AMA Task Force to Reduce Opioid Abuse
National Rx Drug and Heroin Abuse Summit
Atlanta, GA

Patrice A. Harris, MD, MA
Chair-elect
American Medical Association

March 29, 2016

Good morning and thank you for being here. I am Dr. Patrice Harris – a psychiatrist from here in Atlanta, and the chair-elect of the American Medical Association. I also am the chair of the AMA Task Force to Reduce Opioid Abuse.

This morning, I want to lay out the AMA’s vision for ending this epidemic that touches every one of us here. Every state; every socio-economic class and demographic; our co-workers and neighbors; our family and friends.

The AMA’s vision for a national solution starts with a focus on what physicians can do to turn this tide. The AMA’s vision defines what it means for physicians to be leaders. Because let me be clear – physicians must take responsibility to end this epidemic.

And through the advocacy of the AMA and the work of the AMA’s Task Force to Reduce Opioid Abuse, I believe we can end this epidemic.

First – what is this task force? More than 25 physician organizations and the American Dental Association joined as partners last year to see what we could do – together – to develop policy recommendations that could be used to guide state and federal legislative advocacy; to urge physicians to take specific actions to implement those recommendations.

One component of leadership is taking action. Physicians are trained to do just that – to go toward an emergency – not away from one. Implementing these recommendations is the beginning of the Task Force’s solution on what physicians can do to end the epidemic. We urge physicians to:

- Register and use the state prescription drug monitoring program to check a patient's prescription history.
- Educate yourself on managing pain and promoting safe, responsible opioid prescribing.
- Support overdose prevention measures, such as increased access to naloxone.
- Reduce the stigma of substance use disorders and enhance access to treatment.
- Ensure patients in pain aren't stigmatized and can receive comprehensive treatment.

Today, I will share more information on each, including some of the data that you might not have considered or be aware of. But first, let’s look at this chart. Many have seen this before. And I think we all understand that the sharply rising lines are a national tragedy – not just a national epidemic. An epidemic that has claimed more than 250,000 lives since 1999.
But let me also add another sobering reality – and something that we need to consider when charts like this are shown. Mortality from opioid analgesics and heroin will likely continue to increase in the near term because so many individuals who have an opioid use disorder do not have access to treatment; the “treatment gap” is not just a term of policy – it is a sad truth that millions of Americans with a substance use disorder receive no treatment. Millions of Americans who – if they do not receive treatment – will continue to experience harm – and will unfortunately continue to die. We still have a lot of work to do.

This is why AMA President Dr. Steven Stack just a few weeks ago issued a national call to action. A call that encourages all of us to work together to turn the tide of this national epidemic. A call to action based on evidence-based solutions – and rooted in our vision. Actions that physicians – and many other health care professionals can take – as leaders in organized medicine, other health professions and in our communities.

This was the first national call to action from the AMA of this kind in years. We know the changes must start with us. And there actually is some good news; signs of progress. For the past two years, the total number of prescriptions for opioids has decreased.

From 2013 to 2014, opioid prescriptions decreased 2.9 percent nationally. From 2014 to 2015, opioid prescriptions decreased another 6.8 percent nationally. From 2014 to 2015 – every state in the nation saw a decrease in the number of opioid prescriptions. Every state in the nation. Physicians have changed their prescribing practices for many reasons, which is a good sign, a sign of progress, but I think we all can agree that there is more work to do.

To begin, the AMA Task Force urges all physicians to register for and use their state PDMP to help make more informed prescribing decisions and recognize patients who may have a substance use disorder. When PDMPs are fully funded, containing relevant and reliable real-time data that can be integrated into the workflow, they are positioned to better inform clinical decision-making.

This includes the ability to quickly access a patient's prescription history for opioids, and other controlled substances that might increase risks — or allow a delegate in your practice to do so. The AMA strongly supports delegate access to the PDMP.

Effective PDMPs also allow physicians to determine immediately whether patients have received opioids and other controlled substances from other physicians and pharmacies, both in and out of state; create alerts when a patient reaches certain thresholds for number of concurrent prescriptions, dosage or quantity limits; identify when we may need to counsel and refer the patient for treatment for a substance abuse disorder.

