AMA
AMERICAN MEDICAL ASSOCIATION

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

Re: American Medical Association Recommendations on NCOIL Proposed Best Practices to Address Opioid Abuse, Misuse and Diversion

Dear Ms. Thorson:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am encouraged by National Conference of State Legislature's (NCOIL) continued leadership and efforts to bring increased attention to the nation's prescription drug abuse, diversion, overdose, and death epidemic. The AMA was pleased to comment on earlier drafts as well as provide testimony before the Workers Compensation Committee considering the proposed NCOIL Best Practices at your July 2013 meeting in Philadelphia. When final, we believe NCOIL's thoughtful work will be very helpful to legislators and others in the 2014 and future state legislative sessions.

Nuance Essential to State Strategies for Combating Prescription Drug Abuse and Diversion

Before providing specific comments, I wanted to first provide an overview of several key areas. First, the AMA strongly supports NCOIL's recognition that nuance and state flexibility must guide policy to effectively curb prescription drug abuse, overuse, misuse and death. Pain is among the most difficult medical conditions to effectively diagnose, treat and manage. This is particularly true for patients suffering from chronic pain, which may be associated with other medical and psychological needs. Physicians work extremely hard to balance their ethical obligation to treat pain against the need to recognize signs of abuse and diversion. NCOIL's proposed Best Practices largely gets that balance right by providing a wide range of recommendations rather than seeking one-size-fits-all solutions.

Second, the AMA agrees with NCOIL that state licensing boards and state medical, pharmacy and other stakeholders should work together toward solutions that will reduce prescription drug abuse, overdose and death – as well as increase access to much-needed treatment and prevention. NCOIL rightly notes that prescription drug abuse, overdose and death rates have greatly increased in recent years. The AMA also points out that during this time, access to prevention and treatment services have been greatly lacking. According to 2011 data analyzed by the Substance Abuse and Mental Health Services Administration

(SAMHSA), "19.3 million persons (7.5 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty facility in the past year."[1]

We appreciate (and discuss in more detail below) that the proposed Best Practices support increased attention for treatment and prevention. The AMA encourages NCOIL, however, to more clearly highlight the need for access to treatment and prevention services in its introduction. This will help ensure that – as legislators understandably confront supply-side prescription drug abuse policies – that they simultaneously consider the need to address the demand side of the prescription drug abuse and diversion
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epidemic. Without both, this issue will continue to suffer from "whack-a-mole" strategies that may seem to solve one piece of the complex issue without fully addressing the larger needs of patients and their communities.[2] That is, if policymakers only curb the amount of prescription pain relievers available to patients, they may unintentionally drive those patients to other, more dangerous drugs such as heroin.[3]

PDMPs can be a powerful tool when fully funded and modernized

NCOIL's comprehensive discussion of prescription drug monitoring programs (PDMPs) provides an excellent roadmap for state legislators. We agree that PDMPs can be "essential" if they have several components – providing data at the point of care; interoperable with other states, state agencies and health care professionals; and that the PDMPs contain reliable, real-time information. NCOIL's proposed Best Practices touches on each, to varying degrees, so we offer only a few comments for further emphasis.

First, the AMA encourages NCOIL to not simply recommend that "enhanced interstate data sharing" is a "best practice," but rather an essential one. Because of the geographic makeup of the United States, which allows such ease of travel between cities large and small, the AMA believes that all states must be able to share data to be able to fully identify potential situations of abuse and diversion – as well as when patients may need interventions for treatment. The use of Internet-based pharmacies also makes the interoperability of PDMPs across state lines essential.

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[1] 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

[2] SAMHSA also reports that nonmedical use of prescription pain relievers may raise the risk of turning to heroin use: http://www.samhsa.gov/newsroom/advisories/1308215815.aspx; and the National Institute on Drug Abuse has stated that "that abuse of [prescription painkillers] may open the door to heroin abuse." See http://www.drugabuse.gov/publications/drugfacts/heroin (last accessed Sept. 23, 2013).

[3] See, for example, "OxyContin use down in Vt. but heroin use increases," Dave Bram, Associated Press, Nov. 23, 2012. Available at http://www.boston.com/news/local/vermont/2012/11/23/oxycontin-use-down-but-heroin-use-increases/4U0o7LltDJb6q4dg9f7dOO/story.html

Second, with respect to helping ensure physicians and other prescribers have access to real-time information, dispenser reporting may be an excellent first step toward accomplishing that goal. In terms of real-time access, expanding the categories of authorized users also may enhance a PDMP's effectiveness. Increased access, however, must be balanced with strong patient privacy and confidentiality protections. That is, delegates who access PDMPs on behalf of a physician or other user, must be held to the same legal and ethical standards and penalties as all other authorized users. NCOIL may wish to clarify this in its final version.

Third, the AMA agrees that PDMPs contain a large amount of data that can be used to evaluate outcomes and conduct research. The AMA also encourages NCOIL to recognize that the data also may be useful to identify areas in the state where increased prevention and treatment services may be needed as well as opportunities for additional, community-based services to help educate people about abuse and diversion.

