Fentanyl in Yakima: Why Overdose Risk is Different Now – and What Primary Care Can Do Today

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- **Disclosures:** None

Learning objectives slide

- Describe why fentanyl is driving unprecedented overdose risk in Yakima County
- Recognize how fentanyl changes opioid withdrawal, overdose risk, and treatment engagement
- Identify practical steps primary care can take today, including MOUD, naloxone, and referral pathways
- Review local Yakima treatment and harm-reduction resources

Yakima’s Fentanyl Crisis

Before community naloxone and coordinated response, overdose was far more likely to be fatal.

Bystanders had few tools to intervene, and response systems were less coordinated.

Today, naloxone, rapid first-responder response, real-time overdose tracking, and stronger partnerships are helping communities save lives.

Primary care providers play a critical role by recognizing OUD early, prescribing naloxone, initiating treatment, and connecting patients to ongoing care.

Yakima County ODMAP Impact

- Safe Yakima Valley launched and led Yakima County's ODMAP rollout beginning in October 2023.
- Before ODMAP, non-fatal overdoses were not being tracked, hiding the true scale of the crisis.
- A 2023 Yakima Fire review projected ~6,000 overdoses countywide in one year.
- By April 2024, Safe Yakima Valley had helped connect nearly 70% of local fire and law enforcement agencies to ODMAP.
- ODMAP and targeted response strategies helped Yakima move from #1 to #7 in Washington for overdose death rate, with deaths falling from 145 in 2024 to an estimated 109 in 2025.

96

Overdose Deaths

(visible problem)