Now – I know two things. First – many of you in this room know that PDMPs can do these things. But unfortunately – not all state PDMPs can do these things. This is why the AMA is advocating for what PDMPs should do – rather than having to work with an underfunded or ineffective tool that does not effectively support our ability to provide patient care.

The AMA recently released a national survey of physicians in active practice and who regularly prescribe opioids. The results highlight our support for PDMPs. 87 percent of those surveyed believe that PDMPs can help us be fully informed about our patients’ prescription history; and 87 percent of us believe that PDMPs can help us identify when patients receive multiple prescriptions.

Physicians support new technology that improves our practices and our quality of care. In states that have high-quality PDMPs – physicians use and value them. Our vision is to help all states have those high-quality tools.
The second recommendation of the Task Force is to enhance physician education. The national physician survey I just mentioned found nearly 70 percent of physicians have taken education on safe opioid prescribing. And more than 50 percent have taken education on pain management with opioid alternatives. That’s very good news.

Yet we also learned that many physicians are not sure where to go for practice- or specialty-specific information. This underscores the Task Force goal to help enhance physician education.

To help accomplish this, the AMA has gathered more than 200 resources — from nearly every state, leading specialty societies, and federal agencies, including those from CDC, ONDCP and SAMHSA.

This collection of resources represents the best of the best — these tools are both practical and physician-supported. The key point here is that while the AMA knows that many support an educational mandate — different specialties have different prescribing and educational needs. We do not believe a one-size-fits-all mandate is the type of meaningful policy that will help physicians.

Let me be clear — we strongly support education — and we want it to be meaningful and we want it to help physicians re-commit to best prescribing practices. The AMA wants physicians to enhance their education — and do it in ways that directly improve patients’ care.

And here are additional findings from the national survey that provide important background on the types of education physicians have engaged in. This is good, but keep in mind that the survey found that 1 in 4 physicians said that education was not readily available for his or her specialty or did not directly address the practice needs of his or her specialty.

There are many other takeaways I’m sure that you’ll have from this slide — but please keep in mind that this was the first national survey of its kind. For example, is that fact that 15 percent of physicians in this sample had taken MAT education a high or low percentage? Depending on your outlook, it could be one or the other.

The AMA wants physicians to become more aware of the signs that their patients may be at increased risk for — or have a substance use disorder. And we also want more physicians to become trained to provide in-office treatment using buprenorphine. If the survey results are such that only 15 percent of physicians understand what MAT is — we need to address that. But if the survey results showed that 15 percent of physicians are trained to provide MAT — that raises a different set of questions, such as, why aren’t more physicians treating patients with substance use disorders. What barriers exist to such treatment? How can we further incentivize such treatment? This survey gives us a good place to establish a baseline and conduct further quantitative and qualitative analysis and research.

Another source that the AMA believes provides an excellent framework is the National Pain Strategy — the vision for the nation to truly improve pain care. This brings me to the third key recommendation of the AMA Task Force to Reduce Opioid Abuse.

Stigma has no place in medicine or society, yet its prevalence is clear, and unless physicians speak out, the suffering of patients with chronic pain will grow. Patients with pain deserve our care and compassion — not our judgment. The key is to ensure that we are providing the most effective treatment possible, which may or may not include opioids.

This means we need to turn the national discussion away from simply how to reduce the number of opioid prescriptions as a one-size-fits-all approach — but rather, how to ensure access to the most appropriate care.

I mentioned earlier that every state in the nation has seen a decrease in the number of opioids prescribed. The AMA believes that this is due to many factors, including physicians being more
judicious in their prescribing decisions; physicians paying more attention to dose and duration for acute 
pain; and to be honest, there are physicians who do not prescribe opioids any longer out of fear.

Most will agree that a reduction in the supply of opioids is a good thing, but it requires context. One 
thing we do not know – and why the National Pain Strategy is so important – is that we also need a 
comprehensive strategy to provide physicians and other health care professionals with truly evidence-
based “practical advice and tools” to help physicians most effectively treat acute and chronic pain.

