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Candace Thorson
National Conference of Insurance Legislators
385 Jordan Road
Troy, NY 12180

Re: American Medical Association Recommendations for Proposed NCOIL Best Practices

Dear Ms. Thorson:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate your leadership and efforts to draw attention to prescription drug abuse, diversion, overdose and death. Thank you for providing the AMA with the opportunity to outline our efforts to address this crisis, as well as the chance to identify best practices to combat this growing epidemic.

Physicians work hard to balance their ethical obligation to treat patients with legitimate pain management needs against the need to identify drug seekers and prevent abuse, overdose, and death from prescription drugs. Physicians must confront numerous challenges in their efforts to maintain that balance. The recommendations below emphasize that balance, and raise areas for additional consideration and concern. Please know that the AMA welcomes the opportunity to work with you and other policymakers to determine next steps.

The AMA's comments focus on six main areas:

- Using modernized, interoperable Prescription Drug Monitoring Programs (PDMPs), which can be a powerful clinical tool;
- Promoting educational opportunities for physicians to increase their knowledge with information relevant to the patient population they serve;
- Expanding capacity of treatment and recovery programs while promoting strategic planning to facilitate access to existing programs;
- Increasing data sharing (including epidemiological) to develop informed, targeted solutions based on local and regional needs;
- Harmonizing and streamlining state and federal laws governing disposal of prescription drugs including controlled substances while expanding awareness and access to local disposal sites; and
- Increasing use of drug courts to offer additional state legislative strategies.

Each is discussed in more detail below.

The AMA supports modernized, interoperable Prescription Drug Monitoring Programs (PDMPs)

PDMPs have the potential to serve as a critical clinical tool in the fight against prescription drug abuse, misuse and diversion. Generally, however, physicians do not have access to reliable, real-time information about prescriptions patients have obtained (and filled) from other prescribers, particularly controlled substances.

In 2005, the National All Schedules Prescription Electronic Reporting Act of 2005 (NASPER) was signed into law. Although $52 million was authorized over a five-year period, it was not until 2009 that federal funds were appropriated to support the state adoption of PDMPs. In theory, PDMPs were to provide reliable and actionable information.

In reality, however, it has been only in the past couple of years that most states have finally passed state legislation establishing PDMPs, and the majority of PDMPs are not real-time, interoperable, or available at the point of care as part of a physician's workflow. Only five states provide data within 24 hours, according to the National Alliance for Model State Drug Laws (NAMSDL); one state provides data within three days, 32 states take up to a week to provide data, and nine states take between two weeks and one month.[1] With respect to interstate interoperability, NMSDL reports that 43 states can legally share data across state lines, but only 20 can legally share data with other PDMPs. These are two areas where the AMA believes NCOIL can play a direct role.

Another area for NCOIL's attention is the need for PDMPs to be adequately funded, maintained and modernized to ensure their long-term ability to help combat prescription drug abuse, misuse and diversion.[2] The Congressional Research Service estimates that PDMP costs may vary widely, with start-up costs ranging from $450,000 to over $1.5 million and annual operating costs ranging from $125,000 to nearly $1 million.[3] Despite AMA's advocacy, it appears improbable in the foreseeable future that Congress will appropriate sufficient funding even if NASPER is reauthorized to help states maintain and undertake much needed upgrades and modernization of PDMPs.

In the rare instances when PDMPs have been adequately maintained and funded, are available at the point-of-care with up-to-date information, and integrated into physician workflow, the efficacy of PDMPs is remarkable. As a pilot, Ohio placed PDMPs in emergency departments and found that 41 percent of prescribers given PDMP data altered their prescribing for patients receiving multiple simultaneous narcotic prescriptions. Of these providers, 63 percent prescribed no narcotics or

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[1] See, generally, National Alliance for Model State Drug Laws, www.namsdl.org

[2] The funding piece deserves increased attention nationwide. A 2012 report from the Pew Charitable Trusts revealed that PDMP funding might come from grants, licensing revenue, licensing boards, general revenue, settlement funds, asset forfeiture and other areas. http://www.pewhealth.org/uploadedFiles/PHG/Content_Level_Pages/Reports/PDMP%20Update%201-31-2013.pdf

[3] Report available at http://www.fas.org/sgp/crs/misc/R42593.pdf

fewer narcotics than originally planned.[4] This indicates that PDMP data can help inform sound clinical decision-making to ensure prescriptions are medically-necessary, reducing illicit use of controlled substances.

