May 5, 2017

Richard J. Baum
Acting Director
White House Office of National Drug Control Policy
750 17th St NW,
Washington, DC 20006

Dear Director Baum,

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 4,300 physicians and other clinicians who specialize in the treatment of addiction, I'd like to thank you for the opportunity to provide input into the development of the *2017 National Drug Control Strategy (Strategy).* We are grateful that the Administration has signaled its intention to pursue a swift and thoughtful approach to combatting our nation's opioid misuse and overdose epidemic through the appointment of the President's Commission on Combating Drug Addiction and the Opioid Crisis (Commission). We hope these comments will inform both the 2017 *Strategy* as well as the work of the Commission.

Despite the bipartisan and multi-stakeholder efforts to date, we believe there remain opportunities to strengthen America's drug policies to enhance prevention and early intervention efforts as well as promote comprehensive treatment of addiction and recovery support services.

*Prevention*

To date, federal prevention efforts have focused on community-based initiatives such as those designed to be delivered through the workplace, schools, or faith-based or civic organizations. However, we also need strategies to prevent prescription drug misuse through the health care system, which is where most people first encounter controlled substances and where many patients continue to access them even while presenting with risk factors or symptoms of a

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substance use disorder. Specifically, we know that the rate of opioid-related overdose deaths has risen dramatically over the past fifteen years, a trend that mirrors the significant increase in sales of prescription opioids.[1]

ASAM is not alone in its belief that the amount of opioids being prescribed by our nation's doctors, dentists and nurses is excessive. While opioids offer relief to many patients with pain and should remain an available and acceptable option for pain management when medically indicated, it is clear from prescribing data and related addiction treatment admission and overdose death data that the medical community has over-relied on opioids to treat pain. The federal government has taken steps to inform more judicious opioid prescribing through the development of the Centers for Disease Control and Prevention's (CDC) *Guideline for Prescribing Opioids for Chronic Pain (Guideline)* and the dissemination of free and low-cost education programs through the National Institute on Drug Abuse (NIDA) and the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy (REMS) for extended-release, long-acting opioids.

However, ASAM recommends ONDCP include in the 2017 *Strategy* additional prevention principles related to prescriber education and coverage of non-pharmacological pain management options through federal health benefits. Specifically, we recommend ONDCP work with the CDC to promote the dissemination and implementation of its *Guideline*, work with federal agencies who employ prescribing clinicians to ensure they are trained in safe prescribing practices and the recognition of a potential substance use disorder, and facilitate coordination between the Food and Drug Administration (FDA) and Drug Enforcement Agency (DEA) to implement a requirement that clinicians who apply for a registration to prescribe controlled substances demonstrate competency in safe prescribing, pain management, and substance use disorder identification. We also recommend ONDCP work with the Centers for Medicare and Medicaid Services (CMS), the Departments of Defense and Veterans Affairs, and the Office of Personnel Management to ensure federally sponsored and supported health plans provide sufficient coverage of non-pharmacologic pain management options such as physical therapy, weight management, and counseling services.

*Early Intervention*

ASAM recommends the 2017 *Strategy* promote early intervention by supporting the development of training for primary care providers to know how to engage a patient whose prescription drug monitoring programs (PDMP) report indicates he or she may be inappropriately accessing controlled substances. As PDMPs are enhanced and prescribers are encouraged to access them before prescribing, it's important to ensure that health care providers know what to do when the report suggests prescription drug misuse. Too often, we hear that patients are simply denied a medication and turned away. This response does nothing to address the patient's potential substance use disorder. Instead, prescribers should be trained in engagement strategies that result in linking patients to treatment when indicated.

*Treatment*

It has been well-noted that America has a large addiction treatment gap. Specifically, the Substance Abuse and Mental Health Services Administration (SAMHSA) reports that in 2015, an estimated 21.7 million people aged 12 or older (8.1% of that population) needed substance use treatment, but only an estimated 2.3 million people aged 12 or older who needed substance use treatment received treatment at a specialty facility. Stated another way, only 10.8 percent of adolescents and adults who needed treatment received it.[2]

While some administrative progress has been made in recent years to expand treatment access, such as increasing the office-based opioid treatment patient limit for physicians, too often patients face barriers to addiction treatment that they would not face for any other chronic disease. One of the most critical issues is limited or lacking insurance coverage of evidence-based therapies such as medications for opioid addiction and needed psychosocial supports. ASAM strongly recommends ONDCP use the full strength of its influence and every policy lever available to it to ensure payers cover evidence-based addiction treatment just as they would treatment for other chronic medical conditions. This may include working with CMS to influence state Medicaid programs, many of which do not cover all FDA-approved medications for opioid addiction treatment, and working with the Department of Labor to enhance enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA). Simply stated, if a patient needs treatment and is ready to seek it, restrictive payer policies should not prohibit access to the kind of care we know works, but far too often that is the case.

