

Addiction Treatment and the HCV Provider

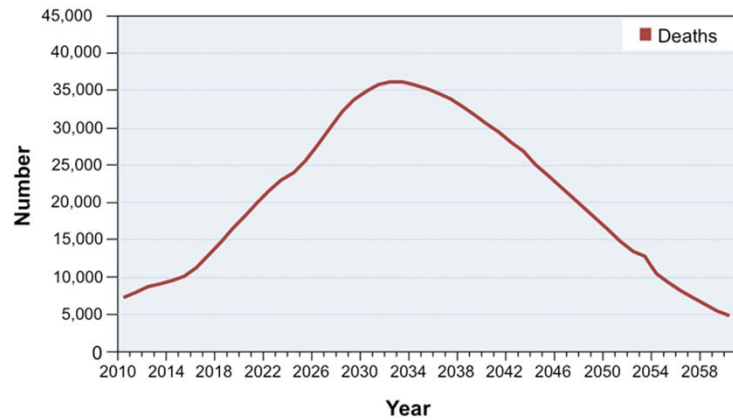
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Oregon Health and Science University

Epidemiology

- Injection drug use now accounts for at least 60 percent of HCV transmission in the United States.
- 75-90% of PWID are HCV Ab positive.

Centers for Disease Control and Prevention. Viral Hepatitis Surveillance—United States, 2014. [LINK.CDC.GOV](https://www.cdc.gov/hepatitis)²

Deaths from
prevalent HCV
forecasted to
peak in
2030s...

