September 5, 2017

Dear Governor Christie and Members of the President's Commission on Combating Drug Addiction and the Opioid Crisis:

On behalf of more than 115,000 PAs (physician assistants), the American Academy of PAs (AAPA) appreciates the opportunity to submit comments to the President's Commission on Combating Drug Addiction and the Opioid Crisis (Commission) regarding the opioid epidemic and the draft report (Report) released by the Commission on July 31, 2017.

PAs are one of three healthcare professionals, including physicians and nurse practitioners, who provide primary medical care in the United States. Many dedicated PAs have long been involved in the fight against the opioid crisis that is currently gripping our nation, practicing in specialties such as addiction medicine, behavioral health, and emergency medicine. AAPA is heartened that the Commission is moving quickly to produce a comprehensive plan to combat this threat to the nation.

As the Commission is acutely aware, the abuse, diversion, morbidity, and mortality associated with the opioid epidemic are devastating families and communities across the U.S. According to the Centers for Disease Control and Prevention (CDC), the most recent data estimates that 142 Americans die every day from a drug overdose, with the overall number of opioid overdoses in America having quadrupled since 1999. As the crisis has grown, the capacity to provide treatment has fallen far below the demand. PAs are part of the solution to this problem.

As noted in the Commission's draft report, as a nation "we have an enormous problem that is often not beginning on street corners;" it is frequently starting in hospitals and medical providers' offices. AAPA believes that a fine line must be maintained between fighting opioid abuse and ensuring that patients who are in need of pain management are able to access it. As such, AAPA supports initiatives to stop opioid addiction before it occurs through the use of safe prescribing practices, patient monitoring, and screening for potential abuse. We also believe the current epidemic will not improve without enlisting the help of additional providers to treat those who are already addicted. Therefore, AAPA supports initiatives to increase access to treatment for opioid addiction, both traditional therapy and medication-assisted treatment (MAT), as well as proposals to strengthen provider training in the areas of pain management, safe prescribing practices, and treatment of patients who are already struggling with addiction.

Any initiatives addressing the opioid crisis are more likely to succeed if the considerable abilities of PAs are fully utilized.

PA Education and Practice

PA programs provide a broad medical education over approximately 27 continuous months (approximately three academic years) which consists of two parts. The didactic phase includes coursework in anatomy, physiology, biochemistry, pharmacology, physical diagnosis, behavioral sciences, and medical ethics. This is followed by the clinical phase, which includes rotations in medical and surgical disciplines such as family medicine, internal

medicine, general surgery, pediatrics, obstetrics and gynecology, emergency medicine, and psychiatry. Due to these demanding rotation requirements, PA students will have completed at least 2,000 hours of supervised clinical practice in various settings and locations by graduation, with the majority of PA programs awarding a master's degree.

PAs practice and prescribe medication in all 50 states, the District of Columbia, and all U.S. territories with the exception of Puerto Rico. They manage the full scope of patient care, often handling patients with multiple comorbidities. In their normal course of work, PAs conduct physical exams, order and interpret tests, diagnose and treat illnesses, assist in surgery, and counsel on preventative healthcare. The rigorous education and clinical training of PAs enables them to be fully qualified and equipped to manage the treatment of patients with opioid addiction.

PAs currently have the authority to prescribe up to Schedule III controlled substances needed by their patients in 49 states and D.C.; 46 states and D.C. authorize PAs to prescribe Schedule II medications. In some states, PAs have been authorized to prescribe controlled medications for more than 30 years. Once granted, no state has ever rescinded PA authority to prescribe controlled medications. There has been no record of increased liability or malpractice claims due to PA prescribing of scheduled drugs, and professional liability insurers have not increased premiums when PAs have been granted authority to prescribe controlled medications.

PAs frequently work with patients who struggle with opioid dependency. While many PAs specialize in addiction medicine, there are also approximately 30,000 PAs practicing as primary care providers on the "front lines" of patient care in hospitals, private practices, community health centers, rural health clinics, non-federally qualified public or community health clinics, prisons, behavioral healthcare facilities, and free clinics, where they commonly encounter patients who present with or are at risk of opioid addiction. This care is especially critical in rural and medically-underserved areas, where PAs may serve as the only primary care clinician or in areas where PAs own and serve their own medical practices.

The following are our comments on specific recommendations from the Report.