Modernized PDMPs can provide physicians with a basic tool to make treatment determinations based on patient-specific needs. Legislators should use caution, however, that reducing drug use and preventing death cannot be fully achieved through well-meaning, but untested strategies such as requiring all prescribers to check an antiquated and poorly maintained PDMP for all patients as a condition of prescribing a controlled substance.

For example, while it makes sense for a pain medicine specialist to regularly consult a modernized PDMP that provides comprehensive, accurate data for his or her patients to review patient compliance and the potential for doctor shopping, it makes little sense for a pediatrician to consult a PDMP prior to giving a 10-year-old a sports physical. Similarly, it makes sense for a physician who is contemplating initiating treatment with opioids but believes the patient may be a risk for aberrant behavior or a physician who is treating patients with chronic pain with opioid analgesics, to consult the PDMP – if the PDMP data quality is high. The key as to which physicians should be required to check a PDMP prior to prescribing a controlled substance is to carefully consider the type of practice and the patient population of the physician: e.g., the vast differences between providing care in an oncology practice, interventional radiology practice, emergency department – each raises different issues whose "solutions for prescription drug abuse and diversion" cannot be understood or achieved through a one-size-fits-all mandate to check the PDMP. In order for NCOIL to help ensure a PDMP can provide physicians with the type of clinical tool that will enhance clinical decision-making, the AMA strongly recommends the highest attention be paid to physician practice distinctions as well as data quality considerations that are outlined in this letter.

In states that recently have enacted legislation requiring mandatory checks, there is impressive– but ultimately unsurprising data – showing that the supply of opioid analgesics has decreased.[5] **Reductions in the supply of legal painkillers, however, may be a key factor in the unintended – yet tragic consequence of increases in illicit drug use – most commonly, heroin.** Heroin is a less expensive yet more potent opiate. According to the National Survey on Drug Use and Health, "[t]he number of persons who were past year heroin users in 2011 (620,000) was higher than the number in 2007 (373,000)."[6] This is why – as discussed in more detail below – the AMA strongly believes that as legislators consider strategies to curb inappropriate use of prescription drugs, a

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[4] Baehren, David F., M.D., et al. A Statewide Prescription Monitoring Program Affects Emergency Department Prescribing Behaviors. Annals of Emergency Medicine, Vol. 56 No. 1, July 2010. Available at http://download.journals.elsevierhealth.com/pdfs/journals/0196-0644/PIIS0196064409018125.pdf

[5] According to the Kentucky Office of Drug Control, "In the last six months since [mandatory PDMP checks] took effect, total doses of all controlled substances dropped 10.4 percent from the same time period a year earlier." This included reductions in Hydrocodone and Oxycodone prescriptions by nearly 12 percent. Available at http://odcp.ky.gov/ Last accessed May 16, 2013.

[6] Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Available at http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.htm#High

simultaneous effort must be made to address the need for the prevention of illicit drug use and the treatment of those who are addicted. Just addressing the supply will not – by itself – solve the problem of demand and could drive an unintended increase in overdose and death.

We raise two additional points regarding mandates on checking a PDMP in states where the PDMP is not real-time, unreliable, not available at the point of care or is not interoperable with other states and state agencies. First, consider that physicians welcome the opportunity to use best practices, regularly rely on evidence-based approaches to treatment, and have been trained in how to analyze scientific information as part of their medical practice. This is why the AMA urges NCOIL to strongly support modernized PDMPs so that physicians will be encouraged to adopt a reliable decision-making tool as part of their practice. Second, consider that physicians are only one part of the puzzle to increasing PDMP use. That is why the AMA encourages NCOIL to support discussions among all stakeholders – and all state agencies – to determine everyone in the health care chain, from prescriber to dispenser, who needs to be involved. With shared responsibility to provide information to the PDMP and to maintain and appropriately analyze that information, that provides the best environment for PDMPs to help combat prescription drug abuse and diversion – and prevent misuse, overdose and death.

