Public Policy Statement on the Recognition and Role of Addiction Specialist Physicians in Health Care in the United States

Background

Addiction specialist physicians (ASPs) include physicians from multiple different primary specialties. Four medical subspecialty certifications for ASPs demonstrate and define expertise in addiction treatment:

1. Subspecialty board certification in addiction medicine by the American Board of Preventive Medicine (ABPM);
2. Subspecialty board certification in addiction psychiatry by the American Board of Psychiatry and Neurology (ABPN);
3. Subspecialty board certification in addiction medicine by the American Osteopathic Association (AOA); or
4. Certification by the American Board of Addiction Medicine (ABAM).

These certifications attest to a physician's knowledge to:

1. Recognize and accurately diagnose addiction, regardless of the substance or behavior involved according to current scientific understanding;
2. Identify, through screening, the risk for, or early warning signs of, addiction and perform early interventions;
3. Prescribe a comprehensive range of prevention and treatment services at the appropriate level of care for patients and monitor the effectiveness of treatment; and
4. Recognize, manage, and/or seek appropriate consultation to address any medical and psychiatric co-occurring conditions.

Professional skills of an ASP should include the ability to:

1. Convey an empathetic, positive, and hopeful attitude toward the person with addiction as well as toward family members and significant others in order to develop and maintain a therapeutic alliance;
2. Employ motivational enhancement with patients, their families, or significant others to facilitate positive changes toward improving their health and engaging with treatment appropriate for each patient's goals and needs;
3. Appropriately use multidisciplinary care models (MCMs);
4. Effectively use pharmacotherapy as appropriate for a given diagnosis;
5. Consider and address social determinants of health (SDoH) as part of the patient's comprehensive treatment and recovery;

6. Understand the importance of and compassionately employ a trauma-informed, nondiscriminatory, and antiracist[1] approach to prevention, treatment, advocacy, and recovery support services; and
7. Help patients access appropriate levels of care, including harm reduction services.

Addiction treatment in the United States is often delivered to patients using MCMs of health care professionals who work together to address patients' biopsychosocial needs. Examples of these models include specialized addiction treatment programs, the Patient Centered Medical Home (PCMH), the "hub-and-spoke" model, the nurse care management model, and the Collaborative Care Model (CoCM), which exist on a spectrum of integration with general medical treatment.[2, 3]

Physicians, psychologists, social workers, addiction counselors, physician assistants (PAs), advanced practice registered nurses (APRNs), pharmacists, occupational therapists, vocational rehabilitation counselors, and peer coaches, among others, work collaboratively and complement each other with expertise that benefits their patients. MCMs have evolved to harness and integrate the skills of physicians and other health care professionals to address patients' comprehensive care needs. ASPs are an integral part of MCMs in addiction prevention and treatment.

This clinical knowledge and its related skills set uniquely qualify ASPs to lead MCMs. ASP leadership of MCMs can also lead to greater integration of addiction treatment into general medical and mental health treatment settings. This integration has the potential to increase access to care, improve treatment retention rates, and ensure more comprehensive and coordinated care of co-occurring conditions.[4] ASP-led MCMs can increase capacity to provide addiction treatment in primary care and other specialty settings, especially in areas where addiction treatment resources may be scarce.

A barrier to the integration of ASPs into more clinical settings is the number of insurance networks which do not properly recognize -or in fact restrict- some ASPs' eligibility to receive payment for their addiction medicine-related services. Billing code structures are not currently designed to accommodate appropriate billing by all ASPs regardless of primary specialty.

The ASP workforce is growing, but small and will not in the foreseeable future be robust enough to meet the needs of millions of Americans with addiction. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that tens of millions of Americans need addiction treatment, while only a small percentage receive any type of addiction treatment.[5] This treatment gap makes it clear that properly credentialing ASPs in insurance networks is necessary to meet the treatment needs of individuals with an addiction.

Recommendations

1. Payers should ensure their networks include adequate numbers of ASPs to meet the addiction-related health needs of their beneficiaries.

2. Payers must be willing and able to process claims submitted by all ASPs, regardless of primary specialty. Therefore, ASPs who are psychiatrists and those who are in specialties other than psychiatry should be reimbursed at parity, regardless of taxonomy code.

3. Within an addiction treatment team, the ASP should be a leader, collaborate with other professionals on patient care, and delegate responsibilities as appropriate to optimize patient care. Leadership and collaboration will vary by clinical setting and/or level of care and should include involvement in the assessment of patients and in the development of individual treatment plans for these patients while under the ASP's care.

4. ASPs should support the increasing involvement of primary care and other specialty clinicians in addressing the needs of patients with addiction, with the goal of maximizing the capacity and ability of non-ASPs to prevent addiction and care for patients with addiction.

5. ASPs should make themselves available to collaborate with and mentor their addiction care team colleagues and participate as members of healthcare teams in various settings. The use of telehealth capabilities may facilitate collaboration.

6. The composition of a multidisciplinary addiction treatment team should be designed to meet the needs of the population served and may include embedded ASPs in the practices of other specialties.

7. The ASP should encourage the multidisciplinary addiction treatment team to address SDoH, such as housing, personal safety, food security, education, and legal assistance, among others. ASPs should attempt to accomplish these goals through collaboration with community resources. Similarly, the ASP should lead the multidisciplinary addiction treatment team to consciously and intentionally consider and employ a trauma-informed, antiracist approach to the care of all patients with addiction and their families.

8. Payers should invest in multidisciplinary and collaborative models of care for addiction, which incorporate the leadership and expertise of ASPs.

9. ASPs should understand the effectiveness of harm reduction and employ or refer for harm reduction interventions as a standard part of patient care.

10. ASPs should be consulted for media inquiries and legislative testimony on matters related to addiction prevention and treatment.

Adopted by the ASAM Board of Directors December 16, 2021.

This policy statement is endorsed by the American Osteopathic Academy of Addiction Medicine and the American College of Academic Addiction Medicine.

AOAAM
The American Osteopathic Academy of Addiction Medicine

American College of Academic Addiction Medicine
ACAAM

American Society of Addiction Medicine
11400 Rockville Pike, Suite 200, Rockville, MD 20852
Phone: 301.656.3920 | Fax: 301.656.3815
www.ASAM.org

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[1] ASAM Public Policy Statement on Advancing Racial Justice in Addiction Medicine. https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2021/08/09/public-policy-statement-on-advancing-racial-justice-in-addiction-medicine. Published February 25, 2021. Accessed November 11, 2021. (footnote 37)

[2] Defining the PCMH. AHRQ. https://pcmh.ahrq.gov/page/defining-pcmh. Accessed September 7, 2021.

[3] Agency for Healthcare Research and Quality, Chou R, Korthuis PT, et al.; 2016. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/opioid-use-disorder_technical-brief.pdf. Accessed September 7, 2021.

[4] Steinberg J, Azofeifa A, Sigounas G. Mobilizing Primary Care to Address the Opioid Use Disorder Treatment Gap. Public Health Reports. 2019;134(5):456-460. doi:10.1177/0033354919863430

[5] Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/