education.

- Create an addiction medicine interest group, or an Overdose Prevention Task Force at your school
- Create a standardized addiction medicine curriculum in College of Medicine (COM) education including naloxone distribution, covering:
    - The importance of emergency opioid antagonists in preventing deaths from opioid overdose;
    - How to recognize the signs and symptoms of a drug overdose;
    - The essential steps in responding to a drug overdose
    - Where to obtain emergency opioid antagonists in your state
    - When to dispense naloxone
    - De-stigmatizing the possession of an emergency opioid antagonist
    - State laws limiting a person's civil and criminal liability for prescribing, dispensing, distributing, or administering emergency opioid antagonists (Good Samaritan Laws)
- Secure grants through the Provider Clinical Support System (PCSS) to improve curriculum for provide training in naloxone use and distribution
- Require naloxone training as part of basic life support training[xii]
- Ensuring good Samaritan laws are in place and grant immunity to individuals administering naloxone as well as those who receive it
- Endorse legislation requiring co-prescribing of an emergency opioid antagonist when a person is prescribed an opioid
- Require health insurance coverage of emergency opioid antagonists like naloxone and prohibit discriminatory life and health insurance practices related to the possession of naloxone
- Ensure standing orders exist for the distribution of naloxone widely throughout the state
- Endorse legislation eliminating naloxone access issues due to financial constraints
- Provide increased access to opioid antagonists in educational institutions and correctional settings
- Ensuring access to naloxone through the creation of local or state naloxone distribution programs, especially in marginalized and underserved communities
- Educating community members on naloxone administration and dispelling myths surrounding enabling substance users by giving a life-saving medication

We encourage all OPTF chapters to adopt one or more of these advocacy items to tackle in their community. Please reach out to us to discuss further.

Pillar 2: Harm Reduction

Problem Overview

What is harm reduction?

Harm reduction is the **various strategies and initiatives directed toward reducing the negative consequences associated with drug use**. It is a national movement and a call for social justice and respect for those with a substance use disorder. It may also be defined as a "proactive and evidence-based approach to reduce the negative personal and public health impacts of behavior associated with alcohol and other substance use at both the individual and community level".[xiii]

There are various approaches to harm reduction that include but are not limited to: naloxone training/distribution within a community, needle and syringe distribution programs, supervised consumption sites, non-abstinence housing, and community mobilization for rights protection.[xiv]

The National Harm Reduction Coalition outlines 8 key principles that should be at the center of any harm reduction initiative:[xv]

1. Accepts for better or worse that licit and illicit drug use is **part of our world** and chooses to work to minimize its harmful effects rather than simply ignore or condemn them
2. Understand drug use as a **complex, multi-faceted phenomenon** that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others
3. Establishes quality of individual and community life and well-being – **not necessarily cessation of all drug use** – as the criteria for successful interventions and policies
4. Calls for **non-judgmental, non-coercive** provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm
5. Ensures that people who use drugs and those with a history of drug use routinely **have a real voice** in the creation of programs and policies designed to serve them
6. Affirms people who uses drugs themselves as the **primary agents of reducing the harms of their drug use** and seeks to **empower them** to share information and support each other in strategies which meet their actual conditions of use
7. Recognize that the **realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequities** affect both people's vulnerability to and capacity for effectively dealing with drug-related harm
8. Does not attempt to minimize or ignore **the real and tragic harm and danger** that can be associated with illicit drug use

The Need

Why is harm reduction important?

As overdose deaths continue to rise in the United States, harm reduction services are going to be critical to address this public health crisis.

