Bridge Over Troubled Waters

Tackling the Opioid Epidemic from the Banks of the Tennessee River

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Tennessee Hospital Association Annual Meeting

September 2024

BRIDGE TO RECOVERY

3 pm Icebreaker

How many of you live in Tennessee?

How many of you have children?

How many of you made a New Year's Resolution this year?
- How many of you kept that resolution?

How many of you have ever had the flu or COVID?

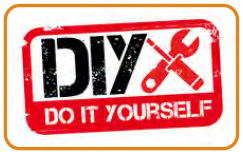
How many of you hold a leadership position in your organization?

Learning Objectives

Understand OUD basics and recognize the problems to solve to foster change amidst the opioid epidemic

Identify stigma and personal bias at your institution and deploy practical countermeasures

Recognize the importance of Health-Related Social Needs in the setting of Opioid Use Disorder



Understand the core components in developing your own DIY Opioid Use Disorder Treatment Program

* Nothing to Disclose

If we're going to fight the opioid epidemic together, we need to understand the basics of the disease

Common terms

PWUD – People Who Use Drugs

OUD – Opioid Use Disorder

MAT – Medication for Addiction Treatment

MOUD – Medication for Opioid Use Disorder

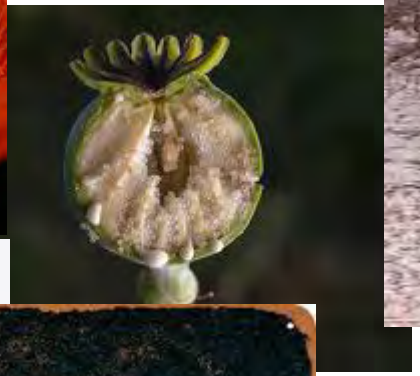
Certified Peer Recovery Specialist (CPRS) or Peer Navigator -

A person in recovery from substance use disorder, who has completed specialized training to serve as a role model, mentor, advocate and motivator to recovering individuals in order to help prevent relapse and promote long-term recovery.

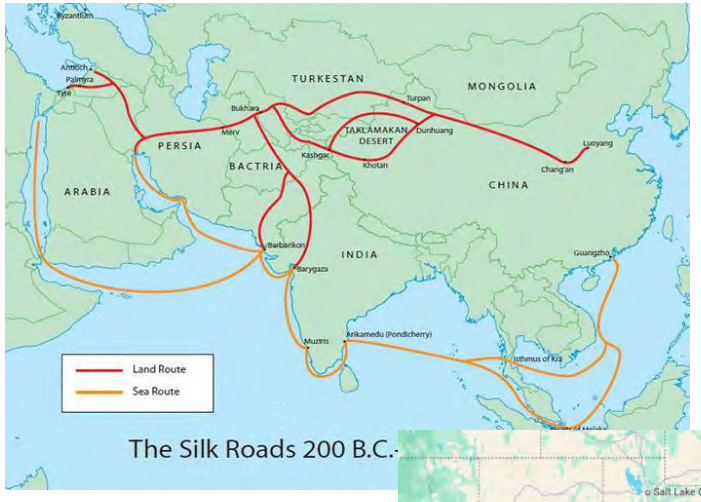
How did we get here?

A HISTORICAL PERSPECTIVE

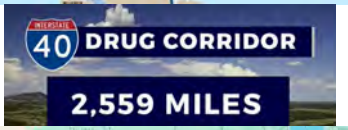
Opium “the joy plant” has been used for centuries for its medicinal and pleasurable properties. Ranging from seeds to smoke to syrup to patch to injection.

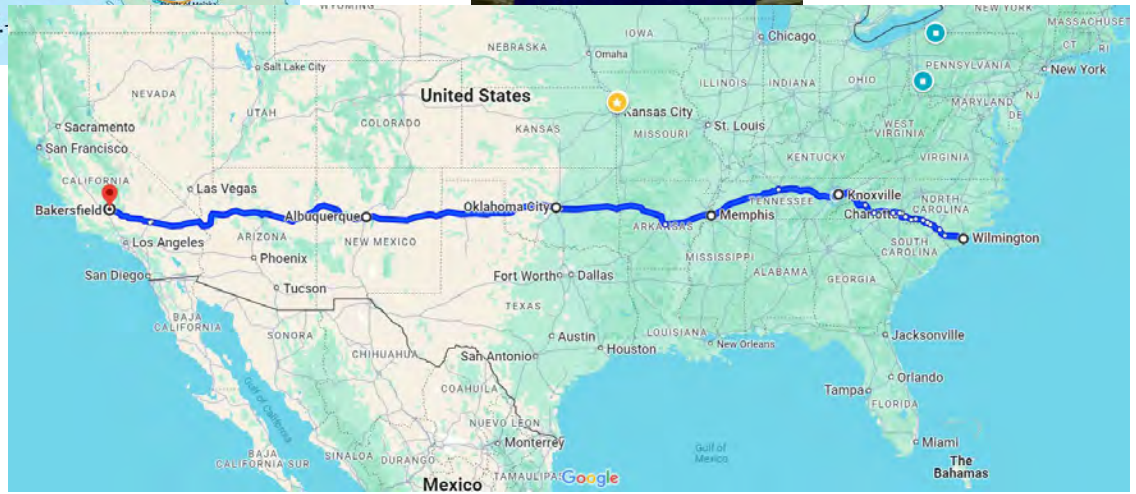


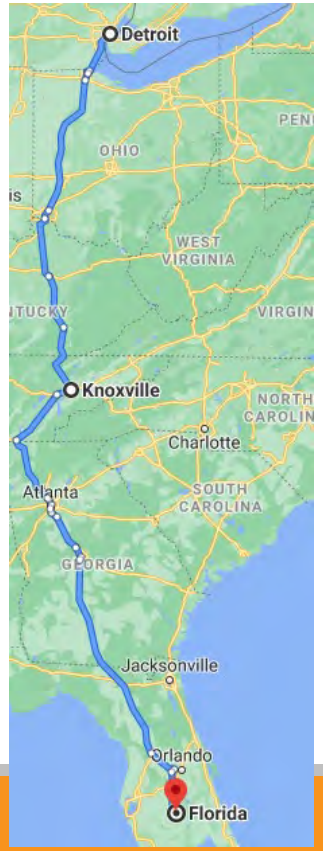
https://museum.dea.gov/exhibits/online-exhibits/cannabis-coca-and-poppy-natures-addictive-plants/opium-poppy#:~:text=The%20earliest%20reference%20to%20opium,it%20on%20to%20the%20Egyptians.



The Silk Roads 200 B.C.-

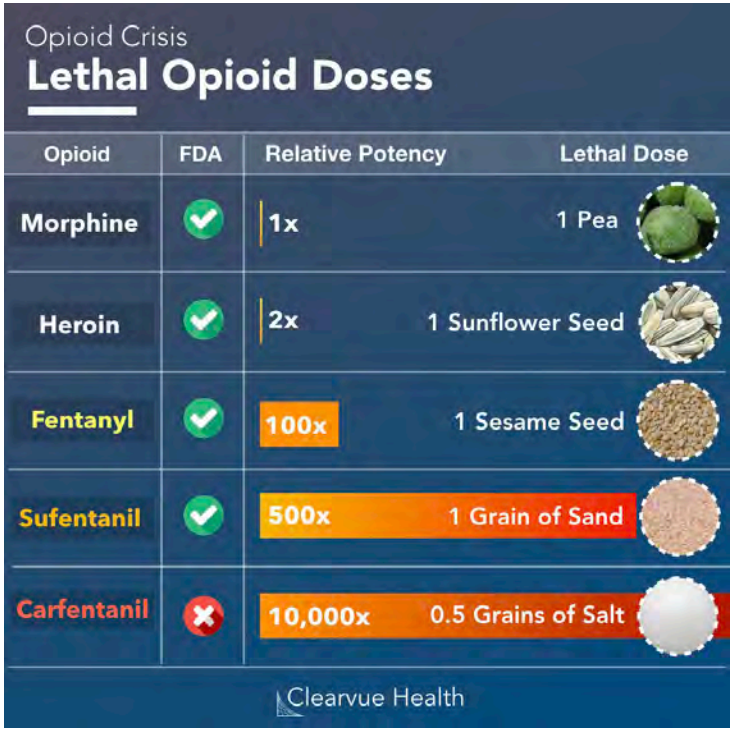


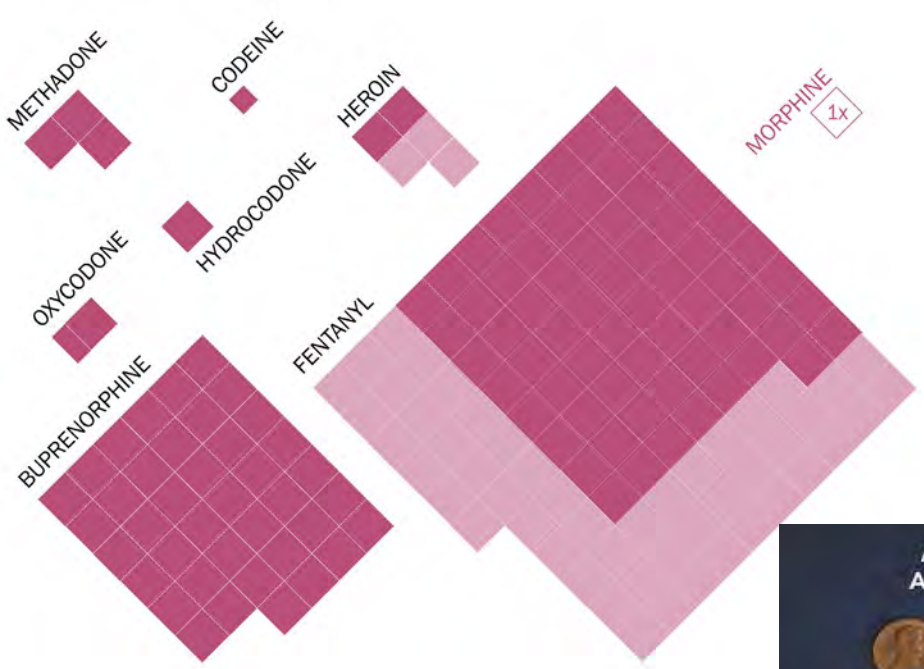




The opium trade routes developed prior to the middle ages and utilized during the opium wars of the 1800's are not that different than the fentanyl trade routes of today

What *is* different is the increasing lethality of the drugs we encounter everyday





https://www.washingtonpost.com/graphics/2017/health/opioids-scale/

Addiction 101

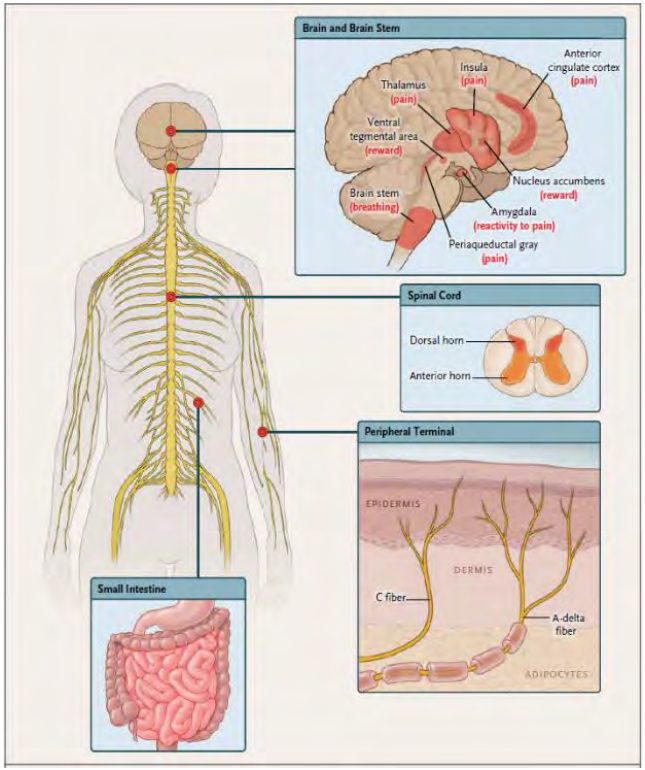
“I want to be an addict when I grow up” ~ said No one, Ever

Answers from 108 individuals in recovery, when asked what they wanted to be when they grew up

Opioids work by binding to Mu receptors in the brain, spinal cord, GI tract and periphery

Brain
- Analgesia
- Sedation
- Euphoria
- Pupil constriction
- Decreased respiration
- Decreased heart rate
- Nausea control

Gut
- Decreased motility (constipation)



Peripheral tissues
- Pain control
- Inflammatory response

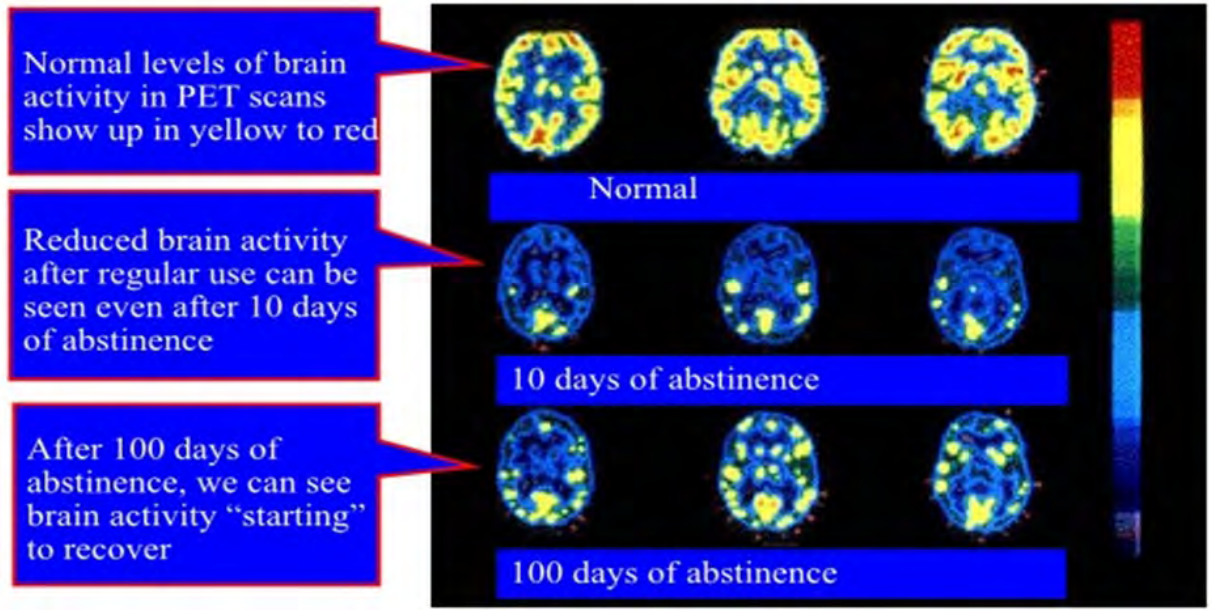
Impact
- Pain perception
- Reward circuit
- Respiratory function

Addiction is defined by NIDA as a *chronic, relapsing brain disease* that is characterized by compulsive drug seeking *and* use, *despite harmful consequences*.

It is considered a brain disease because drugs change the brain; they change its structure and how it works.

These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.

