Recommendations of the
American Psychiatric Association,
American Academy of Addiction Psychiatry, and the
American Osteopathic Academy of Addiction Medicine on
Revisions to the Drug Addiction Treatment Act of 2000

1. **<u>Replace practice limits of 30/100 patients with a 3 tiered system</u>**:

   - **Tier 1: Small Primary Care or Psychiatry practices: physicians can follow up to 30 patients at one time, as with the present system**. There will be <u>NO DEA INSPECTIONS</u> unless DEA or single state agency review of state PDMP data suggests the 30 patient limit has been exceeded (or other violations of standard clinical practice regulations have occurred).

     <u>Comment</u>: DEA inspections are frequently mentioned as a reason for physicians not prescribing. This change should expand the number of small prescribers. Data groups & SAMHSA should notify all individuals who have taken waiver training of this new option and widely publicize the change.

   - **Tier 2:**
     - ***OPTION ONE – SOLO PRACTICE MODEL* (this practice can occur in a group setting, or multiple physicians can practice within the same system)**
     - **After 1 year of practice, physicians can apply to go up from the 30 patient limit to 150 patients.**
     - Prescribers in this group would be required to:

       1. take 3 hours of approved addiction related CME annually,
       2. certify that they follow a nationally recognized set of standard evidence-based guidelines for the treatment of patients with substance use disorders, and
       3. would be subject to occasional DEA inspections as in the current system.

       <u>Comment</u>: This tier is comparable to the current system. The increase to 150 patients would immediately address identified need for additional services but not increase the numbers in individual practices to a range that is incompatible with good clinical practice.

     - ***OPTION TWO - MULTIDISCIPLINARY PRACTICE***
     - **After 1 year of practice, a physician can apply to go from the 30 patient limit to a range of up to 340 patients with the addition of up to three physician extenders to the practice (Physician Assistant, Nurse Practitioner).** The physician would be capped at

100 patients, each physician extender would be capped at 80 patients, with the total practice capped at 180 to 340 patients depending on the number of physician extenders in the group. This group of practitioners would be required to:

1. take 3 hours of approved addiction related CME/CEU annually,
2. certify that they follow a nationally recognized set of standard evidence-based guidelines for the treatment of patients with substance use disorders, and
3. be subject to occasional DEA inspections as in the current system.

Physicians in this type of practice would be **required to be certified** in Addiction Psychiatry by the ABPN or in Addiction Medicine by ABAM or ASAM, or have subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA), unless SAMHSA grants an exemption for non-specialists practicing in high-need rural areas.

Comment: In this type of multidisciplinary practice the physician would be required to supervise the physician extenders. ***To allow for the time for required supervision, should the physician be capped at 80 patients? This would drop the total maximum number for the practice to 320.***

- **Tier 3: Practices that are over 340 patients would require separate registration as a specialized Opioid Treatment Program, and would be monitored accordingly** with varying staffing requirements related to the number of patients being treated, much more specific regulation of practice, and would be subject to periodic reviews by DEA and CARF or The Joint Commission. Physicians working in such a setting would be required to be certified in Addiction Psychiatry by the ABPN or in Addiction Medicine by ABAM or ASAM or have subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA),. SAMHSA/CSAT should call a meeting of the DATA groups, the DEA, CARF, The Joint Commission to work out the details of regulations for this class of OTP. Practices of this type could be staffed by one or more physicians and a mix of RNs, MSWs, PhDs, Pharmacists and drug counselors comparable to the staffing in a methadone maintenance program, or they could follow the staffing guidelines described for Tier 2/Option Two above.

  Comment: While this model is inconsistent with the intent of DATA 2000, it recognizes the need for expanded services and protects the integrity of the DATA 2000 system, which is much better suited for providing services that are integrated into standard mental health and primary care settings under the ACA.

2. **Permit buprenorphine prescribing by Physician Assistants and Nurse Practitioners** in those states or jurisdictions where such practice is permitted. Prescribers will be required to take a standard 8 hour face-to-face waiver course, practice under the supervision of a physician certified in Addiction Psychiatry by the American Board of Psychiatry and Neurology (ABPN) or Addiction Medicine by the American Board of Addiction Medicine (ABAM) or the American Society of Addiction Medicine (ASAM) or have subspecialty board certification in addiction medicine from the American Osteopathic Association (AOA), (unless exempted by SAMHSA for non-specialists working in high-need, rural areas), and take 3 hours of approved addiction related CME/CEU annually. See Tier 2/Option Two above.

3. **Explore options under telemedicine that would permit delivery of buprenorphine services in rural or underserved areas**. Those telemedicine programs treating more than 340 patients will be held to Tier 3 standards.

4. **Additional Federal funds are needed for buprenorphine training for physicians and physician extenders, and for ongoing CME programs to enhance the clinical skills of treatment providers. Additionally, set-aside funding is recommended for residency training programs to provide training in Medication Assisted Treatment and would also provide physician training in MAT through funding additional ABPN-approved addiction psychiatry fellowships, as well as general practice addiction medicine fellowships.**

5. **Funds are also needed to cover the costs for an expanded treatment system for uninsured individuals with opioid use disorders, as well as those covered under Medicaid programs.**

6. **This program should be enacted for a trial period and re-evaluated in three years to determine if it is successful in expanding treatment capacity and whether increasing the number of patients treated by each waivered physicians has a negative impact on the quality of treatment, or a negative impact on public health associated with increased diversion of buprenorphine or other unanticipated negative consequences.**