I urge all of you to read the National Pain Strategy because it contains the type of comprehensive, 
multifaceted approach that the AMA strongly supports.

Let me first thank our colleagues at the American Society for Addiction Medicine for this slide. Like 
patients with pain, patients with substance use disorders often face stigma. They are called “junkies,” 
“addicts”, “stoners” and much worse. A patient with a substance use disorder often cannot find or, if they 
do find it, they often cannot afford treatment.

And just like treatment for chronic pain, treatments for substance use disorders are often subject to 
limits imposed by insurers and others. Treatment for a complex, chronic disease is not something that fits 
neatly into a 5- or 10-visit box.

It is distressing to me when I hear my colleagues talk about prior authorization, step therapy and fail 
first protocols that often limit access to MAT therapy; or for patients in pain, non-opioid therapies. 

We need to work together to ensure that policies support optimal treatment – and like the approach to 
pain management, we need to change the national discussion. We need to work together to advocate for 
policies such as lifting the cap on treating patients in our offices with buprenorphine. 

I know that those attending this conference understand, but we need to carry this important message 
beyond this conference. This is necessary to reduce the treatment gap that you see on this slide. This is 
necessary to turn the tide of a nationwide epidemic that claims approximately 78 lives per day.

Let me take a second here to reflect back on the slide showing increasing numbers of people dying 
from heroin and opioid analgesics. I’m often asked when we will know that we have ended the epidemic. 
I tell people, quite simply, when we prevent new cases; when a new generation of our loved ones no 
longer dies from overdose; and when we are treating all who need it. 

That would be success. And that is why the President’s call for increased state- and federal funding 
for treatment is essential. We must close the treatment gap. And to help us get there, the AMA calls on all 
states to work with us to support and enact policies that will truly end the treatment gap. 

The fifth Task Force recommendation also is one that physicians have in their control. The Task 
Force recommends that we take a close look at when we should be co-prescribing naloxone. The AMA is 
strongly encouraging physicians to co-prescribe naloxone to a patient – or a member of that patient’s 
family – if a risk of overdose exists.

The Task Force developed a list of questions for physicians to consider. This is a sample:

- Is my patient on a high opioid dose?
- Is my patient also on a concomitant benzodiazepine prescription?
- Does my patient have a history of substance use disorder?
- Does my patient have an underlying mental health condition that might make him or her more 
susceptible to overdose?
- Does my patient have a medical condition, such as a respiratory disease or other co-morbidities, 
which might make him or her susceptible to opioid toxicity, respiratory distress or overdose?
• Might my patient be in a position to aid someone who is at risk of opioid overdose?

Consider that naloxone – which has been around for more than 40 years – is saving lives every day in the community and in hospitals. We can play an important role if we, too, prescribe this potentially life-saving medication. The rate of co-prescribing is increasing – and more lives are being saved. Increased availability and use of naloxone won’t end the epidemic --- but it has prevented it from becoming much worse.

I want to conclude with returning to the Task Force recommendations – and also leaving you with a clear view of the AMA’s vision for ending this national epidemic.

I mentioned at the beginning that the organizations leading the Task Force came together to have a national impact. That is the message that the AMA is giving to every medical organization – and every physician. We all are working together to end this epidemic.

The task force recommendations are based on the actions that we believe physicians can take. I can report to you today that measureable steps have been taken; steps that have been taking place within medicine, steps that were announced by the Administration last October in West Virginia, and steps that were recommended by the National Governors Association last month.

It is progress that more physicians are registering for and using their state PDMPs. There is an increased national commitment to treat more patients with a substance use disorder. And there is an increased national commitment for physicians to re-examine how we treat our patients’ pain. Prescriptions for opioid analgesics have decreased.

More physicians are co-prescribing naloxone, and medical societies are making excellent CME available for our members.

But, our vision will only be complete when we not only are implementing proven solutions for treatment, but also when America’s flawed perceptions about pain and substance abuse come to an end. We still have a long way to go on stigma – and that is where everyone here can play a role, and you have our commitment to join you in this critical effort.

It is truly up to each of us to work together to end this epidemic. And on behalf of America’s physicians, the AMA welcomes this responsibility.

Thank you.

###