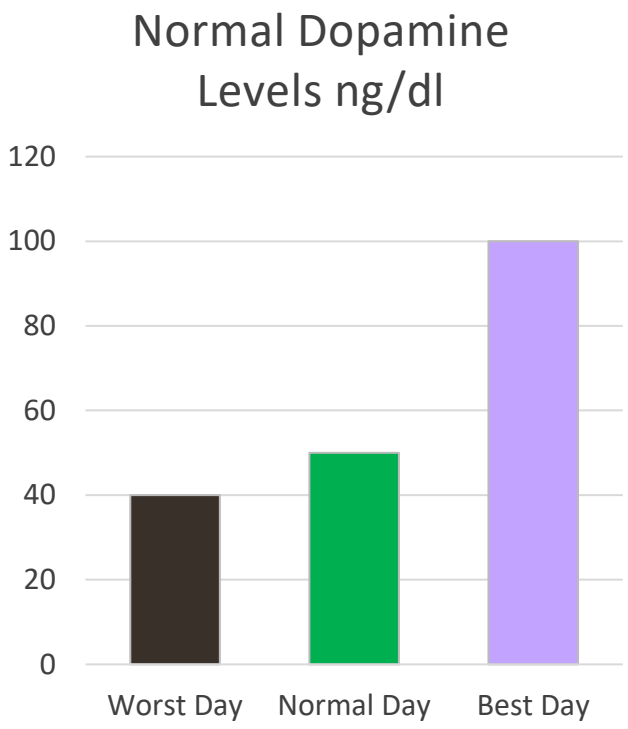
~ National Institute of Drug Abuse (NIDA), 2014

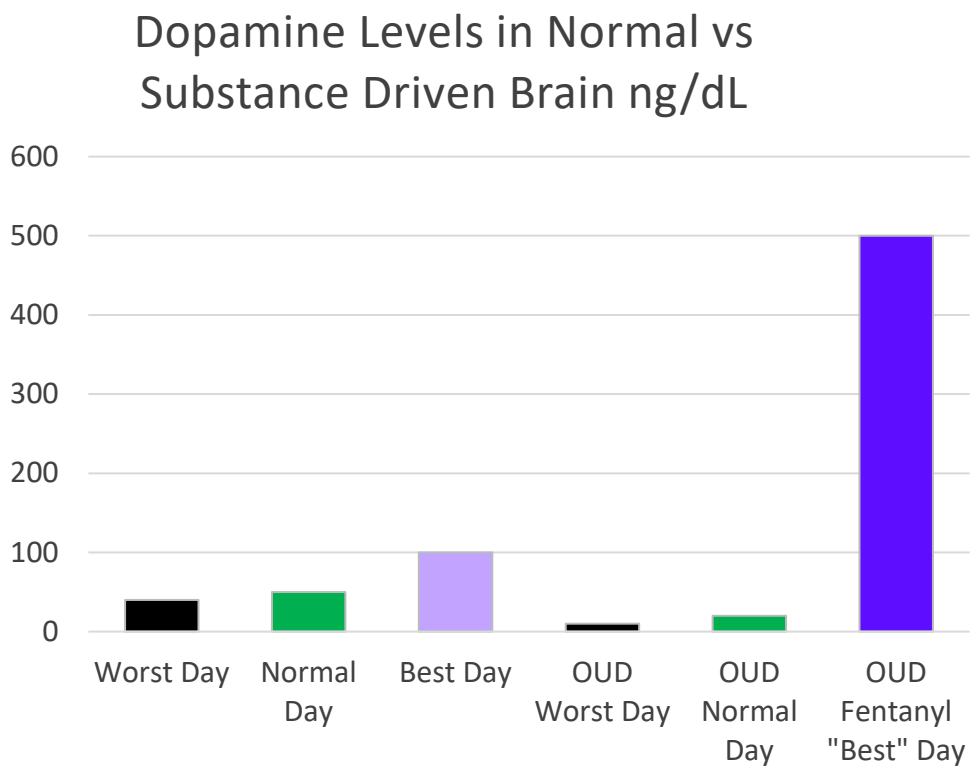


Source: Volkow ND, et al. Synapse 11:184-190, 1992; Volkow ND, et al. Synapse 14:169-177, 1993.

Science = Solutions

1. We are pleasure seeking individuals. 2. The brain is built to survive. 3. Dopamine drives survival.

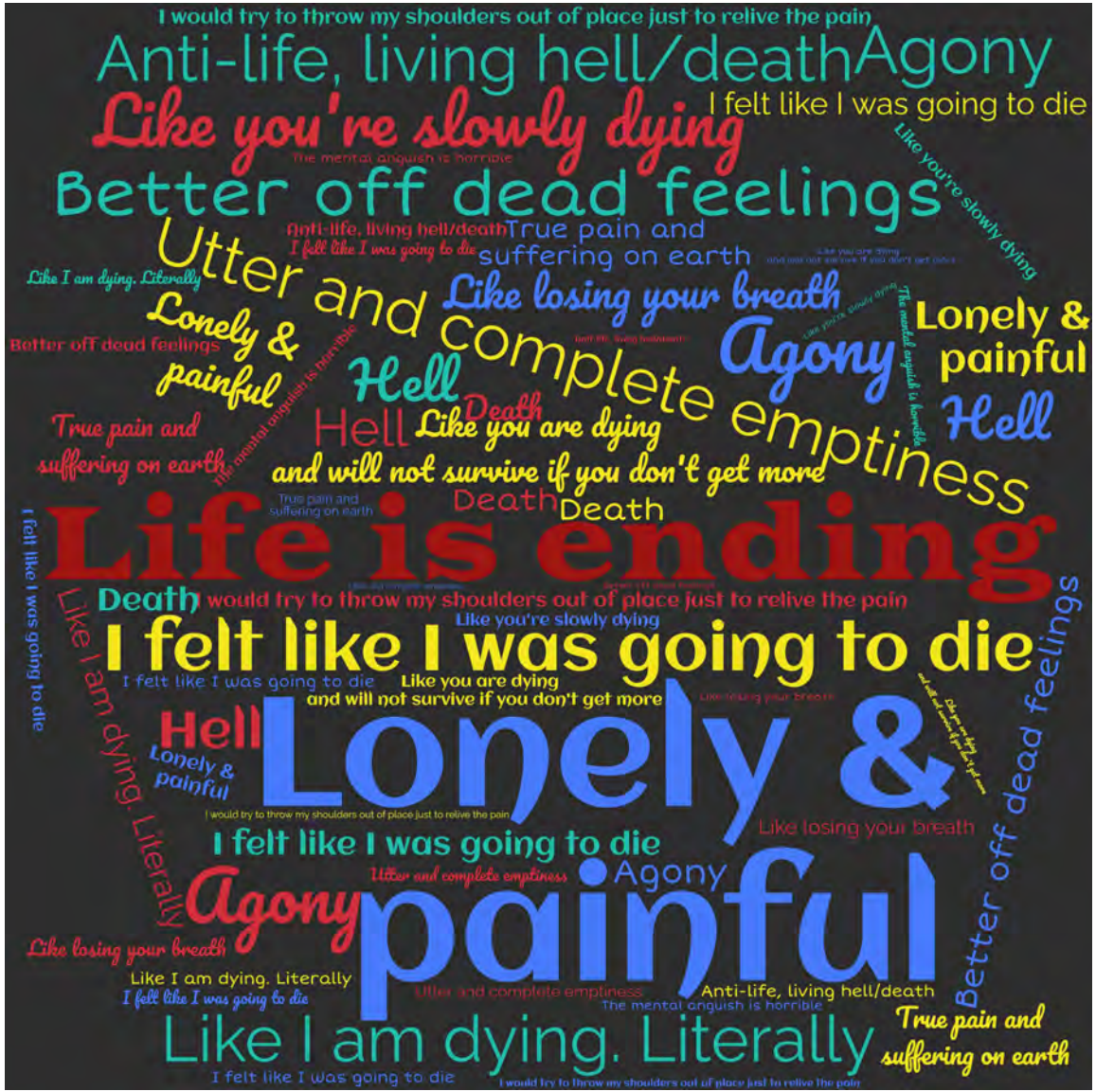




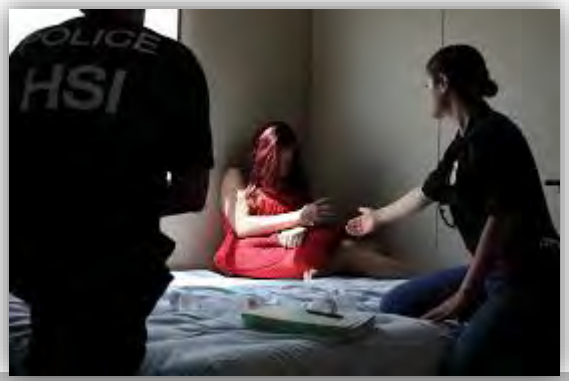
The normal range for dopamine in the human brain is 40 – 100 nanograms/deciliter

In the opioid driven brain, dopamine falls to abnormally low levels and puts the person into a crisis state of fight or flight.

What does lack of dopamine feel like?

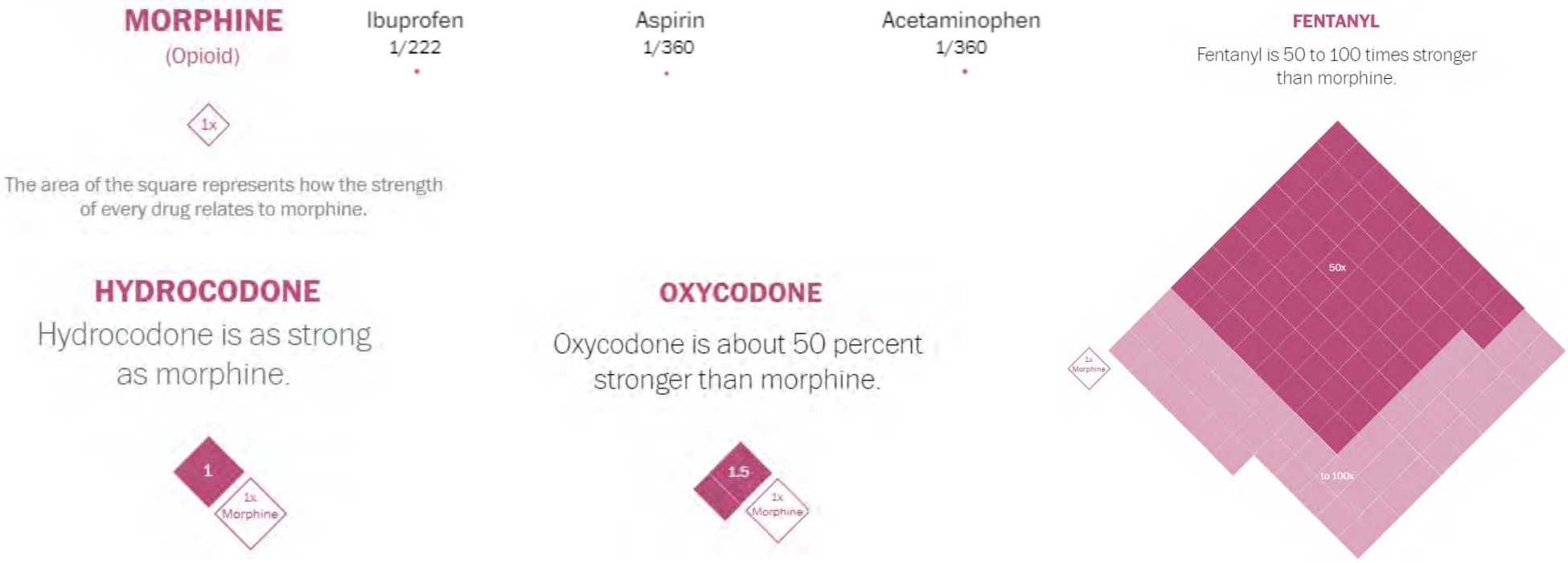


Because of this feeling of impending doom, PWUD will do anything to stop the pain.
These behaviors are what drive our bias and stigma.



How do you recognize stigma in yourself and others and what to do about it?

Do you or your providers use oxycodone as a medication for withdrawal and then wean the patient off it quickly because it's "not good for them?"



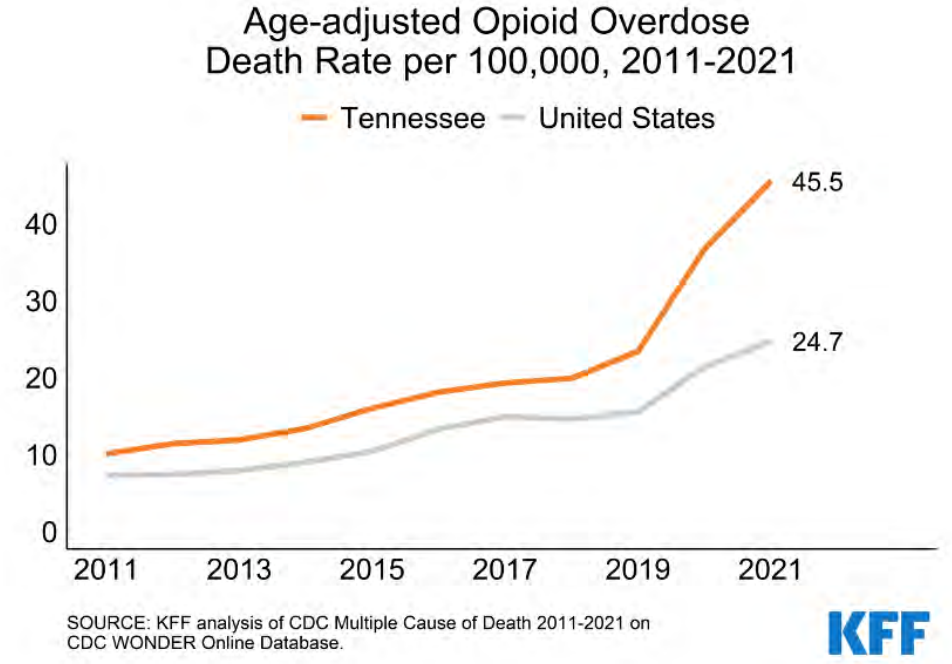
How willing are we to advocate for treatment for the patient in front of us?

Stigmatized Care	Equitable Care
Do we have fentanyl as a substance on our urine drug screen?	How quickly did we deploy COVID testing?
Do we put naloxone in the hand of every opioid use disorder patient that we encounter?	How quickly did we make masks available at every entrance of the hospital during COVID?
Do we tell the patient that opioids aren't good for them, and we need to wean them off?	Do we utilize peer recovery specialists in our hospital and emergency room to promote recovery?
Feel relief when a person with OUD leaves without being seen or against medical advice?	Advocate for treatment every time a person with OUD presents?
Do we ignore the suffering person in front of us as an "addict", a "druggie" or someone who made bad life choices?	Do we recognize that anger, frustration, obvious discomfort and craving are signs and symptoms of untreated withdrawal and seek to provide adequate treatment?

What are we up against?