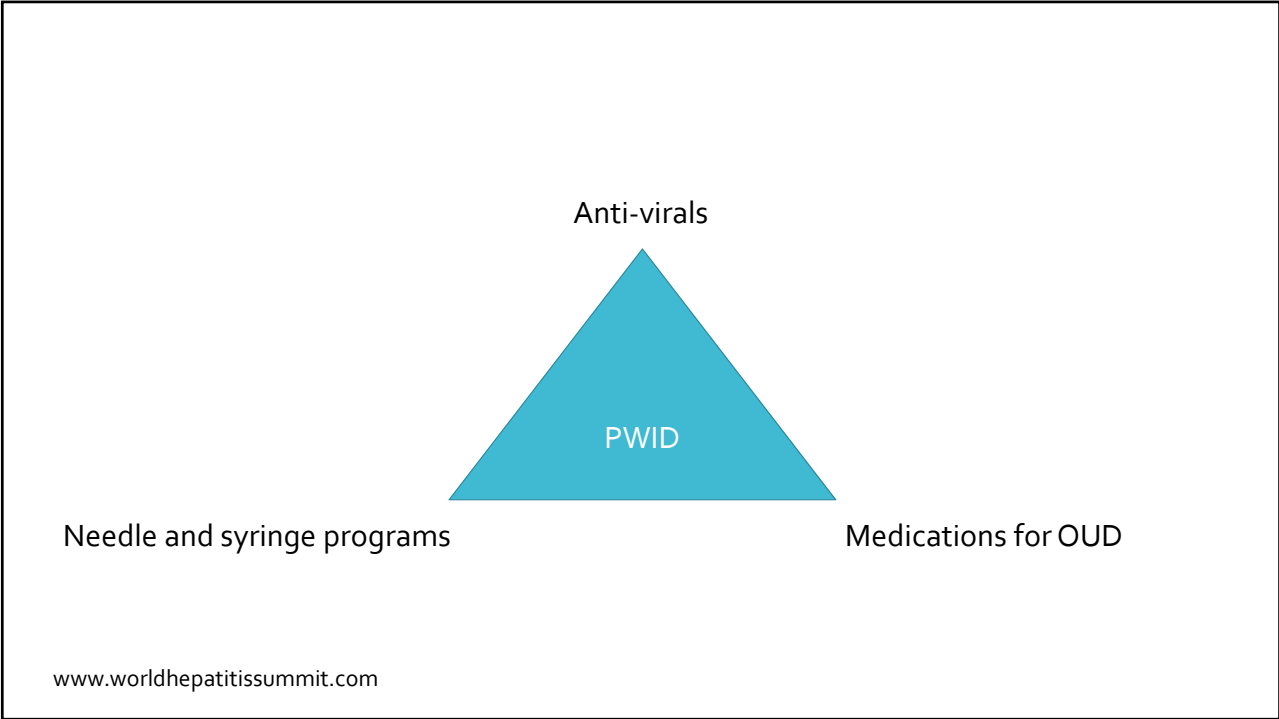


Rein et al. Dig Liver Dis. 2011;43:66-72.

...unless
something
changes

- prevention of drug injection would eliminate the greatest risk factor for HCV infection in the United States
- Buprenorphine/methadone treatment decreases infection by 50%
- Bup/methadone and needle exchange combined decrease infection by 80%

Hutchison et al. Cochrane. 2017, Issue 9.
Turner et al. Addiction 2011



Medications for Opioid Use Disorder (MOUD)

