Addressing the Opioid Crisis: Priorities for the HCH Community

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Remove the cap on the number of patients a physician can treat with buprenorphine. Existing limits are arbitrary and create barriers to accessing treatment. While put in place to mitigate diversion, cap limits may inadvertently aid diversion by limiting the supply of MAT, leading to individuals pursuing self-treatment by purchasing diverted drugs. Ironically, there are no limits to the number of patients a physician can prescribe other opioid drugs that present a much greater risk of causing addiction, overdose, and death (e.g., Methadone, Oxycodone, Hydrocodone, and Fentanyl). Removing the caps will allow providers to determine the number of patients they are able to treat based on the capacity of their practice and other factors, thereby increasing access to treatment.

Expand prescribing rights to clinicians who can prescribe Class III, IV, and V CDS drugs. Limiting prescribing rights to physicians creates an additional barrier to accessing treatment and is incongruent with the existing scope of many clinical practices. Expanding prescribing rights to Nurse Practitioners, Physicians Assistants, and other clinicians who are authorized to prescribe Class III, IV, and V CDS drugs will expand treatment opportunities and decrease barriers to care. Clinicians who can prescribe opioids for pain should also be able to prescribe buprenorphine to treat the addictions that sometimes result.

> *"As a physician, I can only see so many patients a day and I have many other patients with other needs – having others on my team be able to prescribe buprenorphine would be a huge help."* *Physician at HCH Baltimore*

Require training to prescribe all opioids, not just buprenorphine. Specialized training is required to prescribe buprenorphine, but no other drug (opioid or otherwise) requires this as a condition of practice. Given the lower risks associated with diversion of buprenorphine, and the elevated risk associated with many opiates that can be prescribed with few restrictions, training should be extended to the prescribing of any opioid and focus on administering and monitoring prescriptions and understanding the nature of addiction. In addition prescribers should have greater access to technical assistance and resources to develop plans to identify and avoid diversion.

Enforce parity laws. Substance abuse treatment and other behavioral health services should be just as easy to access as primary care services. Parity laws are in place to ensure insurance plans treat these services equally, and should be enforced. Health insurance practices that require extensive prior authorizations for opioid treatment should be scrutinized, especially when creating barriers to behavioral health care that do not exist for primary care.

Reduce stigma and treat addiction as a disease. Opioid addiction is a treatable disease caused by changes in brain chemistry, yet many still see it as a criminal activity, a character flaw or a moral failing. This stigmatization creates barriers to seeking and receiving treatment, and wrongfully separates addiction from other health problems. Stigmatization also causes and exacerbates homelessness as individuals with even minor drug offenses are often excluded from housing and employment opportunities. Laws should focus on connecting people to treatment and the availability of treatment should be equal to other health care access.

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