BY THE NUMBERS

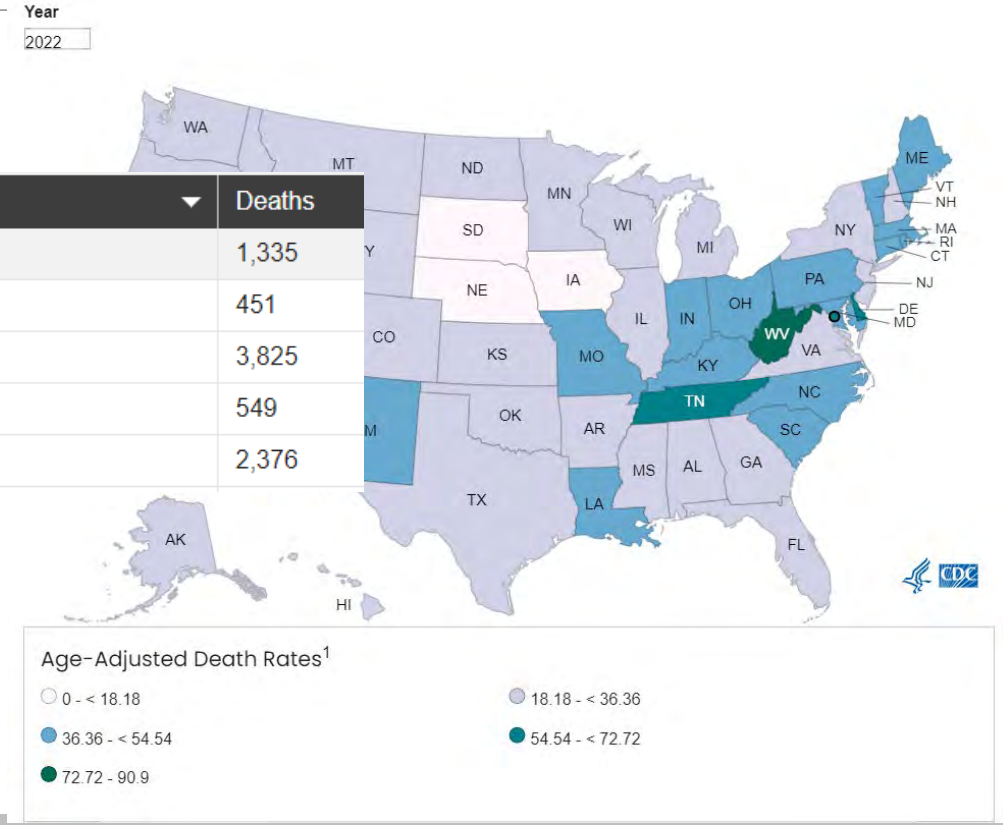
Opioid Use Disorder is a treatable, chronic disease with a high mortality rate.



https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/tennessee/#:~:text=In%202021%2C%20there%20were%203%2C038,in%20the%20country%20in%202021.

Tennessee ranks 3rd in the nation for overdose mortality

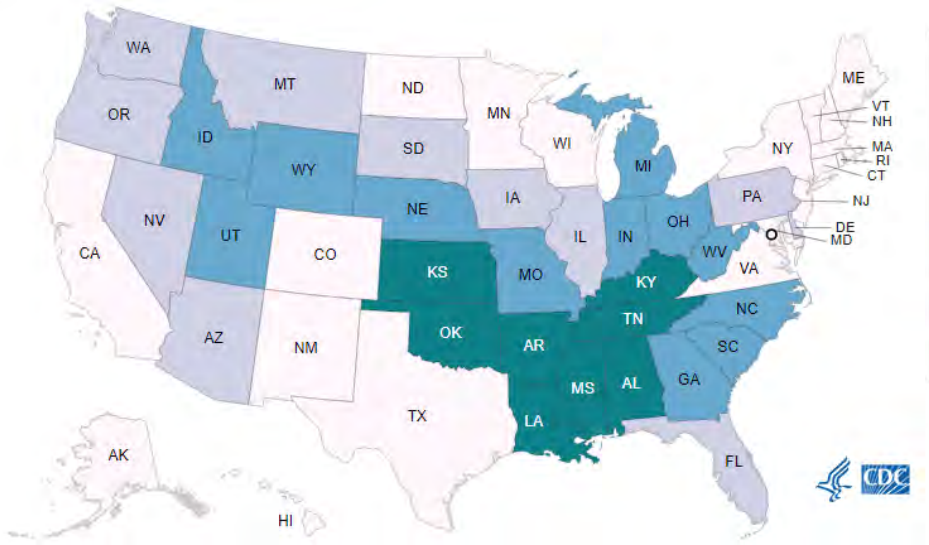
Location	Death Rate (Click for Rankings)	Deaths
West Virginia	80.9	1,335
District Of Columbia	64.3	451
Tennessee	56	3,825
Delaware	55.3	549
Louisiana	54.5	2,376



https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm

Tennessee ranks 6th in the nation for opioid dispensing rates/100 persons

Year
2022



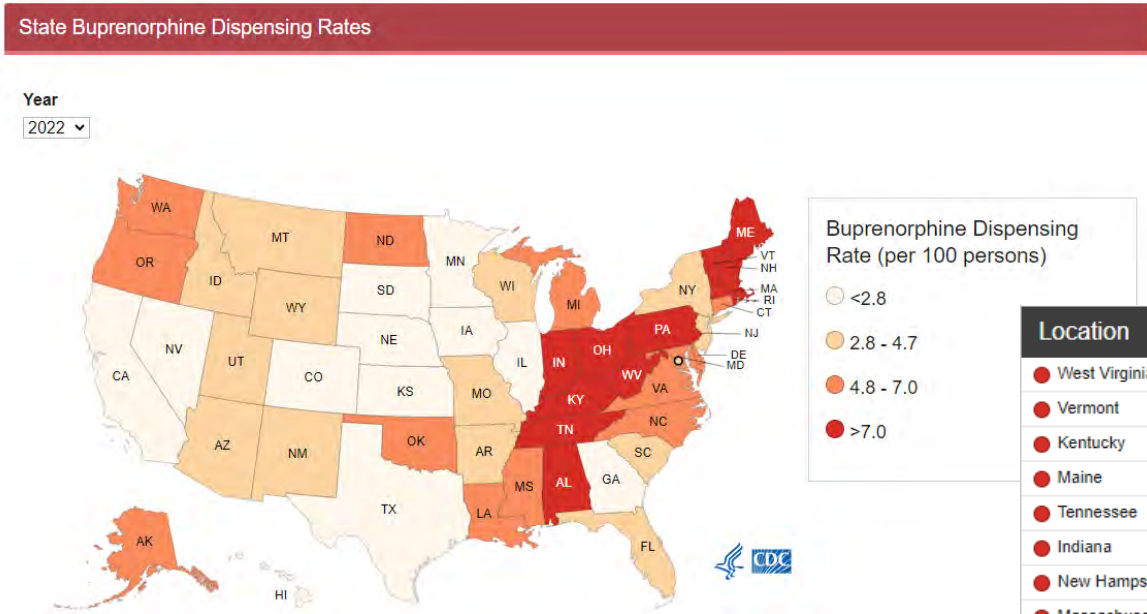
Opioid Dispensing Rate (per 100 persons)

- <36.1
- 36.1 - 42.7
- 42.8 - 52.8
- >52.8

Location	Opioid Dispensing Rate
Alabama	74.5
Arkansas	72.2
Louisiana	65.6
Mississippi	64
Kentucky	61.6
Tennessee	61.5
Oklahoma	55.5
Kansas	55.3
Indiana	52.5
South Carolina	51.5

https://www.cdc.gov/overdose-prevention/data-research/facts-stats/opioid-dispensing-rate-maps.html

Tennessee ranks 5th in the nation for buprenorphine dispensing rates/100 persons

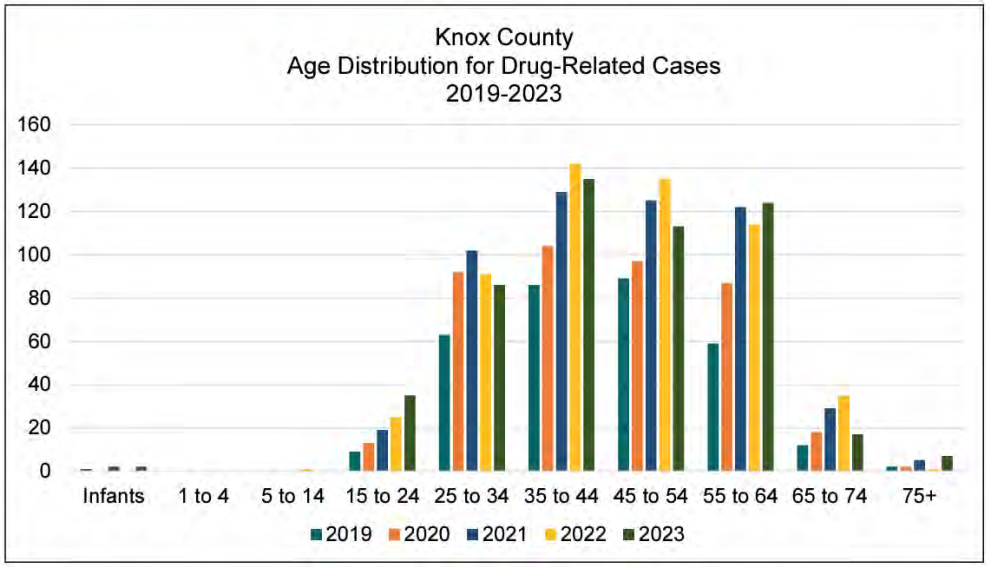


Location	Buprenorphine Dispensing Rate	Year
West Virginia	27.2	2022
Vermont	25.5	2022
Kentucky	23.6	2022
Maine	17.8	2022
Tennessee	10.9	2022
Indiana	10.7	2022
New Hampshire	10.7	2022
Massachusetts	9.6	2022
Pennsylvania	9.2	2022
Rhode Island	8.7	2022
Ohio	8.4	2022
Alabama	7.3	2022

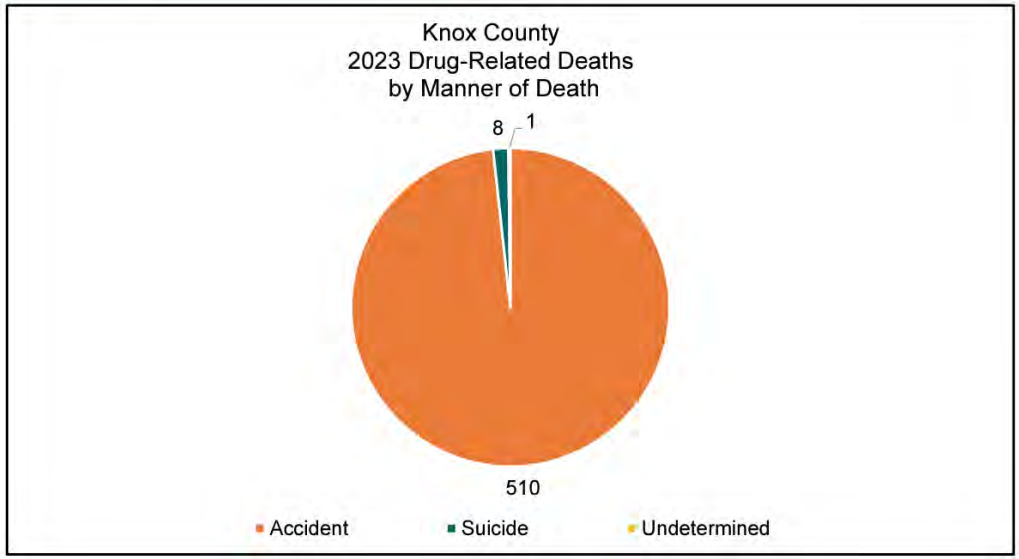
https://www.cdc.gov/overdose-prevention/data-research/facts-stats/buprenorphine-dispensing-maps.html

There were 519 drug-related deaths in Knox County in 2023. 98% were unintentional.

