Fighting Opioid Addiction: Medication Assisted Treatment (MAT) Saves Lives

1 Inadequate Access to OUD Treatment

Significant numbers of Americans struggling with opioid use disorder (OUD) still lack access to certified providers who can provide MAT, the gold standard in treatment. An estimated 80% of Americans with OUD don't receive treatment.[1]

2 Severe Provider Shortages for MAT

An inadequate number of providers are certified to prescribe buprenorphine (the leading MAT treatment), causing severe treatments shortages and wait times for weeks or even months. Although approximately 435,000 primary care physicians practice in the U.S., only around 30,000 have a waiver to prescribe buprenorphine, and only about half of those are actually treating OUD.[2]

3 Need for Additional MAT Access

Providers already authorized to prescribe opioids and provide more complex care under state law are facing federal barriers blocking them from helping patients with OUD. Approving permanent buprenorphine waiver authority for eligible PAs and NPs, and providing additional authority for other advanced practice nurses, will create desperately needed access to the gold standard treatment for OUD.

About MAT

- MAT is an important component of any OUD treatment regimen, proven to reduce illicit opioid use and decrease overdose deaths, lower rates of arrest and recidivism, decrease rates of disease transmission, and increase treatment compliance for co-occurring morbidities. Improved outcomes are reported for individuals, including pregnant women and infants. [2, 3, 4]
- Introduction of buprenorphine into areas with particularly high rates of heroin abuse and death reveal a strong link to a decline in heroin overdose deaths. [4]
- Buprenorphine has a superior safety profile, featuring a ceiling effect at high doses, the ability to be formulated with naloxone to limit injection abuse, and lower abuse potential compared to full opioid agonists. It also appears superior to that of methadone, with 2- to 3-fold lower rates of drug diversion reports and poison center calls. [3,4]

CALL TO ACTION: Include Section 3003 of H.R. 6 in Senate Opioids Package

- **Makes waiver authority permanent for PAs and NPs, protecting the more than 200,000 patient treatment access points made possible under CARA.**
- **Creates 5 year waiver authority for certified nurse midwives, clinical nurse specialists, and nurse anesthetists.**
- **Protects state scope of practice, prescribing authority, and MAT protocol.**
- **Includes study on provider prescribing, MAT protocol, and potential diversion.**

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DEA: Authorizing Additional MAT Providers Creates Economic Benefit[5]

- The DEA conducted an economic analysis of Section 303 in CARA, which temporarily expands the types of practitioners who may prescribe MAT to include PAs and NPs.
- The provision's estimated net economic benefit – primarily due to increased labor productivity and decreased healthcare and legal costs – are $68m, $132m, $169m, $202m, and $237 million in years one through five of waiver authority, respectively.
- Total estimated net economic benefit is $640-729m, depending on the discount rate.

New England Journal of Medicine: Myths & Realities of OUD Treatment[1]

- **MYTH:** Buprenorphine is more dangerous than other chronic disease management.
  - **REALITY:** Buprenorphine is simpler than many other routine treatments in primary care, such as titrating insulin, but providers receive more training for it.
- **MYTH:** Buprenorphine is simply a "replacement addiction."
  - **REALITY:** Taking prescribed medication to manage a chronic illness does not meet the definition of addiction (i.e. compulsively using a drug despite harm).
- **MYTH:** Detoxification is an effective treatment for OUD.
  - **REALITY:** No data show detoxification is as effective in treating OUD. In fact, detoxification may increase likelihood of overdose death by eliminating tolerance.
- **MYTH:** Reducing opioid prescribing alone will reduce overdose deaths.
  - **REALITY:** Despite a decrease in opioid prescribing, overdose mortality has increased. Patients with OUD may shift to the illicit drug market, where the risk of overdose is higher. We must prioritize increasing access to proven treatments.

> *Buprenorphine is the third-most commonly prescribed opioid, and therefore it is the third-most commonly diverted opioid. It is much safer than pain pills in terms of its ability to cause lethal overdose, unless it is mixed with other substances. The thing that causes the most buprenorphine diversion is the lack of access to buprenorphine treatment in the community."*
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> **Dr. Kelly Clark, President, ASAM**

Supporters of Section 3003 in H.R. 6:

- American Society of Addition Medicine
- National Coalition on Health Care
- American College of Obstetricians and Gynecologists
- American Academy of PAs
- American Association of Nurse Practitioners
- American Nurses Association
- American Association of Nurse Anesthetists
- American College of Nurse-Midwives

1. NEJM, "Primary Care and the Opioid-Overdose Crisis — Buprenorphine Myths and Realities," July 5, 2018.
2. U.S. Department of Health and Human Services, "Facing Addiction in America," 2016.
3. NCBI, "Buprenorphine and Buprenorphine/Naloxone Diversion, Misuse, and Illicit Use: An International Review," March 1, 2011.
4. NCBI, "A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences from Around the World," September 1, 2015.
5. DEA, "Implementation of the Provision of the Comprehensive Addiction and Recovery Act of 2016 Relating to the Dispensing of Narcotic Drugs for Opioid Use Disorder," January 23, 2018.
6. Drugfree.org, "Improving Buprenorphine Access While Reducing Diversion: Q&A With ASAM President," April 20, 2016.