April 19, 2018

Zach Dareshori
Legislative Clerk
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Re: Questions for the record of the hearing entitled "Combatting the Opioid Crisis: Helping Communities Balance Enforcement and Patient Safety"

Dear Mr. Dareshori,

It was my pleasure to appear before the Subcommittee on Health on February 28, 2018 to testify at the hearing entitled "Combatting the Opioid Crisis: Helping Communities Balance Enforcement and Patient Safety." Please find below my responses to the additional questions for the record submitted by Members.

The Honorable Susan W. Brooks
1. Would you say it is uncommon for a primary care physician or the physician prescribing opioids to detect and diagnose addiction?
A: *Yes. Given that most clinicians receive no or minimal training on diagnosing or treating addiction in their clinical training programs, most are not equipped to recognize the signs and symptoms of addiction or diagnose it. Primary care physicians are especially pressed for time with patients, and likely do not have the time to screen or assess patients for addiction during a typical visit.*

Even if a primary care physician has the time and training to detect and diagnose addiction in a patient, too often the patient is not offered or engaged in evidence-based treatment for their disease. Diagnosing without intervening in a positive manner is not useful. A patient with suspected opioid use disorder should receive a comprehensive assessment with a biopsychosocial approach that comports with the ASAM Criteria to determine the type and intensity of treatment that the patient needs. The clinician should then discuss and offer to the patient all therapeutic options, including all FDA-approved medications for

opioid use disorder unless clinically contraindicated. The patient and treating clinician should decide together the best treatment options and individualized treatment plan.

2. Aside from Continuing Medical Education, what can be done to better equip physicians who may not be addiction specialists to detect addiction while evaluating their patents?
A: *Prescription drug monitoring programs (PDMPs) are valuable tools that can help inform safe prescribing and alert clinicians to possible substance misuse by a patient. However, the quality and timeliness of PDMP data varies by state, and many PDMP programs are not integrated into normal clinician workflow, making it more difficult for clinicians to check the reports. Additional federal investments to help states improve the quality and timeliness of their PDMP data and better integrate their systems with clinician workflow and electronic medical records could increase their use and usefulness. Additionally, helping states to make their PDMPs interoperable with neighboring states will give clinicians a more complete picture of their patient's prescription history.*

In addition to investments in PDMPs, the federal government should invest in improved healthcare professional curricula to ensure the next generation of healthcare professionals is better equipped to diagnose and treat addiction among its patients. These investments could come in the form of grants to healthcare professional schools to support the revision or expansion of their curricula to include enhanced training on diagnosing and treating addiction as well as managing patients with chronic pain.

Again, it is important to stress that detecting addiction without intervening to engage the patient in treatment is unproductive. While clinicians needs to be better trained and have better tools at their disposal to detect and diagnose addiction among their patients, they must also be able to engage patients in evidence-based treatment, whether they treat the patient themselves or refer the patient to a qualified specialist.

3. Are there best practices or education techniques that you know of to help communities and local law enforcement combat addiction by teaching individuals to detect addiction in loved ones?
A: *As with any medical condition, addiction should be diagnosed by a trained and licensed medical professional. However, community members and law enforcement officials can play an important role in supporting those with addiction in their treatment and recovery, providing emergency medical help to individuals who have experienced an overdose, and connecting persons with addiction to community-based resources for assessment and treatment. There are best practices for community programs to prevent addiction, training for the use of naloxone in the event of an overdose, and law enforcement-assisted diversion to redirect persons with addiction from the criminal justice system into treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) oversees programs in all three of these areas and would be best suited to discuss further the role of community members and law enforcement officers in responding to the opioid crisis.*

Naloxone access, as recently recommended by the Surgeon General, for people suffering from addiction, their families, and the community are critical to prevent and reverse fatal overdoses. 50% of people who overdose currently do so in their own home. Encouraging co-prescribing of naloxone with high risk opioid regimens would increase access to naloxone. Many states have state standing orders for naloxone that all citizens can access.

Amendment of telemedicine laws consistent with my prior testimony would allow for more rapid access to treatment.

Initiation of Medication for Addiction Treatment such as buprenorphine or long-acting injectable naltrexone in Emergency Departments, inpatient hospitals, and correctional facilities would reduce the high risk of fatal overdose associated with discharge from criminal justice.

Coalition building is critical as there is no one place that can identify all of the patients. Supporting community opioid safety coalitions would be a valuable role.

Spreading a message of universal precautions to patients, their families, and their doctors around opioids is critical in preventing new inappropriate opioid medication starts. Universal precautions like with bodily fluids recognizes that the medication carries risks and the risks should be mitigated. Risk assessment is a great concept; however, we know that even low risk individuals can become physically dependent and/or addicted.

The Honorable Dianna DeGette
Opioids play an important role in pain management, but when they are prescribed in excess quantities they increase the risk for misuse and abuse. This past decade the United States experienced a parallel increase in opioid prescriptions and the incidence of opioid use disorders among pain patients. Reducing opioid prescriptions should be one part of the federal government's response to the drug epidemic. This goal can be partially achieved by educating providers on safe opioid prescribing practices. Congressman Schneider's bill, the Opioid Preventing Abuse through Continuing Education (PACE) Act, would require physicians to complete a yearly four-hour course on the use of opioid therapy in pain management. Do you believe that the training proposed under the PACE Act is a reasonable requirement for physicians who prescribe opioids?

A: *Yes. ASAM has long endorsed mandatory education for prescribers of controlled substances as a condition of obtaining or renewing a registration to prescribe or dispense controlled substances, including opioids. ASAM is pleased to endorse the PACE Act, as we believe it would help reduce unnecessary exposure to controlled medications by requiring prescribers to be educated on safe prescribing practices and addiction. Still, ASAM has offered the following recommendations to strengthen the bill, ensure it is streamlined with federal efforts already underway to inform safe prescribing, and minimize its burden on prescribers who are already well-versed on issues related to pain management and addiction:*

- *Make the new training requirement a condition of registration to prescribe or dispense benzodiazepines in addition to opioids for the treatment of pain.*
- *Streamline federal efforts to promote safe opioid prescribing by incorporating the recommendations included in the CDC Guideline for Prescribing Opioids for Chronic Pain. There is no need for duplicative federal recommendations on opioid prescribing; in fact, duplicative efforts may only confuse practitioners and further clutter an already-crowded educational space on this topic.*
- *Offer a "test-out" option that would give practitioners the opportunity to demonstrate their knowledge and "test-out" of this mandatory training requirement.*

Thank you again for the opportunity to provide testimony to the Subcommittee. If ASAM can be of further assistance to the Committee as it considers addiction-related legislation, please don't hesitate to contact ASAM's Director of Advocacy and Government Relations, Kelly Corredor, at kcorredor@asam.org or 301-547-4111.

Sincerely,

David Kan, MD