

U.S. Department of Health and Human Services

Minutes of the Interdepartmental Substance Use Disorders Coordinating Committee Full Committee Meeting

March 16, 2022

1 p.m. to 4 p.m. (Eastern Time Zone)

Substance Abuse and Mental Health Services Administration

5600 Fishers Lane

Rockville, MD 20857

(Via Zoom)

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Call to Order, Committee Roll Call, and Consideration of Minutes

Tracy Goss, Designated Federal Officer (DFO), Interdepartmental Substance Use Disorders Coordinating Committee (ISUDCC), called the meeting to order at 1:02 p.m. She established a quorum following the roll call.

Federal ISUDCC Members or Designees Present

- Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Yngvild K. Olsen, M.D., MPH, Acting Director, Center for Substance Abuse Treatment (CSAT), SAMHSA
- Ruth Ryder, Deputy Assistant Secretary for the Office of Policy and Programs – Formula Grants, Office of Elementary and Secondary Education, Department of Education (ED)
- Joseph Liberto, M.D., Deputy National Mental Health Program Director for Substance Use Disorders, Department of Veterans Affairs (VA)
- June Sivilli, Senior Advisor, Public Health, Education and Treatment, Office of National Drug Control Policy (ONDCP)
- Christopher Jones, PharmD, DrPH, MPH, Acting Director, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC)
- Jennifer Hobin, Ph.D., Director, Office of Science Policy and Communications, National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH)
- Patricia Powell, Ph.D., Deputy Director, National Institute on Alcohol Abuse and Alcoholism (NIAAA), NIH
- Marta Sokolowska, Ph.D., Associate Director for Controlled Substances, Office of the Center Director / Center for Drug Evaluation and Research, Food and Drug Administration (FDA)
- Kellie Kubena, Deputy Innovation Officer, Rural Development, Department of Agriculture (USDA)

Federal ISUDCC Members Not Present

- U.S. Department of Justice (DOJ)
- U.S. Department of Labor (DOL)
- U.S. Department of Housing and Urban Development (HUD)
- Social Security Administration (SSA)
- Office of Personnel Management (OPM)

Non-Federal ISUDCC Members Present

- Chad Audi, Ph.D., President and CEO, Detroit Rescue Mission Ministries
- Caleb Banta-Green, Ph.D., MPH, MSW, Principal Research Scientist, Alcohol & Drug Abuse Institute, University of Washington
- Honorable Nancy L. Butts, President Judge, Lycoming County, Pennsylvania

- Meredith Canada, MSW, MPA, LCSW, Public Health Analyst, Indiana High-Intensity Drug Trafficking Area Overdose Response Strategy
- Jamie Chrisman Low, M.Ed., NCC, Recovery Consultant, Statewide Recovery Community, Network Weaver, Certified Peer Support Specialist
- Judy Goforth Parker, Ph.D., A.P.R.N., F.A.C.H.E., Commissioner of Health Policy, Chickasaw Nation
- Sara A. Goldsby, MSW, MPH, Director, South Carolina Department of Alcohol and Other Drug Abuse Services
- Keith Humphreys, Ph.D., Esther Ting Memorial Professor, Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine
- Sheryl Ryan, M.D., FAAP, Division Chief, Professor of Pediatrics, Adolescent Medicine and Eating Disorders, Penn State Health
- Amanda S., Patient, and Advocate
- Cynthia Seivwright, LCMHC, CQIA, Director, Division of Alcohol and Drug Abuse Programs, Vermont Department of Health, Single State Agency for Substance Abuse Services
- Daniel Sledge, BA, LP, Lead Outreach Paramedic, Wilco EMS-MOT
- Richard Spoth, Ph.D., Director, Partnerships in Prevention Science Institute, Iowa State University
- Luis R. Torres, Ph.D., Associate Professor, Center for Drug and Social Policy Research, University of Houston

Non-Federal ISUDCC Members Not Present

- Susan Dawson, Ed.D., PMHNP-BC, Psychiatric Nurse Practitioner, Assisted Recovery Center of America, and State Targeted Response Team for the Opioid Crisis Trainer for Professionals
- Nicholas Estabrook, Addictive Disease Recovery Support Specialist, Department of Behavioral Health and Developmental Disabilities
- Erik Hess, M.D., MSc, Professor and Vice Chair for Research, Department of Emergency Medicine, the University of Alabama at Birmingham School of Medicine
- Steven Jenkusky, M.D., M.A., F.A.P.A., Vice President and Medical Director of Magellan Healthcare

The DFO entertained a motion to adopt the minutes from the ISUDCC meeting on December 9, 2021. She noted that the minutes were certified in accordance with the Federal Advisory Committee Act (FACA) regulations and included edits. Dr. Audi moved to adopt the minutes. The DFO called for a vote to adopt the minutes after she heard no response to her call for discussion. A unanimous vote adopted the minutes.