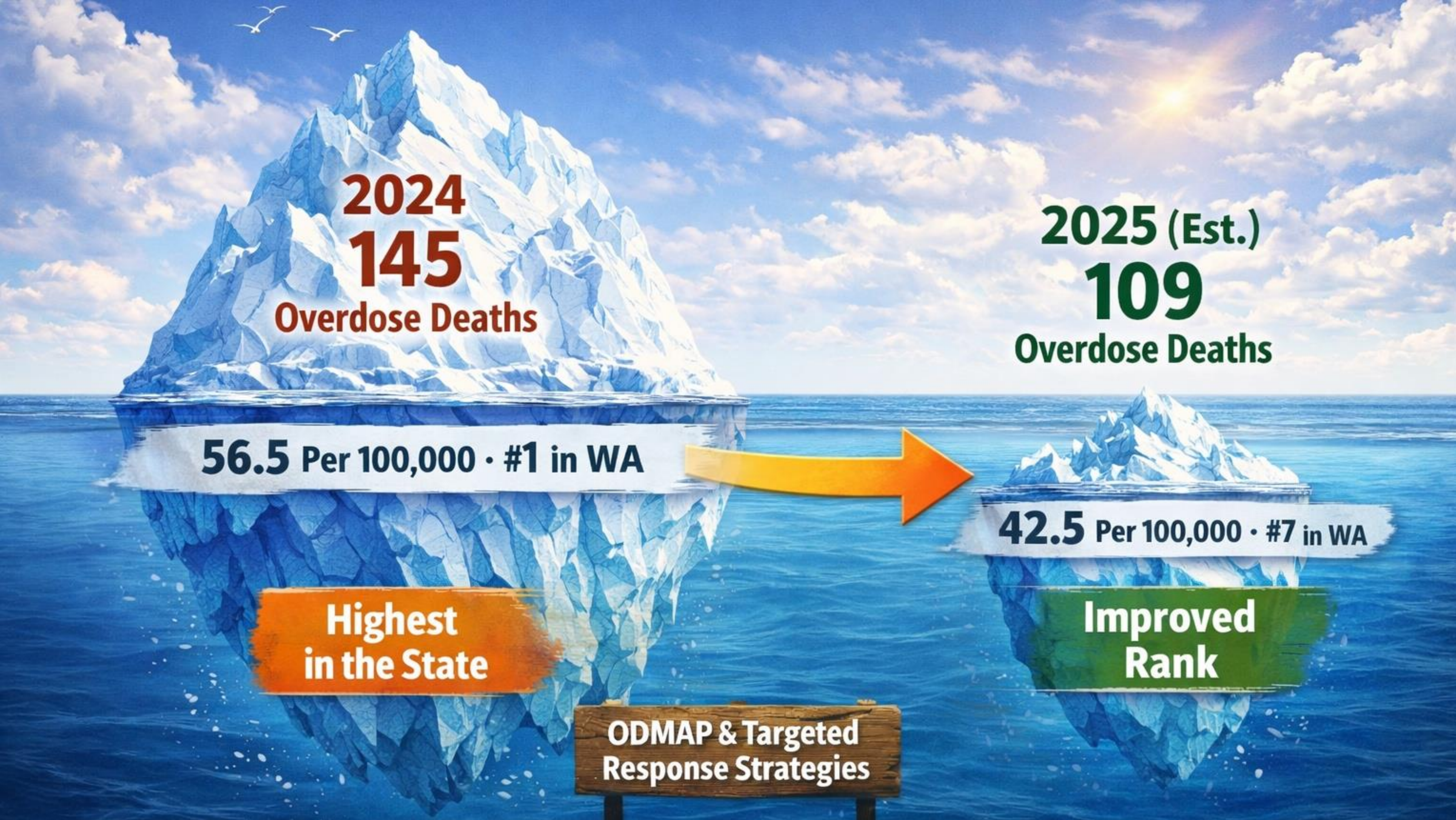
WATERLINE

~6,000

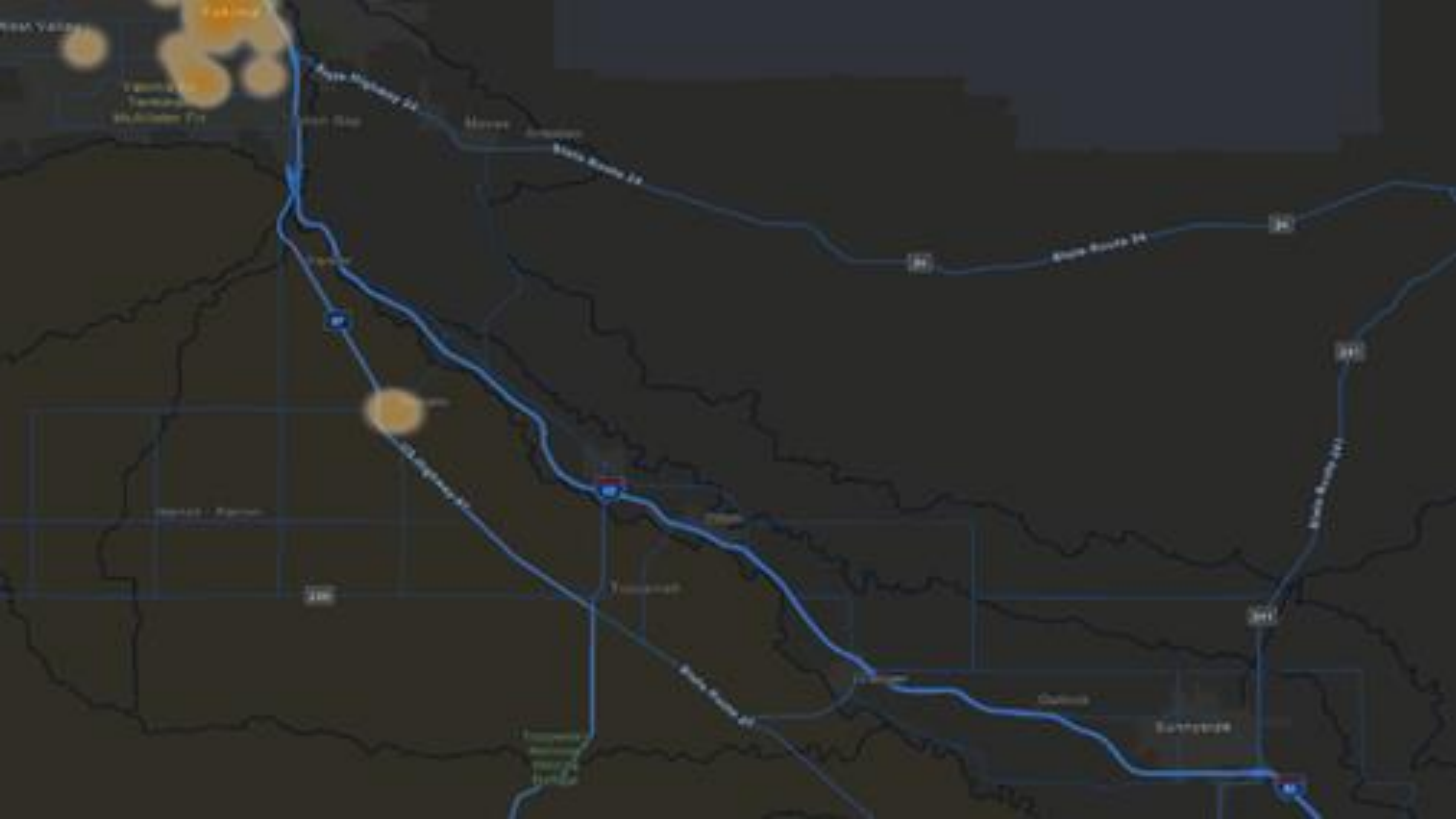
Total Overdoses

(fatal + non-fatal annually)

Thousands of people survive overdoses each year because first responders intervene with naloxone



2024
145
Overdose Deaths
2025 (Est.)
109
Overdose Deaths
56.5 Per 100,000 · #1 in WA
42.5 Per 100,000 · #7 in WA
Highest in the State
Improved Rank
ODMAP & Targeted Response Strategies



State Route 24
24
24
State Route 24
241
Sunnyside

Why Fentanyl Is So Hard to Stop

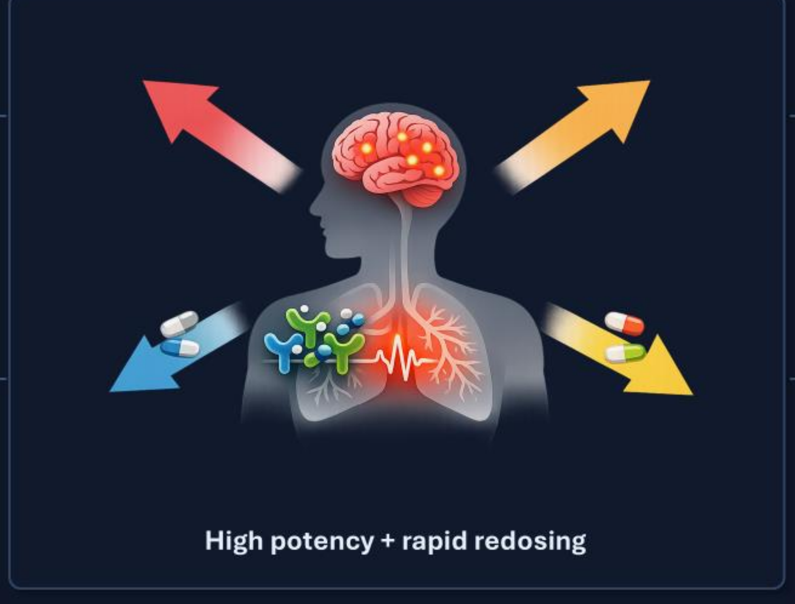
Primary care takeaway: withdrawal is intense, presentations vary, and medication-supported treatment is often needed.

1. Extreme potency

Tiny amounts can produce major opioid effects, so tolerance and physical dependence build quickly.

2. Fast tolerance, harsh withdrawal

Use shifts from chasing euphoria to avoiding withdrawal, which drives repeated redosing just to feel normal.



3. Unpredictable supply

Illicit fentanyl is often mixed with other substances, so symptoms and treatment response vary.

4. Detox alone is fragile

Tolerance falls quickly after stopping, but craving and relapse risk stay high. MOUD is often safer.

Why "detox" is so difficult

High potency → Rapid dependence → Severe withdrawal → Repeated use to feel normal → Relapse / overdose risk

Barriers to prescribing MOUD

- Hospital clinicians are motivated to treat opioid use disorder but lack the training, experience, and specialist support needed to confidently initiate medications for opioid use disorder (MOUD).