2023 Drug-Related Death Report

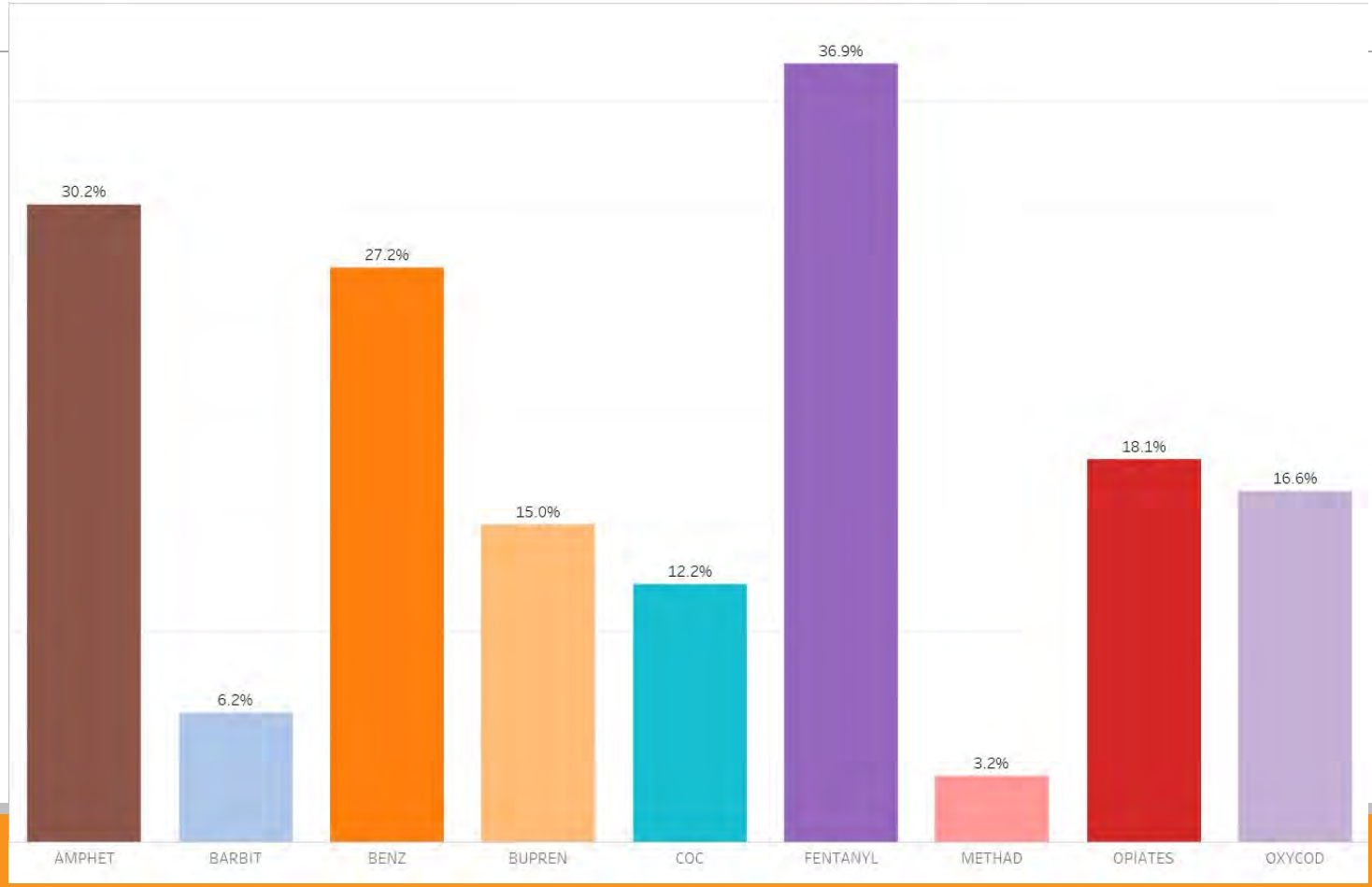


2023 Drug-Related Death Report

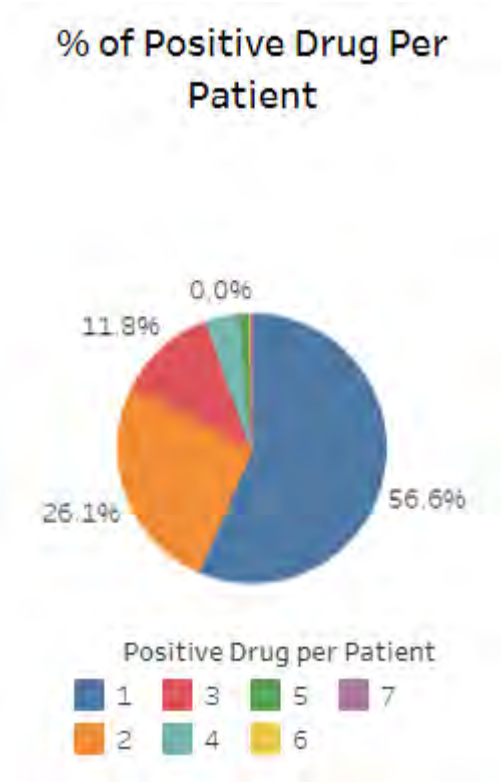


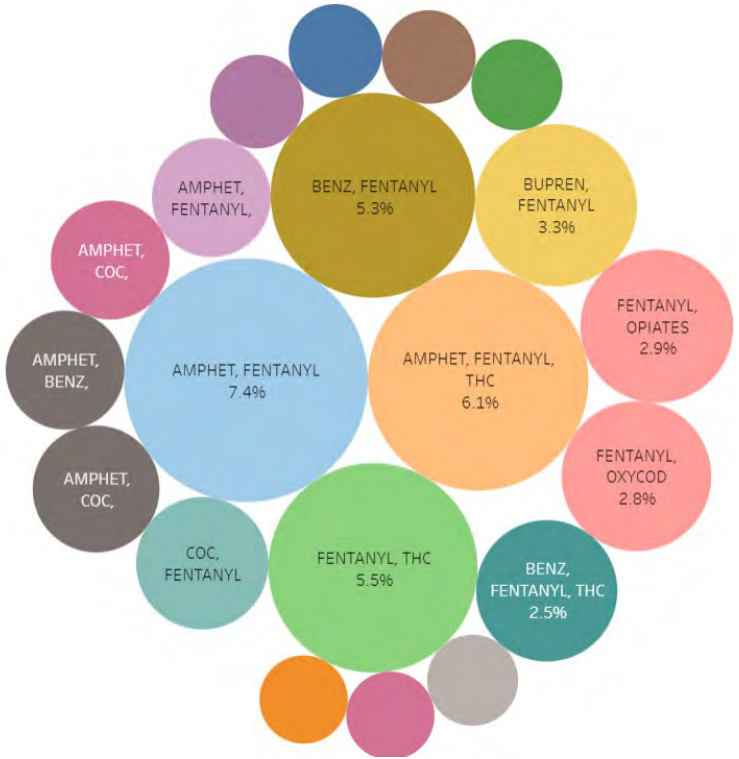
chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://knoxcounty.org/rfc/pdfs/KCRFC_DRD_Report_2023.pdf

UTMC has seen 5,031 positive urine drug screens in 2024 YTD. 37% contain fentanyl.

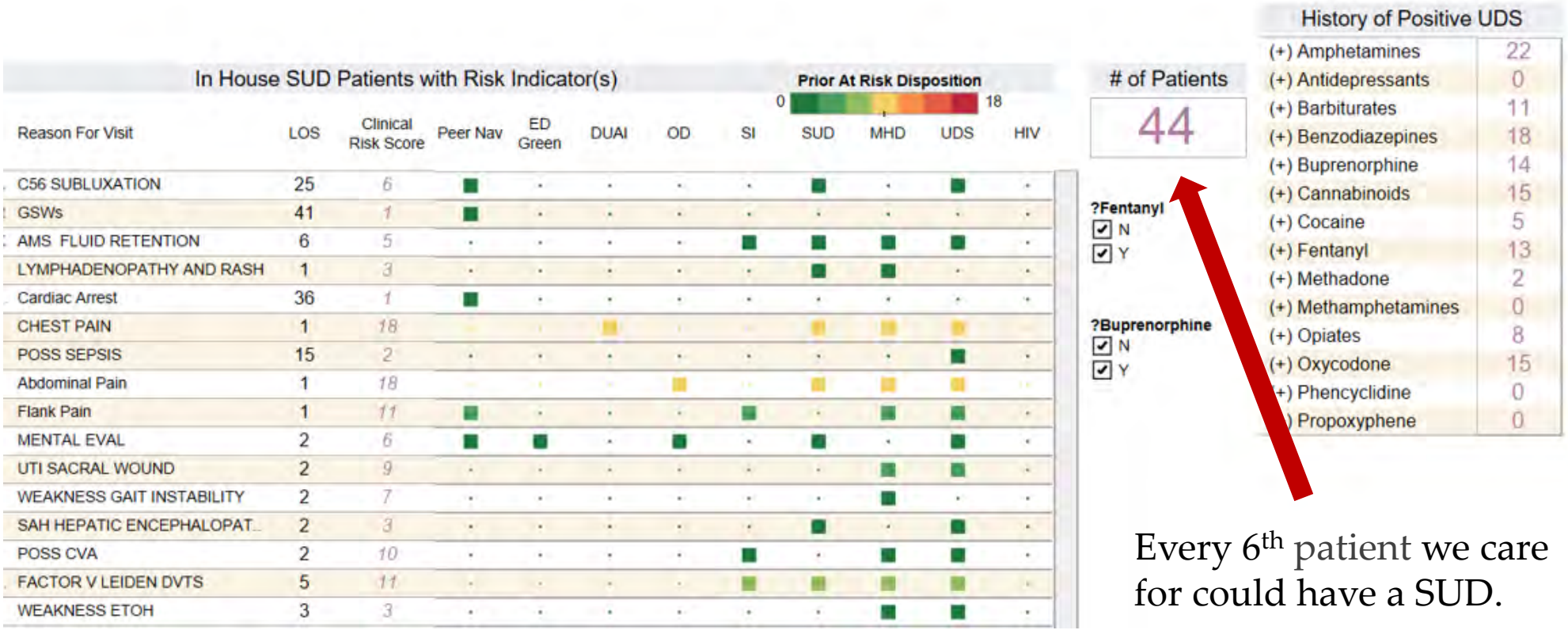


44% of UDS are positive for more than 1 substance. Patients are often unaware of this contamination.





We encounter an average of 42 patients every day who have been previously evaluated for SUD.



In House SUD Patients with Risk Indicator(s)

Prior At Risk Disposition: 0 – 18

Reason For Visit	LOS	Clinical Risk Score	Peer Nav	ED Green	DUAI	OD	SI	SUD	MHD	UDS	HIV
C56 SUBLUXATION	25	6	■	·	·	·	·	■	·	■	·
GSWs	41	1	■	·	·	·	·	·	·	·	·
AMS FLUID RETENTION	6	5	·	·	·	·	■	■	■	■	·
LYMPHADENOPATHY AND RASH	1	3	·	·	·	·	·	■	■	·	·
Cardiac Arrest	36	1	■	·	·	·	·	·	·	·	·
CHEST PAIN	1	18	·	·	■	·	·	■	■	■	·
POSS SEPSIS	15	2	·	·	·	·	·	·	·	■	·
Abdominal Pain	1	18	·	·	·	■	·	■	■	■	·
Flank Pain	1	11	■	·	·	·	■	·	■	■	·
MENTAL EVAL	2	6	■	■	·	■	·	■	·	■	·
UTI SACRAL WOUND	2	9	·	·	·	·	·	·	■	■	·
WEAKNESS GAIT INSTABILITY	2	7	·	·	·	·	·	·	■	·	·
SAH HEPATIC ENCEPHALOPAT..	2	3	·	·	·	·	·	■	·	■	·
POSS CVA	2	10	·	·	·	·	■	·	■	■	·
FACTOR V LEIDEN DVTS	5	11	·	·	·	·	■	■	■	■	·
WEAKNESS ETOH	3	3	·	·	·	·	·	·	■	■	·

# of Patients: 44

?Fentanyl
- ☑ N
- ☑ Y

?Buprenorphine
- ☑ N
- ☑ Y

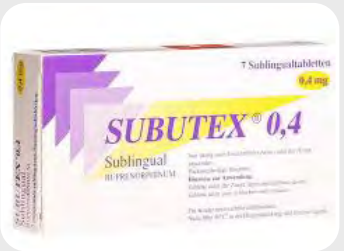
History of Positive UDS

(+) Amphetamines	22
(+) Antidepressants	0
(+) Barbiturates	11
(+) Benzodiazepines	18
(+) Buprenorphine	14
(+) Cannabinoids	15
(+) Cocaine	5
(+) Fentanyl	13
(+) Methadone	2
(+) Methamphetamines	0
(+) Opiates	8
(+) Oxycodone	15
(+) Phencyclidine	0
(+) Propoxyphene	0

Every 6th patient we care for could have a SUD.

Medications for opioid use disorder (MOUD) are the evidence-based best practice in treating individuals with opioid use disorder.

Methadone – Prevents withdrawal symptoms and reduces cravings in people with OUD. It does not cause a euphoric feeling once patients become tolerant to its effects. It is available only in specially regulated clinics.



Buprenorphine (Subutex)– Partially blocks the effects of other opioids, displaces current opioids in the body, and reduces or eliminates withdrawal symptoms and cravings.

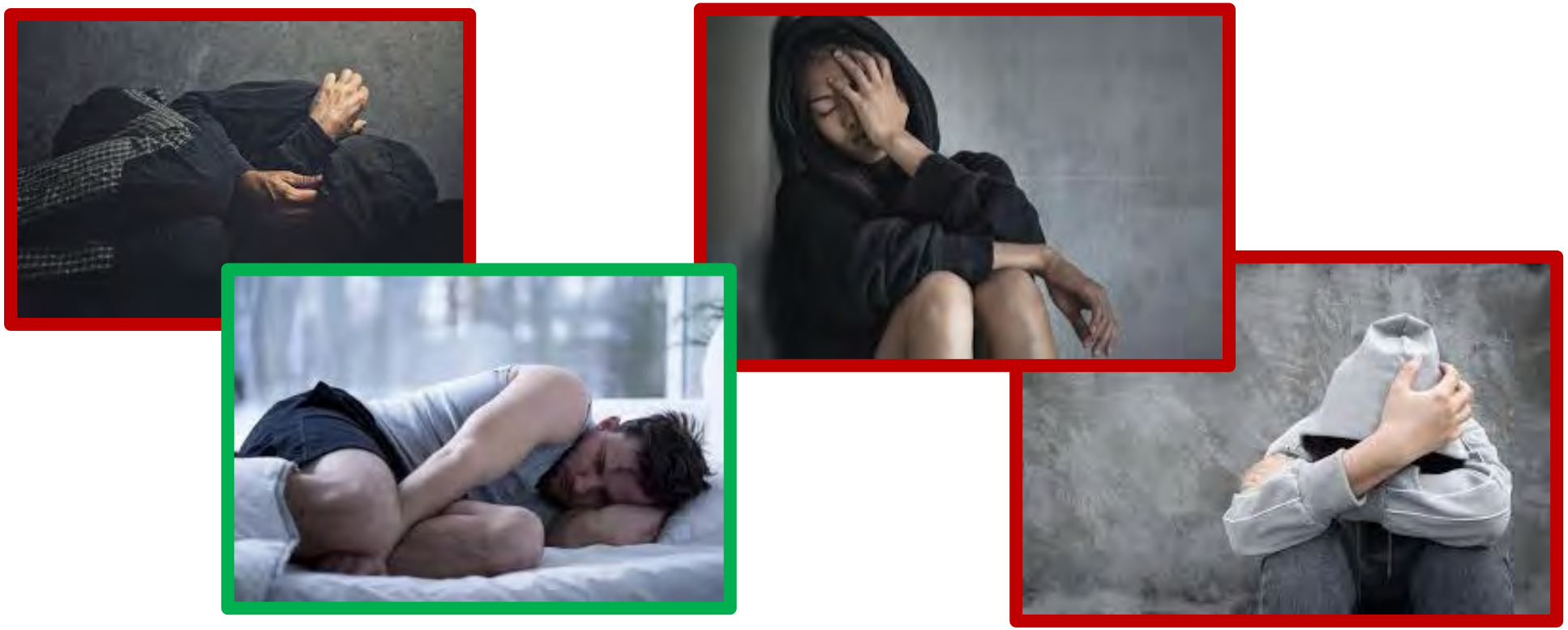
Buprenorphine-Naloxone (Suboxone) - As stated above, buprenorphine partially blocks the effects of opioids. Suboxone combines buprenorphine with naloxone (see below) to prevent accidental or intentional use to get high.

Buprenorphine extended-release (Sublocade) – a once-a-month injection of buprenorphine that is available to individuals that have shown tolerance to oral buprenorphine.

Naltrexone – Blocks the effects of other opioids preventing the feeling of euphoria. It is available from office-based providers in pill form or monthly injection

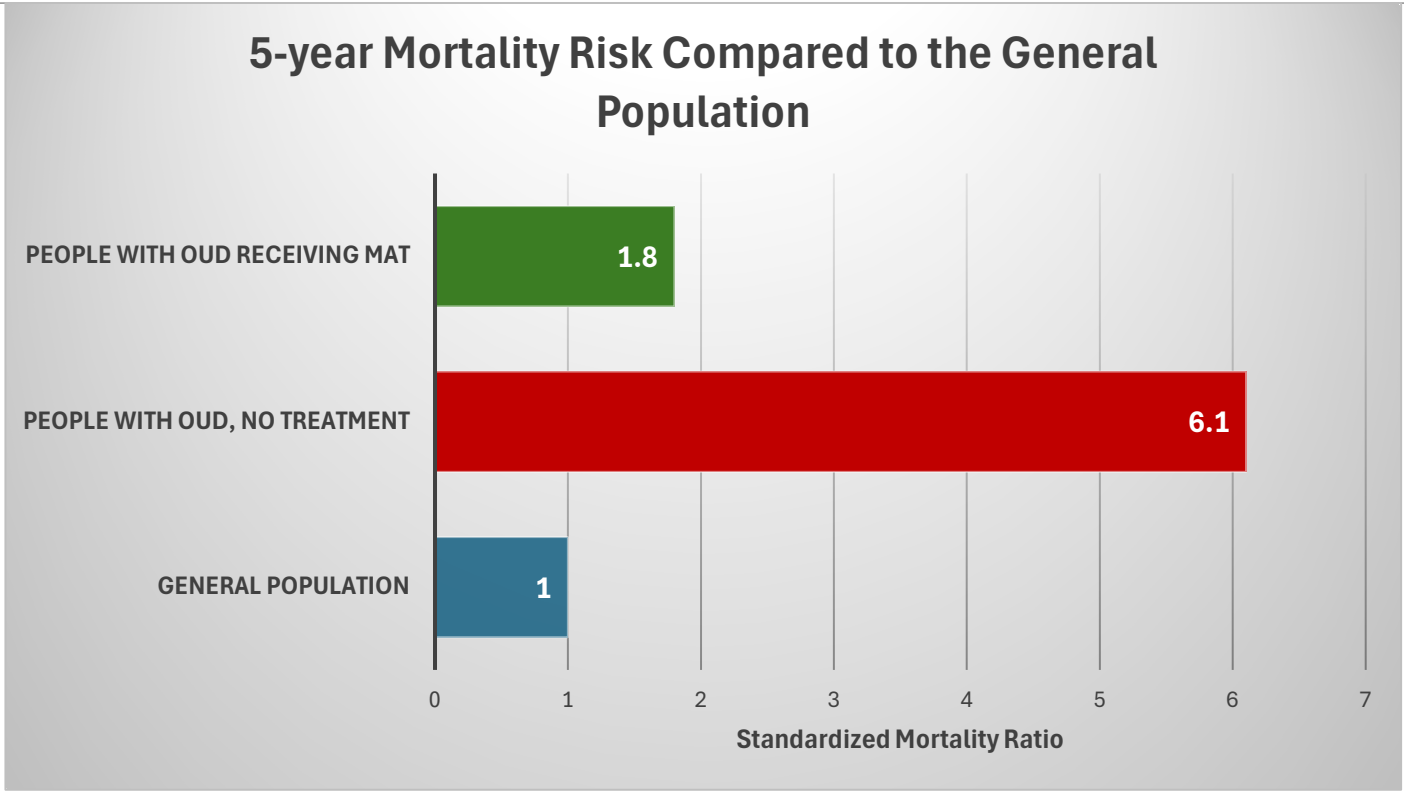
https://www.psychiatry.org/patients-families/opioid-use-disorder

Although effective treatments are available, only 1 in 4 people with opioid use disorder receive disease-specific treatment



https://www.psychiatry.org/patients-families/opioid-use-disorder

In 2015, Evans et al. demonstrated that the use of MAT saves lives.



https://pubmed.ncbi.nlm.nih.gov/25644938/

Only Need to Treat 2 patients with buprenorphine to promote recovery and reduce risk of overdose

Number Needed to Treat (NNT)	
Aspirin in ST-elevation MI	42 to save a life
Steroids in chronic obstructive pulmonary disease (COPD)	10 to prevent treatment failure
Defibrillation in cardiac arrest	2.5 to save a life
Buprenorphine in opioid use disorder	2 to retain in treatment program

Why should we care?

