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April 23, 2014

The Honorable Mary Wakefield
Health Resources and Services Administration
US Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Administrator Wakefield:

In the past decade, prescription opioid drug use has increased dramatically and so have the harms resulting from drug use—including destruction of families and communities, burdens of increased theft and incarceration, and rise in overdose deaths. Like all addictions, the first step to recovery for opioid abusers is typically detoxification followed by therapy and treatment. To date, the Food and Drug Administration (FDA) has approved three medication-assisted treatment (MAT) options for opioid addictions.[1] These MAT options help the brain readjust to the absence of the abused substance and/or quiet the cravings that typically lead to relapse. Some of these more recently-approved treatments can be administered, managed and integrated into outpatient primary care settings, such as community health centers that typically are the source of comprehensive care for underserved populations. As the federal government refocuses its efforts to combat the prescription drug abuse epidemic, the Health Resources and Services Administration (HRSA) plays a critical role in supporting and expanding access to treatments for substance abuse for patients who need it most and in helping to address some of the barriers that exist to the integration of substance abuse services into community health centers.

Many persons with substance use disorders do not seek services from addiction specialists, but may access primary care for a broad array of services. However, as indicated in assessments by the National Association of Community Health Centers (NACHC) in 2010 and 2011, sufficient access to detoxification and linkage to ongoing treatment in community health center settings has been challenging. Only 15 percent of Federally Qualified Health Centers (FQHCs) provide medically-assisted treatments for opiate abuse. The NACHC concluded that,

[1] Methadone in use for addiction treatment since the 1960s; buprenorhpine, approved for opioid addiction treatment in 2002; and intramuscular naltrexone, approved for opioid relapse prevention in 2010. http://www.drugabuse.gov/publications/topics-in-brief/medication-assisted-treatment-opioid-addiction

"the proportion of patients with substance use conditions whose illnesses are recognized and treated [at FQHCs] is miniscule."[2] The assessments identified several barriers to why substance abuse is not more frequently and routinely addressed in FQHCs, including continued negative attitudes toward treatment of substance abuse, difficulty training and retaining qualified staff, and inadequate reimbursement.

Additionally, access to medication-assisted treatment for patients can be limited because of specific restrictions placed on medical professionals wishing to use certain approved treatments. For example, to prescribe buprenorphine products for treatment of opioid addiction, physicians who are not mental health or addiction specialists must complete additional training, submit a notice of intent, and receive a DEA "waiver" to prescribe. Additionally, even when these criteria are met and such a waiver is granted, physicians are limited to prescribing for only 30 patients the first year and 100 patients following years for buprenorphine treatment.[3]

Since 2007, the Massachusetts Department of Public Health (DPH) has partnered with Boston Medical Center to integrate office-base opioid treatment into community health centers. Specifically, DPH has funded 14 community health centers, including 11 FQHCs to employ registered Nurse Care Managers and medical assistants to assist primary care physicians in providing buprenorphine using a "Best Practice" model that combines the use of medication with behavioral health counseling and random drug screening and monitoring. Boston Medical center also received funds to provide technical assistance to the programs at these community health centers. To date, 7,200 clients have been served through these programs. Federal supports for such strategies could expand such models both across Massachusetts and across the country.

Addiction science has taught us there is no panacea for all substance use disorders. Each individual affected requires personalized treatment that may involve a combination of MAT and behavioral therapies. In order to increase access to appropriate treatment programs and modernize our addiction treatment system, it is imperative that as new treatments become available they are scaled up in the appropriate settings, access is simplified, monitoring programs are in place, and implementation science analyzes how to best 'match' patients with the treatment option that gives them the optimal chance of success.