- MOUD initiation is limited: Among 143 clinicians surveyed, 55% had initiated MOUD for a hospitalized patient in the past year.
- Major barriers are knowledge and support: Clinicians reported lack of experience (86%), insufficient training (82%), and limited addiction specialist support (76%).
- Motivation exists despite low confidence: Knowledge and comfort with MOUD were generally low, but clinicians who had initiated MOUD showed higher knowledge and stronger belief in medication effectiveness for OUD.

Jakubowski A, Singh-Tan S, Torres-Lockhart K, Nahvi S, Stein M, Fox AD, Lu T. *Hospital-based clinicians lack knowledge and comfort in initiating medications for opioid use disorder: opportunities for training innovation.* **Substance Abuse Treatment, Prevention, and Policy.** 2023 May 18;18(1):31

X-Waver Eliminated

- The X-waver required a clinician to complete required training, apply for a special DEA number and limited the number of patient they could prescribe buprenorphine to
- Was considered a barrier to treatment
- Before the change most US counties had no buprenorphine prescriber

- Jan 2023, clinicians no longer need an X-waiver to prescribe buprenorphine for OUD
- Because...Buprenorphine has a
  - Ceiling effect for respiratory depression
  - Reduces overdose mortality by about 50%
  - Can be safely prescribed in primary care settings

Patient-Centered Approach

Inform patients of all FDA-approved MOUD options:

- Methadone
- Buprenorphine
- Naltrexone

Shared decision-making is essential

Consider patient goals, treatment history, pregnancy status, fentanyl exposure, and access to care

WA Telebuprenorphine Hotline

Fast and Low-Barrier Opioid Treatment

The Washington Telebuprenorphine (Telebupe) Hotline is a statewide telehealth program providing low-barrier access to buprenorphine, a medication for opioid use disorder (MOUD), to anyone in WA ages 13+ years, including pregnant people. The hotline provides a direct connection from crisis intervention to sustained care to help address Washington's opioid and fentanyl crisis.

No-cost visits - No insurance required - Referrals for long-term care

- **Call the hotline any day of the week from 9 AM-9 PM** - audio or video available
- **Same-day telehealth visit*** with a trained emergency medicine doctor
- **Prescription sent to local pharmacy**
- **Linkage-to-care coordinators** connections to ongoing treatment and support

*Compliant with WA & federal telehealth regulations; DEA-registered providers may prescribe buprenorphine without an in-person visit.

(206) 289-0287
7 days a week, 9:00 AM-9:00 PM

Spread the Word

Share hotline promotional materials with your community.

Give clients the hotline number or call together if they request that support.

Bridge treatment access gaps

Integrate the hotline into your workflow. Include the hotline number on your materials, such as discharge or follow-up plans.

Partner with us

Reach out with questions about our service or ideas on partnering with us.

Fill out the referral partner form to become an organization that receives referrals from the hotline.

Contact WA Telebupe: telebupe@uw.edu **or** learn more at our website

DOH 170-013 October 2025 To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

Lowering barriers to caring for patients who use drugs.

Providing the tools you need to feel competent and confident addressing opioid use disorder during the fentanyl crisis.

Buprenorphine Home Initiation

Dispense Naloxone and provide harm reduction education

- Day 1: once patient is in moderate withdrawal they will take 16mg buprenorphine and wait 30-60 minutes.
- If patient still experiencing withdrawal – patient will take 8-16 mg additional buprenorphine NTE 32mg on day1
- Day 2 and more: Buprenorphine 8mg TID until follow up visit.

Buprenorphine Dosing Guidelines

- Goal:
  - Alleviate withdrawal
  - Suppress cravings
  - Enable discontinuation of illicit opioid use
- ASAM practice guidance:
  - 24 mg/day historically cited upper limit
  - Evidence supports improved retention and reduced opioid use at 16–32 mg/day

Kampman K, Jarvis M; American Society of Addiction Medicine National Practice Guideline for the treatment of Opioid Use Disorder. Journal of Addiction Medicine. 2015; 9(5): 358-367.

