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CURRENT ISSUES

Addiction Medicine After COVID-19: The Imperative of a Trained Workforce

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Amid the ongoing coronavirus disease 2019 (COVID-19) pandemic, substance use disorder (SUD) remains a pressing issue in the U.S. According to the latest National Survey on Drug Use and Health, the number of Americans afflicted with SUD exceeds 20 million, an estimated 2 million of whom are coping with an opioid use disorder (OUD).[1] The efficacy of evidence-based opioid agonist therapy with methadone or buprenorphine notwithstanding, the vast majority of Americans living with OUD do not receive any treatment. Preliminary reports show that opioid overdose deaths have increased significantly during the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic.[2] Despite the understandable focus of the healthcare system on COVID-19, contending with SUDs must not be compromised. Now more than ever, attending to SUDs constitutes a public health imperative for preventive medicine, especially given that addiction medicine is a multispecialty subspecialty under the auspices of the American Board of Preventive Medicine. At the time of this writing, patients afflicted with SUD are facing both established as well as new pandemic-imposed obstacles to care. One major obstacle is the lack of trained physicians who are qualified to provide evidence-based SUD care. The bipartisan Opioid Workforce Act of 2019, a bill sponsored in both the House (H.R. 3414) and the Senate (S. 2892), would dramatically strengthen the physician workforce with expertise in addiction medicine.[3] This paper discusses the origins of the Opioid Workforce Act of 2019, emphasizes its increased importance in the face of the pandemic, and discusses its potential downstream promise.

Sponsored by Senators Maggie Hassan (Democrat-NH) and Susan Collins (Republican-ME) in the Senate and by Representatives Brad Schneider (Democrat-IL), Susan Brooks (Republican-IN), Ann Kuster (Democratic-NH), and Elise Stefanik (Republican-NY) in the House, the Opioid Workforce Act of 2019 is intent on increasing the "number of residency positions eligible for graduate medical education payments under Medicare for hospitals that have addiction or pain medicine programs." On its first introduction in both the House and the Senate in 2018, the bill failed to make it out of the cognate committees to which it was assigned. On its reintroduction in 2019, the bill enjoyed substantially enhanced co-sponsorship in both the House and the Senate. Moreover, the bill was strongly supported by as many as 80 medical organizations, including the American Association of Medical Colleges, the American Medical Association, and the American Society of Addiction Medicine.[4] Now overtaken by current events, it is critical that the Opioid Workforce Act of 2019 be reintroduced and actively promoted. If enacted, the bill would complement previous legislative efforts to address the opioid crisis such as the Comprehensive Addiction and Recovery Act of 2016 and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018, which were signed into law by Presidents Obama and Trump, respectively. The SUPPORT for Patients and Communities Act included provisions to broaden the reach of SUD providers, for example, by making the temporary authority of some physician assistants and nurse practitioners to prescribe buprenorphine conferred by the Comprehensive Addiction and Recovery Act of 2016 permanent. The Opioid Workforce Act of 2019 shares the goals of these statutory predecessors to expand the SUD treatment workforce, albeit with a specific focus on strengthening residency training programs in addiction or pain medicine.

If enacted, the Opioid Workforce Act of 2019 would add 1,000 graduate medical education (GME) positions to the national resident physician complement over a 5-year period. In its first fiscal year, the bill will see to the distribution of a total of 500 new GME positions among

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"hospitals that have established. . .approved programs in addiction medicine, addiction psychiatry, or pain medicine." In the subsequent 4 fiscal years, an additional 500 GME positions are to be distributed to hospitals that have or will establish an approved residency training program in addiction medicine, addiction psychiatry, or pain medicine. GME positions may also be directed to the manifold prerequisite residency training programs, including but not limited to internal medicine, family medicine, or psychiatry, which prepare trainees for the more specialized disciplines of addiction medicine, addiction psychiatry, or pain medicine. However, no hospital is to receive >25 full-time equivalent positions. Funding of the Opioid Workforce Act of 2019 will be accomplished by amending title XVIII of the Social Security Act, which currently limits the number of GME positions funded by Medicare. In so doing, the bill will "provide for the distribution of additional residency positions to help combat the opioid crisis." At present, it is estimated that there are only around 2,600 addiction medicine physicians certified in the multispecialty subspecialty of addiction medicine, 1,202 board-certified addiction psychiatrists, and 2,200 board-certified pain medicine physicians in the workforce.[5,6] The addition of 1,000 GME positions to the national resident physician complement would therefore constitute a substantial strengthening of the addiction medicine workforce.

