



December 6, 2019

**Association of
American Medical Colleges**
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The Honorable Richard Neal
Chairman, Ways & Means Committee
U.S. House of Representatives
Washington D.C. 20515

The Honorable Kevin Brady
Ranking Member, Ways & Means Committee
U.S. House of Representatives
Washington D.C. 20515

The Honorable Danny Davis
Ways & Means Committee
U.S. House of Representatives
Washington D.C. 20515

The Honorable Brad Wenstrup
Ways & Means Committee
U.S. House of Representatives
Washington D.C. 20515

The Honorable Terri Sewell
Ways & Means Committee
U.S. House of Representatives
Washington D.C. 20515

The Honorable Jodey Arrington
Ways & Means Committee
U.S. House of Representatives
Washington D.C. 20515

Dear Chairman Neal, Ranking Member Brady, and Rural and Underserved Communities Health Task Force Co-Chairs Davis, Sewell, Wenstrup, and Arrington:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to provide comments in response to the Rural and Underserved Communities Health Task Force's (Task Force) request for information (RFI) on strategies to improve health care outcomes within underserved communities.

The AAMC is a not-for-profit association comprised of all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

We very much appreciate the Task Force for taking the lead on this important issue and hope to be part of an ongoing dialogue to improve the health of rural and other underserved communities. Inequities in health result from causes across various levels and systems: Genetics, biology, individual behavior, the built environment, and social and economic factors all contribute to the health gaps endemic in the United States. These disparities are particularly persistent in certain underserved populations such as racial/ethnic subgroups, the elderly, veterans, individuals from lower socioeconomic status backgrounds, the LGBTQ community, and rural populations.

In addition to the specific questions you raise, we believe it also is critical to recognize that a significant and pervasive challenge for rural and underserved communities is the fact that demand for physicians continues to grow faster than supply. This is leading to a projected national shortfall of between 46,900 to 121,900 physicians by 2032 with predicted shortages in both primary and specialty care.¹ Indeed, the Health Resources and Services Administration estimates that there are currently 78 million individuals living in 7,611 federally designated primary care Health Professions Shortages Areas (HPSAs), and we would need 14,218 primary care practitioners to eliminate these HPSAs. Likewise, the AAMC surveys 5,500 U.S. adults every year about their experiences getting care and the 2019 data show that 25 million U.S. adults could not get care when they needed it within the past 12 months. Physicians are a critical element of our national health care infrastructure and workforce, and if we do not address this impending problem, patients from both rural and underserved communities, will find it difficult to access the care they need. While this is a serious issue for all of us, it is especially problematic because of our aging population and physician retirement.

A key component of addressing the physician shortage and improving care delivery and health outcomes for patients and families is ending the 20-plus year freeze on Medicare support for graduate medical education (GME). The AAMC has endorsed the *Resident Physician Shortage Reduction Act of 2019* (H.R. 1763), bipartisan legislation introduced by Task Force Co-Chair Rep. Terri Sewell and Rep. John Katko, that would partially lift hospital-specific resident funding caps and enable teaching hospitals to train more physicians. This bill would direct new GME funding to shortage specialty residency programs and prioritize communities that have invested in new medical schools to address physician shortages. The legislation also targets positions at underserved communities by prioritizing hospitals that operate rural training track programs, affiliate with Veterans Affairs medical centers, and emphasize training in community-based settings or hospital outpatient departments. Over 75 physician and other stakeholder organizations signed a letter supporting the bill, including groups representing both primary care physicians and specialists (attached).

Additionally, Reps. Brad Schneider, Susan Brooks, Ann Kuster, and Elise Stefanik introduced the *Opioid Workforce Act of 2019* (H.R. 3414), which the AAMC also supports. This more targeted, bipartisan legislation would address the widespread need for additional physicians who are specialized to treat patients with substance use disorders and chronic pain. In 2018, only 11% of individuals with a substance use disorder received treatment and 50 million Americans battled chronic pain. This bill would improve the lives of patients and families in both rural and underserved communities by providing Medicare support for an additional 1,000 GME positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine. We are grateful that the Ways & Means Committee passed this legislation in June, and we urge the full House to pass this important bill in order to meet the needs of communities struggling with substance use disorders and the opioid crisis. As part of the June 26 mark up, the AAMC submitted a letter of support that included over 80 signatures (attached).