Clinical Opiate Withdrawal Scale (COWS)

- **Assessment Components (11 items)**
- Resting pulse rate
- Sweating
- Restlessness
- Pupil size
- Bone or joint aches
- Gastrointestinal upset
- Tremor
- Yawning
- Anxiety or irritability
- Gooseflesh skin
- Runny nose or tearing

Total Score	Severity Level	Clinical Interpretation
5–12	Mild Withdrawal	Early withdrawal symptoms; usually monitored before medication initiation
13–24	Moderate Withdrawal	Appropriate range for **buprenorphine induction**
25–36	Moderately Severe Withdrawal	Significant withdrawal symptoms requiring treatment
>36	Severe Withdrawal	Severe physiologic withdrawal requiring urgent management

Managing Ongoing Withdrawal

- Administer additional buprenorphine
- Supplement with alpha-2 agonists if needed
- Evaluate for:
    - Withdrawal from other substances
    - Adverse effects (e.g., nausea)

Precipitated Opioid Withdrawal (POW)

Most people in withdrawal can start bup without issue

- Prospective ED trial: 0.76% overall; about 1% among fentanyl users

D'Onofrio, Gail; Et. Al. Incidence of Precipitated Withdrawal During a mUltisite Emergency Department – Initiated Buprenorphine Clinical Trial in the Era of Fentanyl. Jama Network Open: March 30, 2023.

Management

- For precipitated withdrawal:
- Immediately give 16 mg of Buprenorphine (2 strips or tablets) dissolve under tongue for 20 mins.
- You may repeat 8-16 mg of buprenorphine again in 1-2 hours if needed (40+ mg OK)
- Ondansetron 4-8 mg dissolve under tongue for nausea
- Clonidine 0.1 mg 1-2 tabs every 4 hours for restlessness and sweating
- Comfort meds as needed: tizanidine, hydroxyzine, trazodone,NSAIDS, gabapentin, ketamine/benzodiazepines/hydromorphone (inpatient)

Phases of Buprenorphine Treatment

Induction Phase

- Safely start Bupe
- Stop opioid use

Stabilization Phase

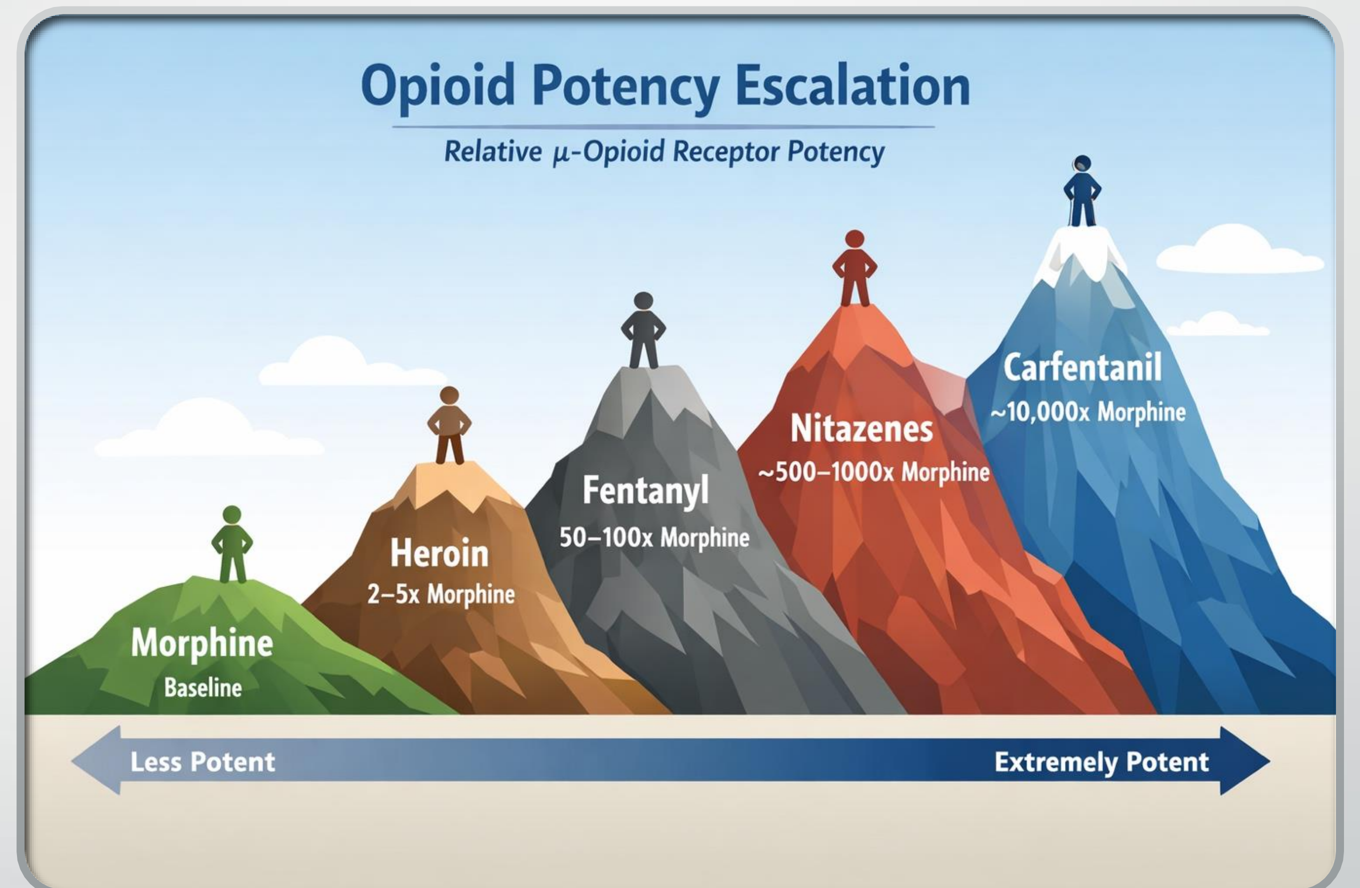
- No opioid withdrawal symptoms
- Reduction in cravings
- Functional stability