People afflicted by SUD are particularly vulnerable during the current pandemic. Social distancing increases the likelihood of opioid overdosing in the absence of a witness to administer life-saving naloxone. The pandemic has also exacerbated the risks of drug use, for instance, by disrupting illicit drug supply chains. Consequently, people with SUD are experiencing longer gaps between use, turning to new dealers, or using new drugs with unfamiliar potency.[7] Given the evidence now available that drug overdoses have sharply increased since the start of the COVID-19 pandemic,[2] the imperative of an addiction workforce is stronger than ever. Congress must act now to mitigate the aftermath of COVID-19 on the opioid epidemic. In strengthening the addiction workforce, special consideration should be given to extant disparities in SUD treatment access and workforce. Although the addiction crisis has impacted communities all across the country, certain populations have been disproportionately affected, including but not limited to rural populations, veterans, and justice-involved populations. Furthermore, significant racial, ethnic, and geographic disparities exist in treatment access and treatment capacity.[8] Because the Opioid Workforce Act of 2019 does not include specific stipulations on where the GME slots are to be allocated, a leading challenge will be ensuring that residency positions and the resultant workforce are distributed accordingly to mitigate the aforementioned disparities in receipt of the SUD treatment and workforce.

Broadly viewed, the Opioid Workforce Act of 2019 is destined to improve the nation's capacity to address SUDs in at least 3 ways. First, the bill would increase the number of highly trained physicians with expertise in addiction recognition and treatment. Such an increase would not only strengthen the addiction workforce in the imminent future but would also significantly enhance the number of senior physician educators in a position to train the next generation of providers in the longer term. Without such, residents in training will continue to rely on self-training by the way of OUD-focused Internet modules.[9] Second, SUDs are not limited to the abuse of opioids. Although most overdose-related deaths are due to opioids, alcohol and nonopioid drug addictions, especially addictions to cocaine and methamphetamine, constitute serious health issues as well. In addition, SUDs are often intricately linked to chronic medical conditions, such as diabetes and asthma, and to mental health conditions, such as depression and anxiety. The coexistence of SUDs with other underlying medical conditions complicates the management of the patients in question. In a word, substance use cannot be addressed in isolation. Viewed in this light, the Opioid Workforce Act of 2019 is poised to facilitate the training of physicians to recognize and treat addiction in all of its forms and comorbidities. Third, expanding the addiction workforce may reduce the stigma attached to SUDs. Many medical professionals still harbor the erroneous belief that opioid agonist therapy is replacing one opioid dependence with another. Moreover, it was ignorance about OUD on the part of physicians, one compounded by the promotion of opioids by the pharmaceutical industry, that led to opioid overprescribing and thereby to the opioid epidemic. The development of a skilled addiction workforce will not only improve attitudes toward SUDs but will also inform physicians about the risks of inappropriate overprescribing of drugs.

Apart and distinct from the Opioid Workforce Act of 2019, additional measures to advance the training of physicians will be needed to stem the drug overdose crisis. One possibility is to require that addiction training be afforded to all residents regardless of their field of specialization. To advance this cause, we and others have urged the Accreditation Council for Graduate Medical Education to require that all residents and fellows in training, regardless of specialty, undergo instruction in the treatment of OUD.[10] Another possibility, which may well have gained traction owing to the COVID-19 pandemic, entails the leveraging of technology to address the current gap in training. Telehealth programs have

proven invaluable in connecting addiction specialists to healthcare providers consulting on complex SUD cases, and the relaxed regulations during the pandemic have been life saving for many.

The COVID-19 pandemic has underscored the imperative of an adequately trained medical workforce to address a broad swath of healthcare issues, including SUD. The pandemic may also have altered the trajectory of the opioid epidemic for the worse. Systemic changes such as the passage and enactment of the Opioid Workforce Act of 2019 are needed to equip more physicians with the expertise required to respond to addiction as a legitimate and treatable medical disorder. The development of a skilled workforce will also improve the education of future physicians on the common intersection of substance use with other fields of medicine. It is up to the medical profession to take ownership of its role in starting the opioid epidemic and to take the necessary steps to end it. Communities all across the country are in need of better care for SUDs. Passage of the Opioid Workforce Act of 2019 is an important step toward achieving this goal.

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