The AAMC supports the efforts of the Rural and Underserved Communities Health Task Force to identify other strategies to address the challenges that contribute to health inequities in rural and other underserved populations. To help the Task Force further these efforts, the AAMC offers the following input on the RFI's priority areas:

¹ [The Complexities of Physician Supply and Demand: Projections from 2017-2032](#)

I. Main health care-related factors that influence patient outcomes in rural and/or urban underserved areas

The health and well-being of underserved rural and urban communities, as well as the health inequities these communities experience, are influenced by a host of factors both within and beyond health care settings. Health care-related factors include inequities in insurance coverage, access (due to provider shortages, difficulty navigating complex health care systems, etc.), utilization (due to inability to take time off work, mistrust of the healthcare system, unaffordability, etc.), and quality (due to implicit and explicit biases, lack of cultural humility, etc.).

Increasingly, providers and policymakers are aware that social and community conditions play a significant role in facilitating or impeding the health and well-being of all communities. These factors include both patient-level, health-related social needs such as personal food insecurity, housing instability, and transportation access, and their community-level social determinant correlates (i.e. lack of supermarkets, dearth of affordable housing units, and absence of reliable public transportation in the communities from which patients hail). Hospitals and health systems have begun to address social factors at both levels by (a) screening and referring patients for health-related social needs and (b) partnering with community members and public health experts to assess, prioritize, and intervene on social determinants via their required community health needs assessment processes.

Finally, larger social forces such as racism, classism, xenophobia, homophobia, etc. (often operationalized through policy and regulation), are “root” or “fundamental” causes of health inequities as they determine the distribution of social determinants across communities, thereby influencing the social and clinical needs of patients from underserved communities.

II. Successful models addressing the social determinants of health (SDOH) which have shown a demonstrable, positive impact on health outcomes within rural or underserved communities

Many academic health centers partner with community-based organization to address social determinants of health (SDOH) such as transportation, housing stability, and food insecurity. Research has shown that addressing SDOH can lead to better health outcomes in local communities.² For example, the Boston Medical Center emergency department partnered with 20 clinics to screen for food insecurity in emergency department and provides food to 7,000 to 8,000 patients and families per month. Lack of access to transportation for both rural and urban communities limits patients’ ability to seek care Denver Health is addressing this by providing bus and taxi vouchers for patients to attend medical appointments. MedStar Health and a growing list of other teaching hospitals have formed partnerships with Uber and Lyft to provide transportation for patients to and from appointments. To address housing stability, academic health centers such as the University of Illinois Hospital in Chicago implemented a housing-first initiative which helped place chronically homeless emergency department patients into permanent housing.

In a state where 73 out of 75 counties are designated as medically underserved, the University of Arkansas for Medical Sciences launched the Antenatal and Neonatal Guidelines, Education, and Learning system (ANGELS) program to increase access to care for pregnant women through a statewide telemedicine network. Since its launch in 2002, this program addressing high-risk pregnancies has seen a decrease in neonatal deaths due to increased access to specialists and regular tele-education opportunities for providers across the state.

² [Achieving Health Equity: How Academic Medicine Is Addressing the Social Determinants of Health](#)

III. Patient Volume Adequacy in Rural Areas

The Accreditation Council for Graduate Medical Education (ACGME) core residency program requirements ensure that a GME program's educational and clinical resources are adequate to support the number of residents in the program. Of particular concern to rural areas, the patient population on which the GME educational program is based must be sufficient in volume and variety so that the broad spectrum of experiences necessary to meet the educational objectives will be provided. Likewise, at each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location. At a time when rural hospital closures are increasing, some rural institutions may struggle to meet the financial requirements to support a robust GME infrastructure without partnering with large academic medical centers. Rural Training Tracks, where urban teaching hospitals partner with rural hospitals for the purpose of cross-training medical residents, can help address these volume and financial issues while enhancing Medicare investment in GME programs.

