

Clinical Briefing

## Clinical Briefing: What is Medication Assisted Treatment and How to Apply It

Oct 21, 2016 17:00 EST

*Care Management Technologies (CMT), a Relias Learning company, is on the forefront of population health management through data analytics with special expertise in the behavioral healthcare world. As such and as part of its ongoing Intelligence Reports series, CMT is pleased to present the following Clinical Briefing.*

*This edition of CMT's Clinical Briefing is geared towards the vital topic of Medication Assisted Treatment and the surging opioid issue facing society. In utilizing its extensive clinical experience, CMT has been involved in this crucial conversation and the research surrounding it. In so doing, CMT offers the following perspective and insights on Medication Assisted Treatment and how to apply it most effectively.*

The well-publicized “prescription opioid epidemic” has revealed an ever-growing population of people who, despite having clear problems related to long-term opioid use, are unable to simply stop take them. A subgroup of these individuals meet full DSM-5 criteria for opioid use disorder. All require medical attention in order to reverse opioid addiction.

There are a number of methods for treating opioid addiction, including several forms of psychotherapy, 12-step abstinence programs, and inpatient rehabilitation. One such treatment is medication assisted treatment (MAT). Efficacy is particularly strong for this underutilized treatment approach. MAT for opioid addiction is effective in maintaining recovery and reducing the risk of overdose (Volkow et al, 2014). From a programmatic point of view, there is evidence that MAT for opioid addiction is associated with reduced general health care expenditures and utilization (Mohlman et al, 2016). Unfortunately, MAT is substantially underutilized for the treatment of patients with opioid addiction (Lembke & Chen, 2016).

The underutilization of buprenorphine is particularly dramatic and generally driven by policy and reimbursement decisions. Only about 4% of the nearly 1 million US physicians who are licensed to prescribed opioid analgesics have a license to prescribe buprenorphine. And of those who are able to prescribe buprenorphine, few actually do (Vestal, 2016). There are many reasons for the lack of MAT administered to opioid addicted patients, including stigmatization (“just replacing one addiction with another”), low reimbursement rates for addiction treatment providers, lack of training of physicians in addiction medicine, limits placed on the number of patients each licensed physicians can treat with buprenorphine, and, as mentioned above, the shortage of physicians licensed to prescribe buprenorphine (Vestal, 2016).

Three medications are approved for the treatment of opioid addiction, methadone, buprenorphine (including buprenorphine-naloxone combination) and naltrexone. Methadone can only be administered in the context of special clinics, so we will focus here on the two office-based medications, buprenorphine and naltrexone.

Buprenorphine is a partial agonist at the mu-opioid receptor, meaning that it binds to and stimulates the opioid receptor but does not produce a full effect as do methadone or opioid analgesics like fentanyl and morphine. The combined buprenorphine/naloxone preparation (Suboxone) combines buprenorphine and the opioid antagonist naloxone in a 4:1 ratio and reduces the abuse potential of buprenorphine alone (Orman & Keating, 2009). Many studies have shown that buprenorphine is a safe and effective intervention for opioid use disorder. Buprenorphine may be continued for long periods of time,

Naltrexone is a full opioid receptor antagonist, so it blocks the ability of any opioid to bind to the opioid receptor. Naltrexone therefore blocks all of the effects of opioids, including euphoria, sedation, and analgesia. It is administered either daily in oral form or monthly via a long-acting injectable preparation. It has very few adverse side effects, but patients must be completely abstinent from opioids when they initiate naltrexone treatment. Poor adherence has been a problem with oral naltrexone, a problem that is obviated by the depot formulation.

Both buprenorphine and naltrexone treatments can be administered in primary care physician offices. There is even evidence that buprenorphine can be successfully initiated for opioid-addicted patients during an emergency department visit (D'Onofrio et al, 2015).

Psychosocial support, counseling family and group therapy, and other psychosocial interventions can enhance the effectiveness of MAT and should be considered as adjunctive treatments (Center for Substance Abuse Treatment, 2005; Dunlap & Cifu, 2016).

The U.S. now faces an enormous problem with prescription opioid abuse and addiction and opioid overdose has become a major cause of death. MAT is a safe and cost-effective approach to treating opioid addiction and preventing overdoses. It is imperative that all health care systems develop methods to identify patients who may be abusing or addicted to prescription opioids and develop and implement policies that encourage evidence-based treatment, especially MAT.

### **Care Management Technologies Contribution to Identifying and Addressing Opioid Addiction**

CMT, a Relias Learning Company, is a population health data analytics company that transforms data in to clinically actionable information. CMT's opioid measures shine a light on persons for whom MAT could be the treatment of choice and provides clinical information to support physician decision-making about this approach.

Stigma, staff bias, fear of waiting rooms full of SUD patients; fears of aiding addictions, and feeling inadequately trained and supported are all factors in the slow uptake of this evidence based practice. CMT's evidenced based algorithms point to opportunities to support efficacious use of this approach and supports physicians in these sensitive decisions.

Coming soon, CMT will be releasing a Risk Stratification and Tiered Intervention tool for Opioid Prescription Management which will provide even further clinical support for Medication Assisted Treatment.

For additional CMT Intelligence Reports, please visit our web site at [www.cmthealthcare.com](http://www.cmthealthcare.com). For more information about CMT's population health management and data analytic resources or Relias Learning's educational support resources, please contact John Tote, Senior Director of Strategic Development at 919-219-3944 or [jtote@cmthealthcare.com](mailto:jtote@cmthealthcare.com).

#### References:

Center for Substance Abuse Treatment: Medication-assisted treatment for opioid addiction in opioid treatment programs. Treatment Improvement Protocol (TIP) Series 43, HHS Publication No. (SMA) 12-4214, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005

D'Onofrio G, et al: Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence. JAMA 2015;313:1636-1644

Dunlap B, Sifu AD: Clinical Management of of opioid use disorder, JAMA, 2016;316

Lembke A, Chen JH: Use of opioid agonist therapy for Medicare patients in 2013. JAMA Psychiatry 2016;1390

Mohlman MK, et al: Impact of medication-assisted treatment for opioid addiction on Medicaid expenditures and health services utilization rates in Vermont. J Subst Abuse Treat 2016;67:9-14

Orman JS, Keating GM: Buprenorphine/naloxone: a review of it use in the treatment of opioid dependence. Drugs 2009;69:577-607

Vestal C: In fighting an opioid epidemic, medication-assisted treatment is effective but underused. Health Affairs 2016;35:1052-1057

Volkow ND, et al: Medication-assisted therapies—tackling the opioid-overdose epidemic. *New Eng J Med.* 2014;370:2063-2066

808 Aviation Parkway, Suite 700 | Morrisville, NC | [919.674.2520](tel:919.674.2520) | [cmtinfo@cmthealthcare.com](mailto:cmtinfo@cmthealthcare.com)  
[www.cmthealthcare.com](http://www.cmthealthcare.com)

Connect with us:   