Evaluation of the Final Report of the President's Commission on Combating Drug Addiction and the Opioid Crisis

Prepared by ACP's Division of Governmental Affairs and Public Policy
November 20, 2017

The Commission's recommendations are compared with ACP policy below, where applicable.

Commission Report Recommendation	**ACP Policy Statement**
5. The Commission recommends the Administration fund and collaborate with private sector and non-profit partners to design and implement a wide-reaching, national multi-platform media campaign addressing the hazards of substance use, the danger of opioids, and stigma. A similar mass media/educational campaign was launched during the AIDs public health crisis.	**Substance use disorders are treatable chronic medical conditions that should be addressed through expansion of evidence-based public and individual health initiatives to prevent, treat, and promote recovery. ACP supports appropriate and effective efforts to reduce all substance use, including educational, prevention, diagnostic, and treatment efforts. In addition, ACP supports medical research on substance use disorders, including causes and treatment. ACP emphasizes the importance of addressing the stigma surrounding substance use disorders among the health care community and the general public. (1)** **The ACP recommends that all relevant stakeholders initiate programs to reduce the stigma associated with behavioral health. These programs need to address negative perceptions held by the general population and by many physicians and other health care professionals. (2)**
6. The Commission recommends HHS, the Department of Labor (DOL), VA/DOD, FDA, and ONDCP work with stakeholders to develop model statutes, regulations, and policies that ensure informed patient consent prior to an opioid prescription for chronic pain. Patients need to understand the risks, benefits and alternatives to taking opioids. This is not the standard today.	**ACP recommends the consideration of patient-provider treatment agreements between physician and patients as a tool for the treatment of pain. (3)**

7. The Commission recommends that HHS coordinate the development of a national curriculum and standard of care for opioid prescribers. An updated set of guidelines for prescription pain medications should be established by an expert committee composed of various specialty practices to supplement the CDC guideline that are specifically targeted to primary care physicians.	ACP supported the CDC Guideline for the Use of Opioids for Chronic Pain while emphasizing that the guideline should be used as a set of recommendations and not prescriptive standards. The College also encouraged that the CDC add a discussion within the Guideline document reflecting how the recommendations "align with the other federal efforts (e.g. Office of National Drug Control Policy; initiatives of the National Institute on Drug Abuse and the Substance Abuse and Mental Health Administration; and the recently released initiative through the Department of Health and Human Services) to address the problems related to opioid medication use and misuse. The effectiveness of the CDC Guidelines depends upon the success of these other federal efforts --- to promote relevant education, reduce barriers to the full array of available pain treatments, increase monitoring efforts regarding opioid use, promote further necessary research, reduce the effects of stigma on receiving appropriate care, and effectively reduce illicit diversion --- and these parallel efforts should be reflected within the Guideline document." **(ACP comments on CDC Guideline LINK)** **Physicians are obligated by the standards of medical ethics and professionalism to practice evidence-based, conscientious pain management that prevents illness, reduces patient risk, and promotes health. ACP strongly believes that physicians must become familiar with, and follow as appropriate, clinical guidelines related to pain management and controlled substances, such as prescription opioids, as well as nonopioid pharmacologics and nonpharmacologic interventions. (1)** ***Training in the treatment of substance use disorder should be embedded throughout the continuum of medical education.*** **Training in screening and treatment of substance use disorders should be embedded in the continuum of medical education. Continuing medical education providers should offer courses to train physicians in addiction medicine, medication-assisted therapy, evidence-based prescribing, and identification and treatment of substance use disorders. (1)**

8. The Commission recommends that federal agencies work to collect participation data. Data on prescribing patterns should be matched with participation in continuing medical education data to determine program effectiveness and such analytics shared with clinicians and stakeholders such as state licensing boards.	ACP Comments: This is a recommendation for federal direction of educational outcomes assessments. Because both prescribing patterns and CME are tracked, there is no current barrier to performing this assessment. That said, if the government chooses to perform this research, we suggest that the analyses must be performed with appropriate study design, directed by or partnered with educational outcomes research scientists.
9. The Commission recommends that the Administration develop a model training program to be disseminated to all levels of medical education (including all prescribers) on screening for substance use and mental health status to identify at risk patients.	**Training in screening and treatment of substance use disorders should be embedded in the continuum of medical education. Continuing medical education providers should offer courses to train physicians in addiction medicine, medication-assisted therapy, evidence-based prescribing, and identification and treatment of substance use disorders**. Additional comments: Educationally, it would be inappropriate to use a single model training program for all levels of medical education and all prescribers. What is needed is a complete curricular plan that addresses training needs across the learning spectrum. This curricular plan must be profession-driven and evidence based. A federally developed model is unlikely to meet the training needs of all providers. What is instead needed is federal support for professionally developed and targeted curricula.
10. The Commission recommends the Administration work with Congress to amend the Controlled Substances Act to allow the DEA to require that all prescribers desiring to	"We favor the use of positive incentives to encourage physicians to complete educational requirements, such as a waiver of the $550 Drug Enforcement Agency (DEA) registration