IV. Lessons from Service Line Reduction or Elimination in Hospitals that Serve Underserved Communities

Rural hospitals provide a centralized place to deliver core health services, such as obstetrics/gynecology, general surgery, and emergency medicine, that would not otherwise be available. However, rural hospitals are closing at a rapid rate and the rural hospitals remaining are often forced to cut various units (in particular, obstetric units.³ Additional research is needed to understand the full impact of these closures on the community (e.g. lack of care, migration of physicians and other health care providers, etc.).

Furthermore, additional research on the potential for non-hospital options to deliver bundles of necessary services from a single place or point of care, especially in rural areas where maintaining hospitals is not financially feasible, could inform future workforce planning. For example, multispecialty clinics might also provide outpatient surgery, radiology, laboratory tests, etc., and a growing number of retail stores now offer basic and preventive health care services such as vaccinations, wellness checks and physicals, health screens, and treatment for non-serious injuries and illnesses.

V. Approaches and Challenges to Form Regional Networks of Care

Two national programs, Project ECHO (Extension for Community Healthcare Outcomes) and AAMC's Project CORE: Coordinating Optimal Referral Experiences, are increasingly being implemented across the nation as health systems strive to improve care coordination and communication between providers, improve local access to specialty expertise, and meet the needs of their patients.

To date, Project ECHO is available to health systems across 48 states with 517 programs. Project CORE is implemented in over 30 health systems across 14 states. Both programs leverage technology to support primary care providers seeking specialty expertise, allowing them to maintain continuity with their patients and improve the comprehensiveness of primary care. ECHO's main challenge continues to be finding a reimbursement paradigm that covers cost and supports the clinician's time. Project CORE's main challenges continue to be managing the changes in interoperability across EMRs and variable payer engagement. Despite the challenges, these two models are finding success in leveraging health technology to improve care for millions of patients.

³ Hung P, Kozhimannil KB, Casey MM, Moscovice IS. Why Are Obstetric Units in Rural Hospitals Closing Their Doors? *Health Serv Res.* 2016;51(4):1546–1560. doi:10.1111/1475-6773.12441

VI. Successful Models that Show a Demonstrable, Positive Impact on Addressing Workforce Shortages in Rural and Underserved Areas

In light of the current and projected physician shortages, it is important to develop a robust pipeline to address rural and underserved workforce challenges by recruiting individuals more likely to practice in these settings. These programs often are focused on academic enrichment in the sciences, exposure to clinical settings, coaching on the application process to medical school, and connecting with mentors and role models.

The Robert Wood Johnson Foundation has invested in the Summer Health Professions Education Program (started as Minority Medical Education Program – MMEP in 1989), a successful 30-year model program that has served over 27,000 college students. Data show that it has significantly increased the number of diverse candidates applying, matriculating and graduating from medical and dental school. Data also show that the combination of academic support, mentoring, and career development contributes to positive workforce outcomes.

The HRSA Title VII pipeline programs, such as the Health Career Opportunity Program (HCOP) and Centers of Excellence (COE), help recruit and retain students who are more likely to practice in rural and underserved areas. The AAMC has endorsed the *EMPOWER for Health Act* (H.R. 2781), which would reauthorize HCOP and COE.

While the RWJ and HRSA programs are making a demonstratable impact, more funding is needed to expand on these initiatives and to increase exposure of students earlier in the K-16 pipeline.

VII. Approaches communities or states have taken to address gaps in access to oral, behavioral, and substance use resources in rural and underserved communities

The HRSA Title VII programs seek to address gaps in oral, behavioral, and substance use care in rural areas. Programs such as Graduate Psychology Education, Opioid Workforce Enhancement Program, Behavioral Health Workforce Education and Training (BHWET), work with members of local communities to provide interdisciplinary mental health and substance use disorder care. These programs are designed to adapt to the ever-changing public health needs of rural and underserved areas.

AAMC recommends for providers and stakeholders working with underserved communities at the state or community level to adopt tenets of interprofessional education and collaborative practice (IPECP) in order to provide comprehensive, accessible, and appropriate care.