Harm Reduction and Osteopathic Medical Students

- At this time there is **not concrete data** on the current osteopathic medical schools that spend time teaching their students about harm reduction
- Medical students often choose to participating in unofficial special interest groups at their individual medical schools
- The U.S. Department of Health and Human Services **provides in-depth resources on the current overdose prevention strategies** that have thus far been initiated by the National Institute of Health (NIH), Centers for Disease Control (CDC), Food and Drug Administration (FDA) and Substance Abuse and Mental Health Services Administration (SAMHSA). These may serve as resources for students and include:[xvi]
    - Evidence-based use of Fentanyl Testing Strips and drug checking utilization in community and clinical settings
    - Implementing comprehensive HIV services in syringe services program
    - Widening access to opioid overdose reversal treatments (naloxone)
    - Harm Reduction Technical Assistance Program
    - Harm Reduction Grants
    - Mobile crisis intervention services planning grants and state option in Medicaid
    - Stop Overdose Campaign (CDC)

The Substance Abuse and Mental Health Services Administration (SAMHSA) outlines specific prevention goals with the associated harm reduction activities:

Prevention Goals	Related Harm Reduction Activities*
• Reduce the spread of sexually transmitted and other blood-borne infections, including HIV and viral hepatitis • Increase knowledge around safer sex and sexual health	• Access to PrEP • Access to HIV and viral hepatitis testing and treatment • Access to condoms • Comprehensive sex education
• Reduce overdose deaths and other early deaths among people who use substances, including alcohol • Increase knowledge around safer substance use	• Syringe service programs • Fentanyl test strips • Naloxone and overdose education kits
• Reduce sharing of substance use equipment • Improve physical health • Reduce the spread of infectious diseases	• Sterile syringes and other injection equipment to prevent and control the spread of infectious diseases • Syringe Service Programs • Safe smoking supplies • Medical care including wound care • Use of masks, social distancing, and vaccines
• Reduce stigma and increase access to health services • Increase referrals to support programs and health and social services (including treatment and recovery support services)	• Counseling • Motivational interviewing • Low threshold medication for opioid use disorder • Fentanyl test strips • Naloxone and overdose education kits • Peer support specialists • Case managers

Advocacy Tools: Call to Action

Due to the current lack of education and involvement of osteopathic medical students in harm reduction strategies it is important to take the necessary advocacy efforts to increase awareness of harm reduction strategies. Harm reduction should be an integral part of medical student education as well as promote further involvement in the local communities. The following list may serve as a guide of how medical students can further educate themselves and others on the current harm reduction initiatives that have already been established by national agencies.

- If financially doable, students could complete the Foundations of Harm Reduction online training to understand the core principles and stigmas associated with harm reduction.[xvii] Students may also consider applying for a grant for medical students to have free access to the training.
- Encourage establishing mandatory PCSS DATA Waiver Training at each osteopathic medical school so that students may review and identify evidence-based treatments, pharmacology of opioids, and appropriate management of opioid use disorder. Completing the training results in eligibility for a waiver that allows you to treat up to 100 patients with certain forms of buprenorphine for the treatment of opioid use disorders after obtaining your DEA license.
- Consider obtaining a PCSS grant to provide access to the above training[xviii]
- Choose one of the following specific harm reduction interests and establish where in their community they can assist:[xix]
    - Syringe access
    - Overdose prevention
    - Safer drug use
    - Fentanyl test strip availability
    - Medication for opioid use disorder
    - Sex work
    - HIV and Hepatitis C testing and treatment access
    - Supervised Consumption services
- As substance use disorder education is a critical part in understanding harm reduction, the CDC provides education in the Stop Overdose Campaign. This information may be used to create a presentation and generate conversation at your school[xx]
- Support and partner with organizations that practice harm reduction[xxi]
- Along with Basic Life Training, incorporate naloxone training and other harm reduction techniques available to those with substance use disorder
- Increasing research into incorporating harm reduction in osteopathic medical education

