

Background Information Statement
Submitted to
U.S. Senate Committee on Health, Education, Labor and Pensions
Regarding the December 8, 2015 Hearing on
“Opioid Abuse in America: Facing the Epidemic and Examining Solutions”
On Behalf of the American Academy of PAs

On behalf of the more than 104,000 nationally-certified physician assistants (PAs), the American Academy of PAs (AAPA) appreciates the Senate Committee on Health, Education, Labor and Pensions’ continued work on combating opioid abuse in the U.S. We are pleased that the Committee is addressing this important issue, and we believe that PAs can be an integral part of the solution to this growing crisis.

Millions of Americans have been prescribed opioid medications to treat acute or chronic pain. While the majority of patients use these drugs without incident, many become dependent on them over time, leading to grave consequences. According to the Centers for Disease Control and Prevention, drug overdoses have surpassed traffic fatalities as the leading cause of accidental deaths in the U.S. Just as troubling, the National Institute on Drug Abuse (NIDA) has found that opioid drugs are responsible for more of these deaths than any other type of drug. While changes have been made to curb prescription drug abuse at both the healthcare provider and drug manufacturing levels, they have had little impact on the overall epidemic. Worse, it appears that limiting the ability to abuse these drugs has led to a dangerous, unintended consequence: it has become cheaper and easier for many individuals who are dependent on opioids to turn to heroin to achieve similar effects. As a result, the U.S. saw a 39% increase in the number of deaths due to heroin abuse between 2012 and 2013, and a recent NIDA report cited a 2012 study which found that 86% of “young, urban injection drug users” had first abused prescription opioid medications.

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, we support Congress’ desire to stop opioid addiction before it occurs through the use of safe prescribing practices, patient monitoring, and screening for potential abuse. However, we also believe that the current epidemic will not improve without enlisting the help of additional providers to treat those who are already addicted.

PA Education and Practice

PAs receive a broad medical education over approximately three academic years which includes coursework in anatomy, physiology, biochemistry, pharmacology, physical diagnosis, behavioral sciences, and medical ethics as well as more than 2,000 hours of clinical rotations. PA rotations include primary care, emergency medicine, family medicine and psychiatry among other areas of specialty, and they often vary in practice setting and location. The majority of PA programs award a master’s degree to graduates, and PAs must pass the Physician Assistant National Certifying Examination and be licensed by their state to become certified to practice. Once practicing, PAs must complete 100 hours of continuing medical education (CME) every two years and pass a national recertification exam every ten years to maintain their certification.

PAs practice and prescribe medication in all 50 states, the District of Columbia, and all U.S. territories with the exception of Puerto Rico, and 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.

Medication-Assisted Treatment for Opioid Addiction

Individuals struggling with opioid addiction often require personalized treatment plans which take into account a number of factors, including patients' home and family situations, history of criminal behavior, and their likelihood of remaining in treatment over the long term. Treatment plans are typically built on a bedrock of counseling and behavioral therapy, but in many cases, the use of medication-assisted treatment (MAT) is also appropriate. Currently, four different medications are used to treat opioid addiction:

- **Methadone:** Methadone is a synthetic opioid used to reduce withdrawal symptoms by blocking pain and reducing cravings. Due to the potential for misuse and dependence, methadone may only be dispensed through a certified opioid treatment program. It is the oldest, strongest, and most well-known of the medications used to treat opioid addiction. Under current federal law, PAs may prescribe methadone for 30 days to treat chronic pain. PAs who are employed at methadone treatment programs may order methadone dosage changes and participate in the care and treatment of patients who are dependent on opioid drugs.
- **Buprenorphine:** Buprenorphine is an opioid partial antagonist which, like methadone, reduces withdrawal symptoms and cravings. However, buprenorphine also creates a "ceiling" in which the opioid effects of the drug eventually level off, even if additional doses are taken. As a result, buprenorphine is less likely than methadone to be misused, and the side effects are typically less severe. Buprenorphine may be prescribed and dispensed in more settings than methadone, including physicians' offices, health departments, and correctional facilities. Under current federal law, PAs may prescribe buprenorphine for pain management purposes, but they may not prescribe it for the treatment of opioid addiction.
- **Naltrexone:** Naltrexone blocks the euphoric effects of opioids. While it reportedly reduces cravings for opioids, it differs from methadone and buprenorphine in that it does not mimic the effects of opioid drugs or reduce withdrawal symptoms. Naltrexone is available in settings outside of opioid treatment programs, and it is not a controlled substance. As such, federal laws allow any licensed prescriber (including PAs) to prescribe and administer this drug.
- **Naloxone:** Naloxone is a fast-acting drug which is used to reverse the effects of an opioid drug overdose. It is typically prescribed to high-risk MAT patients, including those who were taking high doses of opioids for chronic pain, those who are on complicated MAT regimens, and those who have already suffered an overdose. Naloxone is also often added to buprenorphine to reduce diversion and misuse. While naloxone is not a controlled substance, states have differing laws regarding the prescription and dispensing of this drug. Currently, 48 states allow PAs to prescribe naloxone without on-site physician supervision (subject to licensing and educational requirements). Twenty-five states allow PAs to dispense naloxone without significant restrictions, and 22 states allow PAs to dispense the drug under certain circumstances. State laws are expected to continue to move in the direction of allowing PAs to have more authority when it comes to prescribing this lifesaving drug.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), MAT used in conjunction with traditional therapies has been proven to increase patient survival and retention in treatment, decrease criminal activity, and better allow patients to become and stay employed.