Opioid Agonists



Methadone

Full agonist at the opioid receptor

Half life greater than 24 hours

Opioid treatment program only

OK to dispense in hospitals

Methadone

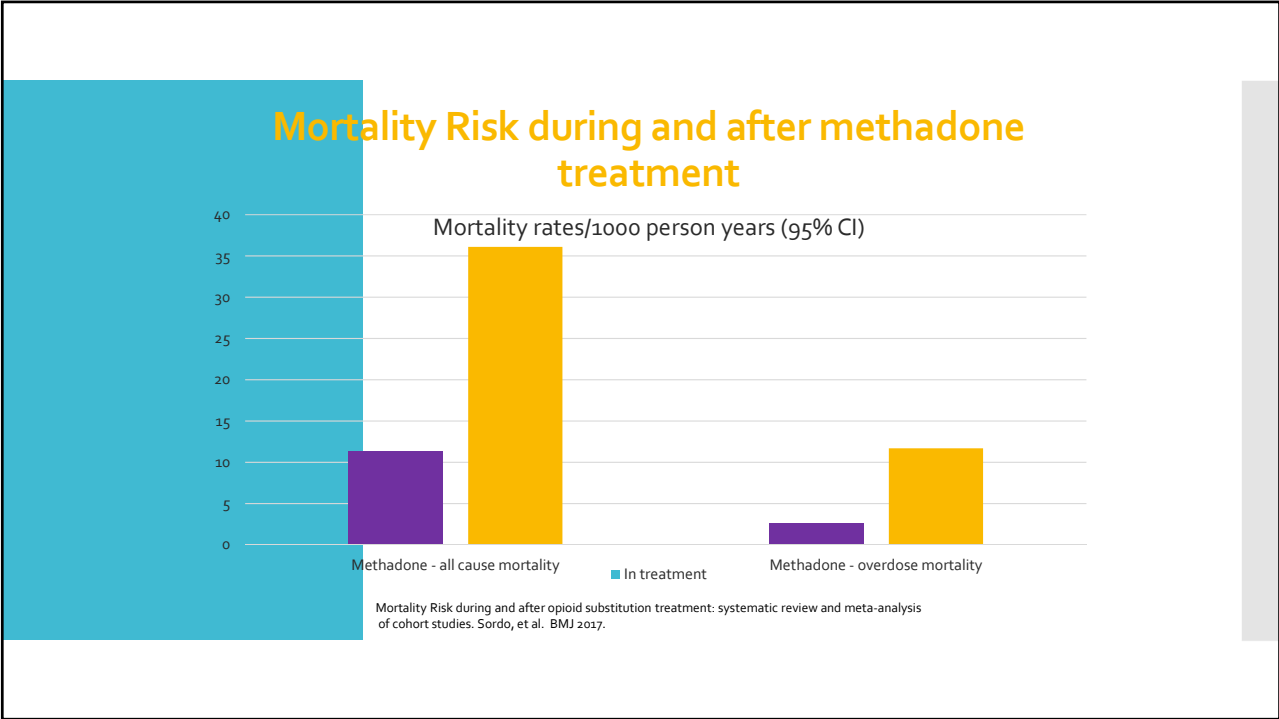
Decreases use of illicit opioids

Increases retention in treatment

Decreases incidence of new HIV/Hepatitis C infections

Reduces criminality

Gowing LR, Farrell M, Bornemann R, et al *J Gen Intern Med.* 2006.
Lawrinson P, Ali R, Buavirat A, et al. *Addiction.* 2008.
Nolan S, Dias Lima V, Fairbairn N, et al. *Addict Abingdon Engl.*
MacArthur, G.J., et al., *BMJ*, 2012.



Buprenorphine

Partial agonist at the opioid receptor

Prescribers must have a DATA waiver

Patients limits (30/100/275)