be relicensed to prescribe opioids show participation in an approved continuing medical education program on opioid prescribing. 11. The Commission recommends that HHS, DOJ/DEA, ONDCP, and pharmacy associations train pharmacists on best practices to evaluate legitimacy of opioid prescriptions, and not penalize pharmacists for denying inappropriate prescriptions.	fee, for completion of voluntary course(s) to increase the number of physicians who obtain adequate training on pain management and the recognition of substance use disorders." (Joint letter to FDA Commissioner Hamburg LINK) **Physicians are obligated by the standards of medical ethics and professionalism to practice evidence-based, conscientious pain management that prevents illness, reduces patient risk, and promotes health. ACP strongly believes that physicians must become familiar with, and follow as appropriate, clinical guidelines related to pain management and controlled substances, such as prescription opioids, as well as nonopioid pharmacologics and nonpharmacologic interventions. (1)** ***Training in the treatment of substance use disorder should be embedded throughout the continuum of medical education.*** **Training in screening and treatment of substance use disorders should be embedded in the continuum of medical education. Continuing medical education providers should offer courses to train physicians in addiction medicine, medication-assisted therapy, evidence-based prescribing, and identification and treatment of substance use disorders. (1)**
PDMP Enhancements 12. The Commission recommends the Administration's support of the Prescription Drug Monitoring (PDMP) Act to mandate states that receive grant funds to comply with PDMP requirements, including data sharing. This Act directs DOJ to fund the establishment and maintenance of a data-sharing hub. 13. The Commission recommends federal agencies mandate PDMP checks, and consider amending requirements under the Emergency	**e. ACP reiterates its support for the establishment of a national PDMP. Until such a program is implemented, ACP endorses efforts to standardize state PDMPs through the federal National All Schedules Prescription Electronic Reporting program. ACP strongly urges prescribers and dispensers to check PDMPs in their own and neighboring states (as permitted) before writing and filling prescriptions for medications containing controlled substances. All PDMPs should maintain strong protections to ensure confidentiality and privacy. Efforts should be**

Medical Treatment and Labor Act (EMTALA), which requires hospitals to screen and stabilize patients in an emergency department, regardless of insurance status or ability to pay. 14. The Commission recommends that PDMP data integration with electronic health records, overdose episodes, and SUD-related decision support tools for providers is necessary to increase effectiveness.	**made to facilitate the use of PDMPs, such as by linking information with electronic medical records and permitting other members of the health care team to consult PDMPs. (1)**
15. The Commission recommends ONDCP and DEA increase electronic prescribing to prevent diversion and forgery. The DEA should revise regulations regarding electronic prescribing for controlled substances.	The ACP recommends the passage of legislation by all 50 states permitting the electronic prescription of all scheduled controlled substances (3) ACP supports an amendment to the Controlled Substance Act to permit electronic transmission of prescriptions of controlled substances using appropriate and reasonable security standards and audit capabilities; and will encourage the Centers of Medicare/Medicaid Services (CMS) and the Drug Enforcement Agency (DEA) to work together to modify the regulation. If this is not feasible, legislation should be passed to allow for a statutory change in the law. (4)
16. The Commission recommends that the Federal Government work with states to remove legal barriers and ensure PDMPs incorporate available overdose/naloxone deployment data, including the Department of Transportation's (DOT) Emergency Medical Technician (EMT) overdose database. It is necessary to have overdose data/naloxone deployment data in the PDMP to allow users of the PDMP to assist patients.	**e. ACP reiterates its support for the establishment of a national PDMP. Until such a program is implemented, ACP endorses efforts to standardize state PDMPs through the federal National All Schedules Prescription Electronic Reporting program. ACP strongly urges prescribers and dispensers to check PDMPs in their own and neighboring states (as permitted) before writing and filling prescriptions for medications containing controlled substances. All PDMPs should maintain strong protections to ensure confidentiality and privacy. Efforts should be made to facilitate the use of PDMPs, such as by linking information with electronic medical records and permitting other members of the health care team to consult PDMPs. (1)**
17. The Commission recommends community-based stakeholders utilize Take Back Day to inform the public about drug screening and	**ACP supports a comprehensive national policy on prescription drug abuse containing education, monitoring, proper disposal, and**