Vermont's Hub and Spoke Model provides a framework for leveraging Medication Assisted Treatment (MAT) to address opioid use disorder both regionally and locally through moderated provider interventions. Additionally, the Arizona Department of Health Services recently developed a Pain and Addiction Curriculum for the full spectrum of health provider education (classroom to clinical) in order to promote quality and community informed care.

The [Center for Integration of Primary Care and Oral Health](#) (CIPCOH) is a national repository of systems level research on incorporating oral health into primary care training which emphasizes patient-focused care among underserved communities.

VIII. Approaches to address gaps in care delivery and the associated challenges of social isolation

Recognizing the significant adverse impact of social isolation on health outcomes, in 2007, the [Robert Wood Johnson Foundation](#) issued a call for proposals that resulted in a range of ideas from an international community. Some of these were implemented in New York and Alaska to reduce social isolation, particularly in rural communities.

In February 2019, the Agency for Healthcare Research and Quality (AHRQ⁴) released a report which showed that physical activity interventions to reduce isolation were the most effective among older adults. Additionally, their review found that for interventions that improved social isolation or health/health care utilization outcomes there was not a direct relationship between effects on social isolation and effects on health or health care utilization.

Area Health Education Centers (AHEC), authorized under HRSA Title VII programs, support workforce development and training for medical and public health professionals in rural areas. These centers provided continuing education to 214,789 practicing health professionals across the country in 2018.⁵ By partnering with rural community health, AHEC helps fill the gaps in care delivery in rural areas that are isolated.

IX. Data definitions or data elements that are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity

Health systems have increased screening for patient-level, health-related social needs. However, screening tools are not standardized, making aggregation and interoperability difficult. The University of California, San Francisco launched the “[Gravity Project](#)” to develop use cases to document social risk, identify common data elements and value sets to support the cases, and develop a set of recommendations for capturing and grouping social risk data for *interoperable electronic exchange and aggregation*.

Hospitals often leap from social need screening to social service referral, skipping formal diagnosis via ICD-10 Z-codes which would ensure these data appear in claims datasets, thus allowing for a deeper understanding of how social factors impact quality indicators like cost and readmissions. The AAMC supports UnitedHealthcare and the American Medical Association in proposing to expand existing ICD-10 Z-code categories.⁶ More specific ICD-10 Z-codes will inform changes to risk adjustment models where their inclusion will ensure that more providers utilize the codes and are not unfairly penalized for serving patients from underserved rural and urban communities.

Efforts to understand rural and urban health inequities are often stalled by lack of granularity in public health data sets. Social determinant data are only available at the county or 5-digit zip code level which may represent multiple neighborhoods with vastly different social determinant profiles.

Finally, while rural and underserved areas face workforce shortages across the full spectrum of medical specialties, federally defined HRSA shortage designations — HPSAs, Medically Underserved Areas, and Medically Underserved Populations — only track primary care, dental, and mental and behavioral health needs.

⁴ <https://effectivehealthcare.ahrq.gov/products/social-isolation/rapid-product>

⁵ <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2020.pdf>

⁶ <https://www.aamc.org/system/files/c/1/497496-aamccommentsonproposaltoexpandicd-10codesforsocialdeterminantso.pdf>

X. Institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations

Implementing sociodemographic status (SDS) factors in risk adjustment for hospital quality measurement is a key policy needed to strengthen patient safety and quality. Reports^{7,8} have found that accounting for social risk in Medicare performance programs is critical in validly assessing the quality of providers. Furthermore, hospitals caring for large numbers of disadvantaged patients are more likely to receive penalties in Medicare performance programs due to inadequate risk adjustment for SDS. The lack of SDS adjustment can worsen health care disparities because the penalties divert resources away from hospitals and other providers treating large proportions of vulnerable patients. Hospitals providing care to rural and underserved populations need to be able to invest in quality improvement and are unable to do so when critical resources are withheld under quality performance programs.

Greater investment is needed for quality improvement activities specific to delivering care to underserved populations and in the rural setting. Providers furnishing care to these populations often are unable to devote their limited resources in quality improvement training and projects to test ideas specific to improving the quality of care in their unique setting.