OK to dispense in hospitals

Buprenorphine

Decreases use of illicit opioids

Increases retention in treatment

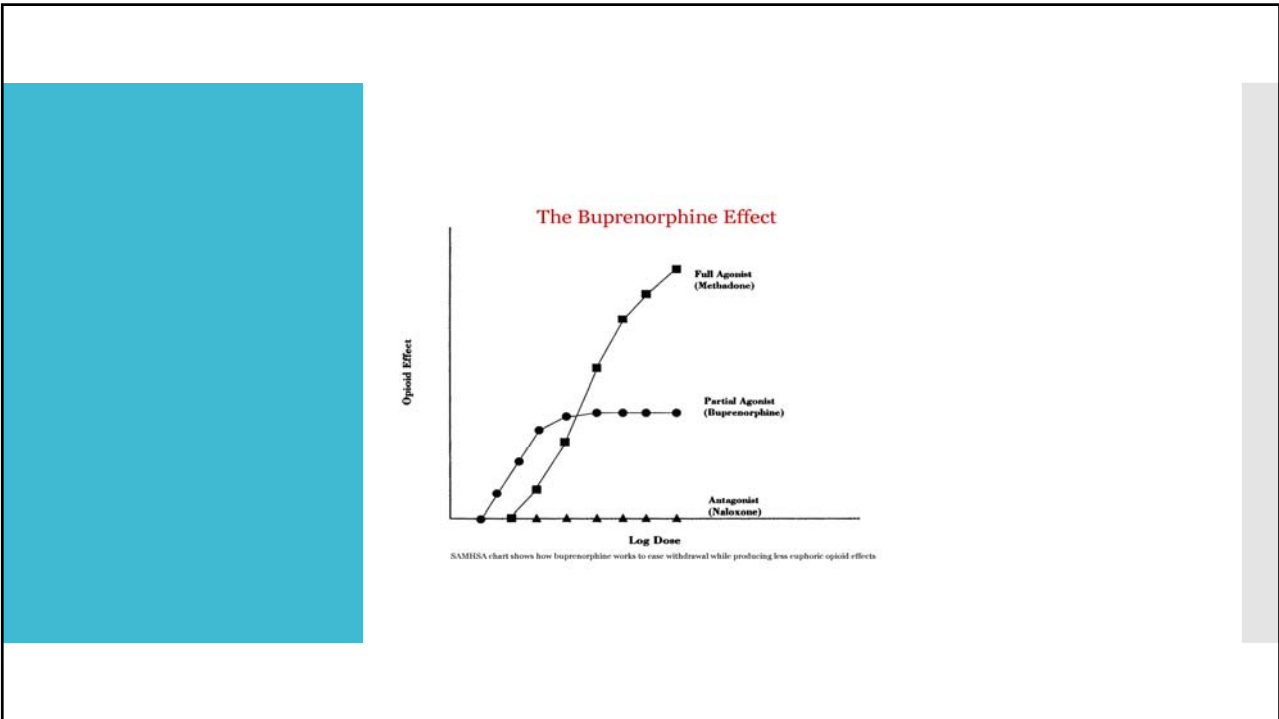
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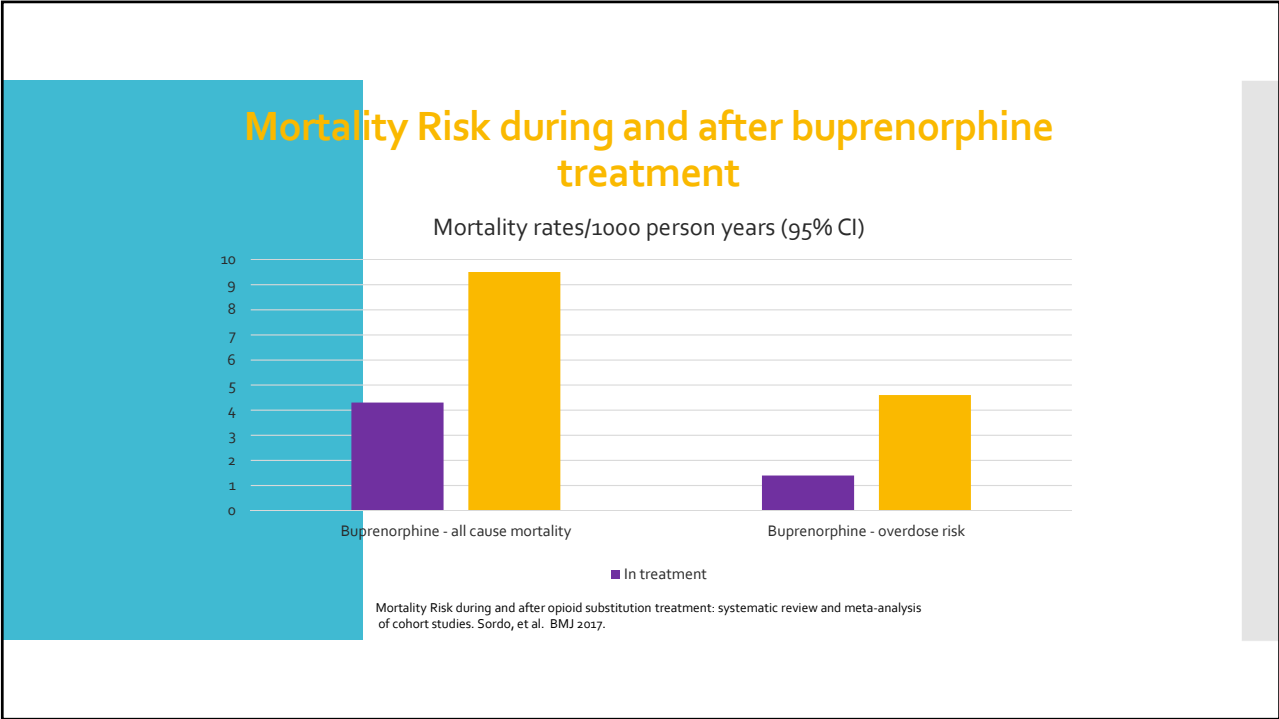
Associated with decreases in ED visits and hospitalizations

14% fewer ED visits and 18% fewer hospital admissions after 1 year

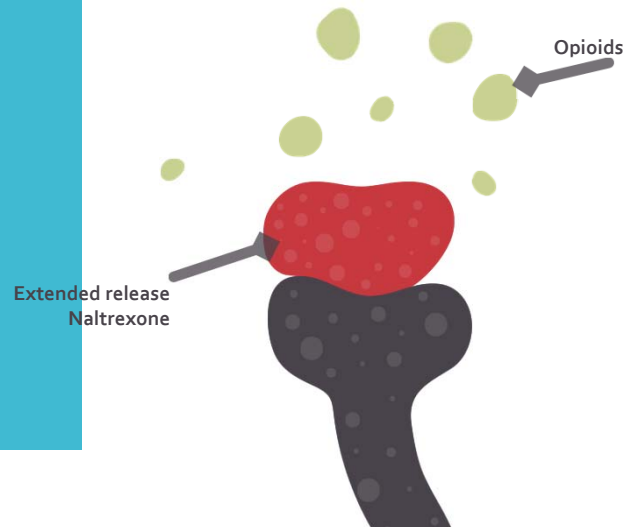
30 day and 90 day readmission reduced by 53% and 43% for patients with OUD on buprenorphine v no buprenorphine