Therefore, the AMA believes a more workable approach than legislative mandates on prescribing practices would involve the appropriate medical, dental, and other licensing boards working together to develop comprehensive recommendations to help guide prescribers and dispensers, rather than a one-size-fits-all approach. This would encourage the boards to play a complementary role in curbing this epidemic alongside the medical and other health care professional community.

The AMA supports promoting educational opportunities at nominal cost for physicians to increase their knowledge with information relevant to the patient populations they serve

The AMA strongly supports physicians and other prescribers relying on the most up-to-date education and training when it comes to pain management, prescribing opioid analgesics and other pain medications. A multitude of resources exist for physicians on these topics from state, specialty and other medical and health care organizations – including the federal government. For example, as part of the U.S. Food and Drug Administration's (FDA) Risk Evaluation and Mitigation Strategy (REMS) for extended release and long-acting opioids, the FDA expects this voluntary program administered via accredited Continuing Medical Education (CME) providers to train 25 percent of the 320,000 prescribers of these drugs by the end of the first year following its implementation, 50 percent after two years, and 60 percent within four years of the start of training. The AMA strongly supports the FDA's efforts.

As for the AMA's own efforts, over the past two years, AMA has updated and progressively increased the education offerings available to physicians on best practices for managing pain while reducing the risk of prescription drug abuse. However, significant opportunities remain to educate practicing physicians on the scope of the crisis and provide them with appropriate educational opportunities to meet their needs. The AMA will be expanding our communications and media efforts to increase awareness of these educational offerings.

The initial launch of the AMA's educational and awareness programs were undertaken at two AMA national meetings, our state meetings, our website, as well as, widely accessible and consulted publications including the *AMNews* and AMA journals.

Specifically, the AMA has offered a free online CME program since 2003 that underwent a revision this year and will be re-launched shortly. We have developed a new, 12-webinar series on topics related to responsible opioid prescribing as part of the collaborative for the Prescriber Clinical Support System for Opioid Therapies (PCSS-O).[7] This collaborative effort is led by the American Academy of Addiction Psychiatry and joined by the American Dental Association, American Osteopathic Academy of Addiction Medicine, American Psychiatric Association, American Society for Pain Management Nursing, the International Nurses Society on Addictions, and the AMA. PCSSO-O has many course offerings and other resources for physicians to choose from – depending on what fits best for their practice needs and patient population.

Just as with PDMPs, however, the AMA believes that improving physicians' clinical decision-making and overall education on appropriate use of opioids and other pain-relieving modalities is best achieved by tailoring activities to physician practices rather than a one-size fits all mandate for physicians. We understand that many policymakers believe the only way to ensure appropriate prescribing behavior is to mandate physician training and education on a specific topic. The AMA believes that it would be more beneficial if programs were tailored to meet a physician's practice and patient population needs. That simply cannot be done through legislative mandates.

While the AMA understands the reasoning behind some advocates' support for legislative mandates, the AMA believes that positive incentives should exist for voluntary educational programs that help physicians understand current opioid drug labels, appropriate risk management and prescribing practices, as well as patient education and monitoring strategies to prevent abuse and diversion. **The AMA would strongly support legislation and grants that support development and deployment of voluntary CME that promotes appropriate prescribing for pain management and to combat diversion.**

Another area of potential legislative activity could focus on waiving all or a portion of state licensing fees for prescribers who take relevant CME or have qualifying specialized training. This could extend to bonus payments under Medicaid or other targeted incentives. This ensures that underserved communities and vulnerable populations do not lose access to appropriate and medically necessary pain management.

The AMA believes that expertise for education and training lies with the appropriate licensing boards to work together to ensure that ample course offerings are readily available in each state, and that the boards work with the professional health care associations and other stakeholders to identify and promote the full range of CME offerings. In addition, the AMA notes that much of the legislative discussion in 2013 has focused on physician practices. The AMA recommends that this discussion be expanded to medical schools, nursing schools, physician assistant programs, dental programs and

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[7] There are many online modules focused on increasing practitioners' understanding of the current state of opioid-dependence treatment and improve clinical decision-making. Available at http://www.pcss-o.org/online-modules

other appropriate schools to help prepare tomorrow's health care professionals for combating this issue.