treatment services. The Commission encourages more hospitals/clinics and retail pharmacies to become year-round authorized collectors and explore the use of drug deactivation bags.	**enforcement elements. (3)**
The Commission recommends that CMS remove pain survey questions entirely on patient satisfaction surveys, so that providers are never incentivized for offering opioids to raise their survey score. ONDCP and HHS should establish a policy to prevent hospital administrators from using patient ratings from CMS surveys improperly.	"The College strongly supports the proposal to remove the pain management dimension from the calculation of the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain in the HCAHPS Survey score. (ACP OPPS Hospital Proposed Rule comments LINK)
The Commission recommends CMS review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain.	ACP recommends that **"physicians must become familiar with, and follow as appropriate, clinical guidelines related to pain management and controlled substances, such as prescription opioids, as well as nonopioid pharmacologics and nonpharmacologic interventions." (1)** **To facilitate improved access to non-opioid methods of pain control, that the Board of Regents advocates that CMS/Medicare reduce cost sharing and eliminate the need for prior authorization for non-opioid pain management strategies. (ACP Resolution)** **The ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work toward removing payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care. (2)**
31. The Commission recommends HHS, CMS, Substance Abuse and Mental Health Services Administration, the VA, and other federal agencies incorporate quality measures that address addiction screenings and treatment referrals. There is a great need to ensure that health care providers are screening for SUDs and know how to appropriately counsel, or refer a patient. HHS should review the scientific evidence on the latest OUD and SUD treatment options and collaborate with the	**The ACP supports the integration of behavioral health care into primary care and encourages its members to address behavioral health issues within the limits of their competencies and resources.** **The ACP supports increased research to define the most effective and efficient approaches to integrate behavioral health care in the primary care setting. (2)** Additional Comments: In general, ACP has

U.S. Preventive Services Task Force (USPSTF) on provider recommendations.	supporting some quality measures that address addiction screenings and treatment referrals. We have highlighted our general viewpoints on quality measurement in a number of recent letters, most recently in one to CMS in response to their announcement of the "Meaningful Measures" initiative. Our letter to CMS on the initiative reiterates comments on quality measurement that we have made a number of times (e.g., on MACRA as well as the CMS Draft Quality Measure Development Plan). (LINK)
32. The Commission recommends the adoption of process, outcome, and prognostic measures of treatment services as presented by the National Outcome Measurement and the American Society of Addiction Medicine (ASAM). Addiction is a chronic relapsing disease of the brain which affects multiple aspects of a person's life. Providers, practitioners, and funders often face challenges in helping individuals achieve positive long-term outcomes without relapse.	***Substance use disorder is a chronic medical condition and should be managed as such.*** **Substance use disorders are treatable chronic medical conditions that should be addressed through expansion of evidence-based public and individual health initiatives to prevent, treat, and promote recovery. ACP supports appropriate and effective efforts to reduce all substance use, including educational, prevention, diagnostic, and treatment efforts. In addition, ACP supports medical research on substance use disorders, including causes and treatment. ACP emphasizes the importance of addressing the stigma surrounding substance use disorders among the health care community and the general public. (1)**
33. The Commission recommends HHS/CMS, the Indian Health Service (IHS), Tricare, the DEA, and the VA remove reimbursement and policy barriers to SUD treatment, including those, such as patient limits, that limit access to any forms of FDA-approved medication-assisted treatment (MAT), counseling, inpatient/residential treatment, and other treatment modalities, particularly fail-first protocols and frequent prior authorizations. All primary care providers employed by the above-mentioned health systems should screen for alcohol and drug use and, directly or through referral, provide treatment within 24 to 48 hours.	**Lift barriers that impede access to medications to treat opioid use disorder (methadone, buprenorphine, and naltrexone) and to medications for overdose prevention (naloxone). The federal government should consider lifting the cap on the number of patients who can receive buprenorphine if a physician has been trained in proper prescribing practices. Public and private insurers should remove onerous limits on medications for overdose prevention and medication-assisted treatment, including burdensome prior authorization rules or lifetime limits on buprenorphine that prevent medically necessary care. Oversight and enforcement efforts should be strengthened to protect against misuse, diversion, and**

