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Family Medicine

COMMENTARY

After the MATE Act: Integrating Buprenorphine Prescribing Into Mainstream Family Medicine Education and Practice

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In December 2022, Congress passed the long overdue MATE (Medication Access and Training Expansion) Act, allowing all providers (medical doctors, dentists, nurse practitioners, and physician assistants) with a Drug Enforcement Administration (DEA) license to prescribe buprenorphine for the treatment of opioid use disorder (OUD). Practitioners no longer need to obtain a special X waiver to prescribe this evidence-based and lifesaving medication.

Family medicine practitioners and educators now have an important opportunity to integrate prescribing of buprenorphine into every clinical practice to optimally help our patients struggling with OUD.

Few medications can offer our patients such profound and well-studied mortality benefit. Medications for the treatment of opioid use disorder (MOUD, previously referred to as MAT), including buprenorphine, methadone, and naltrexone, reduce opioid overdose deaths by more than two-thirds.[1–3] While methadone for the treatment of OUD can be dispensed only at a federally licensed opioid treatment program (methadone clinic), family medicine providers can prescribe buprenorphine and naltrexone in the outpatient setting, making treatment more readily accessible for patients. Starting naltrexone requires a 7- to 10-day abstinence period from opioids, often making this transition challenging for patients. Buprenorphine, on the other hand, can be started in the outpatient setting shortly after last opioid use. Buprenorphine works to prevent opioid cravings and withdrawal; it helps patients feel normal (not high or sedated), allowing them to wake up each morning and actively participate in their lives in meaningful ways. While providers may hesitate to prescribe buprenorphine for the first time, remember that buprenorphine has a ceiling effect for sedation and euphoria, making overdosing on buprenorphine difficult. The medication is thus considered both highly effective and safe, and the alternative (patients using street fentanyl) is certainly much riskier.[4,5] Every time I write a prescription for buprenorphine, I know that I am preventing an overdose and perpetuating a life in recovery. Additionally, while providers may worry that they do not have behavioral health and social services to support patients with OUD, remember that studies clearly show that medication alone (regardless of social and behavioral supports) substantially reduces mortality.[6]

My patients show me daily how they can transform their lives when they are on MOUD. One of my patients, who attends our weekly Suboxone groups, spent 10 years in prison for drug-related crimes. Five years later, outside of the prison walls, he shares his humility and gratitude for his freedom and discusses the shame he carries and how he continually works to make amends; he since has successfully grown a self-owned contracting business and has reconnected with his children. He has done all this with deep introspection, with the support of others in recovery, and with buprenorphine that helps him feel normal each day. As one of my colleagues once explained, treating patients with buprenorphine is like a reverse country song, "They get their dog back, they get their kids back, they get their truck back." The medication allows them to then engage in their health care further.

Providers in acute and inpatient settings often see patients when they are at their worst; patients usually are not on MOUD or connected to recovery supports and are suffering the medical sequelae and complications from recent drug use. But when patients engage in long-term recovery on MOUD and we get to be part of that journey, the relationship-based joy of primary care comes to life. While seeing the impact of my everyday primary care practices (eg, slightly lowering a patient's blood pressure or glucose levels) is often difficult, the impact I have on patients who are struggling with OUD feels much more

palpable.

Unfortunately, only two in five patients with OUD currently are receiving treatment.[7,8] With passage of the MATE Act, we can increase access to buprenorphine within our primary care settings and help destigmatize OUD treatment, ending the siloed approach where patients can obtain MOUD only from specialized clinics or from primary care clinicians with specialized X waivers. This mainstreaming of buprenorphine prescribing also makes care more accessible to populations that previously have been marginalized: Black Americans have been 77% less likely to receive buprenorphine than White Americans.[9]

So, what do we need to do as clinicians and educators to save more lives? Since June 27, 2023, any prescriber who applies for or renews a DEA license is required to attest to having completed 8 hours of training related to opioid or other substance use disorders (SUDs) by checking off a box on the DEA registration/renewal form. This is a one-time requirement. So, if you are an educator, make sure that your residents have 8 hours of SUD training integrated into their curriculum. If you are a clinician and are less than 5 years out of residency, your previous residency training counts; if you are more than 5 years out of training, you will need to complete 8 hours of SUD training.

The Society of Teachers of Family Medicine (STFM) has put together a series of 12 online SUD modules that residents and faculty can take and teach: https://www.stfm.org/teachingresources/curriculum/nationaladdictioncurriculum

You also can get extra support through the Providers Clinical Support System at pcssnow.org, which offers individualized mentorship for prescribing buprenorphine and additional training resources. STFM also hosts an Addiction Collaborative that promotes networking and support among family medicine providers who teach about and provide care to patients with SUDs.

A list of other acceptable training sources can be found at the following website: https://www.samhsa.gov/medications-substance-use-disorders/provider-support-services/recommendations-curricular-elements-substance-use-disorders-training

Remember: You need only 8 hours to check off the box on your DEA license to be able to prescribe buprenorphine.

The MATE Act now has opened the doors to increase access to lifesaving medication, reduce stigma associated with treating OUD, and provide more equitable care to our patients. We should *all* be prescribing MOUD! So, get your training done, ensure that medical trainees get theirs, check off your box on the DEA registration form, and start incorporating buprenorphine prescribing into your daily practice.

More information on the MATE Act can be found here: https://www.deadiversion.usdoj.gov/pubs/docs/MATE_training.html

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