Welcome and Opening Remarks

Miriam E. Delphin-Rittmon, Ph.D., ISUDCC Chair, Assistant Secretary for Mental Health and Substance Use

Dr. Delphin-Rittmon welcomed the committee members to the meeting, and she reminded them that the meeting was scheduled as a follow-up to their previous meeting for the purpose of

discussing the establishment and use of subcommittees. She provided an overview of the day's agenda. She then invited Ms. Sherine Hargrove from the Office of the General Counsel, Public Health Division, to discuss the concept of ISUDCC working groups.

ISUDCC Working Groups

Sherine Hargrove, MHS, JD, HHS Office of the General Counsel, Public Health Division

Ms. Hargrove shared remarks concerning working groups, synonymously called subcommittees. She assured the ISUDCC that it, as a Federal Advisory Committee, can form subcommittees to provide recommendations, gather information, and/or help with specific time-limited projects and matters. After noting that her presentation did not constitute legal advice, Ms. Hargrove proceeded to share the legal authority for ISUDCC working groups and information on what the ISUDCC charter says about working groups and the guardrails the Federal Advisory Committee Act (FACA) provides regarding execution and functions of working groups. Highlights from her presentation included the following:

- The ISUDCC is a statutorily authorized advisory committee that is governed by the FACA and its implementing regulations [5 U.S.C. App. 2; 41 C.F.R. Part 102-3], which permit the convening of working groups [Section 7022(g) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Pub. L. 115-271)].
- The ISUDCC Charter says, "The Committee may establish subcommittees (or working groups)...and may hold such meetings as are necessary to enable the subcommittee to carry out the duties delegated to the subcommittee."
- Working groups do not implicate the FACA if they meet the "subcommittee" definition in the FACA regulations, and working groups that report to and provide advice, recommendations, or work products to an advisory committee rather than directly to federal officials do not implicate the FACA.
- The advisory committee must deliberate on any advice, recommendations, or work products from the working group, i.e., no rubber-stamping.
- Consultation with and prior approval of the DFO is required for convening an ISUDCC working group.
- The HHS Committee Management Officer is to be notified when an ISUDCC working group is established and provide information on the working group's name, membership, function, cost, and estimated frequency of meetings.
- Working groups are subject to applicable HHS committee management policies.

Questions and Open Discussion

Ms. Hargrove responded to Dr. Ryan's question about non-advisory committee members serving in working groups; she restated that non-ISUDCC members may participate on subcommittees as needed. Next, Dr. Olsen asked for clarification regarding whether DFO approval was required prior to each subcommittee meeting or only before creating the subcommittee. Ms. Hargrove said that concurrent consultation with the DFO would be needed when the formation of the workgroup is contemplated so that workgroup could obtain requisite approval from the DFO before the start of the working group.

Dr. Banta-Green asked Dr. Delphin-Rittmon about the role of the ISUDCC in making recommendations to her and what is done with the recommendations. In response, Dr. Delphin-Rittmon said, “it depends on the recommendation.” She noted that some recommendations might align with SAMHSA's work, and others might not. She said it might make sense to share some recommendations with the BHCC [Behavioral Health Coordinating Council] or various subcommittees within the BHCC. She added that some recommendations might align with discussions with the Secretary or with Operating Division leads. She said that when the recommendations align with SAMHSA's vision, the goal will be to incorporate and use the feedback in a meaningful way. She added that SAMHSA would provide updates on the recommendations at ISUDCC meetings. On this matter, CAPT Carlos Castillo added that recommendations to the Chair (both deliberated recommendations from a subcommittee to the ISUDCC or a direct recommendation from the ISUDCC) would be captured in the meeting minutes and published for the public to access via yearly reports to the FACA database.

Dr. Torres asked if guidelines existed pertaining to who could be invited to participate in a working group. He also asked how they could ensure having a mix of federal and non-federal partners in the workgroups. Ms. Hargrove said she was not aware of any guidance related to the process for inviting outside experts or who specifically could be invited. She surmised that those decisions would be left up to the ISUDCC in consultation with the DFO. Regarding Dr. Torres' second question, Ms. Hargrove said that the composition of the ISUDCC (having federal and non-federal members) could also be reflected in the workgroups. She noted that the workgroup membership should be guided by the specific delegated task of the group and who would best facilitate the working group in meeting that delegated task.

Ms. Chrisman Low asked if an ISUDCC member could continue working on a subcommittee if their 3-year term on the ISUDCC expires. Ms. Hargrove said the individual could continue working as a designee of an existing ISUDCC member involved in the workgroup; participate as an outside expert in some capacity or contribute as a member of the public if the subcommittee meetings are open to the public. The DFO indicated that the ISUDCC Charter does allow for term extensions.

Dr. Jones shared an example of using a Federal Register notice to solicit individuals with desired expertise to roster a workgroup; he noted that the approach allows for an open, transparent process. He also advised that, based on his experiences, workgroups should be given discrete tasks and deliverables. Dr. Delphin-Rittmon agreed that the subcommittees' assignments should be “targeted.”

Dr. Banta-Green questioned how they would determine items for the subcommittees. Dr. Delphin-Rittmon said Dr. Olsen's presentation would address the planning and structuring of the working groups, as well as operational considerations like how recommendations will move through the groups or sit with groups.