Secondly, ASAM urges that the 2017 *Strategy* include action items related to quality of care. ASAM is committed to promoting evidence-based addiction treatment, and has heard often from policymakers and payers about the challenges they face in identifying and rewarding high-quality care. As the field of addiction treatment works to integrate more fully with traditional medical care, it is imperative that it "catch up" with other medical specialties in terms of clinical guideline development and quality measurement.

As such, ASAM recommends ONDCP expand its efforts to promote quality of care in the 2017 *Strategy* to include: (1) support for the development and dissemination of clinical practice guidelines for addiction treatment, such as the ASAM *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, (2) support for the development and validation of quality measures for addiction treatment, and (3) support for treatment center and/or clinician certification programs that could provide patients, families and payers with a reliable indicator that providers are delivering a certain quality or level of care. Efforts such as these are critically needed to help improve the overall quality of addiction treatment provided in our nation, and assure those who are seeking and paying for treatment that they are receiving medically appropriate and high-quality care.

*Workforce*

The current addiction treatment gap will never be closed with the current addiction treatment workforce. There are simply too few physicians and other clinicians with the requisite training to meet the treatment needs of the estimated 19.4 million Americans suffering from untreated substance use disorders. To make a meaningful and sustainable impact on the current opioid overdose epidemic, and to stave off future epidemics related to other addictive substances such as cocaine, benzodiazepines or methamphetamine, it is imperative that our nation invest in training opportunities for clinicians seeking to specialize in addiction treatment.

Specifically, ASAM urges ONDCP to include in its 2017 *Strategy* a priority related to increasing fellowship opportunities for physicians who want to seek subspecialty board certification in addiction medicine. In 2016, addiction medicine was recognized as an American Board of Medical Specialties (ABMS) subspecialty under the American Board of Preventive Medicine (ABPM). The first ABMS addiction medicine board exam will be offered in October 2017. While the board exam will be open to any American physician with a primary ABMS board certification until 2022, after that time period, physicians will need to complete a year-long fellowship program to be qualified to sit for the exam. In five short years, the number of accredited and funded addiction medicine fellowship programs and slots will be the limiting factor in determining how many addiction medicine specialists can receive board certification. It is critical that all stakeholders work to maximize funded addiction medicine fellowship opportunities before their number begins to limit qualified examinees. Additionally, in the years leading up to 2022, ASAM urges ONDCP to coordinate efforts among federal agencies to raise awareness among qualified physicians of the opportunity to take the board exam without completing a fellowship program.

*Research*

Finally, we urge ONDCP to make the 2017 Drug Control Strategy truly comprehensive by including priorities to increase research into effective ways to prevent substance misuse, treat addiction, reverse overdose, and support individuals in recovery. The National Institute of Drug Abuse (NIDA) and National Institute on Alcoholism and Alcohol Abuse (NIAAA) should be key players in the development of the Administration's *Strategy* and should be targets for additional funding to support needed research.

In the midst of the ongoing opioid epidemic, there is urgent need for research into non-opioid forms of effective pain relief, new and better medications to treat opioid use disorder and reverse overdose, and better psychosocial interventions to help people enter and stay in recovery. There is also a need for basic research to understand better the genetic and environmental underpinnings of addiction, and what factors increase someone's risk of developing addiction or protect them from doing so.

Thank you again for the opportunity to provide input into the development of the 2017 *Strategy.* ASAM looks forward to continuing to work with ONDCP to strengthen our nation's addiction prevention, treatment and recovery support policies and programs in the coming year.

Sincerely,

Kelly J. Clark, MD, MBA, DFAPA, DFASAM
President, American Society of Addiction Medicine

CC: The Honorable Tom Price, MD, Secretary of Health and Human Services

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[1] Centers for Disease Control and Prevention. (2014). Opioid Painkiller Prescribing, Where You Live Makes a Difference. Atlanta, GA: Centers for Disease Control and Prevention. Available at http://www.cdc.gov/vitalsigns/opioid-prescribing/.
[2] Lipari RN, Park-Lee E, and Van Horn S. *America's need for and receipt of substance use treatment in 2015*. The CBHSQ Report: September 29, 2016. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.