	illegal sale of buprenorphine and other opioid treatment drugs. Policymakers should evaluate and consider removing restrictions on office-based methadone treatment provided by trained physicians or other health care professionals. (1) **ACP strongly supports parity of mental health and substance use disorders and the coverage of comprehensive evidence-based treatment of substance use disorders. Strong oversight must be applied to ensure adequate coverage of medication-assisted treatment components, counseling, and other items and services. Components of such treatment, which includes medical services, mental health services, educational services, HIV/AIDS services, legal services, family services, and vocational services, should also be extended to those in need. (1)** Additional Comments: ACP largely supports this recommendation although it may be difficult for a health care professional to provide treatment in 24-48 hours, especially in medically underserved areas.
34. The Commission recommends HHS review and modify rate-setting (including policies that indirectly impact reimbursement) to better cover the true costs of providing SUD treatment, including inpatient psychiatric facility rates and outpatient provider rates.	**The ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work toward removing payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care.**
35. Because the Department of Labor (DOL) regulates health care coverage provided by many large employers, the Commission recommends that Congress provide DOL increased authority to levy monetary penalties on insurers and funders, and permit DOL to launch investigations of health insurers independently for parity violations. 36. The Commission recommends that federal and state regulators should use a standardized tool that requires health plans to document	***Health insurance should be required to cover mental health conditions, including the evidence-based treatment of substance use disorders, and abide parity rules.*** **ACP strongly supports parity of mental health and substance use disorders and the coverage of comprehensive evidence-based treatment of substance use disorders. Strong oversight must be applied to ensure adequate coverage of medication-assisted treatment components, counseling, and other items and services. Components of such treatment,**

and disclose their compliance strategies for nonquantitative treatment limitations (NQTL) parity. NQTLs include stringent prior authorization and medical necessity requirements. HHS, in consultation with DOL and Treasury, should review clinical guidelines and standards to support NQTL parity requirements. Private sector insurers, including employers, should review rate-setting strategies and revise rates when necessary to increase their network of addiction treatment professionals.	**which includes medical services, mental health services, educational services, HIV/AIDS services, legal services, family services, and vocational services, should also be extended to those in need. (1)** **The ACP recommends that federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that are barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws. (2)**
37. The Commission recommends the National Institute on Corrections (NIC), the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and other national, state, local, and tribal stakeholders use medication-assisted treatment (MAT) with pre-trial detainees and continuing treatment upon release.	**ACP supports the implementation of treatment-focused programs as an alternative to incarceration or other criminal penalties for persons with substance use disorders found guilty of the sale or possession of illicit substances.** **Treatment of substance use disorders should be made available in a timely manner, including for those in the criminal justice system, as an alternative to incarceration and other criminal penalties. (1)**
38. The Commission recommends DOJ broadly establish federal drug courts within the federal district court system in all 93 federal judicial districts. States, local units of government, and Indian tribal governments should apply for drug court grants established by 34 U.S.C. § 10611. Individuals with an SUD who violate probation terms with substance use should be diverted into drug court, rather than prison.	**Recommendation: 2. ACP supports the implementation of treatment-focused programs as an alternative to incarceration or other criminal penalties for persons with substance use disorders found guilty of the sale or possession of illicit substances. (1)** **Treatment of substance use disorders should be made available in a timely manner, including for those in the criminal justice system, as an alternative to incarceration and other criminal penalties. (1)** **Supporting context from SUD paper:** "To encourage the use of drug courts, the report calls for funding, development of evidence-based drug court practice standards, participation by more serious offenders, and expansion to serve more participants. Drug courts could be more effective if they direct individuals to medication-assisted therapy,

	such as methadone, buprenorphine, or naltrexone, paired with counseling." (1)
40. The Commission recommends the Health Resources and Services Administration (HRSA) prioritize addiction treatment knowledge across all health disciplines. Adequate resources are needed to recruit and increase the number of addiction-trained psychiatrists and other physicians, nurses, psychologists, social workers, physician assistants, and community health workers and facilitate deployment in needed regions and facilities.	***The workforce of professionals qualified to treat substance use disorders should be expanded.*** **ACP supports policies to increase the professional workforce engaged in treatment of substance use disorder. Loan forgiveness programs, mentoring initiatives, and increased payment may encourage more individuals to train and practice as behavioral health professionals. (1)** ***Training in the treatment of substance use disorder should be embedded throughout the continuum of medical education.*** **Training in screening and treatment of substance use disorders should be embedded in the continuum of medical education. Continuing medical education providers should offer courses to train physicians in addiction medicine, medication-assisted therapy, evidence-based prescribing, and identification and treatment of substance use disorders. (1)** **The ACP encourages efforts by federal and state governments, relevant training programs, and continuing education providers to ensure an adequate workforce to provide for integrated behavioral health care in the primary care setting. (2)**
41. The Commission recommends that federal agencies revise regulations and reimbursement policies to allow for SUD treatment via telemedicine.	**Pre- and postbuprenorphine training support and education tools and resources should be made available and widely disseminated to assist physicians in their treatment efforts. Physician support initiatives, such as mentor programs, shadowing experienced providers, and telemedicine, can help improve education and support efforts around substance use treatment. (1)**
43. The Commission recommends the National Highway Traffic Safety Administration (NHTSA) review its National Emergency Medical Services (EMS) Scope of Practice Model with respect to naloxone, and disseminate best practices for states that may need statutory or	**Funding should be allocated to distribute naloxone to individuals with opioid use disorder to prevent overdose deaths and train law enforcement and emergency medical personnel in its use. Legal protections (that is, Good Samaritan laws)**

