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Why Aren't More Doctors Treating Addiction with Medication?

By COLETTA DORADO

I wrote in the September issue of *Medical News* about medication-assisted treatment (MAT) and counseling in opioid use disorder recovery to manage withdrawal symptoms. On September 9th the American Medical Association and Manatt Health had a press release announcing a new national policy targeting patient access to care, opioid overdose reversal medications, medication-assisted treatment (MAT). As the opioid crisis rages on, states are putting pressure on easing restrictions to treatment. Why, then, are more physicians not looking into treating addiction?

In 2018, the National Institute on Drug Abuse (NIDA) outlined MAT in these four settings:

- Emergency Medicine Setting – A 2015 NIDA study suggest that MAT, initiated by emergency departments, increases engagement in opioid-dependent patients and reduces the risk of opioid misuse, as opposed to just a brief intervention and referral.
- Pediatric/Adolescent Medicine Setting – MAT in this setting is aimed at treating opioid addiction in children and young adults, mainly those in the range of 15-21 years old. Pediatric practices and medication-assisted treatment are especially compatible, as many of the skills necessary to engage young people in MAT—practicing family-based care, understanding developmental stages, and knowing how to speak to young people, for example—are all skills practiced by pediatricians every day.
- Federally Qualified Health Center Setting – FQHCs focus on community-based outpatient care in underserved areas. They approach healthcare in a holistic way, which makes them such a good fit for integrated medication-assisted treatment for opioid use disorder.
- Primary Care Setting – Office-based opioid treatment (OBOT) programs provide another avenue for those with SUDs to seek treatment. Rather than undergoing medication-assisted treatment through a stand-alone drug treatment clinic, patients can receive treatment for addiction right through their physician.

That last item points toward the defining difference between use of buprenorphine and use of methadone as opioid agonists. Since 2003, buprenorphine has been approved for office-based prescribing, creating the OBOT method that took the forefront over methadone.

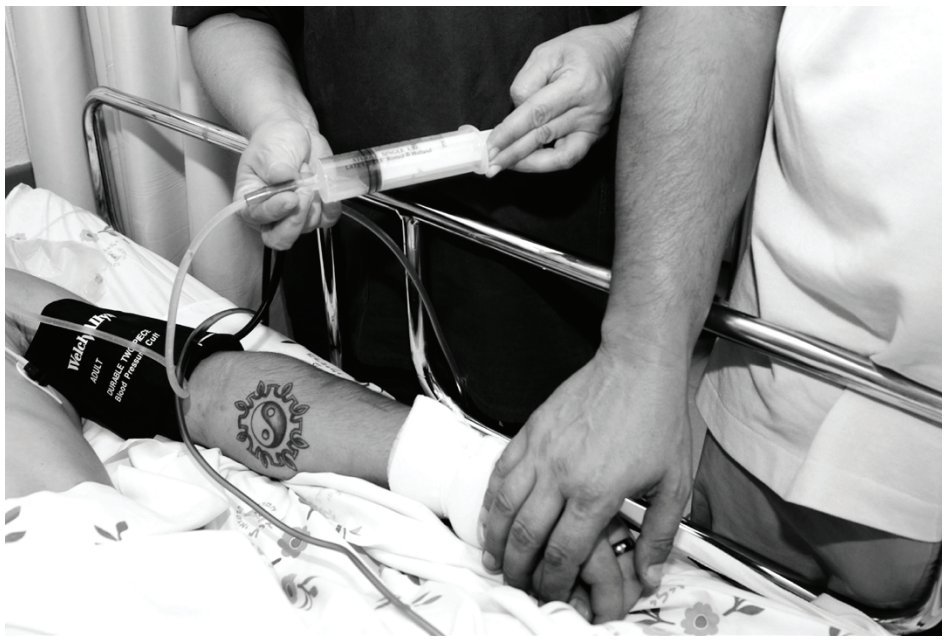
OBOT marks an important step in the destigmatization of MAT as well as in treatment of OUDs. Conceding that MAT is a viable and mainstream treatment method and should be available in the primary care setting (albeit with a waiver) helps to normalize the practice and, more importantly, ensures greater access for those with OUDs.