Dr. Goforth Parker asked if subcommittee members would be required to complete the same paperwork as the ISUDCC members, i.e., the same clearance process. Dr. Delphin-Rittmon did not think the subcommittee members would need to undergo the same process; she asked Ms. Hargrove to confirm. Ms. Hargrove agreed to follow up with the DFO on this matter.

ISUDCC Workgroups Planning Discussion

Yngvild K. Olsen, M.D., MPH, Acting Director, CSAT

Dr. Olsen led a discussion concerning how the ISUDCC could think about and set up the workgroups so they can collectively do the work that will benefit the people they are working to serve. She began her remarks by sharing background information on the ISUDCC, which was authorized in October 2018 by Section 7022 of the SUPPORT Act; the HHS Secretary established the ISUDCC Charter in May 2019. She reminded the group that the main objective of the ISUDCC is “to identify areas for improved coordination related to substance use disorders, including research, services, supports, and prevention activities across all relevant Federal agencies.” She also noted that the ISUDCC is scheduled to sunset no later than May 31, 2025, unless extended by statute.

Next, Dr. Olsen shared principles for framing the workgroups that reflected discussions from the previous ISUDCC meeting; she informed the group of other relevant efforts SAMHSA considered in thinking about where the ISUDCC and workgroups “fit.” Regarding the latter, she noted the following efforts: HHS Overdose Prevention Strategy; ONDCP’s National Drug Control Strategy; SAMHSA and CDC’s National Advisory Councils; Harm Reduction Steering Committee; Interagency Coordinating Committee on the Prevention of Underage Drinking (ICPUD); and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). She said the last two efforts mentioned, both older and chaired by Dr. Delphin-Rittmon, have respectively anchored the work of their subcommittees around their reporting requirements to Congress. She explained that the information provided was for context as the ISUDCC moves forward in thinking about the workgroups it will establish.

Dr. Olsen reemphasized the point that the ISUDCC Charter outlines the duties of the broader committee, and she noted the areas she felt could be assisted by workgroups: 1) Identify and provide recommendations for improving federal prevention, treatment, and recovery programs; 2) Analyze SUD prevention and treatment strategies in different regions and populations, and 3) Evaluate the extent to which federal SUD prevention and treatment strategies are aligned with state and local SUD prevention and treatment strategies. Noting that the ISUDCC does not have a required report to Congress, she suggested that the committee consider having four workgroups that are anchored in the areas delineated by the ISUDCC Charter, i.e., Research, Services, Supports, and Prevention, and then assign ISUDCC member identified topics (e.g., harm reduction, prevention scale-up, provider support, rural health) within those areas.

Turning her remarks to the topic of “membership,” Dr. Olsen said, based on the ISUDCC Charter, three committee members will constitute a quorum on a workgroup (and consultants and ad hoc members will not count towards a quorum and will not participate in voting). She also suggested that the ISUDCC consider pairing federal and non-federal stewards to steer each workgroup. Should the group adopt the idea she presented on having the four workgroups (anchored around Research, Services, Supports, and Prevention), Dr. Olsen outlined the following outstanding questions that would need to be addressed:

- How frequently should working groups meet?

- What document does each working group need to frame its structure and function?
- What are reasonable deliverables for each working group, and over what timeframe?
- What would each working group need to support its work?

Before opening the floor for discussion, Dr. Olsen reminded the group that the ISUDCC is not required to produce a report to Congress but rather must annually publish a publicly available report that summarizes its activities, including any findings resulting from such activities. To this end, she suggested the group also think about a deliverable(s) format that would be most useful for the larger committee and, ultimately, the Assistant Secretary and beyond.

Open Discussion

During this session, ISUDCC members asked questions and shared their thoughts regarding forming subcommittees. Highlights are provided below:

- An alternative to forming subgroups that would be less time-consuming is to provide time on ISUDCC meeting agendas to invite experts to present and inform the committee's work. (Ms. Sivilli)
- It would be helpful to know where the "gaps" are and what has worked in the past so the ISUDCC can work efficiently and quickly. (Dr. Banta-Green)
- Subgroups could be formed around specific topic areas, e.g., low threshold [access to] MOUD [medications for opioid use disorder], overdose prevention sites. The ISUDCC could come up with a list of topics and prioritize them. (Dr. Jones)
- The initial thought was that the ISUDCC would identify topics within each of the four areas and then narrow them down, so there are not 15 different work groups. (Dr. Olsen)
- We are open to thoughts on the structure of the subgroups; some topics may be cross-cutting. Most importantly, the activities should be meaningful and move forward in areas where there are gaps. Current priority areas could help populate some of the work areas, e.g., overdose prevention strategy because they represent known gaps in terms of need. (Dr. Delphin-Rittmon)
- The four proposed areas that would anchor the workgroups are very broad, so it seems like a good idea to define a process whereby we can specify the tasks that could be covered by this group and prioritize them. If we proceed with this idea, what is a realistic timeframe for sorting through the highest priority tasks and setting up a document/form for clarifying for those who might be interested in a subgroup to help get the work(ers) off the ground? What is the timeframe for completing the work? (Dr. Spoth)
- I'm hearing a sense from the group of the need to narrow down the four buckets; we've noted some ideas from previous discussions and today's discussions. We could send ideas out for a vote via email. I'd look to Dr. Delphin-Rittmon regarding the frequency of workgroup meetings as well as updates. The ISUDCC must meet no less than two times a year. (Dr. Olsen)
- I'm open to whatever you recommend regarding ISUDCC meetings' cadence. Potentially, subcommittees could meet a time or two between the broader ISUDCC meetings. The need and the work should drive the cadence and the recommendations. We are open to extending ISUDCC appointments,

