Statement for the Record
Submitted to
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health
Hearing on "Examining Legislative Proposals to Combat our Nation's Drug Abuse Crisis" (Part II)
October 20, 2015
On Behalf of the American Academy of Physician Assistants

On behalf of the more than 104,000 nationally-certified physician assistants (PAs), the American Academy of Physician Assistants (AAPA) appreciates the opportunity to submit a statement for the record regarding legislative proposals to combat opioid drug diversion and abuse. We are pleased that the Subcommittee on Health is addressing this important issue, and we believe that PAs can be a part of the solution to the opioid drug abuse crisis. **As such, we respectfully request that the Subcommittee modify H.R. 2536, the Recovery Enhancement for Addiction Treatment (TREAT) Act, by allowing all PAs to prescribe buprenorphine for the treatment of opioid addiction, subject to state laws and regulations.**

According to the U.S. Department of Health and Human Services, approximately 37% of drug overdose deaths in 2013 were associated with the misuse of prescription opioid medications. While changes have been made to curb prescription drug abuse at both the healthcare provider and drug manufacturing levels, it appears that limiting the availability of prescription opioids 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 use between 2012 and 2013, and a recent research report from the National Institute on Drug Abuse cited a 2012 study which found that 86% of "young, urban injection drug users" had first abused prescription opioid medications. AAPA supports Congress's desire to stop opioid addiction before it occurs; however, these statistics 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 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. PAs manage the full scope of patient care, often handling patients with multiple comorbidities. In their normal course of work, PAs conduct physical exams, assist in surgery, diagnose and treat illnesses, order and interpret tests, and counsel on preventative healthcare. The

rigorous education and clinical training of PAs enable them to be fully qualified and equipped to manage the treatment of patients with opioid addiction.

PA Prescribing Authority and AAPA Actions

PAs are currently permitted to prescribe in all 50 states and the District of Columbia; 41 states and D.C. also allow PAs to prescribe Schedule II drugs. PAs are currently able to prescribe Schedule III buprenorphine to their patients for pain management, but the Drug Addiction Treatment Act of 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, AAPA strongly believes that PAs must be able to treat their patients to the extent allowed under state laws. As such, they should be authorized to prescribe buprenorphine to treat opioid addiction in states where they are already permitted to prescribe similarly-scheduled medications.

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 provide 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.

H.R. 2536, the TREAT Act

AAPA is pleased that the TREAT Act appears to have the intention of allowing PAs to prescribe buprenorphine to patients who are experiencing addiction to opioid drugs as part of a comprehensive treatment plan, as appropriate. However, the legislative language found in Section 4 of the bill, which defines "qualifying practitioner," gives this authority to both PAs and nurse practitioners (NPs) who are "supervised" by physicians under state law, but only does so for NPs who "collaborate" with physicians – not PAs. 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 legislation as currently drafted would arbitrarily leave out a number of PAs and potentially leave out many more as other states update PA practice laws to use the term collaboration.

Due to the nature of the PAs' national certification process, there is no practical difference in education or experience between a PA practicing in a "supervision" state versus a PA practicing in a "collaboration" state. While the term used to describe how PAs interact with physicians is chosen at the discretion of each state, states have largely given PAs a wide scope of practice, with some states 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 practitioner for miles, meaning PAs are their patients' primary medical provider. This is particularly true in Alaska – a state known for its remoteness and limited access to healthcare – but due to the state's use of "collaboration" in its statute, under the TREAT Act, patients in the most rural parts of the state may not have access to all of the tools necessary to combat opioid addiction.

Many states are beginning to recognize that the term "collaboration" is a more accurate description of the relationship between PAs and the physicians with whom they work than "supervision," and several are entertaining legislation to make a change to their statutes to reflect this shift in language and thinking. In 2014, 49 states and D.C. made changes to their laws and regulations with the goal of increasing PA scope of practice. Unfortunately, the TREAT Act as written would represent a step backwards for the PA profession, and more importantly, for patients.

Recommendations

AAPA strongly supports the underlying intentions of the TREAT Act. However, we cannot support the legislation as drafted. Instead, AAPA requests that the language defer to state prescribing and scope of practice laws, regardless of the term used to describe PA practice. This change would ensure that the bill remains up-to-date even as state laws evolve, and it is our belief that it would ultimately represent the sponsors' intentions of increasing access to comprehensive opioid addiction treatment to patients in every state. At the same time, AAPA would support the inclusion of additional training, continuing medical education or transparency measures for PAs who opt to prescribe buprenorphine to their patients.

AAPA stands ready to work with the Subcommittee in advancing the role of PAs in the treatment of opioid addiction. Please do not hesitate to contact Sandy Harding, Senior Director of Federal Affairs, at sharding@aapa.org or 571-319-4338, should you need further information.