As we noted in our previous comments, the AMA agrees that mandated use of PDMPs by all physicians is not warranted. We are pleased that NCOIL recognizes this in the current proposed Best Practices. We are concerned, however, that mandated use of PDMPs for prenatal check-ups – without a state also having a full range of safe harbor referral and treatment options – may have unintended consequences, including pregnant women not seeking prenatal care. Neonatal Abstinence Syndrome (NAS) is a growing public health issue, but one that can be addressed (like the larger prescription drug abuse and diversion epidemic) with a public health focus. Specifically, the AMA is pleased that NCOIL recognizes the growing concern with NAS, but encourages NCOIL to devote a separate Best Practice to this in the "Prescribing Practices" section and work with the AMA, American Congress of Obstetricians and Gynecologists, American Academy of Pediatrics, American Society of Addiction Medicine, American Academy of Pain Medicine and others in drafting this new section.

A final comment about PDMPs is that the AMA appreciates NCOIL's frankness that funding issues "elicits little enthusiasm among policymakers." The AMA clearly understands the great funding challenges present in many states. We have no doubt that legislators want to curb this public health epidemic, which is why we encourage NCOIL to clarify that half-measures, including unreliable funding, will not provide much, if any, relief to this crisis.

Prescribing Practices Would Further Benefit from Medical Input

The AMA has three main comments on this section. First, the AMA strongly supports the recommendation to "not negatively impact clinical decision-making." This recommendation could be further strengthened by encouraging legislators to reach out to the medical and public health community on the nuances and precautions that must be taken when prescribing opioids. Medical societies across the nation already are working on this issue – and the AMA strongly recommends that policy makers take advantage of the unique expertise physicians can bring to this discussion. For example, the specific circumstances and considerations of when detailed, individualized treatment plans are appropriate and beneficial can be an area of productive partnership between the medical and legislative community.

Finally, the AMA encourages NCOIL to make a distinction between a "pill mill" and a "pain clinic." Pill mills are sites of illegal activity that the AMA believes should be shut down and prosecuted to the full extent of the law. They do not provide appropriate pain care, management or treatment. Pain clinics, however, are sites where patients' pain can be evaluated, managed and treated. Pain clinics generally are run by highly specialized physicians and subject to increasing levels of state regulation. Much of the new regulations have been drafted in concert with state medical societies, who can help legislators determine the most effective guidelines for issues including ownership, education, dosage limits, etc. In legislation, distinctions matter, and the AMA would be pleased to work on this further with NCOIL.

The AMA Strongly Supports Increased Education and Outreach

The AMA appreciates NCOIL's discussion on continuing medical education, education for the community, and its support for making use of existing resources, where available. For example, the AMA strongly supports Take Back efforts to remove unused and unwanted prescriptions from the community since the majority of diversion occurs from legally-issued prescriptions. This is an area, however, where harmonization of state laws with regulations from the U. S. Drug Enforcement Agency (DEA) is sorely needed. NCOIL may wish to further encourage this collaboration between state public health and law enforcement agencies with the DEA Outreach to the community is another area where many best practices exist to raise awareness about the dangers of prescription drug abuse and diversion. NCOIL cites a few prominent examples, which is a good first step. This may be an area, however, where NCOIL can further recommend that legislators direct state agencies to identify existing programs in other states for replication. While the AMA understands that what works in one state may not work in another, NCOIL may be able to serve as a forum to bring many states together on this important issue. The AMA would be pleased to help further those discussions.

Similarly, with respect to Council on Medical Education (CME), the AMA, as part of its commitment to providing resources and tools to advance the practice of medicine, has been hosting a series of free webinars to help physicians combat prescription drug abuse and promote responsible pain management. Recent topics have included "Assessing for Risk, Benefit and Harm when Prescribing Opioids for Chronic Pain", "Improving Safety Through Opioid Rotation: Reducing Dosing and Extending Rotation Schedule", "Prescription Opioid Overdose and the Public Health Response", and "Pharmacogenetics and Pain Management."[4]

In addition, the AMA has been collecting the CME activities of the nation's state medical societies for pain-related courses and will soon provide that information to all of the nation's physicians via the AMA Web site. The AMA is glad that NCOIL appears to understand the limitations of mandates. We also understand the intention of legislators about CME mandates concerning prescribing opioids, but we also believe that legislatively mandating aspects of medical practice rarely leads to the desired outcome. Rather, the AMA encourages policymakers, medical societies, and regulatory boards to work together on developing solutions that encourage increased education tailored to physicians' unique practice and patient-population needs.

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[4] The AMA's Prevention and Public Health webinars can be accessed at http://eo2.commpartners.com/users/ama/series.php?id=1214

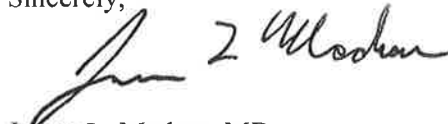
Finally, the AMA strongly supports NCOIL's encouragement for the use of naloxone and reduced barriers for buprenorphine and Suboxone. Additionally, we support the call for establishing and expanding the use of drug courts. With each of these public health strategies, the AMA believes that states pursuing these options will see positive results in the form of reduced death, increased success for treatment and prevention, and reduced costs in the criminal justice system.

Conclusion

The AMA agrees with NCOIL that states have undertaken significant activity to address the numerous issues surrounding prescription drug abuse, misuse, overdose and death. The AMA has worked with more than 50 state and specialty medical societies on these issues, and we expect to continue our efforts in the 2014 state legislative sessions. In every state, the AMA encourages NCOIL's legislative leaders to reach out to the medical society leaders for partnership and support in tackling these issues. NCOIL's proposed Best Practices are among the nation's most progressive and comprehensive, and the AMA looks forward to working with NCOIL to make them even more robust and practical

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

Sincerely,



James L. Madara, MD