DISCLAIMER

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-18)

Report of Reference Committee B

Francis P. MacMillan, Jr., MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION AS AMENDED

Resolution 235 – Inappropriate Use Of CDC Guidelines For Prescribing Opioids

(20) RESOLUTION 235 – INAPPROPRIATE USE OF CDC GUIDELINES FOR PRESCRIBING OPIOIDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 235:

HOD ACTION: The alternate resolution adopted in lieu of Resolution 235:

RESOLVED, that our American Medical Association (AMA) applaud the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths (Directive To Take Action)

RESOLVED, that our AMA actively continue to communicate and engage with the nation's largest pharmacy chains, pharmacy benefit managers, National Association of Insurance Commissioners, Federation of State Medical Boards, and National Association of Boards of Pharmacy in opposition to communications being sent to physicians that include a blanket proscription against filing prescriptions for opioids that exceed numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical

nuances that would support such prescribing as falling within standards of good quality patient care. (Report back at A-19) (Directive To Take Action)

RESOLVED, that Policies H-120.924, D-95.987, D-160.981, H-265.998, and H-220.951 be reaffirmed. (Reaffirm Existing HOD Policy)

RESOLVED, that our AMA affirms that some patients with acute or chronic pain can benefit from taking opioid pain medications at doses greater than generally recommended in the CDC Guideline for Prescribing Opioids for Chronic Pain and that such care may be medically necessary and appropriate, and be it further

RESOLVED, that our AMA advocate against misapplication of the CDC Guideline for Prescribing Opioids by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit patients' medical access to opioid analgesia, and be it further

RESOLVED, that our AMA advocate that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance, and physicians should not be subject to professional discipline, loss of board certification, loss of clinical privileges, criminal prosecution, civil liability, or other penalties or practice limitations solely for prescribing opioids at a quantitative level above the MME thresholds found in the CDC Guideline for Prescribing Opioids."

Resolution 235 asks that our American Medical Association applaud the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths; and be it further, that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance and that MME thresholds should not be used to completely prohibit the prescribing of, or the filling of prescriptions for, medications used in oncology care, palliative medicine care, and addiction medicine care (New HOD Policy); and be it further, that our AMA communicate with the nation's largest pharmacy chains and pharmacy benefit managers to recommend that they cease and desist with writing threatening letters to physicians and cease and desist with presenting policies, procedures and directives to retail pharmacists that include a blanket proscription against filling prescriptions for opioids that exceed certain numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances that would support such prescribing as falling within standards of good quality patient care (New HOD Policy); and be it further, that AMA Policy opposing the legislating of numerical limits on medication dosage, duration of therapy, numbers of pills/tablets, etc., be reaffirmed (Reaffirm HOD Policy); and be it further, that physicians should not be subject to professional discipline or loss of board certification or loss of clinical privileges simply for prescribing opioids at a quantitative level that exceeds the MME thresholds found in the CDC Guidelines (New HOD Policy); and be it further, that our AMA encourage the Federation of State Medical Boards and its member boards, medical specialty

societies, and other entities (including, possibly, the CDC) to develop improved guidance on management of pain and management of potential withdrawal syndromes and other aspects of patient care for "legacy patients" who may have been treated for extended periods of time with high-dose opioid therapy for chronic non-malignant pain. (New HOD Policy)

Your Reference Committee heard supportive testimony of the intent of Resolution 235. Your Reference Committee heard testimony that the third resolve should be amended to reflect that our AMA is already working with national pharmacy chains regarding physicians who have received letters about exceeding numerical thresholds. Your Reference Committee also heard testimony that our AMA already has strong policy regarding many of the resolves in Resolution 235, including opposing specific doses or durations limits on pharmacologic therapy not supported by medical evidence and protecting due process for medical staff, professional discipline, and board certifications that covers physicians being subject to professional actions for prescribing opioids at a quantitative level that exceeds CDC guidelines. Further testimony indicated that it would redundant to ask FSMB to develop improved guidance because our AMA's "End the Epidemic" website has more than 400 state- and specialty-specific resources. Accordingly, your Reference Committee recommends that an alternate resolution be adopted in lieu of Resolution 235, including reaffirming existing policy.