regulatory changes to allow Emergency Medical Technicians (EMT) to administer naloxone, including higher doses to account for the rising number of fentanyl overdoses. 44. The Commission recommends HHS implement naloxone co-prescribing pilot programs to confirm initial research and identify best practices. ONDCP should, in coordination with HHS, disseminate a summary of existing research on co-prescribing to stakeholders.	**should be established to encourage use of naloxone and the reporting of opioid overdoses in instances where an individual's life is in danger. Physician standing orders to permit pharmacies to provide naloxone to eligible individuals without a prescription should be explored. Insurance and cost-related barriers that limit access to naloxone should be addressed.**
46. The Commission recommends that HHS implement guidelines and reimbursement policies for Recovery Support Services, including peer-to-peer programs, jobs and life skills training, supportive housing, and recovery housing.	**ACP strongly supports parity of mental health and substance use disorders and the coverage of comprehensive evidence-based treatment of substance use disorders. Strong oversight must be applied to ensure adequate coverage of medication-assisted treatment components, counseling, and other items and services. Components of comprehensive drug addiction treatment should also be extended to those in need, including medical services, mental health services, educational services, HIV/AIDS services, legal services, family services, and vocational services.**
52. The Commission recommends federal agencies, including HHS (National Institutes of Health, CDC, CMS, FDA, and the Substance Abuse and Mental Health Services Administration), DOJ, the Department of Defense (DOD), the VA, and ONDCP, should engage in a comprehensive review of existing research programs and establish goals for pain management and addiction research (both prevention and treatment).	**To accelerate the development of high-quality evidence for non-opioid pain treatments, that the ACP:** • **Advocates for PCORI- and AHRQ-funded research addressing safety, quality, comparative effectiveness, and cost effectiveness of non-opioid pain management strategies; and** • **Advocates for large randomized controlled clinical trials whenever possible; and** • **Encourages the incorporation of patient-centered and patient-reported outcomes in new research to appropriately characterize and assess potential benefits of these therapies; and be it further** **To facilitate improved access to non-opioid methods of pain control, that the ACP advocates that CMS/Medicare reduce cost sharing and eliminate the need for prior authorization for non-opioid pain**

	management strategies. (ACP Resolution) **Substance use disorders are treatable chronic medical conditions that should be addressed through expansion of evidence-based public and individual health initiatives to prevent, treat, and promote recovery. ACP supports appropriate and effective efforts to reduce all substance use, including educational, prevention, diagnostic, and treatment efforts. In addition, ACP supports medical research on substance use disorders, including causes and treatment. ACP emphasizes the importance of addressing the stigma surrounding substance use disorders among the health care community and the general public. (1)**

Key to ACP Policy Sources:

(1) Health and Public Policy to Facilitate Effective Prevention and Treatment of Substance Use Disorders Involving Illicit and Prescription Drugs: An American College of Physicians Position Paper http://annals.org/aim/fullarticle/2613555/health-public-policy-facilitate-effective-prevention-treatment-substance-use-disorders

(2) The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: Executive Summary of an American College of Physicians Position Paper http://annals.org/aim/fullarticle/2362310/integration-care-mental-health-substance-abuse-other-behavioral-health-conditions

(3) Prescription Drug Abuse: Executive Summary of a Policy Position Paper From the American College of Physicians http://annals.org/aim/fullarticle/1788221/prescription-drug-abuse-executive-summary-policy-position-paper-from-american

(4) ACP Policy Compendium. Summer 2016. https://www.acponline.org/system/files/documents/advocacy/acp_policy_compendium_summer_2016.pdf

https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report__11-2-2017.pdf