Finally, another key area for NCOIL consideration is the need for comprehensive patient education and awareness efforts that highlight the risks of prescription drug abuse – and engage all stakeholders to help stop this epidemic. This can be achieved through, for example, targeted public service announcements, multimedia campaigns and other educational efforts in partnership with schools, business, health care organizations, government, and medical societies that are tailored to each state. Some of the elements of this outreach might include:

- Facts that outline the nature and scope of the epidemic within each state;
- Health and other risks associated with illicit prescription drug use;
- The dangers of diversion, including practical tips on how prescription drugs can be safeguarded from children, visitors, and others;
- Steps to take to dispose of unused prescription drugs, particularly pain medication, and most important ;
- Where to seek referrals or direct assistance for individual(s) seeking treatment programs and recovery.

While some of these issues would be covered as part of a physician's prescription for a medication, or a pharmacist's dispensing of the medication to a patient, this epidemic requires much broader, comprehensive community-based messages highlighting the appropriate role and use of prescription drugs, resources available for addiction treatment and prevention, and where patients can safely dispose of unwanted and unused medications.

In addition, to help combat prescription drug abuse and diversion throughout each community in the nation, comprehensive public health education and awareness efforts also must reach family and friends so that they can learn how they can support efforts to stop this epidemic and help those suffering from addiction. Through its support for comprehensive public health education tools and resources to help all those affected by this crisis, including support for engagement with all stakeholders, NCOIL can play a major role in helping all patients – and their families combat prescription drug abuse, diversion, overdose and death.

The AMA supports expanding capacity of treatment and recovery programs while promoting strategic planning to facilitate access to existing programs

The AMA strongly supports data-driven, public health solutions to stemming prescription drug abuse, misuse and diversion. A public health focus emphasizes understanding the root causes of substance abuse disorders and the challenges inherent in developing effective treatment and recovery programs. A public health focus brings to bear the data necessary to develop targeted solutions and to make resources available in areas where they are needed most. Because we understand the tight fiscal

restraints faced by many state legislatures, we believe that a public health focus would be the most efficient use of state resources to tackle this growing problem.

The AMA understands the calls for increased enforcement. This epidemic has claimed the lives of too many people, and the role of illegal pill mills and rogue pharmacies has been well-documented. We wish to be clear: the AMA has no tolerance for illegal prescribing activity, but we believe – like **White House Office of National Drug Control Policy (ONDCP) Director R. Gil Kerlikowske: "We cannot simply arrest our way out of the drug problem.** To bring about real, meaningful change, we need a fundamental shift in how our Nation discusses drug policy. This begins with the acknowledgement that our drug problem is a public health issue, not just a law enforcement issue. It means acknowledging that an ever-growing body of scientific research clearly demonstrates that addiction – the underlying cause of too much crime in this country – is a disease that can be prevented and treated successfully."[8]

Below, we discuss three specific strategies for NCOIL's consideration.

Naloxone saves lives.

We believe that additional national and state focus should be placed on strategies that go beyond combating diversion and misuse, and includes policies that help physicians and other stakeholders to treat overdose and reduce deaths. **The AMA has endorsed state legislation to increase availability of naloxone in several states, a safe and effective FDA-approved medication that reverses opioid overdose.**[9] The AMA also has expressed its support to the FDA, Centers for Disease Control and Prevention (CDC) and the Secretary of the US Department of Health and Human Services, and we welcome the opportunity to work with NCOIL to increase support for this proven, public health strategy.

Since the mid-1990s, community-based programs began offering naloxone and other opioid overdose prevention services to persons who use drugs, their families and friends, and service providers (e.g., health-care providers, homeless shelters, and substance abuse treatment programs). These services include education regarding overdose risk factors, recognition of signs of opioid overdose, appropriate responses to an overdose, and administration of naloxone.

A February 2012 report in the CDC's Morbidity and Mortality Weekly Report summarized the findings from 48 such programs (representing 188 local sites). These programs reported training and distributing naloxone to 53,032 persons and receiving reports of 10,171 overdose reversals.[10]

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[8] "Toward a Smarter Drug Policy" The Huffington Post, Posted: 02/14/2013 11:53 am, R. Gil Kerlikowske and Benjamin Todd Jealous. Available at http://www.huffingtonpost.com/r-gil-kerlikowske/toward-a-smarter-drug-pol_b_2687004.html

[9] See, for example, Colorado Senate Bill 13-014; New Jersey Assembly Bill 3095; and Oklahoma House Bill 1872.