Long-Term Treatment

- Continue treatment as long as patient benefits
- May be years or lifetime
- No arbitrary time limits

High Potency Synthetic Opioids

- Higher buprenorphine concentrations may
- protect against fentanyl-induced respiratory depression
- SL: 24–32 mg/day
- XR: 300 mg IM or SQ



Buprenorphine in Pregnancy

Expanded plasma volume and adipose tissue

Higher doses may be required

Split dosing (2–4x daily) may prevent interdose withdrawal

Long-Acting Buprenorphine

- Both long-acting buprenorphine formulations:
    - Improve treatment adherence
    - Reduce diversion risk
    - Maintain stable plasma buprenorphine levels
- They are particularly useful for patients who:
    - Struggle with daily medication adherence
    - Have unstable housing
    - Are transitioning from inpatient or residential treatment

XR BUPRENORPHINE ACHIEVES SIMILAR OR HIGHER PLASMA LEVELS COMPARED TO 24 MG SL

8–16 WEEKS TO STEADY STATE

SL BUPRENORPHINE MAY BE USED PRN FOR BREAKTHROUGH SYMPTOMS

Long-Acting Injectable Buprenorphine

Methadone

- Full opioid agonist
- Dispensed as a liquid medication in highly regulated opioid treatment programs.
- Locally: Comprehensive Healthcare (Yakima)

Extended-Release Naltrexone

- Considered 2nd line for OUD
- Must be opioid-free 7–10 days – extremely high risk time
- Best initiated in controlled setting
- Reduced tolerance increases overdose risk if relapse occurs
- Requires informed consent and overdose prevention education

Naloxone Access in Washington State

Who can obtain naloxone?