Tsui JJ, Evans JL, Lum PJ, Hahn JA, Page K. *JAMA Intern Med.* 2014
MacArthur, G.J., et al., *BMJ*, 2012.
Lo-Ciganic et al., *Addiction* 2016
Moreno et al, *JAM* 2019





XR Naltrexone



XR Naltrexone

One 380mg deep muscle injection in the buttock, every 4 weeks

No special waiver or training

Abstinent for 7-14 days

¼ of patients do not tolerate induction

No good data on mortality or reduction in HIV/HepC

Naloxone Rescue

46% reduction in community overdose rate in Massachusetts



Walley BMJ 2013

Annals of Internal Medicine

ORIGINAL RESEARCH

Nonrandomized Intervention Study of Naloxone Coprescription for Primary Care Patients Receiving Long-Term Opioid Therapy for Pain

Phillip O. Coffin, MD, MIA; Emily Behar, MA; Christopher Rowe, MPH; Glenn-Milo Santos, PhD, MPH; Diana Coffa, MD; Matthew Bald, MD; and Eric Vittinghoff, PhD

Background: Unintentional overdose involving opioid analgesics is a leading cause of injury-related death in the United States.

Objective: To evaluate the feasibility and effect of implementing naloxone prescription to patients prescribed opioids for chronic pain.

Design: 2-year nonrandomized intervention study.

Setting: 6 safety-net primary care clinics in San Francisco, California.

Participants: 1985 adults receiving long-term opioid therapy for pain.

Intervention: Providers and clinic staff were trained and supported in naloxone prescribing.

Measurements: Outcomes were proportion of patients prescribed naloxone, opioid-related emergency department (ED) visits, and prescribed opioid dose based on chart review.

Results: 38.2% of 1985 patients receiving long-term opioids were prescribed naloxone. Patients prescribed higher doses of opioids and with an opioid-related ED visit in the next 12 months

were independently more likely to be prescribed naloxone. Patients who received a naloxone prescription had 47% fewer opioid-related ED visits per month in the 6 months after receipt of the prescription (incidence rate ratio [IRR], 0.53 [95% CI, 0.34 to 0.83]; $P = 0.005$) and 63% fewer visits after 1 year (IRR, 0.37 [CI, 0.22 to 0.64]; $P < 0.001$) compared with patients who did not receive naloxone. There was no net change over time in opioid dose among those who received naloxone and those who did not (IRR, 1.03 [CI, 0.91 to 1.27]; $P = 0.61$).

Limitation: Results are observational and may not be generalizable beyond safety-net settings.

Conclusion: Naloxone can be coprescribed to primary care patients prescribed opioids for pain. When advised to offer naloxone to all patients receiving opioids, providers may prioritize those with established risk factors. Providing naloxone in primary care settings may have ancillary benefits, such as reducing opioid-related adverse events.

Primary Funding Source: National Institutes of Health.

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For author affiliations, see end of text.
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Naloxone Coprescription

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46% fewer opioid related ED visits per month first 6 months

63% fewer opioid related ED visits per month after 12 months

Summary

To prevent Hepatitis C, treat addiction and emphasize harm reduction

Methadone and buprenorphine use are significantly associated with decreased risk of HIV/Hep C infection

Extended release naltrexone treats opioid use disorder. It is unclear if it also decreases risk of new infections

Don't forget to prescribe naloxone

Registration

- If you haven't already done so, please take a few minutes to sign in using the link or QR Code below. The QR Code can be scanned with your phone's camera to open the link.

<http://sgiz.mobi/s3/Feb-NW-ECHO>



Thank You