[10] Morbidity and Mortality Weekly Report (*MMWR*), Centers for Disease Control and Prevention, Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010, February 17, 2012 / 61(06);101-105. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm?s_cid=mm6106a1_w. Last accessed May 16, 2013.

Increased emphasis is needed to remove barriers to addiction treatment and recovery programs.

While increased access to naloxone helps prevent death from overdose, we are deeply concerned by the barriers faced by physicians in finding and placing patients in addiction treatment and recovery programs. Emergency room physicians are on the frontlines of this dilemma because there is inadequate capacity to refer patients for detoxification and treatment and recovery programs. A profound need exists to address the workforce limitations and the lack of accessible and affordable treatment programs. If the ultimate goal is to stop addiction, overdose, and death, a far greater effort is needed to focus on the treatment and recovery side of this crisis.

For example, the AMA strongly supports increased access to treatment for drug addiction and physician office-based treatment of opioid addiction. There are, however, federal barriers on the limits on the number of patients a physician may treat utilizing buprenorphine, a drug that can be used to facilitate recovery from opiate addiction. There is broad consensus in the medical community that buprenorphine is a major tool to fight addiction, and does not have a high potential for misuse or fatal overdose. Lifting the cap would enable physicians to treat more patients with this highly-effective drug.

In addition, Suboxone®, a combination of buprenorphine (a potent synthetic compound that acts on the same opiate receptors as morphine and methadone) and naloxone (an inhibitor of the opiate receptor), is very safe when administered on an outpatient basis and is available for prescription by any licensed practitioner after completing training that focuses on the pathophysiology of opiate addiction, screening of patients, symptom identification and management, and prescribing of the medication.

Suboxone® prescribers must pay a fee for completion of the course, registration with governmental entities, and after a waiting period, the ability to prescribe Suboxone® to 30 patients for the first year. The prescriber may submit a waiver request to treat up to 100 patients after the first year.

There are two distinct advantages of Suboxone® treatment over methadone: (a) Suboxone® is safe for treating patients on an outpatient basis since the presence of the opiate inhibitor naloxone in the product makes Suboxone® extremely safe in the cases of overdose and diversion due to the co-presence of naloxone in the product; and (b) Suboxone® is extremely effective in the treatment of opiate addiction. The clear benefit of Suboxone® treatment is the fact that treatment can be offered as an outpatient, thereby reducing the stigma associated with participation in methadone clinic and being readily available to more patients.

The regulatory process for becoming a prescriber and the patient limits serve as barriers to increase capacity to treat opiate addiction and the availability of Suboxone to opiate-addicted patients, particularly those patients in jurisdictions that have adopted a law enforcement approach (as opposed to a public safety approach) to combat prescription drug abuse. The advantages of reducing the regulatory burdens to prescribing Suboxone® would not only increase the availability of Suboxone® treatment for patients with opiate addiction, but would also increase clinical identification, awareness, and acceptance of opiate addiction as a disease and reduce the stigma associated with opiate addiction.

There are several options to expand the current capacity to treat opiate addiction. First, Suboxone® training could be offered free-of-charge to prescribers with either renewal or initial application of a prescriber's DEA number. Second, the initial patient cap could be increased with a waiver option after six months instead of one year. In addition, Medicare and Medicaid reimbursement rates for Suboxone® treatment and counseling could be increased as an incentive for prescribers to treat opiate-addicted patients.

To the extent that NCOIL and state legislators can review these barriers to effective treatment of patients addicted to opiates and determine whether there is an appropriate state role, the AMA stands ready to work with you.

Administrative barriers interfere with physicians' clinical judgment.

Finally, one potential barrier to effective treatment and recovery that legislators could address is the requirement in many states for "fail first" and "step therapy" legislation that may inappropriately interfere with a physician's preferred treatment for a patient. Specifically, if a third-party payer requires a drug to be ineffective before allowing the physician to use a preferred drug; this not only increases costs but reduces a physician's ability, for example, to help treat a patient's pain in the most effective manner possible with the least potential for abuse.

