VIEWPOINT

Integrating Responses to the Opioid Use Disorder and Infectious Disease Epidemics

A Report From the National Academies of Sciences, Engineering, and Medicine

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The United States is in the midst of an opioid use disorder (OUD) epidemic,[1] with more than 2.1 million persons affected and more than 700 000 deaths since 1999.[2] In October 2017, President Trump declared the opioid crisis a public health emergency, and a national response was initiated. However, it is estimated that only 1 in 10 people with OUD are receiving needed treatment. The opioid epidemic also has contributed to an increase in bacterial and fungal infections as well as new HIV[3] and hepatitis C virus[4] outbreaks across many parts of the country.[5]

To guide the response to these dueling epidemics, the Department of Health and Human Services (DHHS) Office of Infectious Disease and HIV/AIDS Policy requested that the National Academies of Sciences, Engineering, and Medicine (NASEM) convene a committee that would (1) identify, highlight, and review programs within the United States that are achieving integration of OUD and infectious disease (ID) services; (2) identify and highlight barriers to integration and to suggest strategies to overcome barriers; and (3) provide conclusions and recommendations to inform existing and future projects that promote patient-centered, integrated programs. A summary of the recommendations from the report of this committee[6] is presented in this Viewpoint.

Prior Authorization Policies

Prior authorization policies at the state level are intended to contain costs and limit diversion of high doses of drugs, and require clinicians and health care organizations to obtain permission to prescribe buprenorphine from either a private insurer or the state Medicaid program. Prior authorizations delay care for patients with OUD and therefore increase the risk of ID. Based on the review of programs and the best available evidence, the committee recommended that states remove prior authorization policies for buprenorphine[6] for their state Medicaid programs and for private insurers.

Drug Addiction Treatment Act Waiver Requirement

This waiver requirement of the Drug Addiction Treatment Act of 2000 requires that clinicians must have mandatory training to prescribe buprenorphine and limits the number of patients they can treat. Given the scale of the opioid crisis and the risk of ID epidemics, the committee recommended removing these requirements[7] to incentivize more clinicians to treat OUD and ID simultaneously in the same clinical setting.

Same-Day Billing Restrictions

Some states have implemented restrictions on billing for both behavioral and physical health care visits on the same day.[8] These restrictions are intended to contain costs but often force patients to return to medical centers on a different day or require that the medical center incur financial loss for providing same-day care. The committee recommended that all states amend their policies to allow greater access to treatment for patients who need it.

Inadequate Data Sharing That Limits Integrated Care

Title 42, Part 2 of the *Code of Federal Regulations* (42 CFR Part 2) is a federal regulation that places strong protections around patients' substance use information and prevents sharing this information without explicit patient consent. The committee recognized that there is a balance between confidentiality and sharing of patient information related to substance use[9,10] and recommended that the Substance Abuse and Mental Health Services Administration (SAMHSA) engage with patients, advocacy groups, the general public, and legal experts to determine the benefits and costs of changing 42 CFR Part 2 and aligning it with the Health Insurance Portability and Accountability Act.

Stigma

The committee recommended that SAMHSA support multilevel, sustainable, evidence-based, and measurable interventions to reduce stigma in clinical settings. The goal of this is to create care environments in which patients with OUD and ID can feel respected and cared for from the moment they enter the clinic to the moment they leave.

Payment and Financing Limitations

Some of the services that support greater integration of services are the most difficult to fund. This includes harm reduction services like syringe service programs (SSPs), case management, telemedicine, and peer-recovery counselors. Drawing parallels to the response to the HIV/AIDS epidemic, the committee recommended that Congress authorize and appropriate funding to the Health Resources and Services Administration to comprehensively address the needs of low-income uninsured or underinsured individuals with co-occurring OUD and ID.

Issues With Workforce and Training

The committee recommended that the Health Resources and Services Administration provide additional resources to incentivize clinicians to work in rural areas and use telemedicine approaches to treat OUD and ID

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in an integrated way, and that the DHHS explore incentives for methadone treatment programs to offer a wider array of evidence-based medications and to institute opt-out testing for HIV and hepatitis C virus. In addition, the committee recommended that Congress adjust the Controlled Substances Act to allow primary care clinicians to prescribe methadone for patients with OUD. The committee also recommended that accrediting bodies for health care professional training programs should include integration as a core topic in students' educations and that state licensing boards encourage continuing education on the topic of integration.

Limits on Harm Reduction Services

The cornerstone of harm reduction practices are SSPs, yet access to SSPs is limited. For instance, federal dollars cannot be used to purchase syringes at SSPs—the committee recommended that Congress remove this barrier. In addition, some states have bans on SSPs altogether or allow them only in public health departments. The committee recommended that remaining states remove these bans and promote wider access to SSPs.

The Criminal Justice System and OUD and ID

Many individuals in the criminal justice system are incarcerated for drug-related offenses. Evidence suggests that treating OUD and ID in these settings is feasible and cost-effective. The committee recommended that correctional facilities offer evidence-based screening and treatment for OUD and ID; that states should fund reentry services when people are released from correctional facilities; and that states should ensure that individuals who qualify for Medicaid are automatically reenrolled at the time of release.

In summary, the committee identified many opportunities to better integrate services for OUD and ID. The US health system has not achieved this integration, but it is possible to do so. This will require action on the part of many organizations, clinicians, policy makers, health care administrators, and government funding agencies to better ensure that OUD and ID services are provided in the most integrated and comprehensive way. Given the human toll of these epidemics, prompt implementation of these recommendations is essential.

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