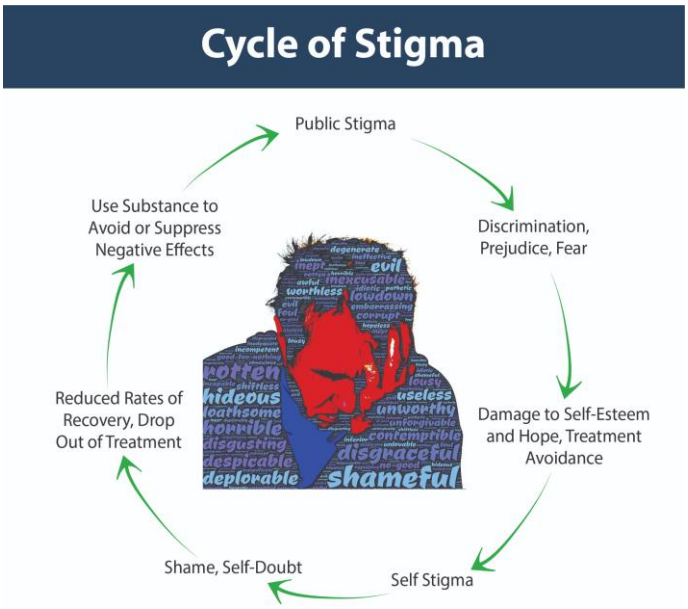
The OPTF encourages all COM leaders to choose one to two of the following initiatives to incorporate into their task force and local community.

Pillar 3: Stigma Reduction

Problem Overview

Stigma is defined as "a mark of disgrace associated with a particular circumstance".[xxii] Health-care related stigma is described as the discrimination that results from negative views and stereotypes associated with a health condition[xxiii].

Patients are often blamed for their substance use disorder.[xxiv] As such, addiction continues to be seen as a moral failing rather than **a health condition and disease**. This discrimination can come from health care providers, communities, and even individuals that have a stigmatized condition.



Why Does Stigma Matter?

Misguided negative beliefs can lead to discrimination in all areas, from trouble getting employment to social isolation. In health care, stigma can affect the way providers treat patients informing their decisions, words and actions. Research has shown that stigma towards Substance Use is associated with low mental and physical health outcomes[xxv].

Current stigmas surrounding Opioid Use Disorder (OUD) and Medications for Opioid Use Disorder (MOUD) prevent adequate access to care, ranging from beliefs that patients cannot be treated, to viewing OUD as a chosen lifestyle. Negative attitudes toward MOUD lead to physician and pharmacist reluctance to dispense.

Self-stigma is strengthened by **public stigma and continues a detrimental cycle**[xxvi]. For those in recovery, experiencing the blame influenced by stigma can perpetuate a negative view of themselves and shame. Medical students can play a part in **breaking the cycle of stigma** and be a part of creating a **safer healthcare environment for future patients**.

The Need

Many healthcare professionals hold negative views towards patients with substance use problems, and often this is simply because providers had not been told otherwise of the detrimental impacts of their stigma at any point in their training or education[xxvii].

We can begin early in medical education to combat the negative stereotypes by incorporating stigma reduction training into the curriculum. There are many ways and points to intervene. And it's not too late for the health care professionals to change their attitudes towards patients.

Advocacy Tools: Call to Action

Even the smallest step in bringing awareness to stigma reduction can go a long way. The following list may serve as a guide of how medical students can further educate themselves and others on the stigma reduction initiatives that have already been established by national agencies.

- Create events at your school and within your community that:
    - Consider how stigma has impacted your perception of individuals using substances
    - Create goals to decrease stigma towards individuals using substances
- Ensure that your learning material, presentations, and lecturers are using non-stigmatizing language ("substance use" or "substance misuse" instead of "substance ***abuse***")
- Advocate for your institution and all osteopathic institutions to incorporate education on stigma reduction for all medical schools
- Reach out to your SOMA representative to write a resolution on reducing stigmatizing language in substance use curriculum
- Host a stigma awareness day at your school
- Invite someone who is in recovery to speak on stigma and how they have seen it impact them personally
- Incorporate all of these calls to action in a day of educational activities and community bonding
- Ask your school to post educational infographics on stigma reduction on your school's social media sites
- Stigma reduction comes from using and enacting all the other actions in this toolkit while being:
    - Mindful
    - Kind
    - Open
    - Present and open with your peers

The OPTF encourages all COM leaders to choose one to two of the following initiatives to incorporate into their task force and local community.

