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PROFICIÊNCIA EM LEITURA EM LÍNGUA INGLESA

Adapted from **AIDS to Opioids[1] — How to Combat an Epidemic – By** Arthur R. Williams, M.D., M.B.E., and Adam Bisaga, M.D.

[1] The United States is facing a vast epidemic of opioid-related deaths. More than 2.4 million Americans have a severe opioid use disorder (OUD) involving dependence on pain medications, heroin, or both, and rates of drug overdose deaths in this country have outpaced mortality from motor vehicle accidents since 2013. The rising death toll has been rivaled in modern history only by that at the peak of the AIDS epidemic in the early 1990s. Although these epidemics differ in nature, the large-scale, highly coordinated response to AIDS that was eventually mounted may be instructive for combating the opioid epidemic.

[2] In the face of growing alarm in communities nationwide, the U.S. Senate recently passed the Comprehensive Addiction and Recovery Act (CARA), which takes incremental steps to combat the epidemic. President Barack Obama signed it into law in July, despite the fact that Congress withheld funding. In his 2017 budget proposal, Obama had incorporated $1.1 billion for expanding access to evidence-based care, including **medication-assisted treatment** (MAT) using methadone, buprenorphine, or injectable naltrexone. Funding would be targeted to hardest-hit states and those proposing the most promising interventions for getting needed treatment to people with OUD.

[3] Funding is critically important and long overdue — but will be insufficient without structural changes, revised regulations, and improved services to help connect marginalized populations with programs and providers that use modern, science-based approaches to treat OUD as a chronic medical condition. Despite the existence of pharmacologic and behavioral treatments based on a generation of research, most treatment programs do not offer evidence-based care and have minimal physician involvement. The substance-abuse treatment system (programs accredited by the Substance Abuse and Mental Health Services Administration) has thus far struggled to implement practices based on science. Too often, treatment centers operate under outdated institutional ideologies favoring abstinence-only approaches that are modeled on mid-20thcentury alcoholism treatment involving traditional counseling. But since opioids pose a risk of injection-related infectious disease and a higher risk than alcohol of death due to overdose, a different approach to evaluating therapeutic risk–

[1] Drugs that act on the nervous system to relieve pain.

benefit ratios is warranted. The evidence indicates that maintenance therapy with methadone or buprenorphine, without arbitrary restrictions on length of care, results in the greatest likelihood of retention in treatment and the greatest reduction in mortality.

[4] Our substance-abuse treatment system is thus ill prepared to address the opioid epidemic, and overdose deaths have increased every year for the past two decades. Office-based treatment of OUD with buprenorphine or injectable naltrexone has also been slow to materialize. In 40% of U.S. counties there is currently no physician authorized to prescribe buprenorphine, and the majority of authorized providers actually treat few or no patients. Integration of substance-abuse treatment into primary care settings holds promise but may not increase access for marginalized populations that are disconnected from care. So instead, every year thousands of patients receive medical treatment to relieve opioid withdrawal only during brief detoxification admissions, lose their tolerance to opioids, and are discharged with referrals to medication-free residential or outpatient care. Of these patients, 70 to 90% quickly relapse and face a high risk of overdose death.

[5] The response to the AIDS epidemic may help to inform an effective approach to the opioid epidemic. Once the country was mobilized against AIDS, intensive efforts were devoted to training and supporting clinicians, many of whom were new to the treatment of viral infections in immunocompromised patients. Treatment guidelines were promulgated through newly formed AIDS Education and Training Centers. Funding was provided to connect patients with capable providers of wrap-around social services supported by grants from the Ryan White HIV/AIDS Program. Similarly, social workers, nurse care managers, and outreach workers could be deployed strategically to help marginalized populations with OUD obtain substance-abuse treatment in primary care settings, and funding incentives authorized by the Affordable Care Act (ACA), such as health homes and accountable care organizations, could help cover the costs. Since most medical school and residency programs offer limited training in addiction pathophysiology and treatment, too few physicians are trained to treat OUD, especially outside major metropolitan areas — a substantial barrier to care. Just as regulations were loosened to allow the Food and Drug Administration (FDA) to fast-track antiretroviral drug development for HIV beginning in the late 1980s, a possible solution here would be regulatory change permitting enlargement of the network of professionals authorized to deliver treatment and broadened access to MAT through such avenues as specialized community pharmacies, telemedicine, and hub-and spoke systems of care.

[6] Canada has embraced an effective model, offering greatly expanded access to methadone through directly observed daily dosing in local pharmacies. This model could be adapted to include buprenorphine and even injectable naltrexone. New regulation could increase treatment access for

patients who need to be seen daily, especially in less densely populated communities.

