ASAM The Voice of Addiction Medicine

American Society of Addiction Medicine

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Senator Levin and Senator Hatch, thank you for the opportunity to present here today.

My name is Dr. Corey Waller and I am the Director of the Center for Integrative Medicine, Substance Use Disorder Medical Director for Network180 (Community Mental Health) and the acting Chief for the Division of Pain Management at Spectrum Health Hospitals in Grand Rapids, Michigan.

I am representing the American Society of Addiction Medicine (ASAM). Established in 1954, ASAM is a professional medical society representing over 3,000 physicians and allied health professionals, including a growing number of nurse practitioners and physician assistants. ASAM is dedicated to increasing access and improving quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addictions.

Last fall, ASAM released the latest version of its patient placement criteria, which is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. Today *The ASAM Criteria* have become the most widely used and comprehensive set of guidelines for treatment placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. *The ASAM Criteria* are required in over 30 states. The benefits of substance use disorder (SUD) treatment on patients and communities are optimized when individual patients are matched with appropriate levels of care. ASAM believes all patients should have access to addiction treatment that is matched to their individual needs, including access to all FDA-approved medications for the treatment of addiction.

***Background***

The Drug Addiction Treatment Act of 2000 (DATA 2000) enables qualifying physicians to receive a waiver from the special registration requirements of the Controlled Substances Act for the provision of medication-assisted opioid treatment therapy, specifically buprenorphine. In order to qualify for the waiver to treat up to 100 patients with buprenorphine, a physician must meet specific requirements, such as, among others, that they hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties, the physician holds an addiction certification from the American Society of Addiction Medicine or the physician has completed at least 8 hours of training provided by an accepted organization such as, among others, the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry or the American Medical Association. Furthermore, a physician is unable to treat up to 100 patients until after they have treated up to 30 patients for a period of one year.

Unfortunately, the combination of an addiction treatment shortage at large, an opioid epidemic and the 100 patient limit is seriously restricting patient access to treatment. ASAM surveyed its members regarding their buprenorphine prescribing practices, in 2013. The results illustrate the difficulties even addiction medicine specialists are having in meeting patient demand. Over 90% of respondents reported having a DEA waiver to prescribe buprenorphine to at least 30 patients with three quarters of those prescribing buprenorphine certified to treat up to 100 patients. However, nearly half reported patient demand in excess of 100 individuals. Furthermore, according to the American Board of Addiction Medicine (ABAM), by 2020 there will be a demand for at least 7,000 qualified addiction physicians just to treat the estimated 7 million patients with severe drug dependence. This does not take into account the additional primary care physicians who will need to be educated about proper prescribing of prescription pain therapies and about addiction prevention, screening, and brief interventions, in order to move prevention and care of substance use disorders into mainstream healthcare.

In response, ASAM is recommending that one part of the solution for tackling the prescription drug and heroin abuse epidemic is to raise the buprenorphine prescribing limit.

***Scope of the Problem***

Unfortunately, the last two decades have seen a dramatic increase in use of and addiction to opioid prescription drugs. According to the Centers for Disease Control and Prevention (CDC), drug overdose death rates have more than tripled since 1990 and 100 individuals in the US die every day from drug overdoses. In 2012, 8 million Americans needed treatment for an illicit drug problem, but only 1.5 million received it. In other words, nearly 80% of individuals who needed treatment for an illicit drug use problem did not receive it.[1] Moreover, in a recent national survey conducted by the National Association of State Alcohol and Drug Abuse Directors (NASADAD), 37 states reported increases in admissions for heroin abuse.[2]

The statistics for Michigan and Utah alone are equally dramatic:

- According to the CDC, Michigan's drug overdose death rate in 2010 was 14 per 100,000 people, above the national average of 12.4 per 100,000 people.[3]
- Opioid-related hospitalizations in our state increased 120% between 2000 and 2011, from 9,157 to 20,191 hospitalizations respectively.[4]
- In 2010 there were 973 deaths in the state due to unintentional drug poisonings. Of these deaths, 22.7% involved opioid analgesics.[5]

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[1] Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

[2] National Association of State Alcohol and Drug Abuse Directors. State Substance Abuse Agencies, Prescription Drugs, and Heroin Abuse: Results from a NASADAD Membership Survey. Retrieved from: http://nasadad.org/wp-content/uploads/2014/06/NASADAD-Prescription-Drug-and-Heroin-Abuse-Inquiry-Full-Report-Final.pdf

[3] CDC 2013 Michigan Prevention Status Report: Prescription Drug Overdose. Retrieved from: http://www.cdc.gov/stltpublichealth/psr/prescriptiondrug/2013/MI-pdo.pdf

