GUIDE

2024 Update: Opioid Overdose And Buprenorphine Access

October 2024

This brief is intended to provide an update on the current state of opioid overdose and outpatient buprenorphine treatment in the United States. The brief will focus on disparities in treatment access and fatal overdose, as well as on opportunities to close care gaps and make buprenorphine treatment more accessible to people experiencing homelessness.

Opioid Overdose in the United States

- Currently, over 100,000 Americans are dying annually due to accidental drug overdoses; this represents a nearly quadruple increase in overdose deaths since 2002. Opioids, and predominantly fentanyl, are involved in a majority of overdose deaths. [1]
- According to the Centers for Disease Control, 111,029 Americans died from accidental drug overdoses in 2022; of those deaths, 84,181 involved an opioid.
- It is estimated that overall overdose deaths will decrease to 107,543 in 2023, with opioids involved in 81,083 of those deaths.[1]
- Accidental drug overdose remains the leading cause of death for people experiencing homelessness (PEH) in the U.S.[2] Multiple community-level studies have demonstrated increasing rates of accidental drug overdose deaths among PEH in recent years, the majority of which involve opioids.[3,4]

Health implications beyond fatal overdose, such as non-fatal overdoses, infectious disease transmission, and wounds, also impact people who use drugs. Like other health concerns, non-fatal health implications of substance use can be more difficult to address while experiencing homelessness.

Buprenorphine

- Buprenorphine is a medication used to treat opioid use disorder; it can be dissolved under the tongue or given as a long-acting injection.
- Buprenorphine can be prescribed in primary care settings by any provider who can prescribe controlled substances.
- Buprenorphine is a safe medication with a low risk of misuse and overdose. [5,6]
- Buprenorphine is an opioid partial agonist, meaning it has some effect on opioid receptors. Buprenorphine causes less euphoria and respiratory depression than full agonist opioids like fentanyl and can curtail both withdrawal symptoms and cravings to use opioids.
- Taking buprenorphine decreases overall overdose risk, even for people who continue to use opioids after starting treatment.[7]
- Buprenorphine has not been found to have recreational uses; prescribed medication that is diverted into the community is most often used to self-manage treatment and withdrawal.[5]
- Buprenorphine is one of three medications that are approved by the FDA to treat opioid use disorder; the other two are methadone and extended-release injectable naltrexone. Only buprenorphine and methadone have been shown to decrease fatal overdoses. Currently, methadone can only be prescribed in a specialized outpatient treatment program and not in primary care settings.[8]

Current Barriers and Disparities

- Accessing needed medical care, including substance use treatment, can be particularly challenging for people experiencing homelessness. Barriers such as lack of identification, insurance, and transportation, along with stigma and the need to focus on meeting basic survival needs, can all impact a person's ability to seek and remain in treatment.
- In 2021, only 1 in 5 people in the U.S. with opioid use disorder received medications to treat their substance use.[9]
- There are racial and ethnic-based disparities in who is dying from drug overdoses in the U.S., and in recent years these disparities have increased.[10] Currently, age-adjusted overdose rates are highest for American Indian and Alaska Native populations, followed by Black non-Hispanic populations.[1]
- Since 2020, there has been a shift in opioid overdose deaths away from rural, white populations and towards urban, Black populations, despite opioid use disorder rates not being higher among urban, Black populations.
- Black non-Hispanic, American Indian/Alaska Native, and Hispanic people are less likely than their white counterparts to be prescribed buprenorphine for opioid use disorder,[11,12] and, when prescribed buprenorphine, have a shorter average duration of treatment.[13]
- People who have a mental health or pain diagnosis, or who are non-English speakers, are also less likely to receive buprenorphine from medical providers they encounter in both outpatient and emergency department settings.[10]
- Medicaid covers nearly 40% of all non-elderly adults diagnosed with opioid use disorder in the U.S.[14]; for people living in the ten states that have not expanded Medicaid and those not eligible for insurance, lack of insurance coverage can pose another significant barrier to treatment.
- People living in rural areas are less likely to have access to buprenorphine prescribers[15] and pharmacies[16] that carry the medication compared to people living in urban areas.