[7] Another avenue is providing MAT in community programs through telemedicine, remotely connecting patients with physicians who can prescribe MAT and ensuring adequate reimbursement for tele-visits. Vermont offers a robust version of a hub-and spoke model whereby central, specialized substance-abuse treatment programs stabilize patients using MAT before referring them to local "spokes" such as community health centers or private practitioners. Revising the federal substance-abuse confidentiality regulations, which hinder the sharing of patient information related to substance-abuse treatment, could facilitate the provision of high-quality care across sites.

[8] Even with improved access, MAT's cost would remain a substantial barrier for many patients, since those with insurance often face burdensome prior-authorization requirements. In 1987, after the FDA approved zidovudine, the first HIV–AIDS medication, Congress approved $30 million in emergency funding to states to pay for HIV medications — laying the groundwork for what became the AIDS Drug Assistance Program (ADAP), which was authorized by the Ryan White Comprehensive AIDS Resources Emergency Act in 1990. ADAPs now exist in every U.S. state and territory, and states determine their own eligibility criteria within federally set parameters.

[9] The creation of ADAP-like programs or vouchers (covering MAT medications and the overdose reversal agent naloxone), perhaps as a new mechanism under the Substance Abuse Prevention and Treatment Block Grant program or Medicaid demonstration waivers, could provide access for many people with OUD, even in states that haven't expanded Medicaid under the ACA. Although the mental health parity law of 2008 requires most managed-Medicaid and private insurance plans that cover substance-abuse treatment to do so at the same level as other medical care, violations abound. Despite the requirement that substance-abuse treatment be considered an essential health benefit, and despite the fact that the National Institute on Drug Abuse deems MAT the first-line treatment for OUD, the Centers for Medicare and Medicaid Services has not yet made methadone or buprenorphine maintenance treatment for OUD a mandated benefit.

[10] Finally, another innovation of the response to AIDS was the creation of the Office of AIDS Research within the National Institutes of Health (NIH) to coordinate HIV–AIDS research efforts across institutes and programs. Such an office overseeing a national strategy for addressing the opioid epidemic could be developed and housed within the NIH or an appropriate division of the Department of Health and Human Services; it could emphasize that OUD is a chronic medical disorder, as Surgeon General Vivek Murthy has insisted, that should be managed according to standards analogous to those for other chronic disorders.

[11] The scope of reform needed to respond appropriately to this epidemic is daunting. The response

to AIDS, however, established a precedent for expanding access to lifesaving medications and supporting clinicians in implementing evidence-based treatment in marginalized populations. Current federal and state efforts have largely fallen short in addressing the opioid epidemic, as witnessed by ever-increasing mortality. We believe that federal funding should be used to promote new and effective models that provide patients with evidence-based treatment rather than supporting outdated treatment programs that are unwilling or unable to evolve.

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RESPONDA DE ACORDO COM O TEXTO. AS RESPOSTAS DEVEM SER EM PORTUGUÊS

1) **Considere o Parágrafo [1].** Os Estados Unidos estão enfrentando que tipo de epidemia e quais os efeitos da mesma nessa sociedade estadunidense? (2,0 pontos)

   Os Estados Unidos enfreta a epidemia de mortes relacionadas com opióides. O efeito dessa epidemia gera a dependência de analgésicos, heroína, ou ambos, as taxas de mortes ultrapassaram a mortalidade por acidentes de veículos desde 2013.

2) **Considere o parágrafo [4].** Em 40% dos condados dos Estados Unidos há qual dificuldade? (2,0 pontos)

   Os estados unidos não possuem nenhum médico autorizado a prescrever buprenorfina e a maioria dos provedores autorizados realmente trata poucos ou nenhum paciente.

3) **Considere o Parágrafo [6].** O Canadá adotou que tipo de modelo de tratamento assistido por medicação? (2,0 pontos)

   Um modelo que oferece acesso expandido à metadona através da dosagem diária feita em farmácias locais.

4) **Considere o Parágrafo [7].** Explique como o MAT (Tratamento Assistido por Medicação) vem sendo oferecido em programas comunitários. (2,0 pontos)

   A telemedicina, que conecta pacientes com médicos que podem prescrever um tratamento assistido por medicação (MAT) e assegurar o reembolso adequado para televisitas.

5) **Considere o Parágrafo [10].** Qual foi a outra inovação nos EUA em resposta à AIDS e qual seu objetivo? (2,0 pontos)

   A criação do Escritório de Pesquisas sobre a Aids nos Institutos Nacionais de Saúde (NIH) para coordenar os esforços de pesquisa sobre HIV-AIDS entre institutos e programas.