The ultimate takeaway is that physicians are best equipped to evaluate the medication needs of their patients, and third-party payers should not promote the adoption of policies that substitute physician clinical judgment with that of a plan's without a process for engaging physicians and understanding a patient's underlying medical needs.

The AMA supports increased data sharing as necessary to develop informed, targeted solutions

There is no shortage of data showing the increasing numbers of Americans abusing prescription drugs and dying from unintentional overdose. And there are increasing data on the rise of neonatal abstinence syndrome[11] (NAS). Despite these trends, no central or coordinated system exists for sharing the available data at the state or federal levels. During the course of national stakeholder meetings in 2012 and 2013 including the National Governors Association, National Safety Council, National Conference of State Legislatures, and others, the challenge of using all available data sources to combat prescription drug abuse and diversion was identified as representing perhaps the largest challenge facing legislators.

Currently, there are numerous entities that collect and store data on prescription drug use, misuse and diversion. At the state level, these include prescription drug monitoring programs, state Medicaid agencies, pharmacy benefit management systems, pharmacies, electronic health records, hospitals, private health insurers, law enforcement and more. At the federal level, data exists within Medicare and the Veterans Administration, and data are collected and analyzed by the CDC, Substance Abuse

[11] Neonatal abstinence syndrome (NAS) is a condition affecting newborns whose mothers used opiates during pregnancy. As detailed in the April 30, 2012 issue of the *Journal of the American Medical Association*, NAS not only can have severe health consequences on fetuses and newborn babies, but NAS raises issues concerning Medicaid, appropriate treatment of pregnant women and the financial costs to the health care system.

and Mental Health Services Administration, the National Institute for Drug Abuse and more.

At a minimum, the AMA recommends that states identify all existing potential sources of data on prescription drug use, abuse and diversion within the state. This can occur either by interagency cooperation, administrative direction or through legislation directing the administrative branches to take specific action(s). Regardless of the process used, knowing what data are available would begin a conversation to determine the steps required as to how the data might be used, the privacy considerations that must be taken into account, and the technology and resources that would be required to make the data useful in terms of identifying prescription drug abuse, diversion, overdose, and death. Taking these steps will require enormous commitment from all parties, but the AMA believes that solutions to the problems must begin with a clear understanding of the data.

For example, one clear need is to identify – in each state – the source of prescription drug abuse, misuse and diversion. Nationally, the Substance Abuse and Mental Health Services Administration survey data show that 54 percent of individuals admitting to nonmedical use of prescription pain relievers obtained them from friends or family. Of those drugs, 82 percent came from one physician.[12] It is not possible to determine whether those medications were inappropriately prescribed based on the available data. It is clear, however, that the "medicine cabinet" plays a role in the nation's prescription drug abuse and diversion epidemic. We need better prospective data to make informed decisions that will help guide effective policy interventions.

Once robust data are available, epidemiologists and other public health experts will be able to determine state-specific answers to questions, including: Who are the high prescribers? Are those prescribers prescribing appropriately – or are they in need of additional education. The data also would support enforcement actions to halt "pill mill" activities and rogue online pharmacies. In addition, the data would be able to support increased coordination with public health efforts to expand access to addiction treatment and recovery in order to ensure that those suffering from addictions do not resort to illicit drug use, such as heroin.

The AMA supports harmonizing and stream-lining state and federal laws governing disposal of prescription drugs including controlled substances, while expanding awareness and access to local disposal sites

There is no question that a large supply of prescription drugs are dispensed in the United States. There also is no question that physicians face challenges when advising patients on proper disposal of unused prescription drugs that sit in their patients' medicine cabinets at home. As noted above, it is well understood that youth in particular are able to access leftover medications in their home and this

[12] See Figure 2.14, "Source Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2010-2011. Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Available at http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.htm#High

is an important source of initial exposure leading to diversion and substance misuse. But how do we dispose of all of the unwanted and unused prescription drugs in a safe and efficient manner?

Currently, we do not have a national infrastructure to safely and efficiently dispose of unused prescription drugs. This has not only contributed to the prescription drug diversion crisis, but raised very serious public health concerns as increasingly our drinking water has become contaminated with prescription drugs. In 2008, an investigation found that at least 46 million Americans were exposed to prescription drugs through their drinking water.[13] This included the water supplies of 24 major metropolitan areas and the water supplies of many of the nation's watersheds.