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[2] NACHC 2010 Assessment of Behavioral Health Services in Federally Qualified Health Centers http://www.nachc.com/client/NACHC%202010%20Assessment%20of%20Behavioral%20Health%20Services%20in%20FQHCs_1_14_11_FINAL.pdf. NACHC Assessment of FQHCs' Integrated Behavioral Health Services (2011) http://www.nachc.com/client//2011%20Assessment%20of%20FQHCs%20Integrated%20Behavioral%20Health%20Services.pdf

[3] Physician Waiver Qualifications. http://buprenorphine.samhsa.gov/waiver_qualifications.html

Prescription drug abuse is a multifaceted problem that has become an epidemic in this country. As such, its treatment requires a concerted public health effort to ensure that measured results can be achieved. To better understand the role of HRSA and HRSA-supported community health centers in expanding access to addiction treatment and recovery services including medication-assisted treatment, I respectfully ask that you respond to the following questions:

1. How many and what proportion of FQHC clients are estimated to struggle with opioid addiction? To what extent is this related to prescription drug use? What proportion of FQHC clients are routinely screened for substance abuse, for example using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach?[4]
2. How many FQHCs have programs to administer intramuscular naltrexone as part of addiction treatment? How many clients are being treated with intramuscular naltrexone at FQHCs? Please share examples of "best practice" programs for this treatment among FQHCs.
3. How many total FQHC providers have waivers to prescribe buprenorphine? How many FQHCs have at least one or health care provider who has a waiver to prescribe buprenorphine? How many FQHC clients are being treated with buprenorphine? Please provide this data by state, if available. Please share any evaluation of pilots or models that integrate buprenorphine treatment into the primary care setting.
4. The 2011 NACHC assessment of integrated behavioral health services identified staff attitudes and receptiveness towards treating patients with substance use disorders as a problem.[5] What HRSA-supported technical assistance or trainings have been provided to specifically address stigma and negative attitudes towards treating patients with substance use disorders? Please describe the number of sites and/or providers who have received this assistance.
5. How many FQHCs are in designated Mental Health Professional Shortage Areas (MHPSA)? How many Mental Health Professionals does HRSA currently support in MHPSAs? Please comment, to the extent possible, on what proportion of these professionals have special training in addiction medicine and/or include addiction treatment in their clinical responsibilities.

6. Please describe any mapping or analysis HRSA has used to identify areas of 'high need' for addiction treatment and overlap with geographic areas served by FQHCs? Are

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[4] Screening, Brief Intervention, and Referral to Treatment (SBIRT). http://www.samhsa.gov/prevention/sbirt/
[5] NACHC Assessment of FQHCs' Integrated Behavioral Health Services (2011) http://www.nachc.com/client//2011%20Assessment%20of%20FQHCs%20Integrated%20Behavioral%20Health%20Services.pdf

FQHCs in highly affected areas specifically encouraged to develop addiction screening, treatment and service plans? Please describe how this is encouraged and how HRSA monitors these service plans. What additional resources would HRSA need to assist FQHCs in expanding MAT treatment programs? Please provide any estimates or data, including estimates of unmet MAT needs, you have available.

7. Please describe how HRSA works with other Department of Health and Human Services agencies to identify needs and reduce barriers to integration of substance abuse services into FQHC settings. Specifically, how does HRSA work with the Centers for Disease Control and SAMSHA for surveillance, surveys of community need, and technical assistance? How does HRSA work with Centers for Medicare & Medicaid Services to eliminate frequently-cited payment barriers to FQHC addiction treatment, including Medicaid rules on same-day billing for medical and behavioral health services?
8. To the extent data and analysis are not available to answer the questions above, please describe the limitations of current reporting systems and special evaluations. What additional resources, special studies, or data systems would be required to more fully assess the evolving role of FQHCs in responding to the urgent and escalating epidemic of opioid addiction? What tools are needed for HRSA and/or FQHCs to assess the quality and outcomes of addiction treatment services that are provided?
9. What current limitations on HRSA authorities prevent HRSA from playing a more active role in identifying geographic areas of unmet need for addiction services and actively engaging FQHCs in these areas to implement effective addiction treatment programs?
10. What current limitations in authorities or resources prevent HRSA from tracking the degree to which FQHCs are identifying addiction as a community problem and addressing it with their services?

Thank you for your assistance and cooperation in responding to this request by May 23, 2014. Should you have any questions, please have your staff contact Dr. Shannon Hader or Dr. Avenel Joseph of my staff at 202-224-2742.

Sincerely,

Edward J. Markey

Edward J. Markey
United States Senator

cc:
Michael Botticelli, Acting Director, White House Office of National Drug Control Policy
Pamela Hyde, Administrator, HHS/Substance Abuse and Mental Health Services Administration