or maybe this group can put forth a document with recommendations to lay out the work for the committee moving forward. (Dr. Delphin-Rittmon)

- Revisiting the duties of the ISUDCC might help narrow the focus of some topics. (Dr. Olsen)
- Perhaps the four buckets could be: Research, Support, Services, and Strategies. Within each bucket, you could have prevention, treatment, and recovery as sub-categories. (Ms. Chrisman Low)
- The last couple of comments highlights the benefit of rethinking the anchors and underscoring how broad the area of "prevention" is. A gap analysis would help us prioritize each of these areas. For example, the arena of prevention, specifically the scale-up of evidence-based preventive interventions, would directly pertain to gaps concerning that first area—i.e., identify and provide recommendations for improving federal prevention, treatment, and recovery programs—and those specific improvements that have already been identified but haven't been implemented. Critically evaluating where the gaps are for each of the three ISUDCC "duty" areas can be helpful, especially if it includes looking at groups already doing relevant work in identifying and providing recommendations concerning federal programs. (Dr. Spoth)
- A cross-cutting piece the committee should not lose sight of is that of workforce development. SAMHSA invests much in workforce development through the TTCs [Technology Transfer Centers]. Perhaps we can incorporate some of that into these different domains as we think about the work of the subgroups. (Dr. Torres)

Dr. Olsen acknowledged feedback from various ISUDCC members that reflected moving away from the four broad anchors, shifting towards topical areas, and having a gap analysis as the first task that would cut across the three ISUDCC “duty” areas discussed. The “duty” areas referenced, again, were:

1. Identify and provide recommendations for improving federal prevention, treatment, and recovery programs.
2. Analyze SUD prevention and treatment strategies in different regions and populations.
3. Evaluate the extent to which federal SUD prevention and treatment strategies are aligned with state and local SUD prevention and treatment strategies.

Dr. Olsen recapped the topical areas she heard from the group, noting that the members mentioned some in previous conversations and some were from the day's conversation: prevention, workforce development, and harm reduction.

Dr. Banta-Green commented that he was drawn to the ISUDCC because of its “interdepartmental” and “coordinating” aspects. He encouraged the group to think about how it could build up the "systems" web to get things done quickly and show the major "fault lines" within the system. For example, he said, "we would take pressing issues like harm reduction, methamphetamine, and fentanyl and transform our systems and workforce to be in a very different place a year from now and have actually made a meaningful dent in overdose deaths and support recovery.” Dr. Olsen said Dr. Banta-Green’s proposed approach would get at how the federal piece connects to state and local components of their work. Dr.

Delphin-Rittmon commented on the richness of the discussion and stated that she, too, is often

very interested in the "system components," i.e., how do they make impacts from a systems perspective, and what are the gaps or areas in the system that create challenges? Noting that any of the suggested approaches could work, Dr. Delphin-Rittmon indicated that she did see how the "system perspective" could bring real value.

Ms. Goldsby expressed her support for where the conversation was headed. She suggested that the ISUDCC could support the Administration's priorities by making recommendations that improve coordination across the system. To this point, Dr. Delphin-Rittmon commented that the group's discussion was consistent with the Administration's priority of having a cross-departmental and a "whole of government" approach. She recognized that working from a place of intersection across multiple agencies and operating divisions has yielded more robust products.

Dr. Audi raised the point of inclusion and the need to remove barriers for people who are shy or do not try to engage and benefit from the services provided throughout treatment and/or prevention. He said a lot of data shows that youth in certain immigrant communities especially are not benefiting from any services provided that would enable them to diminish the number of deaths, drug addiction, alcohol addiction, and notably opioid addiction. He said about the immigrant communities, "They don't see or don't understand the information." He asked, "How do we put our heads together to make some recommendations that will encourage and incentivize those particular communities to take advantage of what the government and the providers are providing?" Dr. Olsen said Dr. Audi's point spoke to prevention, youth and adolescence, equity, and cultural competency. She suggested that his point could be worked into the reworked frame the group is developing. She said that the workgroups could be structured around the four areas of prevention, treatment, harm reduction, and recovery. She said subcomponents of those four areas might include data, workforce, gaps, and barriers.

Dr. Spoth, piggybacking on Dr. Banta-Green's previous comment, said the idea of facilitating, and coordinating among federal agencies, especially to address more significant systems-level issues, appealed to him. To this point, he shared an example of how an interdepartmental agreement was used to underscore coordination between federal agencies.