Who did you first use with?

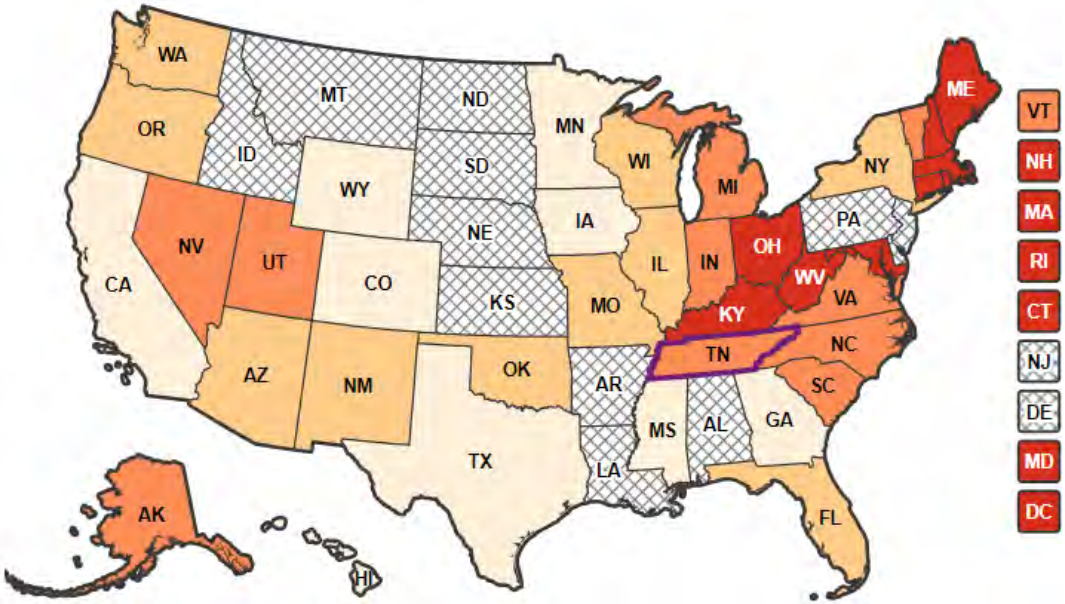
How old were you when you first used substances?

The opioid epidemic cost Tennesseans $3,631 per capita in 2022

Opioid use disorder costs include:

- health care costs
- substance use treatment costs
- criminal justice costs
- lost productivity
- value of reduced quality of life

Economic Cost by State: Total Costs



Location	Population	Total Costs	Per Capita Total Costs
United States	325,719,178	$1.02 T	$3,134
Tennessee	6,715,984	$24.39 B	$3,631

What does Dopesick feel like?

That we all understand what it means to “relapse”.

The Anatomy of Opioid Use Disorder

Chief complaints of patients with OUD over a 3-year period

Gigi's Story

1989 - Born at UTMC

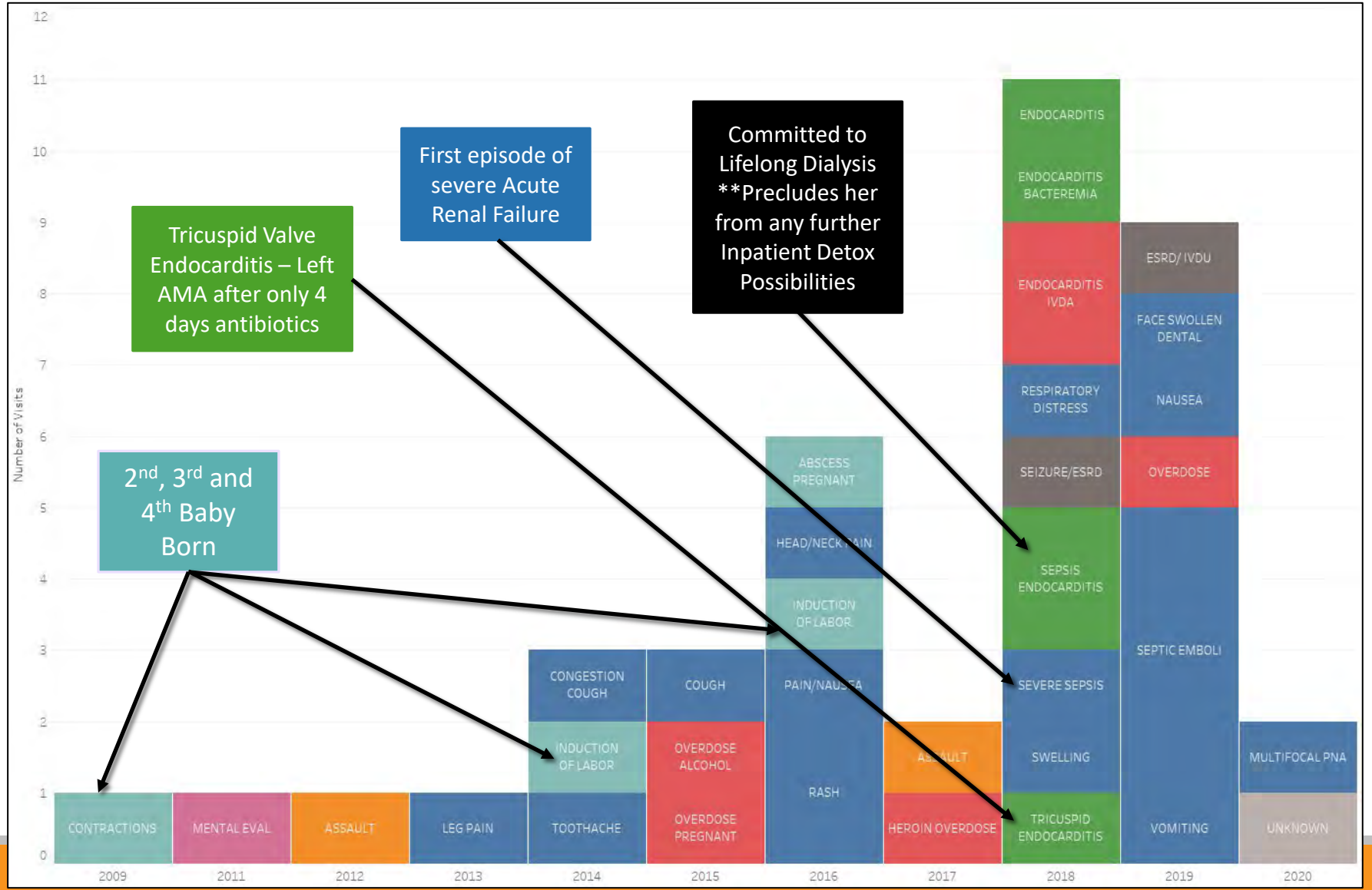
Started using Heroin in 2008

Uses ½ gram Heroin daily

Has been to "Rehab" 10 times

Single with 4 children, does not have custody

2009 – 2013
4 opportunities to intervene



In House SUD Patients with Risk Indicator(s)

Prior At Risk Disposition: 0 – 22

Chief Complaint	LOS	Clinical Risk Score	ED Green	MHD	DUAI	HIV	OD	SI	Drug	UDS	HIN
ICH ENDOCARDITIS	93	11	·	■	■	·	·	·	■	■	■
ENDOCARDITIS IVDU CP	33	2	·	·	■	·	·	·	·	■	·
AMS	32	1	·	·	·	·	·	·	·	■	·
SEPTIC ARTHRITIS LUMBAR DIS..	31	53	·	■	■	·	·	■	■	■	·
OSTEOMYELITIS METABOLIC ACI..	28	2	·	·	·	·	·	·	■	■	·
ETOH ABUSE	23	9	·	■	·	·	·	·	·	■	·
SEPSIS PNA	22	1	·	·	■	·	·	·	·	·	·
PNA SEPSIS OLEURAL EFFUSIO..	21	7	·	■	·	·	·	·	■	■	■
ACUTE on CHRONIC HYPONATR..	15	17	·	■	·	·	·	■	■	■	■
HYPERTENSIVE EMEERGENCY S..	15	8	·	■	·	·	■	·	■	■	·
suspect ENDOCARDITIS SEPSIS ..	15	7	■	■	·	■	·	·	·	■	·
PNEUMOMEDIASTINUM	14	4	·	■	·	·	·	·	·	·	■
PELVIC ABSCESSES PELVIC FX ..	14	1	·	·	·	·	·	·	·	■	·
UNRESPONSIVE	13	17	·	■	·	·	■	·	■	■	·
L2 PAIN WITH HARDWARE	12	6	·	■	■	·	·	·	·	■	·
ALCOHOLIC HEPATITIS	12	1	·	·	·	·	·	·	·	·	·
SEIZURES	9	9	·	■	■	·	·	·	■	■	■
SEVERE AGMA	9	2	■	·	·	·	■	·	·	·	■
GI BLEED ALCOHOL WITHDRAW..	8	5	·	■	·	·	·	·	·	■	·
Scrotal Injury	8	2	·	■	·	·	·	·	·	■	·
DIABETIC FOOT ULCER	6	12	·	■	·	·	·	■	■	■	■
POLY TRAUMA	6	2	·	·	■	·	·	·	·	■	·
CHRONIC CYSTITISEPIDIDYMITI..	5	10	·	■	·	·	·	■	■	■	■

# of Patients	Updated
44	9/04/24 5am

Location

	ED	E	H	S	N
ED	6				
12		1			
11		2			
10		3			
9			2		
8		6	4		
7			3	1	
6		4		2	
5		1		2	
4			2	1	
3		1	1		
2			1		1

This Visit

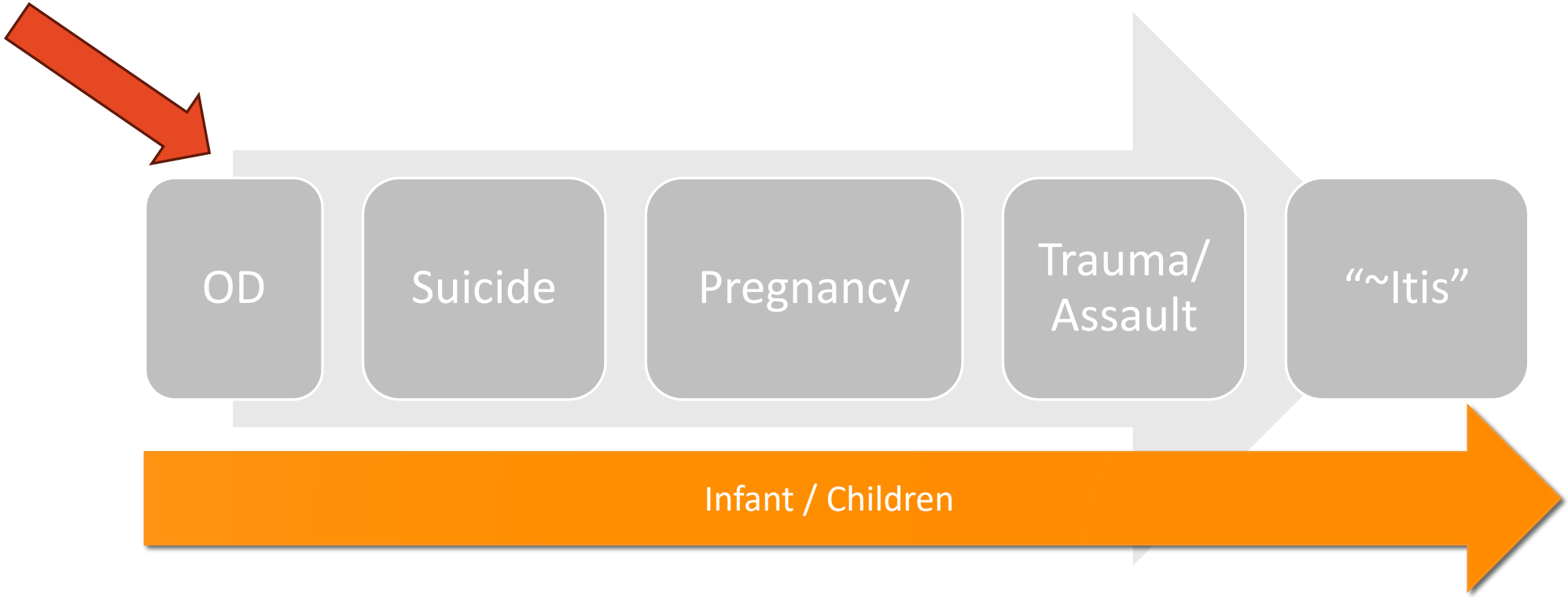
Have Not Seen Peer Nav	27
Saw/Seeing Peer Nav this Encounter	17

Organizational cost of the opioid epidemic when we don't intervene early.

Number of Visits for Patients with 4+ Visits	9136
Average Number of Visits for Patients with 4+ Visits	15.6
Percentage of Total Visits by Patients with 4+ Visits	89.80%
Percentage of Patients with 4+ Visits	28.80%
Assumed Cost of Total Patient Population 3 Years	$ 10,175,000.00
Savings if Reduce an Average of 1 Visit in 4+ Group 3Y	$ 585,000.00

29% of patients are responsible for 90% of the visits

We realized if were going to impact the opioid epidemic, we needed to start at the left end of the SUD continuum.