Evidence-based analysis supports the efficacy of MAT, particularly in comparison to abstinence-based programs. SAMHSA reports only a 5 percent success rate for abstinence-based programs, for patients in their first year. Studies have shown higher rates of success in programs that integrated medication along with recurring counseling sessions during the first year. In an experiment in Sweden of people addicted to heroin, the group receiving buprenorphine had 75 percent retention and negative urine tests after one year of treatment. The group receiving placebos had 0 percent retention.

A 2015 NIDA study suggests that MAT, initiated by emergency departments, increases engagement in opioid-dependent patients and reduces the risk of opioid misuse, as opposed to just a brief intervention and referral. A 2008 study by Gunderson & Fiellin reported that OBOT programs were effective for a "substantial" portion of patients, or about 50-80 percent.

Chris Hassan, the Symmetria Health CEO who played a role in the establishment of OBOT, wrote, "Only 23 percent of publicly funded treatment programs report offering any FDA-approved medications to treat substance use disorders, and less than half of private-sector treatment programs reported that their physicians prescribed FDA approved medication. In some areas, geography can contribute to difficulties in accessing MAT. For example, 53 percent of U.S. counties do not have a physician with the special waiver required to prescribe buprenorphine, one of the medications used for OUD treatment."

This all brings us to this point: why aren't more physicians treating addiction? The number of opioid overdoses has increased every year over the last two decades.



SAMHSA lists 2,364 physicians with buprenorphine waivers in the state of Florida. That is, 2,364 practitioners waived to provide buprenorphine for the treatment of OUD in a city, state or zip code. Within 50 miles of Orlando, there are only 104 locations certified to provide buprenorphine.

Buprenorphine prescription waivers fall under the Drug Addiction Treatment Act of 2000, or DATA 2000, with these regulations. A qualified practitioner:

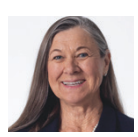
- Is licensed under their state's law
- Is registered with the DEA to dispense controlled substances
- Can only treat a limited number of patients at a time within the first year
- Has undergone mandatory training

Training lasts at least eight hours (24 for nurse practitioners and physician assistants) and could include classroom learning, seminars, or electronic training. Training for a buprenorphine waiver qualifies for continuing medical education (CME) credit. After their first year, qualified prescribers may apply to increase their patient limit from 30 buprenorphine patients at a time to 100 patients or 275 patients. SAMHSA reports that 75 percent of waived practitioners are certified for only 30 patients.

Florida, also, has statutes pertaining to MAT. The short list - nine total - consists of largely common sense regulations. For example, one requires the medications that are prescribed to be packaged and labeled with instructions.

The most important statute is the first one: "Providers of medication-assisted treatment services for opiate addiction may not be licensed unless they provide supportive rehabilitation programs. Supportive rehabilitation programs include, but are not limited to, counseling, therapy, and vocational rehabilitation." This emphasizes a point that's sometimes taken for granted but crucially important in MAT: withdrawal management medication is to be prescribed as part of a more holistic treatment approach and in conjunction with therapy, *not* in place of it.

AMA President Patrice A. Harris, MD, MA, stated when announcing the national policy that "Physicians must continue to demonstrate leadership, but unless these actions occur, the progress we are making will not stop patients from dying." After all, it's called medication assisted treatment. Licensed prescribing physicians are needed to work with the clinical therapists and counselors on long term treatment plans to improve outcomes in the opioid crisis.



Coletta Dorado is the Founder and CEO of AZZLY®, Inc. With more than 30 years business process experience, Dorado and her team are passionate about delivering a powerful EHR and Billing Solution for addiction treatment and behavioral healthcare providers. Based in the GuideWell Innovation Core, in Lake Nona Medical City, contact hello@azzly.com or visit azzly.com to learn more.