Pillar 4: Access to Care

Problem Overview

The Office of Disease Prevention and Health Promotion defines access to care as **"lowering costs, improving insurance coverage, and increasing the use of telehealth"**.[xxviii] Over 2 million people in the United States have an opioid use disorder (OUD). In 2017, **70% of people in the United States who needed treatment for OUD did not receive it**[xxix] . Physician and insurance coverage shortages, limited options for OUD care, providers' stigma, lack of training, etc. are all examples of current barriers to accessing OUD care[24].

Overall, substance use disorder (SUD) treatment services lack capacity to adequately address the current need in all areas (methamphetamines, alcohol, opioids, etc.)[xxx]. Treatment for SUDs has been generally **seen as a social or criminal problem**, rendering health care services for SUDs incredibly limited[25]. Current substance use treatment services for opioids include pharmacotherapies (methadone, buprenorphine, and naltrexone), behavior counseling, case management, and peer support. Lack of access to health care, federal grant funding, and convoluted regulations form gaps in accessing these treatments.

The Need

Medications for Opioid Use Disorders (MOUDs), as stated by Substance Abuse and Mental Health Services Administration (SAMHSA), has proven to **significantly reduce need for inpatient detoxification services, improve patient survival and retention in treatment, and decrease illicit opiate use and other criminal activity among those with substance use disorders**[xxxi].

However, prescriptions for buprenorphine/naloxone (Suboxone™) require qualifying certification – the X-waiver. If a prescriber wants to prescribe for more than 100 patients at one time they are required to complete an 8-hour X-waiver training not required in medical school of residency, then submitting a Notification of Intent (NOI) to the SAMHSA and then receiving the waiver from the DEA. **Fewer than 10% of physicians have completed the training, creating a significant barrier to Opioid Use Disorder (OUD)** treatment.[24]

Many opioid treatment programs do not offer all forms of MOUDs, leaving patients without the option to choose the medication that might work best for them[24].

Lack of insurance coverage and price of treatment services also create a financial barrier for patients. Currently, the average out-of-pocket cost for a thirty-day supply of buprenorphine-naloxone is $202.25[xxxii] and methadone is $42.48[xxxiii]. Medicare covers OUD, but you must enroll in Medicare D to receive covered care. Medicaid covers OUD, but there are strict program rules, and since it is set by each state, standards of care vary by state[24].

All in all, there are significant barriers to SUD/OUD are largely policy and education based. Better financial programs, insurance coverage, and advocacy for political change can improve access to care.

Call to Action

Access to care gaps can be overcome through local and national action. Below is a non-exhaustive list of ways your chapter can become more involved in policy and educational actions to improve access to care.

- Adding addiction medicine and medical assisted therapies for opioid use disorder training to your core competencies in medical curriculum, and eventually to national boards
- Participate in harm reduction courses to reduce personal stigmas
- Enroll and complete the DATA X Waiver training
- Conduct Narcan trainings or participate in a Narcan training to help mitigate overdoses as access to care is limited
- Advocate:
  - to remove physician barriers to prescribing MOUDs e.g., removing X-Waiver requirements to prescribe buprenorphine OR require X-Waiver training in residency or medical school curriculums
  - for additional funding to increase physician shortages, trainings, loan repayments etc.
  - for standardizing MOUD programs by state e.g., expanding Medicaid and Medicare
  - for larger budgets for MOUD treatment programs
  - for good Samaritan laws in your state if one does not currently exist for opioid overdose
  - for "warm handoff" programs in your area
- Educate your peers on current gaps in access to care by:
  - creating informational graphics and distribute accordingly
  - assign members of SOMA/OPTF to research current policies and create plans to address any issues
  - host Data X Waiver trainings as an event your student body can participate in e.g., attending the same training together