THA Grant Goals

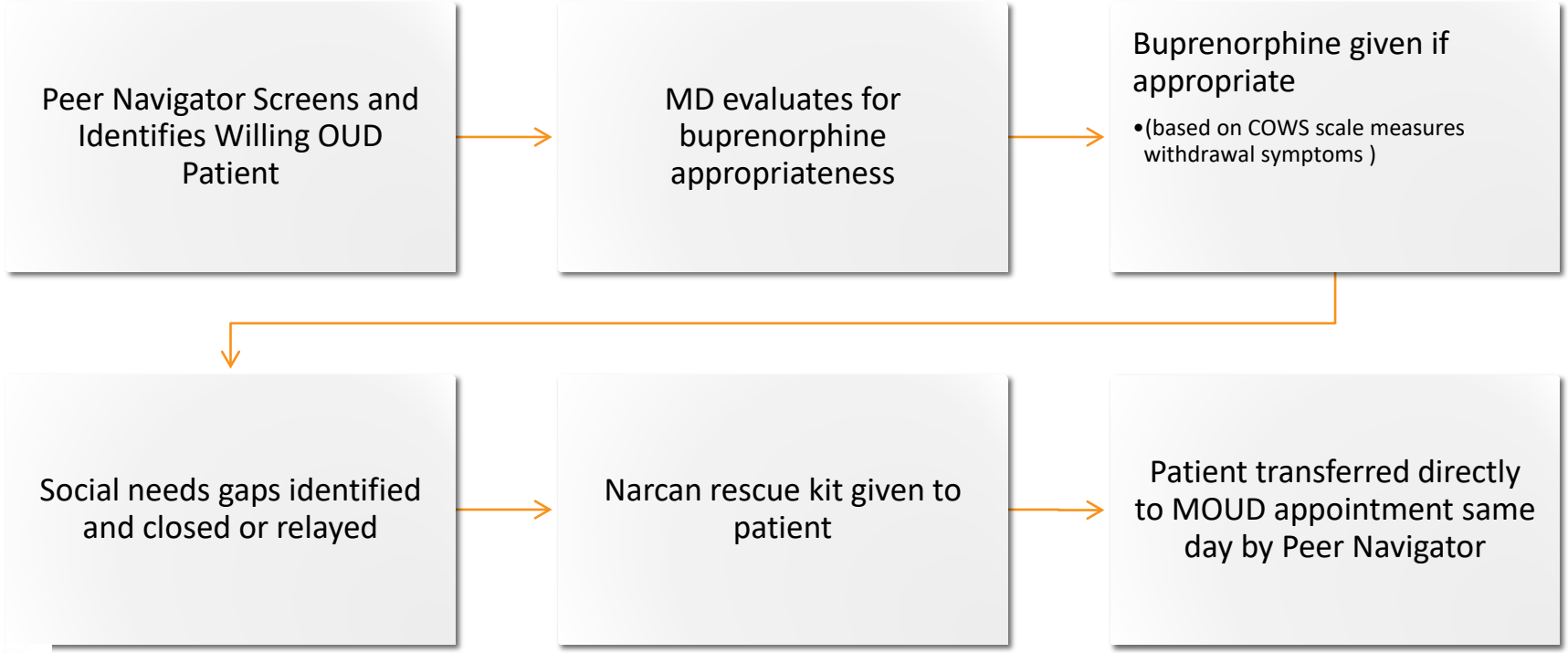
Increase ED inductions of buprenorphine

Increase # of X-waivered physicians

Make Narcan readily available to those at risk

Increase awareness and decrease stigma

BRIDGE Program Design



BRIDGE TO RECOVERY

Embedding the process in EMR helps with standardization and data collection

ED Pathway Buprenorphine Assisted Recovery Outpatient (BRIDGE)

ED Pathway Buprenorphine Assisted Recovery Outpatient (BRIDGE), BRIDGE Phase II (Planned Pending)

Condition/Code Status		
	**NOTE If patient agrees to begin Medication Assisted Treatment at McNabb, document their decision in the order below, have patient sign consent form and notify peer navigator that patient will require transportation. Once the patient has signed the consent, they can receive the first dose of buprenorphine.	
	**NOTE If the patient declines the program, document their decision in the order below, and give them the resource packet for OUD prior to discharge.	
	**NOTE If you are concerned about precipitous withdrawal due to fentanyl use or other long-acting opioids, do NOT start buprenorphine and choose the "Concern for Precipitous Withdrawal" order below	
Vital Signs		
☑	Vital Signs	T;N, Q4H
Nursing Orders		
☑	ED OUD Outpatient Treatment Decision	**Select an order sentence**
☐	Education on OUD Resources	T;N, Provider counseled patient on OUD outpatient treatment options and provided with OUD resour...
☑	Transport to BRIDGE Program	T;N, Peer Navigator, please provide transportation to MAT (BRIDGE) Program.
☐	Concern for Precipitous Withdrawal	**Select an order sentence**
Medications		
	**NOTE Caution: buprenorphine/naloxone (Suboxone) induction is only for patients dependent on short-acting opioids (eg, heroin) and not for those dependent on long-acting opioids (eg, methadone); buprenorphine monotherapy is recommended for induction for long-acting opioids.	
	NOTE Screen all patients for current methadone or MS Contin use	
	NOTE Suboxone (buprenorphine/naloxone) is NOT FOR USE IN PREGNANT WOMEN!	
	NOTE Suboxone (buprenorphine/naloxone) Option**	
☐	buprenorphine-naloxone (buprenorphine-naloxone 8 mg-2 mg sublingual tablet)	1 tab, SUBLINGUAL, 1TIME, STAT, Dose Form: TAB
	**NOTE The Subutex (buprenorphine alone) option is to be used only for patients who are pregnant, have an allergy to naloxone or who are dependent on long-acting opioids (methadone).	
	NOTE Subutex (buprenorphine alone) Option**	
☐	buprenorphine (buprenorphine 8 mg sublingual tablet)	**Select an order sentence**

Buprenorphine as Adjunct Therapy for OUD Pathway

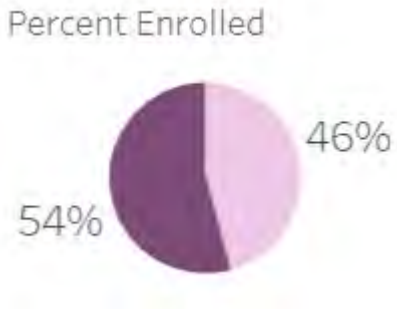
Buprenorphine as Adjunct Therapy for OUD Pathway (for TRAINED Providers Only), Buprenorphine as Adjunct Therapy STEP 2 (Planned Pending)

Condition/Code Status		
Milestone Criteria		
	BRIDGE Milestone Criteria:	
	** Milestone (M) 1: This pathway is to be used as adjunct therapy for Opioid Use Disorder (OUD) patients admitted to the hospital. It is not intended as induction for patients who require detoxification from opioids.	
	** Milestone (M) 2: A COWS scale must be performed on all patients	
	** Milestone (M) 3: Screen and document last fentanyl use	
	** Milestone (M) 4: Signs and symptoms of withdrawal include: Muscle aches and pains, Fever, Sweating, Goosebumps, Runny Nose/Watery Eyes, Insomnia, Dilated pupils, Rapid heartbeat, High blood pressure, Diarrhea, Anxiety/Agitation, Depression or Suicidal Thoughts.	
	** Milestone (M) 5: Buprenorphine education is attached as reference text to this pathway	
Nursing Orders		
Communication Orders		
☑	Communication to Nurse	T;N, Buprenorphine education is attached as reference text to the pathway.
Treatments/Procedures		
Nursing Assessments		
☐	COWS Scale Initial Screen	T;N
☑	COWS Scale Subsequent Screen	T;N, BID, Duration 3, Days
☑	COWS Scale Subsequent Screen	T+3;N, Q DAY
☑	COWS Scale Subsequent Screen	T;N Signs and symptoms of precipitous withdrawal, PRN
Medications		
Narcotic Dependence Medication		
	Suboxone (buprenorphine/naloxone) is NOT FOR USE IN PREGNANT WOMEN!**	
	Suboxone (buprenorphine/naloxone) Option	
	Day 1 Suboxone 2mg/0.5 mg INITIAL Dosing	
☐	buprenorphine-naloxone (buprenorphine-naloxone 2 mg-0.5 mg sublingual tablet)	1 tab, SUBLINGUAL, QID, NOW, Dose Form... Day 1 Dose. Patient education: maximum ...

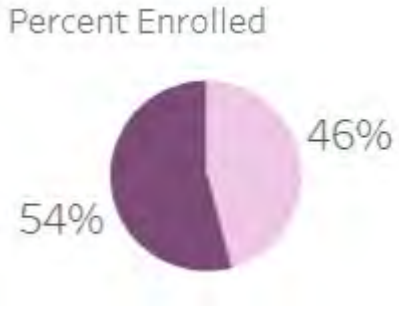
BRIDGE TO RECOVERY

596 patients have been screened since 2022 and 345 have been enrolled.

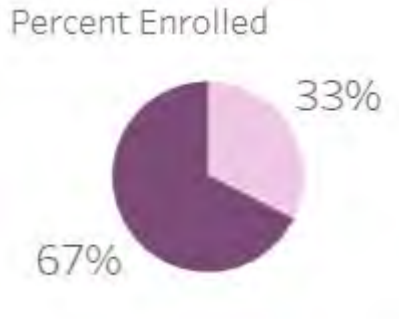
YEAR 1		
Patients Screened	Patients Enrolled	Co Occurring
198	107	74



YEAR 2		
Patients Screened	Patients Enrolled	Co Occurring
233	126	77



YEAR 3		
Patients Screened	Patients Enrolled	Co Occurring
169	114	40



BRIDGE TO RECOVERY

40 patients have been engaged in the program for > 2 years (20%)

Patients Screened	Patients Enrolled	Co Occurring
40	40	17

Decrease in Utilization (ED/IP)	
15.0%	43.9%

BRIDGE TO RECOVERY

Race

Black/African American	41
Declined	2
Multiple	3
Other Race	3
Unavailable	6
White	541

Ethnicity

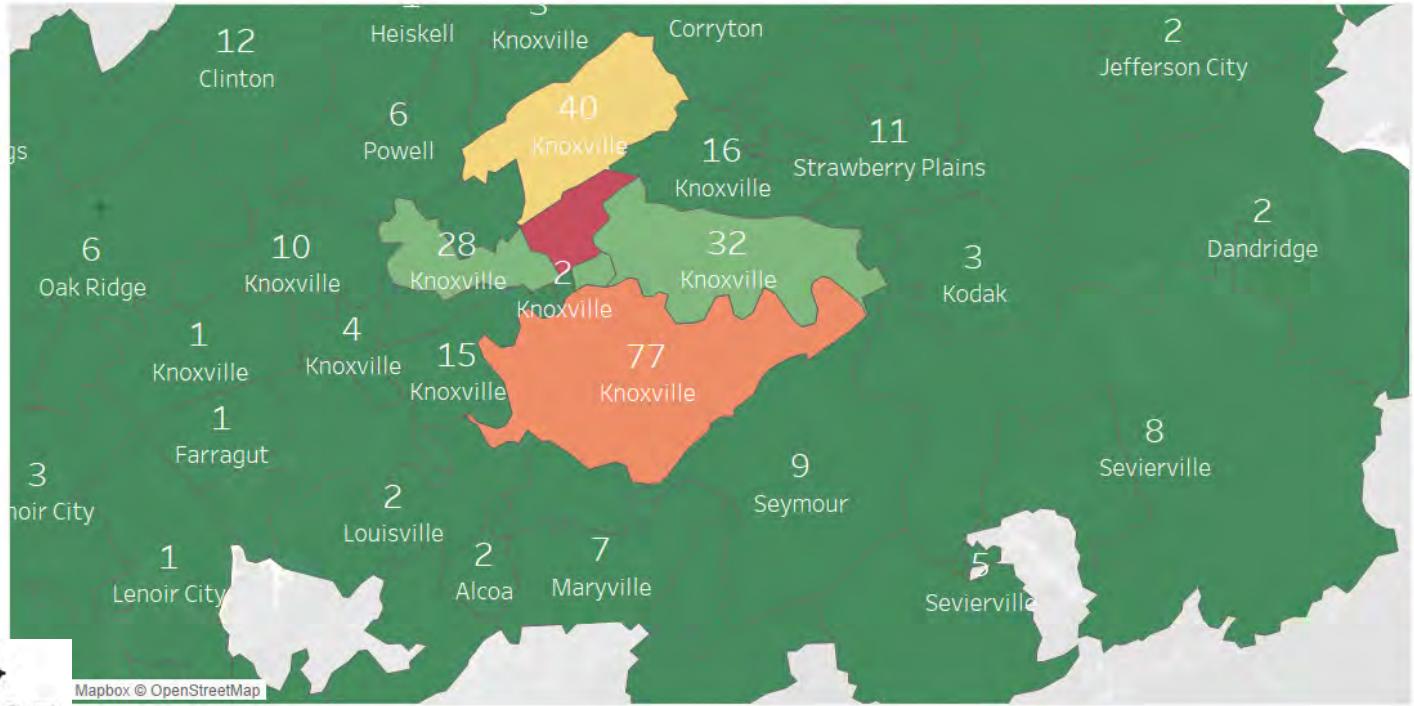
	48
Hispanic/Latino	4
Not Hispanic/Latino	527
Unavailable	17

Age & Gender

Age Range	Female	Male	Grand Total
25 and Younger	13	26	39
26 to 35	63	111	174
36 to 45	94	140	234
46 to 55	44	57	101
56 to 65	16	26	42
66 and Older	1	5	6

Language

English	595
Spanish	1



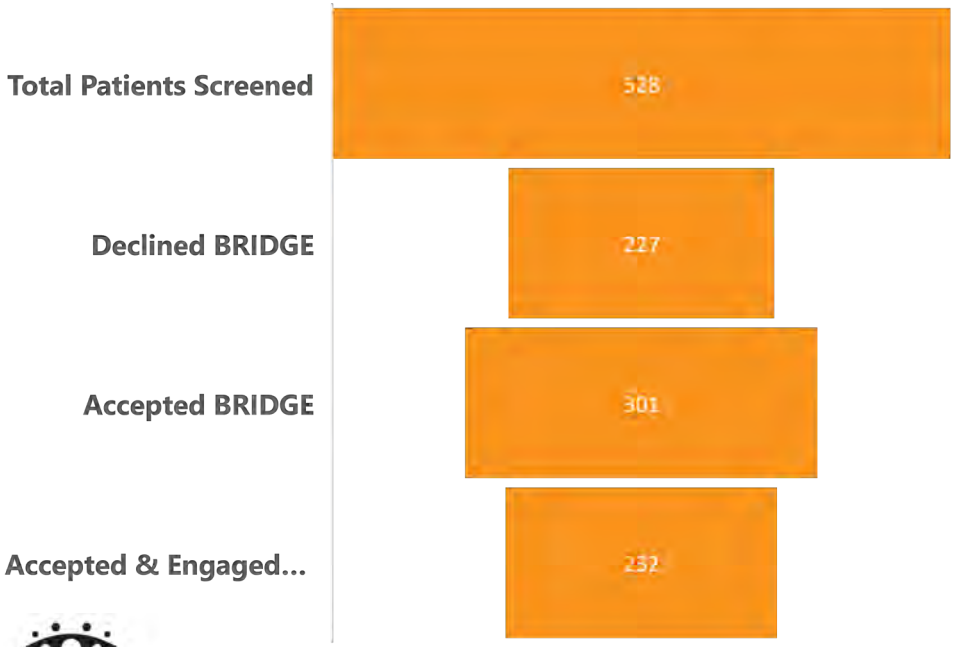
Knox County	405
Blount County	27
Sevier County	25
Anderson County	21
Jefferson County	16
Roane County	14
Campbell County	11
Grainger County	7
Hamblen County	6
Loudon County	6
Mcminn County	5
Union County	5
Claiborne County	4
Bradley County	3
Greene County	3
Monroe County	3
Bell County	2
Davidson County	2
Scott County	2
White County	2
Bedford County	1
Cannon County	1

BRIDGE TO RECOVERY

Demographics

The BRIDGE program has shown an 80% reduction in mortality for patients who remain engaged in the program