Despite these positive outcomes, there is a public perception that MAT simply amounts to replacing one dependency with another. As a result, the stigma associated with these medications has deterred qualified providers from seeking the ability to prescribe them. At the same time, current federal laws which limit the availability of these drugs and restrict the types of providers who may prescribe and dispense them –

particularly buprenorphine – has led to a severe shortage of providers to assist patients with an opioid dependency. In fact, a recent study published in the *American Journal of Public Health* found that in 2012, an estimated 2.3 million Americans either abused or were dependent on opioids, while the capacity for treatment programs offering MAT was only 1.4 million. Meanwhile, according to the U.S. Department of Health and Human Services, more than 60 Americans die from an opioid-related overdose every day. It is clear that additional providers are necessary to combat this growing epidemic.

PA Prescribing Authority and AAPA Actions

PAs are currently permitted to prescribe up to Schedule III controlled substances in all 50 states and D.C.; 41 states and D.C. also allow PAs to prescribe Schedule II drugs. While PAs are able to prescribe Schedule III buprenorphine to their patients for pain management, the Drug Addiction Treatment Act of 2000 (DATA 2000) does not allow PAs to prescribe this medication for the treatment of opioid addiction. In light of the shortage of physicians specializing in mental health and addiction medicine as well as the relative safety of buprenorphine compared to methadone, *AAPA strongly believes that PAs must be able to prescribe buprenorphine to treat opioid addiction in states where they are already permitted to prescribe it for other purposes.*

PAs commonly work with patients who struggle with opioid dependency. While some PAs may choose to specialize in addiction medicine, there are also over 32,000 PAs working at hospitals, community health centers, rural health clinics, non-federally qualified public or community health clinics, and free clinics. This means that a significant number of PAs are working on the “front lines” of patient care. For this reason, AAPA has been proactive in ensuring that PAs have access to continuing education and other coursework related to safely prescribing opioid medications, as well as recognizing and treating patients who are experiencing addiction to such substances. Thousands of PAs have participated in the CO*RE Risk Evaluation and Mitigation Strategy (REMS) educational activity on safely prescribing extended release and long-acting (ER/LA) opioid painkillers, and AAPA is pleased to be a partner among several other provider groups in continuing to create opportunities for inter-professional education in this area. Additionally, AAPA has hosted multiple online and in-person CME courses addressing opioid abuse, pain management, and safe prescribing, and plans to remain active in encouraging PAs to remain up-to-date on current best practices surrounding the responsible prescribing of opioid medications and comprehensive assistance for those who become dependent.

Policy Recommendations

PAs are versatile healthcare practitioners who are qualified to provide comprehensive patient care, and they are already serving as a valuable part of the healthcare team at behavioral health facilities, rural health clinics, and other settings. In fact, during a hearing held by the House Committee on Energy and Commerce’s Health Subcommittee on October 20th (*Examining Legislative Proposals to Combat our Nation’s Drug Abuse Crisis, Part II*), a witness specializing in addiction medicine, Dr. Robert Corey Waller, stated that “without the utilization of my physician assistants, my office doesn’t run.” He went on to say later, “the access for them to be able to write (prescriptions for buprenorphine) from a practical standpoint, it really just has to happen, they are really moving forward as the biggest part of our healthcare system.” AAPA agrees wholeheartedly with Dr. Waller’s assessment.

Several bills have been introduced in the U.S. Senate to address the opioid abuse epidemic. In general, AAPA supports legislation to increase access to treatment for opioid addiction, both traditional therapy and 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 dependency.

At the same time, it is vitally important that any such legislative language either be provider-neutral or affirmatively include PAs. The majority of states give PAs a wide scope of practice, with some even allowing PAs to own their own practices. In many rural and medically-underserved areas, it is not uncommon for a PA to be the only healthcare provider for miles, meaning PAs are their patients' primary medical provider. In particular, the current shortage of providers who are willing or able to prescribe buprenorphine to patients could be partially alleviated by allowing PAs to be eligible to do so.

While one bill, the TREAT Act (S. 1455/H.R. 2536) would amend DATA 2000 to allow PAs to prescribe buprenorphine in part, it leaves out PAs who work in states which use the term "collaborate" rather than "supervised" in their scope of practice laws. This is problematic because the state of Alaska, the District of Columbia, and the U.S. Department of Veterans Affairs use "collaborate" to define the relationship between PAs and physicians. As a result, the bill as currently drafted would arbitrarily exclude a number of PAs and potentially exclude many more as other states update PA practice laws to use the term "collaboration." Therefore, if this legislation is enacted as currently written, it would result in continued lack of access in some of the most high-need areas of the U.S. AAPA recommends referring to state law rather than using terms which have the potential to continue to limit access to PA services to fight the opioid dependency crisis.

AAPA is committed to finding ways to assist in combating opioid addiction in the U.S, and we look forward to working with the committee as it moves forward on this important issue. Please do not hesitate to contact Sandy Harding, AAPA Senior Director of Federal Advocacy, at (571) 319-4338 or sharding@aapa.org with any questions.