Declaration of Emergency

The first recommendation from the Report was for the President to formally declare the opioid epidemic a national emergency. AAPA is heartened President Trump has accepted this recommendation, and that he has promised to officially declare the opioid epidemic is a national emergency. While such a declaration is not a comprehensive plan to combat this problem, it will make more resources available and highlight for the general public the severity of this crisis.

Mandating Prescriber Education Initiatives

The Report recommends mandating prescriber education initiatives, working in tandem with partners to ensure providers are better educated in how to manage pain and avoid over-prescribing. Rather than mandating prescriber education initiatives, AAPA recommends addressing this issue by encouraging all providers who commonly prescribe opioids to obtain continuing medical education (CME) designed to prevent and treat prescription drug abuse among their patients with chronic pain. AAPA has been proactive in ensuring PAs have access to CME and other coursework related to safely prescribing opioid medications, as well as the screening, prevention, and management of prescription drug misuse, and supports initiatives that will provide access to more education opportunities to providers in these areas.

Medication-Assisted Treatment (MAT)

Both the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Drug Abuse (NIDA) have found that individuals who are addicted to opioids often fare better if they have access to MAT, as well as traditional therapies. MAT patients have greater overall survival rates and treatment retention, and they show decreased criminal activity, allowing them to become and stay employed.

The Report includes language recommending the Centers for Medicare & Medicaid Services (CMS) require all federally-qualified health centers (FQHCs) to mandate practitioners on staff, including PAs, be waivered to prescribe buprenorphine. While this is a worthy goal, a mandate will likely be problematic in some states, due to state-specific barriers which prevent PAs from prescribing this medication to treat opioid use disorder even after the change in federal law. For example, Kentucky does not allow PAs to prescribe controlled substances. In Tennessee, PAs may prescribe controlled substances, but their state laws prohibit PAs (and nurse practitioners (NPs)) from prescribing buprenorphine for the purposes of MAT. These barriers (and others like them) must first be addressed to maximize the use of PAs in combating opioid use disorder through the provision of MAT. Therefore, a mandate could result in FQHCs losing PAs and NPs from their staff because they would not be able to meet the requirement.

We would also encourage the commission to consider approaches to making it easier for PAs and NPs to obtain waivers to prescribe buprenorphine. The Secretary of Health and Human Services (Secretary) has the ability to allow PAs and NPs that work in collaboration with a physician to obtain waivers even if the collaborating physician is not a qualified provider. The Secretary also has the authority to streamline the training. This could be done in a manner that would save time without sacrificing needed content.

Naloxone

The Report recommends the development of model legislation to be used by states in writing or expanding their laws related to the prescribing of naloxone.

While all states authorize PAs to order naloxone for immediate administration, only a little more than half of the states currently allow PAs to issue a standing order to a specific pharmacy. A standing order allows the pharmacy to dispense naloxone to a patient who is at risk of an opioid overdose and/or a family member, friend, or caregiver to such a person. Allowing PAs to issue standing orders for naloxone is particularly important in rural and medically underserved areas, where a physician may not be readily available to do so. In light of the high demand for naloxone in underserved areas, AAPA recommends the Commission include PAs in any model legislation aimed at increasing the use of pharmacy-specific or other standing orders for this medication.

Workforce Access and Training Needs

The Report calls for a more thorough examination of healthcare workforce issues, including how best to help providers treat those in underserved areas, along with vulnerable patient populations, including pregnant women and children. PAs are commonly found in underserved communities treating the most vulnerable, and as such AAPA strongly supports initiatives that focus on these issues.

Reducing Barriers to MAT

In spite of the large amount of evidence showing the positive outcomes associated with MAT programs, there is often a public perception that MAT simply amounts to replacing one dependency with another. As a result, there are often commercial, regulatory, and statutory barriers to providers seeking to provide MAT, and patients seeking access to this treatment. AAPA supports removing non-evidence based restrictions on the type of providers who can provide MAT for opioid-addicted patients. Additionally, AAPA strongly supports initiatives to expand access to MAT programs for patients who need treatment for opioid addiction.

State Medicaid Programs

AAPA also recommends state Medicaid programs, including Medicaid managed care organizations, be mandated to credential and cover professionals authorized by state law to treat substance use disorder.

AAPA is committed to combating opioid use disorder in the U.S., and we look forward to working with the Commission and all relevant actors to treat this issue. Please do not hesitate to contact Tate Heuer, AAPA Vice President, Federal Advocacy, at 571-319-4338 or theuer@aapa.org with any questions.

Sincerely,

L. Gail Curtis, MPAS, PA-C, DFAAPA
President and Chair of the Board