BRIDGE Patients Screened by Subgroup



Mortality Among BRIDGE Subgroups

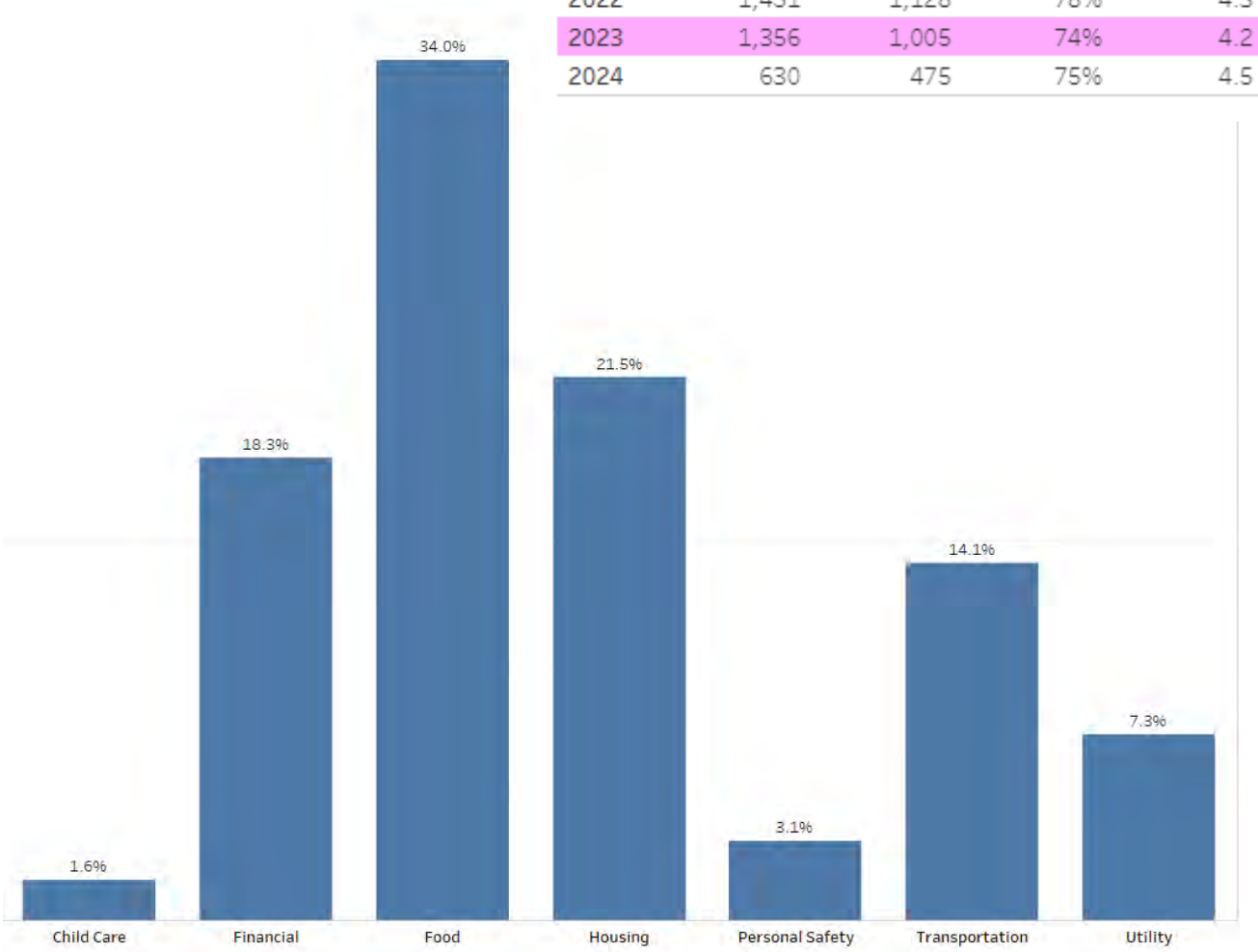
BRIDGE TO RECOVERY

It’s critically important to remember the impact of social drivers in this population!

BRIDGE TO RECOVERY

Social Need

	Visits	Min 1 SN	% Min 1 SN	Avg SN
2022	1,451	1,128	78%	4.3
2023	1,356	1,005	74%	4.2
2024	630	475	75%	4.5



Lessons Learned

Keep it simple

Hire a Peer Navigator and embed them in your ED/Hospital
- Peer navigation on site is superior to peer navigation by phone
- Patients often don't have a phone, or they switch numbers frequently

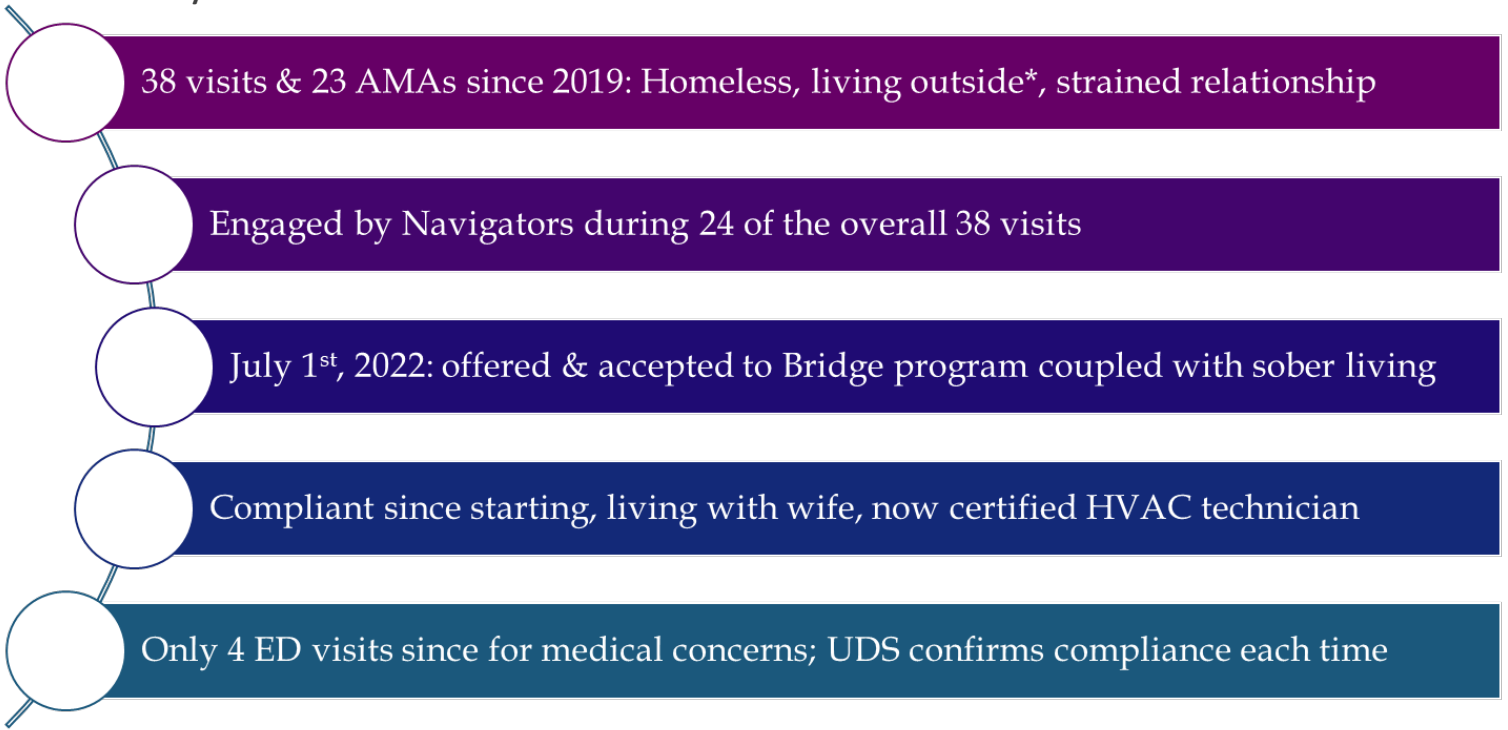
Assume that the patient has social needs that will be a barrier to care
- Transportation to appointments, pharmacy
- Housing needs

Tackle the problem from the patient's perspective– *It must be practical!*
- *Give naloxone kit, not a Rx for naloxone*
- *Start buprenorphine while in the ED or hospital same day*
- *Must treat withdrawals before they leave your care, or they will self-medicate*

Understand and seek the moment of clarity…
When it arrives, *we must act.*

Peers are so important because they understand the journey. They can understand and reach people that we can't.

Rachel's Story: The Power of Persistence

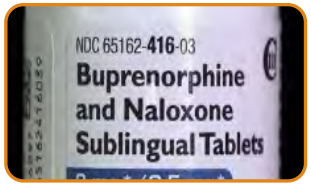


* "I live at 201 W. Springdale Ave."

Problems to Solve

Add Onsite Fentanyl testing to your UDS – Not as a send out

- CLIA waived point of care testing is ideal
- AllTest Fentanyl Urine Test Cassette received preliminary approval from the FDA on 10/26/2023, final market approval pending



Ensure the buprenorphine is available on your formulary without restrictions

- Session 3 in our CME series addresses the “rules” around buprenorphine ordering in the hospital as well prescribing it at discharge

Advocate for medical staff to compete their DEA-MATE Act ASAP

- Session 1 and 3 in our CME series covers MAT basics and how to initiate treatment

Ask Pharmacy partners how to distribute naloxone to *every* patient with OUD before they are discharged

- Giving away free Narcan in the hospital is harder than you think

BRIDGE
TO RECOVERY

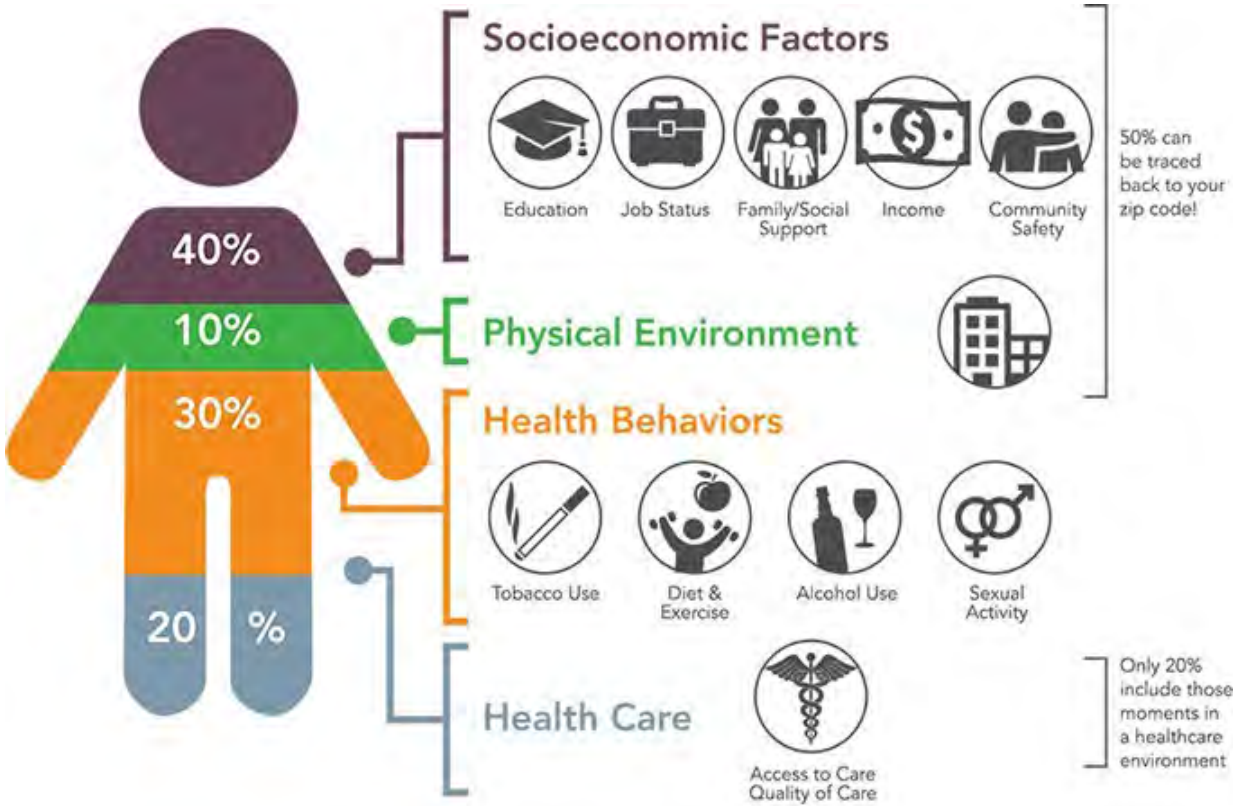
Step 1: Recruit passionate people to join the fight

Every battle needs a secret weapon.

Peer Navigators are the secret sauce.

They will fight the battle for you, because they have been there

BRIDGE TO RECOVERY



2. Evaluate and close social needs gaps

Peers will help you with this, because they ask these questions naturally.

BRIDGE TO RECOVERY

3. Support a culture of ordering & prescribing buprenorphine (MOUD)

Educate your providers to start buprenorphine as soon as possible.

Free Training Available:

We are offering a free CME series that is durable until end of 2025.

BRIDGE TO RECOVERY

Why aren't we treating more people with buprenorphine?

- Buprenorphine has been approved for the treatment of OUD since 2002 (22 years)
- NNT to promote recovery and decrease OD risk = 2
- Lethal Dose of Buprenorphine/Naloxone is 40,000 mg or 5,000 Sublingual films
- *And it makes people feel better within 30 – 60 minutes*

Top 200 Most Prescribed Drugs of 2022:

1. Atorvastatin: Rx=109,582,746, People=27,935,702
2. Metformin: Rx=86,747,907, People=19,536,027
14. Amphetamines: Rx=34,690,297, People=4,652,545
23. Hydrocodone: Rx=23,521,228, People=7,972,417
60. Oxycodone: 11,314,082, People=4,797,946

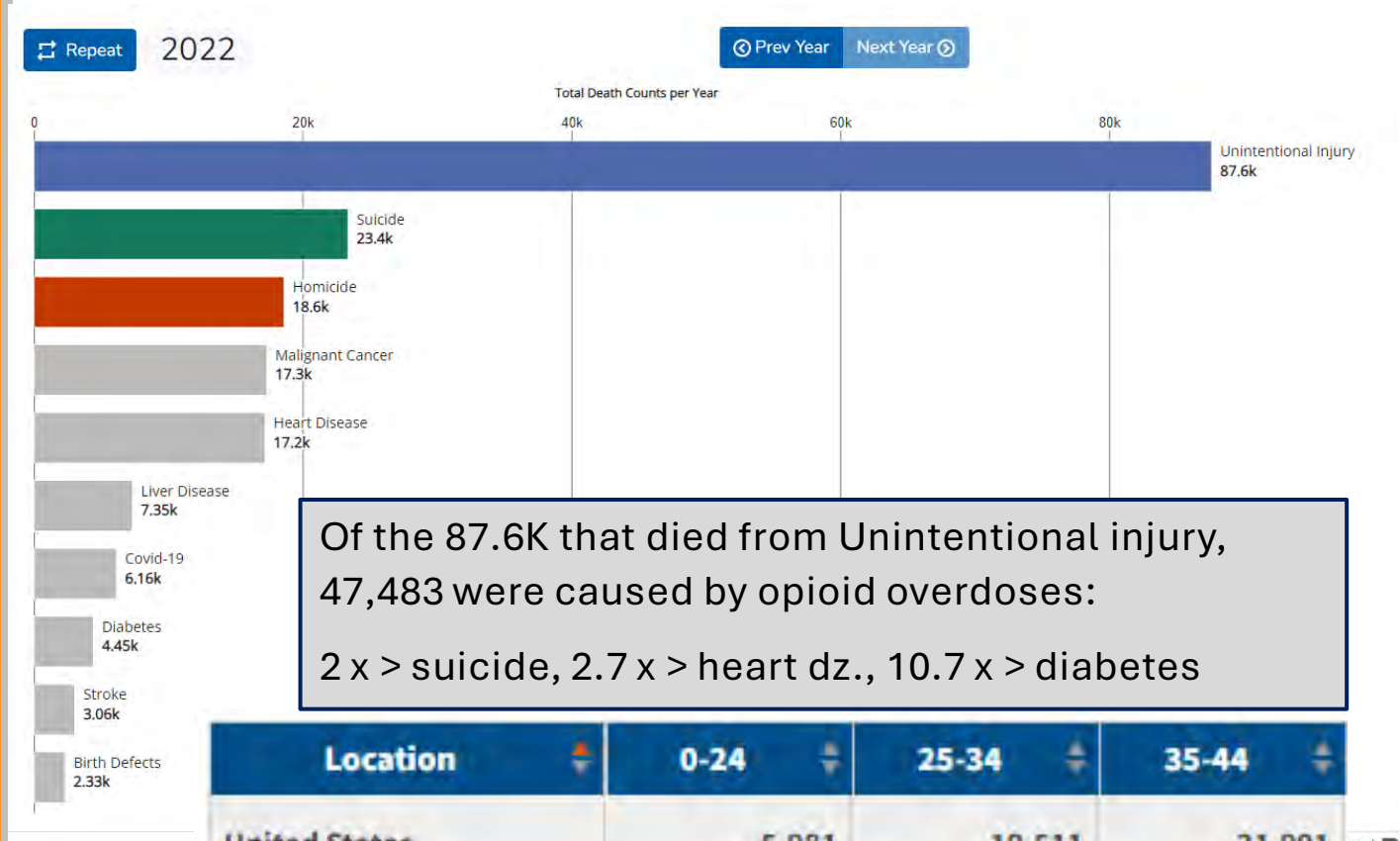
Buprenorphine = not even in the top 200

https://clincalc.com/DrugStats/

4. Connect patients to outpatient MOUD care, same day when possible.

The moment matters!