Elimination of the X Waiver

- In December 2022, the Mainstreaming Addiction Treatment Act, or MAT Act, was passed by Congress and signed by President Biden. This act eliminated federal restrictions on buprenorphine prescribing that had mandated that any provider prescribing buprenorphine complete specialized training and apply for an additional registration with the Drug Enforcement Administration (DEA).
- With the elimination of the X waiver, any prescriber who can prescribe controlled substances can prescribe buprenorphine. This change has the potential to significantly increase buprenorphine prescribing across the U.S. When the X Waiver was in place, only around 5% of prescribers had obtained the additional training and registration necessary to prescribe buprenorphine.[17]
- While the MAT Act broadened the ability to prescribe buprenorphine to all providers, the federal change in policy does not supersede state restrictions. Multiple states still have restrictions in place regarding who can prescribe and receive buprenorphine, as well as the number of buprenorphine patients an individual prescriber can have at one time.

The Role of Primary Care in Treatment Access

- Primary care settings are an integral access point for people seeking treatment for opioid use.

- The elimination of the X Waiver has increased the ability for more primary care providers to include substance use treatment in their menu of services; teams may need additional training, infrastructure, and staffing support to add buprenorphine treatment.
- Primary care teams can work closely with other social service and treatment providers to help coordinate needed care, including additional supports around substance use such as syringe services or behavioral health care.
- Primary care-based programs that are low-threshold, meaning treatment is easy to enter and easy to continue, and that follow a harm reduction approach, are more accessible for people who are experiencing homelessness and using drugs.[18]
- An important characteristic of low-threshold or low-barrier services is the ability to meet people where they are, both physically and with regard to their substance use. Programs that utilize outreach and Street Medicine, that operate using a walk-in model and with extended hours, and that utilize community partnerships to facilitate access, will reach more people who otherwise may not be able to receive desired treatment.

Opportunities to Close Care Gaps

- **Leverage the knowledge of buprenorphine champions** – providers who have been strong and early advocates for integrating substance use treatment into their care delivery – to encourage others to prescribe buprenorphine. Providers who have been doing this work can share their experiences, best practices, and protocols, and serve as mentors for others to facilitate new program starts and internal expansion.
- **Provide non-judgmental services** that make it easier for people to start and continue treatment. Work to meet people where they are both physically and with regards to their drug use, provide a range of options for following up – for example via mobile health or telehealth, and use a harm reduction approach throughout treatment.
- **Offer education and ongoing support**, as well as different options for starting buprenorphine, for clients who may be fearful about experiencing withdrawal when they transition to buprenorphine.
- **Facilitate treatment plan adaptations** for clients who may benefit from other types of treatment or supports, recognizing that what works will be different for each person and may change over time. Primary care providers can work to ease transfers to and from outpatient and inpatient treatment, to and from buprenorphine to methadone or other treatment modalities, from oral (sublingual) buprenorphine to long-acting injectable buprenorphine formulations (Sublocade and Brixadi), and to additional supports like mental health services, wound care, and harm reduction resources. Primary care should continue to be a client's medical home regardless of treatment type.
- **Leverage program data to identify and address disparities** in access, prescribing practices, and treatment retention. *For example, programs can identify if the demographics of their buprenorphine patient population reflect their larger community, or investigate whether non-white or non-English speaking patients are less likely to follow-up for care, have shorter treatment durations, or are more likely to be discharged from treatment. Interventions might include outreach to communities not accessing services, staff training, hiring staff from the community, and ongoing data collection and analysis to look for positive change or other areas for improvement.*

- **Treat the whole person** by recognizing that many people who use opioids are also using other substances, including alcohol. People may have success with using buprenorphine for their opioid use and still struggle with other drugs. Providers can use a harm reduction approach to support people's health and substance use goals, address concerns related to other drugs – including unwanted additives like xylazine, and work with community partners to meet clients' diverse needs.

Looking Ahead to 2025

- Data demonstrating the impact of the elimination of the X Waiver on the number of buprenorphine prescribers is not yet available; we hope to have information on prescriber trends and updated strategies for buprenorphine expansion next year.
- Health Care for the Homeless (HCH) providers have been at the forefront of integrating buprenorphine prescribing into primary care, including via mobile health, outreach, and Street Medicine models. Our community has the potential to educate and support the efforts of other providers interested in adding this vital primary care service.
- It remains important to continue to explore ways to make buprenorphine treatment more accessible to people using opioids who are interested in treatment and reducing overdose risk.

Additional Resources

- National Health Care for the Homeless Council (NHCHC): Substance Use Guides - Substance-specific guides for all types of HCH service providers
- National Health Care for the Homeless Council (NHCHC): Homeless Mortality Data
- National Association of Community Health Centers (NACHC): Equity in Pain Management and Substance Use Treatment Resource
- Substance Abuse and Mental Health Services Administration (SAMHSA): Harm Reduction Framework
- Substance Use and Mental health Services Administration (SAMHSA): Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings

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