Dr. Olsen recapped that tentatively the four workgroups will be prevention, treatment, harm reduction, and recovery; this will mirror the HHS strategic priorities. Within each of those areas, there would be a focus on systems development and workforce development, as two key areas to frame each workgroup around, as well as areas related to data; coordination (particularly coordination across federal government/federal programs and also within systems development, i.e., between federal, state, and local entities); and gaps (doing a bit of a gap analysis). A focus would also be on using the lens of coordination, data, research, systems development, and workforce development to hone in on specific tasks. When she asked if she captured the group's thoughts, Dr. Olsen noted that the chat comments supported looking at gap areas, looking at pressing needs at the local level, and looking at best practices that have been most helpful.

In terms of the following steps, Dr. Olsen said the DFO would assist them in putting the information into a written document. She asked Dr. Delphin-Rittmon if the information could be shared with the group to finalize or at least refine the structure of the workgroups. Dr. Delphin-Rittmon

agreed to have the document shared via email. She said the ISUDCC could then edit and make comments on it. She said the revised document would then be redistributed and a subsequent meeting planned around that document. Dr. Delphin-Rittmon said the following step would then be to form and populate the subcommittees. The members raised no objectives regarding these steps.

Dr. Delphin-Rittmon commended the group on its work and where the discussion landed, and she thanked Dr. Olsen for impressively leading the group through the conversation.

Public Comments

The DFO indicated that one written submission of comments was received and would be included in the meeting minutes. She read aloud the name of the individual who submitted the written comments. That individual was Dr. Steve Postal, Senior Specialist of Policy and Regulation Affairs, American Physical Therapy Association. She thanked him for his remarks.

Final Comments/Adjourn

Miriam E. Delphin-Rittmon, Ph.D., ISUDCC Chair, Assistant Secretary for Mental Health and Substance Use

Dr. Delphin-Rittmon thanked everyone for joining the meeting and reminded the group that SAMHSA would follow up with a meeting summary. The meeting ended with Dr. Delphin-Rittmon wishing everyone a great rest of the day.

The meeting adjourned at 2:55 p.m.

Certification: I hereby certify that, to the best of my knowledge, the foregoing minutes and the attachments are accurate and complete.

Date

Miriam E. Delphin-Rittmon, Ph.D.
Assistant Secretary for Mental Health and Substance Use

Minutes will be formally considered by ISUDCC at its next meeting, and any corrections or notations will be incorporated into the minutes of that meeting.

Attachment: Public Comments



March 4, 2022,

Tracy Goss
ISUDCC Designated Federal Officer
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 13E37B
Rockville, MD 20857

Comments submitted electronically to: Tracy.Goss@samhsa.hhs.gov.

Re: Written Comments to Notice of Meeting for the Interdepartmental Substance Use Disorders Coordinating Committee

Dear Tracy Goss:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association appreciates the opportunity to submit comments in response to the Substance Abuse and Mental Health Services Administration's [notice](#) of meeting for the Interdepartmental Substance Use Disorders Coordinating Committee. APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

The ISUDCC, ahead of its public meeting on March 16, is seeking written comments. APTA provides comments below on the following key duties of ISUDCC:

- Identify areas for improved coordination of activities, if any, related to substance use disorders, including research, services, supports, and prevention activities across all relevant federal agencies; and
- Identify and provide to the Secretary recommendations for improving federal programs for the prevention and treatment of, and recovery from, substance use disorders, including by expanding access to prevention, treatment, and recovery services.

Alternatives to Opioids Must Include Nonpharmacological Options Such as Physical Therapy

APTA encourages SAMHSA to recommend policies that will incentivize and promote nonopioid and nonpharmacological treatments to alleviate pain as well as to help prevent opioid use disorder. Too often, in response to the opioid epidemic, regulators, providers, and payers seek to replace opioids with nonopioid drugs. However, while pain management medication is often a critical component to many acute and chronic pain disorders, it merely masks the pain rather than treat its cause. SAMHSA must develop and promote accompanying policies that increase access to treatments and services that reduce or eliminate the source of pain as well. By doing so, SAMHSA will ensure that beneficiaries have adequate options to receive medically necessary, appropriate care.

The Centers for Disease Control and Prevention, in its recent draft [CDC Clinical Practice Guideline for Prescribing Opioids—United States, 2022](#), stated that “Nonopioid therapies are preferred [over opioid

therapy] for subacute and chronic pain.” The guideline further states that “[c]linicians should use appropriate noninvasive, nonpharmacologic approaches to help manage chronic pain,” including physical therapy. The CDC’s recommendations state that “many noninvasive, nonpharmacologic approaches, including physical therapy ... can improve pain and function without risk for serious harms, and points to “high-quality evidence ... that exercise therapy (a prominent modality in physical therapy)” is effective in reducing pain and improving function for back pain, fibromyalgia, and hip or knee osteoarthritis. Additionally, a number of studies show the efficacy of physical therapy in preventing, minimizing, and, in some cases, eliminating pain in patients following surgery, in patients with cancer, and in other clinical scenarios.