Finally, work must be done to remove barriers to the use of telehealth created by federal and state regulations. Teaching hospitals and their affiliated physicians are providing needed care to rural areas through the use of telehealth. Broader use of telehealth will expand access to timely care to improve the overall quality of care rural and underserved patients receive.

We would welcome the opportunity to expand on the information we have provided above and serve as a resource to you as you continue to seek policy solutions to improve the health of rural and other underserved communities. Please feel free to contact me or Len Marquez, Senior Director, Government Relations, at lmarquez@aamc.org or (202) 828-0525, with any questions.

Sincerely,



Karen Fisher, JD
AAMC Chief Public Policy Officer

⁷ Assistant Secretary for Planning and Evaluation (ASPE) Report: <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>

⁸ National Academy of Medicine (NAM) Report: <https://www.nap.edu/download/23513#>

May 3, 2019

Dear Member of Congress:

The undersigned organizations, representing over 75 associations and specialty societies, strongly encourage you to cosponsor the “The Resident Physician Shortage Reduction Act of 2019” (S. 348, H.R. 1763). This bipartisan legislation would provide a responsible increase in Medicare support for graduate medical education (GME) to address the impending national physician workforce shortage. While we understand the many challenges Congress faces in the coming months, we stress the need to expand Medicare’s support for physician training to ensure all Americans have access to the care they deserve.

As you may know, the demand for physicians continues to grow faster than supply, leading to a projected shortfall of between 46,900 and 121,900 physicians by 2030 with predicted shortages in both primary and specialty care. Physicians are a critical element of our health care infrastructure and workforce, and if we do not address this impending problem, patients from pediatrics to geriatrics, will find it difficult to access the care they need. While this is a serious issue for all of us, it is especially problematic because of our aging population and physician retirement. A person’s need for a physician increases with age, and the U.S. population aged 65 and older is predicted to grow 50% by 2030.

America’s medical schools, teaching hospitals, and their physician partners are doing their part by investing in physician and health care provider training and leading innovations in new care delivery models that are more efficient and include better use of technologies — like telehealth — that improve patient access to care. Even with these efforts, however, shortages and access challenges will persist unless we expand the physician workforce.

Though shortfalls will affect all Americans, the most vulnerable populations, like those in rural and underserved areas, will be the first to feel the impact of the deficit of physicians. We are particularly concerned for our senior population whose Medicare eligibility and utilization of health care grows daily.

We look forward to working together to support the training of future physicians and to secure the passage of this important legislation.

Sincerely,

Alliance for Academic Internal Medicine
Alliance of Specialty Medicine
AMDA - The Society for Post-Acute and Long-Term Care Medicine
America’s Essential Hospitals
American Academy of Addiction Psychiatry
American Academy of Allergy, Asthma & Immunology
American Academy of Hospice and Palliative Medicine
American Academy of Neurology

American Academy of Ophthalmology
American Academy of Otolaryngology- Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Academy of Sleep Medicine
American Association for Anatomy
American Association for Geriatric Psychiatry
American Association of Chairs of Departments of Psychiatry
American Association of Child and Adolescent Psychiatry
American Association of Colleges of Osteopathic Medicine
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Board of Medical Specialties
American College of Academic Addiction Medicine
American College of Cardiology
American College of Clinical Pharmacology®
American College of Obstetricians and Gynecologists
American College of Osteopathic Internists
American College of Physicians
American College of Radiology
American College of Surgeons
American Gastroenterological Association
American Geriatrics Society
American Orthopaedic Association
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Reproductive Medicine
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Breast Surgeons
American Society of Echocardiography
American Society of Hematology
American Society of Plastic Surgeons
American Urological Association
Association of Academic Chairs of Emergency Medicine
Association of Academic Psychiatrists
Association of American Medical Colleges
Association of Directors of Medical Student Education in Psychiatry
Association of Pathology Chairs
Association of Professors of Dermatology
Association of University Professors of Ophthalmology
Catholic Health Association of the United States
Children's Hospital Association
College of American Pathologists
Congress of Neurological Surgeons