- **Anyone** can obtain naloxone without an individual prescription
- Individuals at risk for overdose
- Friends, family members, or bystanders
- Community organizations and outreach programs

- **Retail pharmacies** (no prescription required)
- **Community harm-reduction programs**
- **Public health departments**
- **Substance use treatment programs**
- **Hospitals and emergency departments**

Insurance and cost:

- Covered by Apple Health and most commercial insurance
- Often free through community distribution programs

If the Patient Declines Treatment, Do Harm Reduction Anyway

- **Prescribe naloxone** and teach the patient and family how to use it
- **Warn about fentanyl risk**: potency is unpredictable and may be present in counterfeit pills or other substances
- **Discuss loss of tolerance** after jail, detox, hospitalization, or periods of abstinence
- **Encourage safer use practices** such as not using alone and avoiding mixing opioids with benzodiazepines or alcohol
- **Keep the door open**: a patient who declines MOUD today may accept it tomorrow
- **Schedule follow-up rather than ending the conversation**

Yakima SUD Providers

🏥 Provider	🔎 Key Services	👥 Population Served
Triumph Treatment Services	• ASAM assessments • Outpatient SUD treatment • Residential treatment (ASAM 3.5 / 3.7) • Co-occurring treatment • MOUD	Adults Pregnant & Parenting Women Co-occurring disorders
Comprehensive Healthcare	• ASAM assessments • Outpatient SUD treatment • Mental health services • Crisis services • Detox	Adults & Youth
Merit Resource Services	• ASAM assessments • Outpatient treatment • DUI assessments • Intensive Outpatient (IOP)	Adults Court-involved individuals
Barth (Independent Provider)	• ASAM assessments • Outpatient SUD treatment	Adults
Sundown M Ranch	• ASAM assessments• Residential treatment (Adults & Youth) • Outpatient treatment	Adults & Youth
Yakama Nation Behavioral Health	• SUD treatment and assessment• Tribal health services	

Why Refer for an ASAM Substance Use Assessment?

To determine the **right level of care** and connect patients to **treatment that works.**

What Does an ASAM Assessment Do?

Assesses Severity
of Substance Use & Withdrawal Risk

Determines Level of Care
(Outpatient → Residential)

Identifies Co-Occurring Needs
Mental Health, Medical, Social, Legal

Creates a Treatment Plan
MOUD, Counseling, Recovery Supports

Why It Matters in Primary Care:

- ✓ **Right care** at the **right time**
- ✓ **Better outcomes** & **retention**
- ✓ **Reduces overdose** & **relapse** risk
- ✓ **Required for insurance** & **residential placement**

What's New?

EXPANDING ACCESS

CREATING NEW MODELS OF CARE

SPRINT: Expanding What EMS Can Do After Overdose

After naloxone reversal, Yakima County EMS can initiate buprenorphine in the field for appropriate patients, helping relieve withdrawal and reduce immediate return to fentanyl use.

EMS can then activate a rapid handoff pathway with peers and care coordinators to engage the patient immediately after the overdose.

This creates faster access to treatment, including MOUD follow-up, withdrawal management, outpatient care, or other needed services.

SPRINT helps shift overdose response from resuscitation only to stabilization plus treatment entry.

By improving immediate follow-up and linkage to care, SPRINT can reduce ED burden and interrupt the cycle of repeat overdose and repeat 911 use.

Yakima County's Planned Medically Monitored Withdrawal Facility

- Yakima County is developing a county withdrawal management facility to address a critical gap in the local substance use crisis response system.
- The facility is designed to provide 24/7 medical support and monitoring for individuals undergoing withdrawal who need a higher level of care and stabilization.
- It will also offer 24/7 crisis support, creating a safer setting for patients with acute substance-related or behavioral health needs.
- In addition to stabilization, the program will include discharge planning and care coordination to help connect patients to ongoing treatment, recovery supports, and community services.
- As a county resource, the facility is intended to strengthen the local continuum of care and reduce reliance on emergency departments, law enforcement, and out-of-county placements.

What Primary Care Can Do Today

- Identify opioid use disorder early by asking directly about fentanyl use, cravings, withdrawal, overdose history, and prior treatment attempts
- Offer treatment, not just advice — prescribe buprenorphine when appropriate or make a same-day referral for assessment and treatment
- Prescribe naloxone routinely for patients with opioid use, fentanyl exposure, prior overdose, or reduced tolerance
- Use a harm-reduction approach even if the patient is not ready for treatment
- Arrange close follow-up within 24–72 hours during early treatment or after a high-risk event
- Use warm handoffs to local care for ASAM assessment, outpatient treatment, residential care, or methadone services