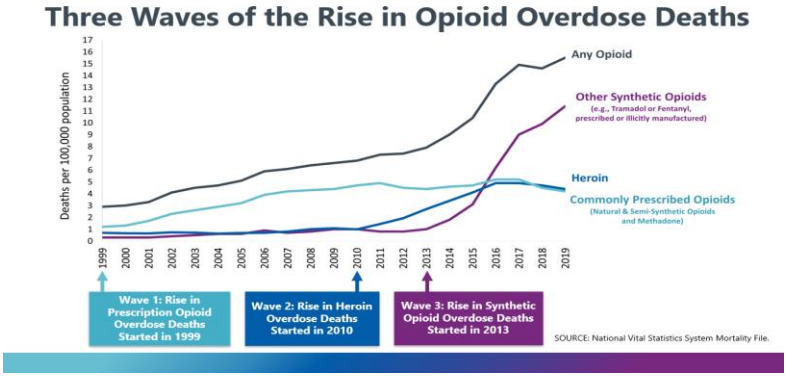
The OPTF encourages all COM leaders to choose one to two of the following initiatives to incorporate into their task force and local community.

Pillar 5: Medication for Opioid Use Disorder (formerly known as Medication Assisted Treatment or MAT)

Problem Overview

Current State of Opioid Addiction and Opioid-Related Overdose Deaths Nationwide

There have been three major waves in the rise of opioid overdose deaths: first when there was an increase in prescription opioid overdose deaths in the late '90s, second when there was a rise in heroin specific overdose deaths beginning in 2010, and finally when overdose deaths were impacted by the rise in synthetic opioids, i.e. fentanyl, beginning in 2013[xxxiv].



What is Medication Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD)?

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), medication-assisted treatment, **or MAT, "is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders[xxxv]"**. All medications available for use in MAT have been given approval and authorization for use by the FDA. MAT options are available for opioid, nicotine and alcohol addiction.

What Medications are Available for MAT for Substance Use Disorders?

Buprenorphine - suppresses and reduces cravings for opioids[xxxvi]
Methadone - reduces opioid cravings and withdrawal, blunts effects of opioids
Naltrexone - blocks the euphoric and sedative effects of opioids and alcohol
Acamprosate - anti-craving drug thought to interact with neuronal NMDA receptors and calcium channels, of which are implicated in the induction of alcohol dependence[xxxvii]

Table 1
FDA-Approved Drugs Used in MAT[21]

Medication	Mechanism of action	Route of administration	Dosing frequency	Available through
Methadone	Full agonist	Available in pill, liquid, and wafer forms	Daily	Opioid treatment program
Buprenorphine	Partial agonist	Pill or film (placed inside the cheek or under the tongue)	Daily	Any prescriber with the appropriate waiver
		Implant (inserted beneath the skin)	Every six months	
Naltrexone	Antagonist	Oral formulations	Daily	Any health care provider with prescribing authority
		Extended-release injectable formulation	Monthly	

Disulfiram - inhibits the enzyme acetaldehyde dehydrogenase 1 which leads to an increased amount of acetaldehyde in the body, a metabolite of alcohol, resulting in unpleasant symptoms such as diaphoresis, nausea, vomiting, tachycardia [xxxviii]
Nicotine Replacement Therapy – provides nicotine without harmful chemicals found in tobacco. NRT can help relieve some of the physical withdrawal symptoms so that patients can focus on the psychological (emotional) aspects of quitting[xxxix]
Varenicline - blocks the ability of nicotine to activate receptors which stimulate the central nervous mesolimbic dopamine system, believed to be the neuronal mechanism underlying reinforcement and reward experienced upon smoking[xl]
Buproprion - exhibits reasonable efficacy as a smoking cessation aid, yet its precise mechanisms of action remain unclear[xli]

The Need

Despite the availability of these medications for use in treatment of substance use disorders, there are several barriers that inhibit these treatment options from reaching their full potential to positively impact the opioid epidemic[xlii]. For example, one study found **that less than 50% of privately funded SUD treatment programs even offer MOUD** and only approximately **33% of the patients with OUD at the same programs receive it**[xliii]. While MAT exists for both alcohol use disorder (AUD) and opioid use disorder, OUD treatment is further complicated by the need for a special waiver to prescribe MAT, unlike the medications for alcohol use disorder (AUD) which can be prescribed by any provider. Read below to further understand some of the barriers inhibiting broad use of these medications.