Council of Residency Directors in Emergency Medicine
Federation of American Hospitals
Greater New York Hospital Association
Healthcare Association of New York State
Illinois Health and Hospital Association
Medical Group Management Association
National Association of Spine Specialists
National Council for Behavioral Health
National Medical Association
Premier Healthcare Alliance
Society for Academic Emergency Medicine
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Academic Associations of Anesthesiology and Perioperative Medicine
Society of Academic Urologists
Society of General Internal Medicine
Society of Neurological Surgeons
The Academy for Professionalism in Health Care
The Society of Thoracic Surgeons
Vizient

June 26, 2019

The Honorable Richard Neal
Chairman
House Ways & Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

The Honorable Kevin Brady
Ranking Member
House Ways & Means Committee
U.S. House of Representatives
1139 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

On behalf of the organizations below, we write to express our support for the Opioid Workforce Act of 2019 (H.R. 3414). This thoughtful, bipartisan legislation would provide Medicare support for an additional 1,000 graduate medical education (GME) positions over five years in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine. We greatly appreciate the Committee's commitment to advancing policies that would strengthen the health care workforce serving on the front lines of the nation's opioid epidemic.

According to the Substance Abuse and Mental Health Services Administration, in 2018 approximately 21 million people needed treatment for a substance use disorder, however only 11% of those received any treatment at all. Part of the reason for this disparity is a shortage of physicians trained in addiction medicine, addiction psychiatry, or pain management. The lack of physicians trained in these specialties reflects the nation's larger physician shortages. Funding new, targeted residency positions will strengthen the health care workforce and help mitigate the effects of the overall physician shortage.

The Opioid Workforce Act of 2019 is a targeted and important step that Congress must take to help ensure a robust physician workforce that can deliver high-quality care to those suffering from substance abuse disorders.

We encourage all members of the Committee to support this bipartisan bill.

Sincerely,

AIDS United
Alabama Society of Addiction Medicine
Alaska Society of Addiction Medicine
Alliance for Academic Internal Medicine
American Academy of Addiction Psychiatry
American Academy of Pain Medicine
American Academy of Physical Medicine and Rehabilitation
American Association of Colleges of Osteopathic Medicine
American College of Academic Addiction Medicine
American College of Physicians

American Medical Group Association
American Osteopathic Academy of Addiction Medicine
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society of Addiction Medicine
America's Essential Hospitals
Arizona Society of Addiction Medicine
Association of American Medical Colleges
California Hospital Association
California Society of Addiction Medicine
Catholic Health Association of the United States
Connecticut Society of Addiction Medicine
Federation of American Hospitals
Greater New York Hospital Association
Healthcare Association of New York State
Healthcare Leadership Council
Illinois Health and Hospital Association
Maryland-DC Society of Addiction Medicine
Massachusetts Health & Hospital Association
Massachusetts Society of Addiction Medicine
Medical Group Management Association
Michigan Society of Addiction Medicine
Midwest Society of Addiction Medicine (Kansas, Missouri, Nebraska)
National Association for Behavioral Healthcare
National Council for Behavioral Health
Nevada Society of Addiction Medicine
New Jersey Society of Addiction Medicine
Northwest Society of Addiction Medicine (Montana, Wyoming, and North Dakota)
Ohio Society of Addiction Medicine
Oklahoma Society of Addiction Medicine
Parents for Addiction Treatment & Healing
Pennsylvania Society of Addiction Medicine
Physicians for Responsible Opioid Prescribing
Rhode Island Society of Addiction Medicine
Shatterproof
SMART Recovery
Society of General Internal Medicine
South Carolina Society of Addiction Medicine
Student Coalition on Addiction
Student National Medicine Association
Texas Society of Addiction Medicine
The Hospitals & Healthsystem Association of Pennsylvania
The Kennedy Forum
Utah Society of Addiction Medicine
Virginia Society of Addiction Medicine

West Virginia Society of Addiction Medicine
Wisconsin Society of Addiction Medicine
Young People in Recovery

CC: Reps. Brad Schneider, Susan Brooks, Annie Kuster, and Elise Stefanik