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care H-120.924
Our AMA will: (1) urge the National Association of Boards of Pharmacy, Federation of State Medical Boards (FSMB), and National Association of Insurance Commissioners (NAIC) to support having national pharmacy chains, health insurance companies, and pharmacy benefits managers (PBMs) testify at state-level public hearings by state medical/pharmacy boards and state departments of insurance, on whether the pharmacy chains, health insurance companies, and PBMs' policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state insurance laws or state laws governing the practice of medicine and pharmacy; and (2) oppose specific dose or duration limits on pharmacologic therapy that are not supported by medical evidence and clinical practice.
BOT Rep. 17, A-18

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. 3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death. (Res. 526, A-06 Modified in lieu of Res. 503, A-12 Appended: Res. 909, I-12 Reaffirmed: BOT Rep. 22, A-16 Modified: Res. 511, A-18)

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. 2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts. 3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages. 4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines. 5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality. (Res. 321, A-08 Appended: Res. 522, A-10 Reaffirmed in lieu of Res. 518, A-12 Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16 Appended: Res. 927, I-16 Appended: Res. 526, A-17 Modified: BOT Action in response to referred for decision Res. 927, I-16)

Guidelines for Due Process H-265.998
While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires: (1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her. (2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity of no less than 30 days to prepare for the hearing. (3) It is the duty and responsibility of the hearing officer to conduct a fair, objective, expeditious and independent hearing pursuant to established rules. (4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing. (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her. (6) The physician is entitled to the opportunity to present a defense to the charges against him or her. (7) To the extent feasible, the hearing panel should evaluate the issues and evidence presented related to the proposed corrective action while blinded to the patient outcome. (8) The hearing panel should render a decision based on the evidence produced at the hearing. (9) The hearing panel should include in its decision the conclusions reached and actions recommended and, as an important focus if feasible, remedial steps for the physician and for the health care facility itself. When feasible, the hearing panel should include terms that permit measurement and

validation of the completed remediation process. (10) The hearing panel should endeavor to state its findings, the clinical basis and support for its findings, its recommendations, and actions as clearly as possible. (11) Within 10 days of the receipt of the hearing panel's decision, the physician, medical executive committee or health care organization, if it brought the correction action, has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts and/or evidence in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical staff bylaws; or (b) the decision is against the manifest weight of the evidence. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician, medical executive committee and the health care organization. The MEC shall appoint an appeal board consisting of members of the medical staff who did not sit on the original hearing panel, or, at the request of the MEC, the governing body or at least three members thereof may sit as the appeal board. The appeal board shall consider the record of the hearing before the hearing panel. If the appeal board determines that significant relevant evidence, which could bear on the outcome of the proceeding, was not entertained by the hearing panel, it may refer the matter back to the hearing panel for further deliberation or, at the appeal board's discretion, it may receive and consider the new evidence. Similarly, if the appeals board determines that there was not substantial compliance with the hearing procedures in the medical staff bylaws, the appeal board may refer the matter back to the hearing body or, at the appeal board's discretion, it may convene additional hearings to correct any defect in the process. Upon completion of the appeal board's deliberations, the appeal board shall present its recommendation(s) to the governing body as to whether the recommendations(s) of the hearing body should be affirmed, modified, or reversed. (12) In any hearing, the interest of patients and the public must be protected. (BOT Rep. II, A-80 Reaffirmed: Sunset Report, I-98 Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05 Reaffirmed: Res. 12, A-06 Reaffirmed: BOT Rep. 06, A-16)

Medical Staff Membership H-220.951

Our AMA (1) requests The Joint Commission to require that conditions for hospital medical staff membership be based only on the physician's professional training, experience, qualifications, and adherence to medical staff bylaws; and (2) will work toward protecting the due process rights of physicians when medical staff privileges are terminated without appropriate due process as described by the medical staff bylaws. (Res. 721, I-91 Reaffirmed by Res. 802, I-94 Reaffirmed: CLRPD 1, A-04 Reaffirmation A-05 Modified: CMS Rep. 1, A-15)