Drug Addiction Treatment Act of 2000 (DATA 2000)

The DATA 2000 Waiver permits providers who meet the appropriate requirements to prescribe buprenorphine above the 30 patient limit (methadone can only be prescribed by specially licensed clinics, thus the DATA 2000 Waiver does not permit prescription of methadone). Originally, providers who wished to obtain a waiver had to be a licensed healthcare provider with an active DEA number and file a notice of intent (NOI) to SAMHSA verifying they are qualified and ready to prescribe after completing the appropriate training. The waiver is currently available to physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse-midwives. **Waivers allow a provider to prescribe MAT for up to 30, 100, or 275 patients depending on certain factors, such as experience level, board certification, and practice setting.**

Recent changes to the guidelines have allowed for an alternative NOI to be used for those seeking to treat only up to 30 patients. This new NOI process allows providers who only wish to prescribe buprenorphine for up to 30 patients to forgo the required training required by the original DATA 2000 Waiver guidelines. The hope is that this alternative NOI process will be attractive to physicians who wish to prescribe buprenorphine but have felt limited by the original waiver guidelines/requirements for any given reason.

Understanding the Issue

A previous study found that from 2007-2017, there were 17.3 providers with waivers to prescribe buprenorphine for every 100,000 people. **Of those with waivers, 72% were approved to prescribe to up to 30 patients, 22% for up to 100 patients, and 6% for a maximum of 275 patients**[xliv].

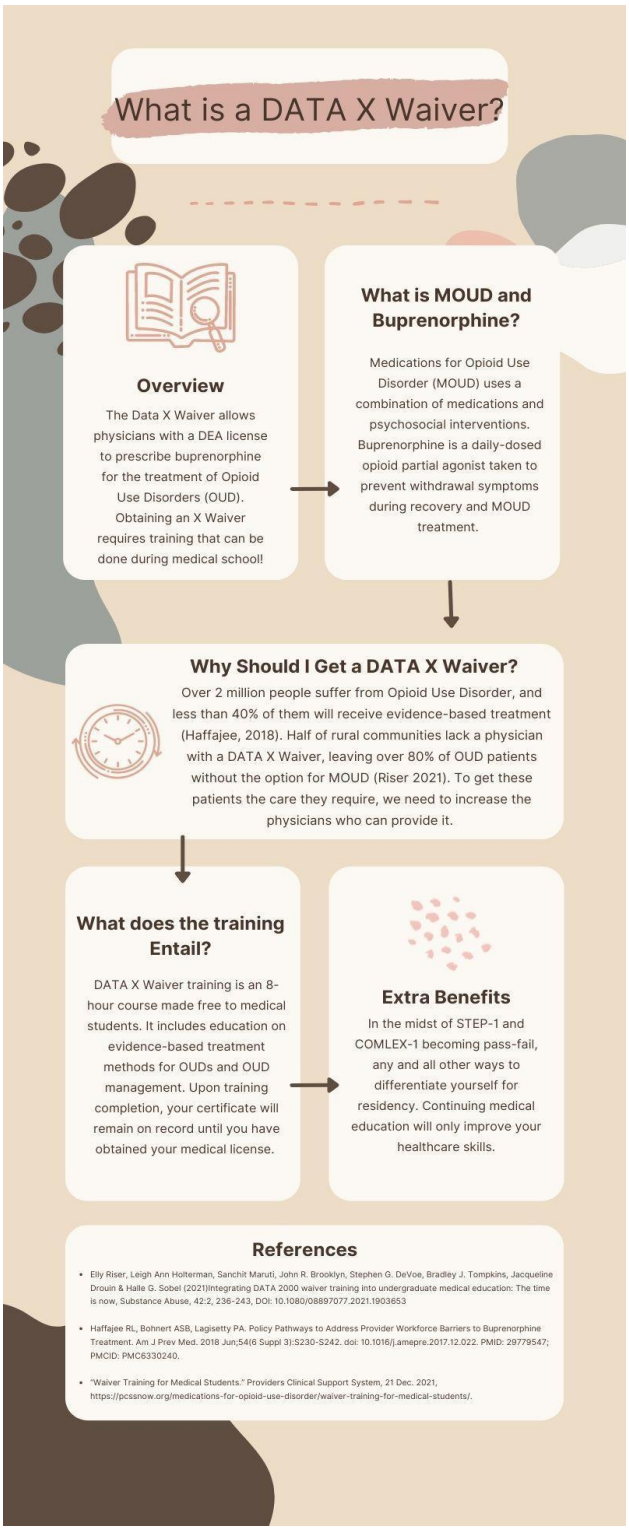
According to the Department of Health and Human Services, as of 2/12/2022, there were 1.27 million Americans receiving medication-assisted treatment and a 106% increase in total DATA waived providers from January 2017 to June 2019[xlv]. This is a great start, but it is currently estimated that over 2 million people in the United States currently have opioid use disorder,[xlvi] so there is still room to expand!

