AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-16)

Introduced by: Resident and Fellow Section

Subject: Expanding the Treatment of Opiate Dependence Using Medication-Assisted Treatment by Physicians in Residency Training Programs

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

Whereas, The Centers for Disease Control and Prevention recently announced that death due to drug overdose has reached an unprecedented 14.7 per 100,000 in 2014 (45,000 people in US), with 61% of deaths involving some form of opioid;[1] and

Whereas, Buprenorphine and naloxone (suboxone) are effective components of the medication-assisted treatment of opioid use disorders which have a favorable safety and tolerability profile in numerous populations;[2] and

Whereas, The Department of Health and Human Services has recently announced a new rule, which expands the patient limit for qualified physicians to treat opioid use disorders using buprenorphine in order to increase access to medication-assisted treatment for opioid abuse and dependence;[3] and

Whereas, The 2014 Buprenorphine Summit held by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute on Drug Abuse (NIDA) notes that increasing resident exposure to medication-assisted treatment for addiction is a strategy to improve patient access to the medication;[4] and

Whereas, The Drug Addiction Treatment Act of 2000 allows for a physician in a residency training program with an unrestricted license and the appropriate Drug Enforcement Administration registration to receive a waiver to prescribe buprenorphine, provided it is in accordance with state laws regarding the use of Schedule III narcotics for detoxification and maintenance therapy;[5] and

Whereas, Addiction clinics in which residents prescribe buprenorphine are prevalent but barriers to resident prescription of the medication remain, including funding for buprenorphine waiver training, supervision and patient continuity from a certified addiction medicine physician, as well as support staff for scheduling, billing and urine drug testing;[6,7,8] therefore be it

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[1] US drug overdose deaths: a global challenge. *Lancet.* 2016;387(10017):404.
[2] Connery HS. Medication-assisted treatment of opioid use disorder: review of the evidence and future directions. Harv Rev Psychiatry. 2015;23(2):63-75.
[3] The White House OotPS. Fact Sheet: Obama Administration Announces Additional Actions to Address the Prescription Opioid Abuse and Heroin Epidemic. https://www.whitehouse.gov/the-press-office/2016/03/29/fact-sheet-obama-administration-announces-additional-actions-addressMarch 29 2016.
[4] NIDA Sa. 2014 Buprenorphine Summit: Report of Proceedings. http://www.samhsa.gov/sites/default/files/proceedings_of_2014_buprenorphine_summit_030915_508.pdf. 2014;1(1):2-20.
[5] SAMHSA. Physicians in Residency Training Programs. In: http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/qualify-for-physician-waiver - Physicians-in-Residency-Training-Programs, ed. Qualify for a Physician Waiver2016.
[6] Suzuki J, Ellison TV, Connery HS, Surber C, Renner JA. Training in Buprenorphine and Office-Based Opioid Treatment: A Survey of Psychiatry Residency Training Programs. Acad Psychiatry. 2015.
[7] D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA. 2015;313(16):1636-1644.
[8] Wakeman SE, Pham-Kanter G, Baggett MV, Campbell EG. Medicine Resident Preparedness to Diagnose and Treat Substance Use Disorders: Impact of an Enhanced Curriculum. Subst Abus. 2015;36(4):427-433.

RESOLVED, That our American Medical Association encourage the expansion of residency and fellowship training opportunities to provide clinical experience in the medication-assisted treatment of opioid use disorders, under the supervision of an appropriately trained physician (New HOD Policy); and be it further

RESOLVED, That our AMA support additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the medication-assisted treatment of opioid use disorders. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 09/12/16

RELEVANT AMA POLICY

Methadone Maintenance in Private Practice H-95.957
Our AMA: (1) reaffirms its position that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further;
(2) supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed;
(3) encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users;
(4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and
(5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management. (CSA Rep. 2, I-94; Reaffirmed: CSA Rep. 12 and Append Res. 412, A-99; Reaffirmation I-00; Modified: CSAPH Rep. 1, A-10)

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose. (Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16)

Third Party Payer Quantity Limits H-185.942
1. Our AMA supports the protection of the patient-physician relationship from interference by payers via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.
2. Our AMA will work with third party payers to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.
3. Our AMA supports interested state legislative efforts and federal action and will develop model state legislation to ensure that third party payers that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:
- physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)- physicians can appeal adverse determinations regarding quantity limitations;- payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;- payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;- physicians with specialized qualifications may not be subject to quantity limits;- payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;- payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in nonurgent situations and one working day in urgent cases; and- physicians or patients can submit any denied appeals to an independent review body for a final, binding decision. (BOT Rep. 12, A-12)

Protection for Physicians Who Prescribe Pain Medication H-120.960
Our AMA supports the following:
(1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection; (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.
Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management. (BOT Rep. 1, I-97; Reaffirm: Res. 237, A-99; Appended: Res. 506, A-01; Appended: Sub. Res. 213, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmed: BOT Rep. 3, I-13; Reaffirmation A-15)

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs. (BOT Rep. 11, A-10)

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985
1.Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.
2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management. (Sub. Res. 508, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Append: Res. 515, A-14; Reaffirmed: BOT Rep. 14, A-15)

Drug Abuse Related to Prescribing Practices H-95.990
1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.
2. Our AMA:
A. promotes physician training and competence on the proper use of controlled substances;
B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.
3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.
4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 907, I-11; Appended: Res. 219, A-12; Reaffirmation A-15; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15)

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999
Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states. (CSA Rep. 12, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09)