Accordingly, APTA encourages SAMHSA to promote innovative pain management therapies, such as physical therapy, to help patients treat the source of their pain rather than only the symptoms.

Physical therapy is a dynamic profession with an established theoretical and scientific basis for evaluating, diagnosing, and creating a plan of care that is capable of restoring, maintaining, and promoting optimal physical function. Physical therapists work independently and as members of interprofessional health care teams to enhance the health, well-being, and quality of life of their patients, who present with a wide range of pain conditions.

[A review of more than 60 randomized controlled trials evaluating exercise therapy for adults with low back pain \(Hayden, 2005\)](#) found that such treatment can decrease pain, improve function, and help people return to work. Additionally, the [American College of Physicians has stated](#) that “non-pharmacologic interventions are considered first-line options in patients with chronic low back pain because fewer harms are associated with these types of therapies than with pharmacologic options.” Moreover, [a review of 35 randomized controlled studies \(Moyer, 2017\)](#) with a total of nearly 3,000 patients found that in patients undergoing total hip arthroplasty, preoperative exercise and education led to significant reductions in pain, shorter lengths of stay postoperatively, and improvements in function. Additional studies have shown that therapeutic exercise programs can reduce pain and improve physical function among individuals with hip and knee osteoarthritis ([Fransen, 2014](#); [Messier, 2013](#)).

Barriers to Nonopioid Pain Management Treatments and Suggested Reforms

Barriers to nonpharmacological care programs or treatments for acute or chronic pain include geography, lack of education and training, and payment and coverage. While opioid addiction has affected all communities, rural and underserved areas have been disproportionately harmed. Payers, policymakers, and other stakeholders should develop policies that will increase access in those communities to incentivize the broader delivery of care, such as expanded student loan repayment programs for health care providers who practice in those areas.

Broad Payment Reform for Pain Management

APTA recommends that SAMHSA advise CMS to implement appropriate payment for a broad range of pain management and treatment services, including evidence-based alternatives to opioids such as physical therapy. Moreover, SAMHSA should advise CMS to increase payment under the physician fee schedule given the recent cuts for PTs that limit access; include physical therapy in more alternative payment models; and/or increase access to coverage in the programs it oversees to ensure that these effective, evidence-based practices are adequately incentivized.

SAMHSA should also examine payment barriers to nonpharmacological pain management treatments, which pose a significant challenge to patients' ability to access such treatments. For example, being required to pay a copay per visit with a physical therapist can be a financial hardship. As a result, patients may avoid treatment — either allowing their pain to worsen or seeking immediate, albeit short-term, relief via an opioid prescription. Eliminating or reducing financial barriers such as copays may promote access to physical therapist services that frequently are the safer, more effective option.

Adding Physical Therapy to Definition of Federally Qualified Health Center and Rural Health Clinic Services

APTA recommends that SAMHSA advise HHS to include physical therapy within the definition of Federally Qualified Health Center and Rural Health Clinic services. Currently, physical therapy may be furnished incident to a physician in FQHCs or RHCs. However, when furnished by a physical therapist incident to a visit with an RHC or FQHC practitioner, they are not billable visits, but the charges are included in the charges for an otherwise billable visit. Moreover, [as stated in the Medicare Benefit Policy Manual, Chapter 13](#), if the services are furnished on a day when no otherwise billable visit has occurred, the PT, OT, or SLP service provided incident to the visit would become part of the cost of operating the RHC or FQHC, and there would be no billable visit. Reimbursing services furnished by physical therapists in a FQHC or RHC at the visit rate would ensure that these facilities are properly reimbursed for providing nonopioid services, helping to prevent the development of acute or chronic pain and minimize the overuse of unnecessary pain medication.

Address Accessibility and Cost Issues Surrounding Physical Therapy for Pain Management

While physical therapy has demonstrated its value in managing acute and chronic pain, several issues surround its accessibility and cost. To address these issues, APTA recommends the following:

Promote Direct and Early Access to Physical Therapy in Benefit Design

Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability. In other words, while physical therapists are experts in delivering services for rehabilitation and habilitation, they also help improve overall health and prevent the need for otherwise avoidable health care conditions and services for individuals of all ages. **Therefore, SAMHSA should advise CMS to evaluate how payer benefit design can be restructured to promote early access to physical therapy. Specifically, the agency should evaluate how Original Medicare, Medicare Advantage, Medicaid fee-for-service programs, and Medicaid managed care organizations can promote direct and early access to physical therapy across the care continuum.** Promoting early access to conservative evidence-based care including physical therapy can reduce the risk of exposure to opioids and other pharmacologicals in the older adult population.

Additionally, to ensure maximum benefit and relapse prevention, these payers should accommodate physical therapy “booster sessions” as needed for treatment and management of chronic pain.