[4] Opioid-related hospitalizations in Michigan. Retrieved from: http://www.michigan.gov/documents/mdch/Opioid-Related_Hospit_2000-2011_05-31-13_427136_7_431273_7.pdf

[5] Unintentional Drug Poisoning Deaths in Michigan. Retrieved from: http://www.michigan.gov/documents/mdch/1_3-13-13_MortalityData9910_431271_7.pdf

- In 2012, an average of 21 Utah adults died as a result of prescription pain medications each month.[6]
- Since 2002, prescription pain medications have been responsible for more drug deaths in Utah than all other drug categories, such as anti-anxiety medications, over-the-counter medications, or illicit drugs.[7]

The rise in prescription drug abuse has also given way to an increase in heroin abuse. According to the National Institute on Drug Abuse (NIDA), nearly half of young people who inject heroin reported abusing prescription drugs before abusing heroin. Individuals may transition from prescription drugs to heroin because it is cheaper and easier to obtain.[8]

Fortunately, there exist highly effective therapies to treat opioid addiction, including FDA-approved pharmacotherapies like buprenorphine. All of these medications, buprenorphine, methadone and naltrexone, have been shown to be both clinically and cost effective addiction treatments but are administered in different ways or settings. Buprenorphine was the first approved to be prescribed in an office-based setting, as a take-home prescription—an advent in opioid addiction pharmacotherapy that had great appeal to many concerned with the stigma associated with methadone treatment programs. For many others, buprenorphine solved a logistical dilemma. Not everyone is able to easily access a methadone clinic, particularly patients coming from suburban and rural areas.

Timing is a crucial element in successful treatment. Addiction treatment providers from all backgrounds often talk about "readiness to change" as a leading factor in treatment success. Conversely, denial of treatment leads to continued misuse and abuse, physical and emotional decline and, ultimately, death. In order for a qualified physician to adequately treat this disease, he must be able to address all of the patients' needs and to offer all of the treatment options, at the point of care. Arbitrary treatment limitations like patient-prescribing limits have resoundingly negative effects on treatment access, quality and outcomes and questionable positive effects on controlling diversion.

The collective experience of our members guided the development of the following proposed solutions to the opioid epidemic. We are grateful for this opportunity to present them here.

***Recommendations***

As referenced above, one solution for tackling this epidemic is to increase the buprenorphine prescribing limit. Specifically, ASAM proposes that either Congress or the Secretary of the Department of Health and Human Services (HHS) increase the limit as follows:

- Over a two-year phase-in, increase the limit for prescribing physicians to 250 patients in year 1 and 500 patients in year 2. Prescribers seeking an increase in patient limit must satisfy additional addiction treatment training requirements approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) that covers prescribing, counseling, treatment planning, drug testing, pill recall, etc. This training would be in

[6] Prescription Pain Medication Deaths in Utah, 2012. Retrieved from: http://www.health.utah.gov/vipp/pdf/FactSheets/2012RxOpioidDeaths.pdf

[7] Ibid.

[8] National Institute on Drug Abuse. How is Heroin Linked to Prescription Drug Abuse? Retrieved from: http://www.drugabuse.gov/publications/research-reports/heroin/how-heroin-linked-to-prescription-drug-abuse

addition to the buprenorphine certification requirement currently required to qualify for the 30/100 patient prescribing limit.

- Prescribing physicians who are expert in treating addiction as evidenced by board certification by ABAM in addiction medicine or the American Board of Psychiatry and Neurology (ABPN) in addiction psychiatry shall not be required to obtain the additional training

- Additionally, we recommend there be a follow up study on the impact of increasing the limit on diversion rates and treatment access. Specifically, after year 2 of the increased prescribing limit, HHS, in consultation with the Drug Enforcement Administration (DEA), and CDC, should determine what impact, if any, the increase in access to opioid addiction medications has had on: decreasing deaths due to opioid overdose; decreasing diversion rates; and improving patient access to the Food and Drug Administration (FDA)-approved opioid addiction pharmacotherapies.

***Conclusion***

Expanding the prescribing limit for qualified addiction treatment providers will have an immediate, positive impact on expanding opioid addiction patient access to a clinically and cost effective addiction pharmacotherapy. It should be part of a larger, long-term effort to assure safe prescribing of opioids for pain, alternate pain therapy options and early identification of and treatment for addiction.

Pain and addiction education should be required curriculum in medical school and encouraged as continuing medical education throughout a physician's career. Communities should have the resources to educate their citizens about these issues and the outreach and surveillance resources necessary to better understand their unique issues and needs.

Finally, we encourage this distinguished panel and your colleague to continue working with the medical community to develop strategies that enhance both the health and well-being of our patients and of the community as a whole.

Thank you, again, for the opportunity to present here today. ASAM looks forward to a continued collaboration on this and other addiction-related issues.

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