Advocacy Tools: Call to Action

Below is a non-exhaustive list of ways your chapter can become more involved in policy and educational actions to improve access to medications for substance use disorder.

- Encourage mandating of fellow osteopathic medical students to complete the DATA 2000 Waiver training prior to graduation and increase advertising of this training to practicing healthcare providers
  - DATA Waiver training is available to medical students at any time utilizing a self-paced training option (registration link included in supplemental resources)
  - **While DATA Waiver training is currently required to be able to prescribe MAT to >30 patients, we recognize that the waiver requirement is a barrier to MAT access, and we ultimately hope to see the requirement be eliminated in the future to increase prescription and access capability*
- Create a standardized curriculum in medical education on medication-assisted treatment (MAT)/medication for opioid use disorder (MOUD) that covers:
  - What medication-assisted treatment/medication for opioid use disorder is
  - Descriptions of each medication available for use in MAT/MOUD, including their class, mechanism of action, side effects, and consideration for use
- *Event idea*: host a panel of local healthcare providers who are prescribing MAT/MOUD to share their experiences around getting trained/certified to prescribe, efficacy of treatment, logistics surrounding incorporating into clinical practice; considering inviting a patient who has or is currently utilizing MAT/MOUD to share their experience
- Advocate for all health insurance companies to cover the cost of medications being used for MAT/MOUD

We encourage all OPTF chapters to adopt one or more of these advocacy items to tackle in their community. Please reach out to us to discuss further.



Pillar 6: Recovery

Problem Overview

Rates of substance use disorders (SUDs) and opioid addiction have been climbing across the nation. It is estimated **that over 16 million people are currently affected by opioid use disorder worldwide**[xlvii]. While much of the fight against the opioid epidemic has been focused on limiting access to opioids and attempting to prevent addiction in the first place, we need to ensure that we also focus on providing adequate resources for those who wish to seek treatment for their addiction and continued support for recovery. Current data suggests there are **about 25 million people who once met diagnostic criteria for SUD are currently in stable remission (1 year or longer)**[xlviii].

The Need

Some currently available resources for individuals with SUD include Alcoholics Anonymous and Narcotics Anonymous, local religious and non-religious support groups, and national hotlines. There are also specific organizations that support healthcare workers (physicians, nurses, medical students, etc.) who may be struggling with SUD, as it is estimated that **more than 100,000 healthcare workers battle addiction every day**[xlix]. The Federation of State Physician Health Programs, Inc. (FSPHP) is a nonprofit that provides confidential assessment, referral to treatment, resources and monitoring for physicians/healthcare professionals, as well as those in training who may be at risk of impairment from mental illness, substance use disorder or other conditions[l].

We need local physicians to be familiar with what treatment and recovery options are available in their communities such that they can share these resources to aid their patients who wish to seek treatment and support them through recovery. Additionally, stigma reduction efforts need to be emphasized to help ensure current healthcare providers are aware of the issue, understand the complexities of substance use disorders, and are able to adequately support their patients and peers facing SUD, not push them away.

Advocacy Tools: A Call to Actiom

Below is a non-exhaustive list of ways your chapter can become more involved in policy and educational actions to support recovery.