Physical therapists can provide evaluation and treatment services within their respective disciplines without need for an order or referral from any other health care professional in accordance with state law (or where allowed by state law). Moreover, since 2005 Medicare has stated that a physician order or referral is not required for coverage of outpatient physical therapy services delivered to Medicare beneficiaries. **Therefore, to promote beneficiary access and improve continuity of care, SAMHSA should advise CMS to modify 42 CFR § 424.24 and accompanying subregulatory guidance,**

including but not limited to the Medicare Benefit Policy Manual, to allow for direct access to physical therapy. Patients should be permitted to seek out therapy, and physical therapists should be permitted to deliver it without needing to seek permission from another provider. While APTA is fully supportive of an interdisciplinary care team working together to address the needs of the patient, the reality is that patient care is systemically delayed or abandoned due to failure to obtain a physician's signature. Better policies can be implemented that allow treatment to occur but still ensure that the physical therapist notifies the patient's primary care provider of the treatment. Unfortunately, under current Medicare rules a physical therapist must obtain physician authorization of the plan of care of every Medicare patient they treat.

This archaic requirement is out of step with current trends in health policy. All 50 states, the District of Columbia, and the U.S. Virgin Islands allow patients to seek some level of treatment from a licensed physical therapist without a prescription or referral from a physician, and 20 have eliminated all restrictions to treatment without a referral. Maintaining this requirement in the Medicaid program handcuffs MCOs and states seeking to implement innovative strategies to address the opioid epidemic. SAMHSA should advise CMS to remove this mandate.

APTA also recommends that SAMHSA examine the lack of uniformity of payment and regulation across professions (in rehabilitation and behavioral health), and the lack of access to nonpharmacological interventions for the prevention, treatment, and/or management of acute or chronic pain.

Promote Access to Telehealth for Physical Therapists

APTA recommends that SAMHSA encourage CMS to ease telehealth coverage restrictions under the Medicare program — namely in Medicare FFS, MA, and alternative payment models, including accountable care organizations and bundled payment models — to allow physical therapists to furnish and bill for such services. To facilitate telehealth expansion, we also recommend that SAMHSA support policy proposals to fund high-quality broadband access.

Such reforms would provide greater flexibility to providers and patients and would increase access to care, particularly to those living in rural or medically underserved areas or individuals living with impaired mobility. Telehealth has become the norm during the COVID-19 pandemic. However, numerous barriers continue to block greater access to telehealth. For instance, only a few provider groups are permanently eligible under Medicare to furnish telehealth services to patients. These include physicians, nurse practitioners, physician assistants, nurse-midwives, clinical nurse specialists, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals. While physical therapists and physical therapist assistants have been granted temporary authority to provide telehealth services under Medicare during the PHE via a waiver, they will lose that authority the moment the PHE ends.

Physical therapist interventions delivered by an electronic or digital medium have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions and readmissions. And, as SARS, MERS, and now COVID-19 have taught us, physical therapist interventions delivered through telehealth also minimize communicable spread of diseases while ensuring that patients do not have to forgo care to reduce the risk of exposure.

Further, the very nature of physical therapist treatment, in that it generally requires multiple sessions per week, makes it well-suited to telehealth. For homebound patients or those who need to travel long distances, the ability to supplement or replace some in-clinic sessions with telehealth sessions greatly reduces the burden of accessing care. Patient and caregiver self-efficacy are inherent goals of care

provided by physical therapists. Patients' and/or caregivers' ability to interact with a physical therapist in their own environment when they are facing a challenge, rather than waiting for the next appointment, can be invaluable in supporting the adoption of effective strategies to improve function, enhance safety, and promote engagement.

Incentivizing the delivery of telehealth by physical therapists will lead to reduced health care expenditures, increased patient access to care, and improved management of chronic disease and quality of life, particularly in rural and underserved areas. Patient geography may no longer be a major barrier to receiving timely, appropriate medical care. Various recent studies demonstrate the potential for cost savings, improved outcomes, increased access, and higher patient satisfaction for telehealth in physical therapy, such as:

- [Physiotherapy via Telehealth for Acute Respiratory Exacerbations in Paediatric Cystic Fibrosis](#) (Benz, 2021).
- [Feasibility Study of Expanded Home-Based Telerehabilitation After Stroke](#) (Cramer, 2021).
- [Physical Therapy for Hospitalized COVID-19 Patients in Isolation: Feasibility and Pilot Implementation of Telehealth for Delivering Individualized Therapy](#) (Turcinovic, 2021).
- [Outpatient Physical, Occupational, and Speech Therapy Synchronous Telemedicine: A Survey Study of Patient Satisfaction With Virtual Visits During the COVID-19 Pandemic](#) (Tenforde, 2020).
- [Evaluation of Pragmatic Telehealth Physical Therapy Implementation During the COVID-19 Pandemic](#) (Miller, 2020).
- [Telemedicine and Multiple Sclerosis: A Comprehensive Literature Review](#) (Yeroushalmi, 2019).
- [Delivering Telerehabilitation to COVID-19 Inpatients: A Retrospective Chart Review Suggests It Is a Viable Option](#) (Rosen, 2020).
- [Combined Effects of Telehealth and Modified Constraint-Induced Movement Therapy for Individuals With Chronic Hemiparesis](#) (Smith, 2020).
- [Teleassessment of Gait and Gait Aids: Validity and Interrater Reliability](#) (Venkataraman, 2020).
- [Video Telehealth Pulmonary Rehabilitation Intervention in Chronic Obstructive Pulmonary Disease Reduces 30-Day Readmissions](#) (Bhatt, 2019).
- [Efficacy of Home-Based Telerehabilitation vs In-Clinic Therapy for Adults After Stroke: A Randomized Clinical Trial](#) (Cramer, 2019).
- [The Role of Virtual Rehabilitation in Total and Unicompartmental Knee Arthroplasty](#) (Chughtai, 2019).
- [Telerehabilitation for Treating Pelvic Floor Dysfunction: A Case Series of 3 Patients' Experiences](#) (Kinder, 2019).