Opioid overdose is # 1 cause of death in people < 45 y.o.



Of the 87.6K that died from Unintentional injury, 47,483 were caused by opioid overdoses:

2 x > suicide, 2.7 x > heart dz., 10.7 x > diabetes

Location	0-24	25-34	35-44
United States	5,981	19,511	21,991

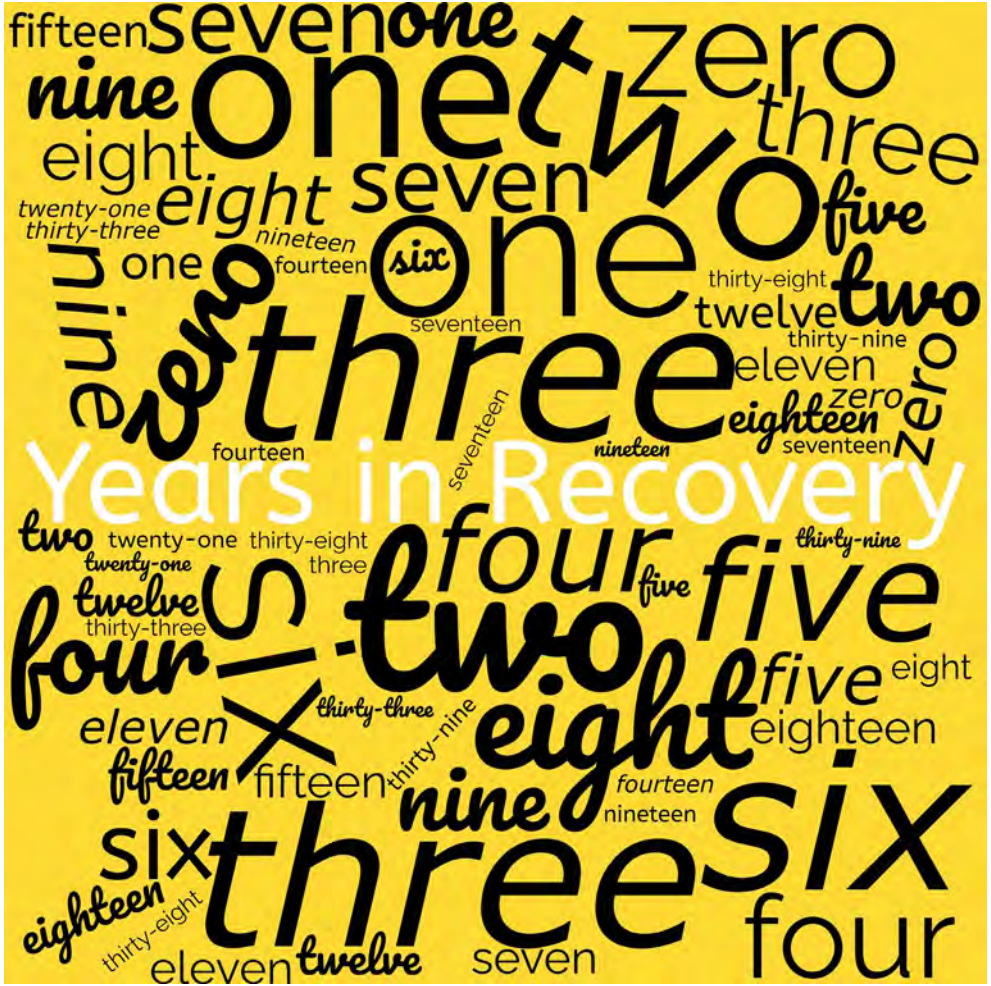
- Unintentional injuries are the leading cause of death for Americans aged 1-44 years old.
- Unintentional injuries include opioid overdoses (unintentional poisoning), motor vehicle crashes, and unintentional falls.

https://www.cdc.gov/injury/wisqars/animated-leading-causes.html

https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-age-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

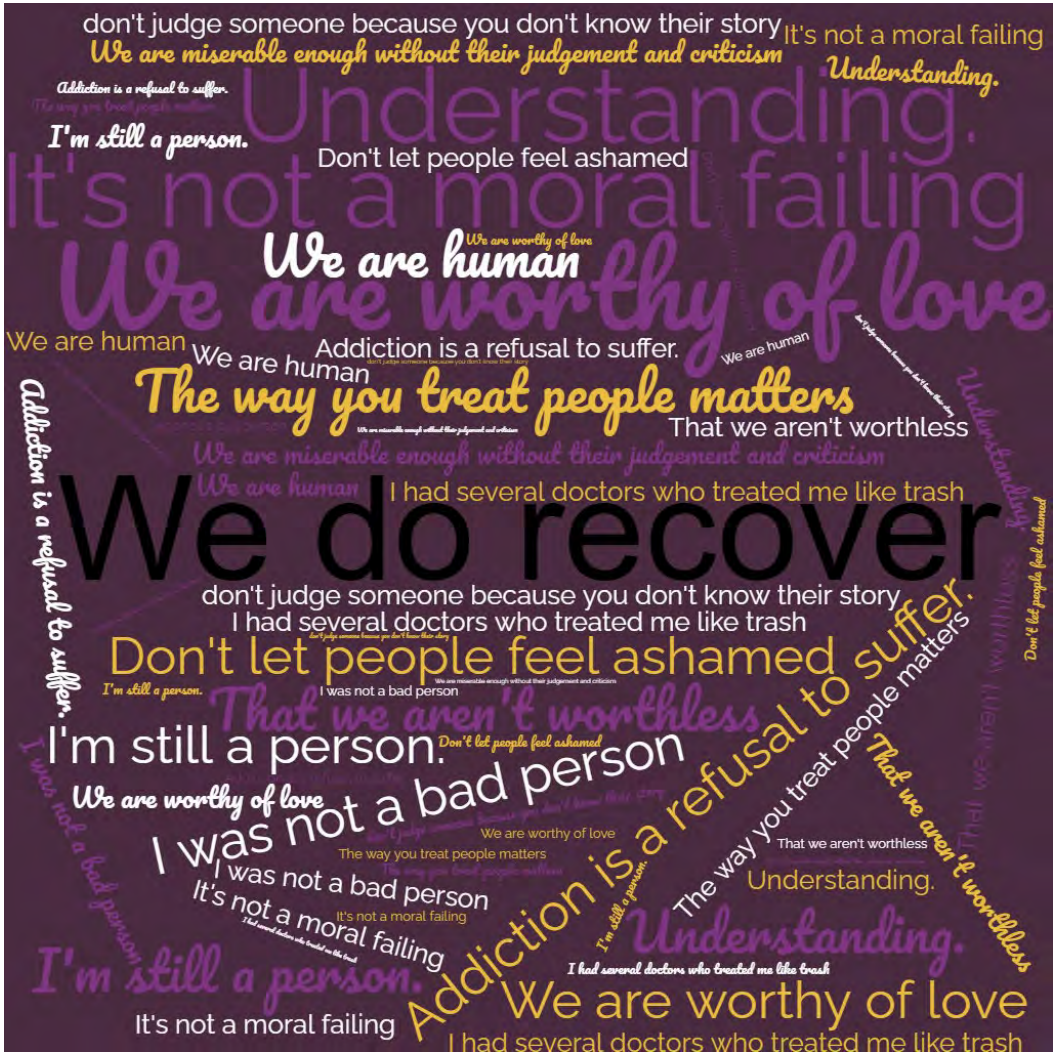
BRIDGE TO RECOVERY

Perspectives from People in Recovery



How many years have you been in recovery?

What is your current occupation?



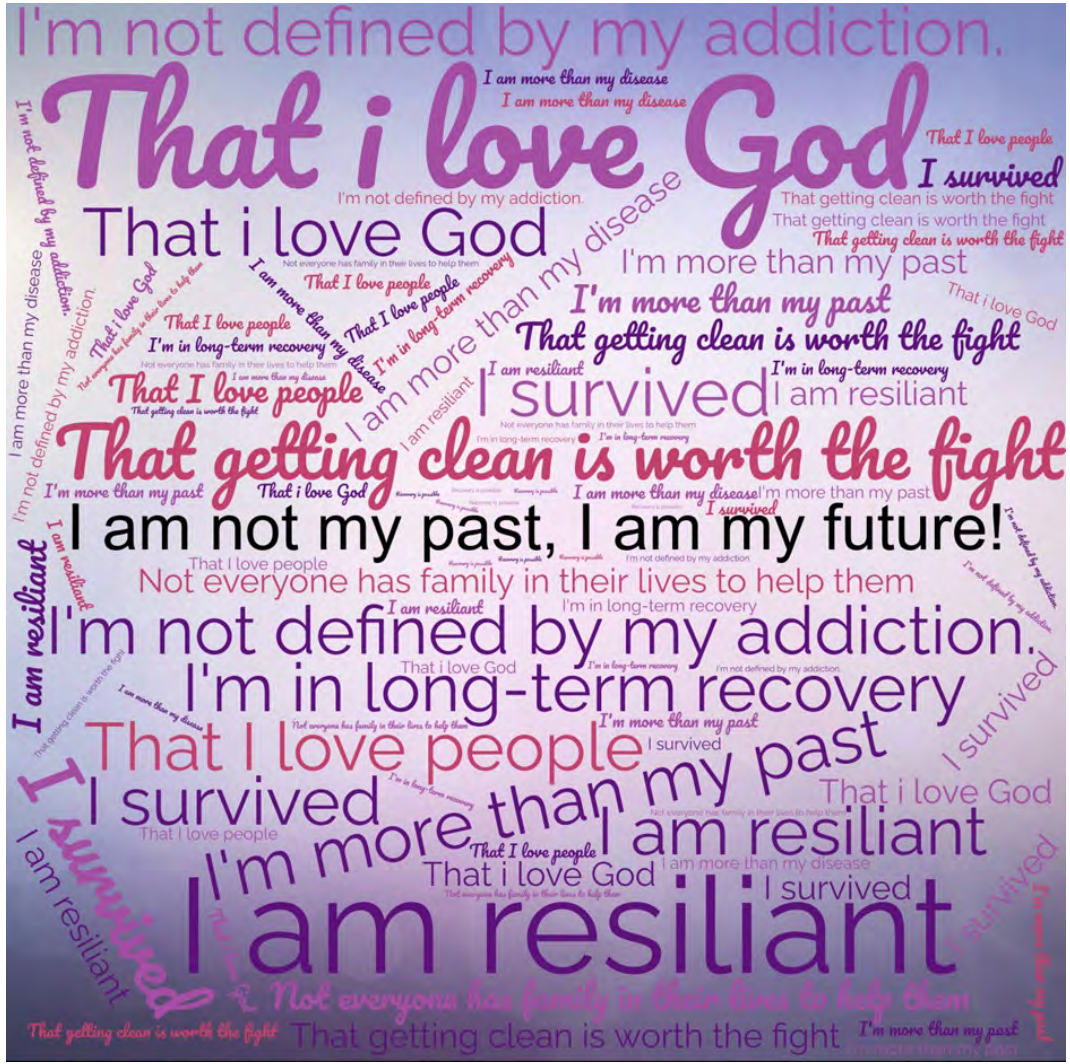
What do you want people to know about you??

What does your sobriety date mean to you?

Offer OUD treatment to *every patient every time*, because the next time, could be the last time

Where there's breath there's life

What do you want people to know about you?



Those who have the *ability* to take action have the *responsibility* to take action.

Questions and Discussion

The University of Tennessee Medical Center Presents:

"The Painless Approach to Substance Use Disorder Treatment"

Tips, Tricks and Training for Clinical Teams

Free Continuing Education Series
Available til End 2025

Join us

for an 8-session series

Live Every Wednesday
12 pm - 1 pm
August 7 - September 25, 2024

This eight-session series is free, will be available for one year, and provides continuing education credits that meet DEA-MATE Act requirements. It is available to everyone at UT Medical Center and our affiliates, partners and other stakeholders.

Objectives:

- Identify bias and stigma surrounding SUD and understand how it affects access to treatment of mental health and other medical diseases.
- Identify and manage patients in need of MAT, and then know when to initiate or re-initiate MAT with follow-up care.
- Utilize available resources at UT Medical Center and resources available through community partners to assist patients with SUD.

Scan to register or email
MLWilliams@utmck.edu

Curriculum

August 7: Overview of Addiction
Neurobiology of this chronic disease & why you should treat SUDs

August 14: Recognizing "Dopesick"
The Challenges it creates & The Trauma-Informed Approach

August 21: An Insider's Scoop on Pharmacology for SUD
Challenges & Impacts of Prescriber Access

August 28: Basics of MAT
How to Identify, Assess, Diagnose, Initiate and Manage Treatment

September 4: Alcohol Use Disorder
Use and Misuse, Withdrawal and Treatment

September 11: What Every Clinician Needs to Know About Current Drug Trends
A Forensic Approach to Drug Testing, Trafficking Patterns, Xylazine and Other Adulterants

September 18: Insights from Tennessee's Recovery Guru, A Physician in Recovery
Neurobiology and Trauma in Addiction and How Hyperalgesia Affects Pain Management

September 25: The Bridge to Recovery
UT Medical Center's Success & What Happens Next

Scan to register or email
MLWilliams@utmck.edu

The University of Tennessee Medical Center is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

The University of Tennessee Health Science Center College of Pharmacy is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the University of Tennessee College of Medicine and The University of Tennessee Medical Center. The University of Tennessee College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

The University of Tennessee College of Medicine designates this live activity for a maximum of 8 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Physician Assistants, Nurse Practitioners and Nurses may use these credit hours toward certification renewal. This credit is acceptable by the American Academy of Physician Assistants (AAPA), American Nurses Credentialing Association (ANCC) and the American Academy of Nurse Practitioners (AANP).