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The effective opioid treatment few doctors are using

By Allison Pohle | July 28, 2017

As Congress debates how many billions of dollars to spend combating the opioid epidemic, health experts are debating the best methods of treatment for opioid addiction. And while there is no single answer, studies have shown that one of the more beneficial therapies is medication-assisted treatment, or MAT.

Yet new data from the athenahealth network show that the healthcare industry has been slow to embrace MAT. A review of approximately 2,500 primary care providers found that prescriptions for medication-assisted therapy have barely budged since 2014.

The share of providers writing these prescriptions shows relatively little growth, as well: 5.7 percent of primary care providers as of the first quarter of 2017, compared to 5.1 percent at the start of 2014.

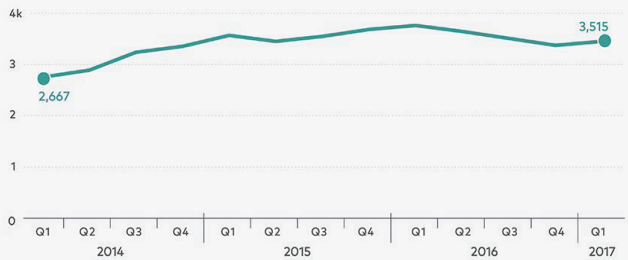
What is medication-assisted treatment?

Medication-assisted treatment involves prescription medication, counseling, and the support of family and friends. In one form of treatment, doctors give patients

Percent of providers prescribing drugs for opioid dependence

Source: athenaResearch
Sample: Approximately 2,500 primary care providers active on athenaNet since 2014 with at least 10 opioid prescriptions written each quarter

Number of patients receiving medication for opioid dependence from a primary care provider



Source: athenaResearch
Sample: Approximately 2,500 primary care providers active on athenaNet since 2014 with at least 10 opioid prescriptions written each quarter

opioids — such as methadone, buprenorphine, and naltrexone — that thwart withdrawal symptoms, thus helping to destroy the connection between taking a drug and feeling high.

Physicians can also give patients a non-opioid drug that blocks the receptors that cause a high, so if patients relapse, they won't experience the same feeling. The evidence for success of the first method is much stronger than for the second. And in both instances, counseling helps patients deal with the psychological impacts of having an substance use disorder.

So why hasn't this method of treatment become widespread in the US? Partly because there aren't enough physicians who feel confident and comfortable working with patients who struggle from addiction, says Scott Hadland, M.D., a pediatrician and addiction specialist at Boston Medical Center.

Hadland recently led a study published in JAMA Pediatrics that analyzed millions of commercial health insurance claims from 2001 to 2014. He and his team found that only one out of every four patients aged 13 to 25 — and only one in ten 16-to-17-year-olds — diagnosed with opioid addiction received prescriptions for buprenorphine or naltrexone. Hispanic, black, and female patients were also much less likely than others to be prescribed MAT drugs.

Hadland says provider bias can play a role in determining whether patients are prescribed medication to treat their addictions.

"All the individuals in our study had health insurance," Hadland says. "But the results raised a separate question of whether they had access to high-quality addiction treatment."

> **"There aren't enough physicians who feel confident and comfortable working with patients who struggle from addiction."**

But even physicians who are willing to prescribe medication-assisted treatment face barriers. Doctors must undergo an 8-hour training course in order to prescribe buprenorphine, as mandated by a federal law. Nurse practitioners can also prescribe buprenorphine, but need to undergo an additional 16 hours of training in order to do so.

So while the demand for the medications is high, the supply of prescribers hasn't kept up, Hadland says. Indeed, an analysis from Pew last year found that, while more than 900,000 U.S. physicians can write prescriptions for OxyContin, Percocet and Vicodin, "fewer than 32,000 doctors are authorized to prescribe buprenorphine to people who become addicted to those and other opioids."

"It's ironic that physicians don't require training to prescribe opioids, but are required to go through an 8-hour training course to prescribe buprenorphine," Hadland says.

Federal law allows doctors, nurse practitioners, and physician assistants to get a Drug Enforcement Administration waiver to prescribe buprenorphine for opioid use disorders, says Caleb Banta-Green, a senior research scientist at the Alcohol and Drug Abuse Institute at the University of Washington. But a scheduled, tiered system limits the number of patients they can treat — historically, anywhere from 30 to 275 patients per provider, depending on the specialty.

Providers might also be discouraged from prescribing MAT because Medicaid reimbursement is not sufficient, Banta-Green says.

Still, prescribers shouldn't ignore the success of buprenorphine and methadone, he says.

"If you don't offer it, people won't talk about it, because they don't know it's an option," says Banta-Green. "MAT programs in Seattle are already reaching capacity, which shows why we need more. It's a treatable medical condition, and can cut overdose mortality by 50 percent."

A public health intervention

Banta-Green points to Project ECHO (for Extension for Community Healthcare Outcomes), a program out of the University of New Mexico School of Medicine that increases access to specialty treatment in rural and underserved areas by training physicians to treat complex conditions. The program's opioid initiative was recognized in 2016 by the journal Substance Abuse, and has trained physicians on prescribing buprenorphine.

"A lot of doctors are worried about becoming a draw for addicted people to their practices," Banta-Green says. "But programs like ECHO help them recognize the need in their areas, and connect patients to care. Still, they are not as sufficient as they could be, because payments for medication-assisted treatment continue to be low."

Above all else, Banta-Green says, medication-assisted treatment is a public health intervention.

"We have to de-stigmatize opioid use disorder, connect people to care, and get people on medication as soon as possible," he says.

"The first priority should be to get a person on medications ASAP, and do everything possible to support them taking it every day," says Banta-Green. "We will have a tiny impact on the public health crisis if we refuse to care for the 90 percent or more of people who cannot get to or navigate our existing healthcare system to get started on medications."

Allison Pohle is a writer based in Boston. Data analysis by Anna Zink.