While rehabilitative services furnished via telehealth do not replace traditional clinical care, telehealth is a valuable resource for physical therapists and physical therapist assistants in expanding their ability to meet the needs of patients when and where those needs arise — which, in turn, may prevent avoidable adverse events resulting from delayed care or contact. **APTA urges SAMHSA to promote expansion of other licensed providers, including physical therapists, to deliver telehealth to Medicare beneficiaries.**

Promote an Interdisciplinary Approach to Pain Management

APTA further recommends that SAMHSA advise CMS to require physicians to work with the beneficiary's prescribers to develop a nonpharmacological, multidisciplinary pain management

treatment plan. SAMHSA also should advise CMS to institute regulatory and subregulatory changes that promote integrated team approaches that support early access to nonpharmacological interventions, including physical therapy, for the primary care of pain conditions.

SAMHSA ultimately should advise CMS to adopt policies that incentivize collaboration, assessment, and care coordination across multiple disciplines. By more strongly advocating for the development of and access to interdisciplinary, comprehensive pain management models that evaluate and treat the different factors influencing the presence of pain, the agency will enhance the effectiveness, efficiency, and safety of care delivered to patients with pain.

Addressing the opioid crisis requires an interdisciplinary approach that focuses on nonpharmacological, multidisciplinary management and interventions for acute and chronic pain. APTA recommends that SAMHSA, CMS, and other agencies adopt an interdisciplinary model for the treatment of pain.

Policymakers also should consider how these models can reach medically underserved and rural communities, and should identify ways to incentivize broader delivery of care in these areas, such as expanded student loan repayment programs or greater flexibility in delivering services via telehealth.

Promote Integrated Care Models That Encourage the Use of Medication-Assisted Treatment

APTA recommends that SAMHSA promote integrated care models that encourage the use of MAT in combination not only with counseling and behavioral therapies to treat substance use disorder, but also with physical rehabilitation. For patients with chronic pain who also are dealing with SUD, an integrated treatment plan is essential. Normal functional performance and engagement in meaningful activities are long-lost components of many of these individuals' lives. Addressing the physical, functional, psychosocial, and socioeconomic impact of their condition requires a skilled team of professionals working in partnership with the individual and that person's support system. SUD presents a pathophysiology with physical and psychosocial complications. Responsible MAT incorporated with physical and mental health services will be key to success for many individuals who have SUD.

Many patients' first exposure to opioids was from a legitimate prescription for a real medical need. Continuing to treat individuals with SUD the same as individuals who became addicted for different reasons will lead to failures in recovery. It is imperative to focus on the underlying medical reasons for which an individual initially sought a pharmacological agent. Often these patients have conditions that never were appropriately addressed, or their treatment fell off track as their substance use increased. Accordingly, to truly rehabilitate these individuals, we must treat not only their addiction to pain medicine, but also their underlying pain-producing condition — with physical rehabilitation as appropriate.

Promote Education of Primary Care Providers

Finally, SAMHSA should recognize that few primary care practitioners receive education on how to treat chronic pain. Without sufficient education on nonpharmacological pain management solutions, providers will neither discuss nor offer options that address patients' physiologic, psychological, and social needs. Therefore, clinicians must be equipped with the knowledge and resources to evaluate pharmacological and nonpharmacological pain management options, so that they can offer a well-informed recommendation on the treatment plan that best meets the patient's specific needs.

Training and educational resources directed to prescribers and other health care professionals should convey the value of nonpharmacological treatments and how to recognize when they are the safer, more effective option for the patient's condition, or when they can decrease the duration of pharmacological use. Ideally, physical therapists will be incorporated into primary care facilities, as research has shown positive patient outcomes and decreased upstream health care costs to the patient and the system as a result. SAMHSA should advise CMS to consider paying physical therapists as providers in a primary care setting.

Conclusion

APTA thanks SAMHSA for the opportunity to offer feedback in response to the notice of meeting for the ISUDCC. Should you have any questions regarding our comments, please contact Steve Postal, JD, senior specialist of policy and regulatory affairs, at stevepostal@apta.org or 703-706-3391; or Kate W. Gilliard, JD, director, health policy and payment, at 703-706-8549 or kategilliard@apta.org.

Sincerely,

/Roger Herr/

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President