- Add education that helps with representation of individuals with lived experience in addiction and recovery
- Advocate for continued and expanded coverage of substance use treatments by health insurance companies
- Advocate for continued expansion of substance use education that includes a focus on **recovery** in medical curriculum
- Expand education in osteopathic medical schools regarding how to discuss substance use disorders and recovery candidly and respectfully with patients
- Create and provide a pamphlet of local substance use treatment centers and recovery resources in your area to share with medical students prior to their clinical years so they are aware of options for patients they might be seeing
- Host a panel of local substance use treatment providers and people in recovery to share their experiences and thoughts on how we can improve the system moving forward
    - If hosting a live panel isn't as feasible, follow this link to access real stories from people with SUDs provided via the CDC: https://www.cdc.gov/rxawareness/stories/index.html
- Encourage medical students to complete DATA Waiver training prior to graduation so they are prepared to start prescribing medication for opioid use disorder when they enter the workforce

We encourage all OPTF chapters to adopt one or more of these advocacy items to tackle in their community. Please reach out to us to discuss further.

Supplemental Resources

Recovery

Health insurance coverage information:

- https://www.hhs.gov/opioids/treatment/insurance-coverage/index.html
- https://www.hhs.gov/programs/health-insurance/mental-health-substance-use-insurance-help/index.html

Find local resources:

- https://findtreatment.samhsa.gov/
- https://www.na.org/meetingsearch/
- https://www.cdc.gov/rxawareness/treatment/index.html

MOUD Pillar

DATA 2000 X waiver Information
Self-Paced Registration:
https://education.sudtraining.org/Public/Catalog/Details.aspx?id=PseLqOPrAbFh%2fGDQ7xJJDg%3d%3d

What is a DATA X Waiver?

A DATA X Waiver (DEA X Waiver) allows you to prescribe buprenorphine for the treatment of Opioid Use Disorders (OUD) as a physician. You will use your DATA Waiver Training certification to apply for the DATA X waiver once you have obtained your DEA license (the certificate that allows you to prescribe controlled substances as a physician). DATA Waiver Training certificates do not expire, and will be kept on record for you.

What are Medications for Opioid Use Disorder (MOUD) and Buprenorphine?

"Medications for Opioid Use Disorder (MOUD) uses a combination of medications that targets the brain, and psychosocial interventions (e.g., counseling, skills development)" to improve treatment outcomes for patients with OUDs (PCSS). Buprenorphine is a daily-dosed opioid partial agonist taken as a replacement agent in the treatment of withdrawal symptoms in heroin and methadone dependence. Buprenorphine is a safer option than other agents because of its 'ceiling effect' in which increasing the dose beyond 24 mg does not increase effects on cardiovascular or respiratory function (PCSS). Importantly, utilization of MOUDs such as buprenorphine is supplementary to other psychosocial OUD interventions such as counseling and social services.

Why should you obtain your DATA X waiver as a medical student?

We are entering the medical field in the midst of an opioid epidemic of which many physicians lack the tools to contribute solutions to. Over 2 million people suffer from Opioid Use Disorder, and less than 40% of them will receive evidence-based treatment (Haffajee, 2018). In rural

areas conditions are worse. Half of rural communities lack a physician with a DATA waiver, leaving over 80% of Opioid Use Disorder patients without the option for MOUD (Riser 2021). DATA Waiver training will improve your clinical knowledge about OUDs, teach you of treatment options for your future patients, and elucidate the role physicians play in addressing substance use disorders in communities. There is already a push to incorporate DATA Waiver Training into medical school curriculum, however, that will likely occur after you graduate. Obtaining your certificate now shows residency programs that you are committed to addressing substance use disorders and the opioid epidemic as a physician.

What does the training entail?

DATA X Waiver training is an 8-hour course made free to medical students. The course includes education on evidence-based treatment methods for OUDs, pharmacology of opioids, incorporation of buprenorphine into treatment, and OUD management in general. Once you complete the training, your certificate will remain on record until you have obtained your medical license. At that point, you will receive your DATA X Waiver and will be able to prescribe buprenorphine for patients with Opioid Use Disorder.

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