Removing unwanted and unused drugs is an important discussion that needs to occur between all stakeholders in your state, and the AMA encourages those discussions.

As one potential solution, the AMA recently submitted formal comments in support of proposed rules from the Drug Enforcement Administration (DEA) that would expand the options available to collect controlled substances from ultimate users for purposes of disposal, including take-back events, mail-back programs, and collection receptacle locations.[14] In addition, the Proposed Rule expands the category of entities authorized to offer these options and would include manufacturers, distributors, reverse distributors, local law enforcement, and retail pharmacies. While the AMA supports the expansion of entities permitted to engage in collection of unused controlled substances, we urged the DEA to reconsider its decision to not allow hospitals that do not have a registered pharmacy to participate in take-back.

However, even if the DEA successfully increases the flexibility of take-back locations, there remain a host of disparate and complicated laws and regulations involving the storage, custody, transportation, and ultimate disposal of drugs gathered in this fashion. Disparate federal and state agencies are involved including the Environmental Protection Agency, Department of Transportation, law enforcement, DEA, Occupational Safety and Health Administration, and other public health and safety agencies. We have urged the DEA to take a lead in partnering with Federal and state stakeholders to harmonize and streamline these requirements.

The AMA supports increased use of drug courts which offer additional state legislative strategies

We continue to urge national and state policymakers to pursue a public health approach to combating addiction. To that end, the AMA supports the use of drug courts. **Specifically, the AMA encourages the establishment of drug courts at the state and local level as an alternative to incarceration and as a means of overcoming addiction for individuals with addictive disease convicted of nonviolent crimes.**

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[13] Associated Press, Pharmaceuticals in water. Available at http://hosted.ap.org/specials/interactives/_national/pharmawater_update/index.html. Last accessed May 16, 2013.

[14] AMA letter to Administrator Michele M. Leonhart, Re: Disposal of Controlled Substances, RIN 1117–AB18, [Docket No. DEA–316], February 19, 2013.

According to the National Association of Drug Court Professionals (NADCP), drug courts are an alternative to individuals with addictive disease, providing them with intensive treatment and regular drug testing. The NADCP has found that drug courts reduce crime, save money, help ensure compliance, and restore families.[15] The National Institute of Justice has similarly found that drug court participants had significantly fewer positive drug tests and reported better improvements in their family relationships.[16]

Individuals with an addictive disease require treatment, and when they are convicted of a nonviolent crime, drug courts can provide the medical attention, support, and accountability needed to help them conquer their addiction and turn their lives around.

Conclusion

There are many areas where legislation can play a powerful role in helping combat prescription drug abuse, misuse and diversion. And there are many other areas where legislators can play a powerful role in ensuring that all appropriate stakeholders work together. To effectively combat this epidemic, the AMA strongly supports legislation that would support appropriate efforts to ensure access to appropriate pain management and support treatment for substance abuse and addiction in addition to legislation to combat prescription drug abuse and diversion. We also strongly support efforts to ensure that all stakeholders are working together. We stand ready to work with NCOIL on both fronts.

If you have any questions, including state-specific efforts that have occurred this year, as well as efforts by state medical societies to combat this epidemic, please contact Daniel Blaney-Koen, Senior Legislative Attorney, Advocacy Resource Center at daniel.blaney-koen@ama-assn.org or 312-464-4954.

Sincerely,

James L. Madara, MD

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[15] See, for example, http://www.nadcp.org/learn/facts-and-figures. According to the NADCP: "FACT: Nationwide, for every $1.00 invested in Drug Court, taxpayers save as much as $3.36 in avoided criminal justice costs alone. **FACT:** When considering other cost offsets such as savings from reduced victimization and healthcare service utilization, studies have shown benefits range up to $27 for every $1 invested. FACT: Drug Courts produce cost savings ranging from $3,000 to $13,000 per client. These cost savings reflect reduced prison costs, reduced revolving-door arrests and trials, and reduced victimization."

[16] See, for example, http://www.nij.gov/nij/topics/courts/drug-courts/work.htm