Ohio State Medical Association
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June 23, 2011

Richard Whitehouse
Executive Director
Ohio State Medical Board
30 East Broad Street
Columbus, Ohio 43215

Dear Director Whitehouse,

On behalf of the 20,000 physician, resident and medical student members of the Ohio State Medical Association (OSMA) and the undersigned organizations, we recommend the following changes to draft rule **Ohio Administrative Code 4731-11-11 – Standards and procedures for review of Ohio Automated Rx Reporting System (OARRS)**.

These recommended changes were developed by the OSMA Prescription Drug Abuse Advisory Committee along with comments from our membership. The Prescription Drug Abuse Advisory Committee consists of 28 physicians from across Ohio specializing in pain medicine, emergency medicine, primary care, psychiatry, physical medicine and rehabilitation, neurology and anesthesiology. The committee has been meeting for more than a year developing policy and recommendations for the OSMA and engaging in an ongoing dialogue with public policymakers and the State Medical Board on the prescription drug abuse epidemic in Ohio.

Proposed changes to draft rule 4731-11-11

Recommendation – The Medical Board should not mandate OARRS queries but rather should adopt a position statement for practice guidelines.

We are recommending the Medical Board adopt the rule as a position statement.

According to Medical Board policy, the board may establish a position statement defined in the following way, *"unlike a statute or rule, a position statement does not have the force and effect of law. Position statements are most often used to announce Medical Board policy, promote certain minimum guidelines and highlight safety concerns. Through a position statement, the Board can also put the public and the profession on notice of what it considers to be the appropriate standard of care."*

Ohio's medical community strongly supported the creation of the OARRS database and encouraged its use based on the clinical judgment of the treating physician (see attachment B - OSMA Resolutions 17 – 2008 and 7-2010). However, the current draft rule mandates the use of OARRS. While we agree OARRS is a helpful tool and applaud the many physicians who have already implemented it into their practices, we do not

support the concept of supplanting the physician's clinical judgment with a rule mandating the use of OARRS.

We are concerned that the proposed OARRS rule could jeopardize legitimate chronic pain patients access to medically necessary pain medications. The proposed OARRS mandate eliminates the physician's ability to use sound clinical judgment in times when an OARRS query may or may not be necessary. Instead, the rule establishes a rigid mandate as to when an OARRS review must be performed, even though often times the report will not enhance the medical care provided or further the fight against prescription drug abuse.

Establishing this proposed rule as a board position statement and practice guideline will inform the physician community that an appropriate standard of care has been established by the board. The position statement will permit the physician to use his/her clinical judgment as when to search the OARRS database in accordance with the standard of care established by the board.

Voluntary Use of OARRS is Prevalent in the Medical Community

Physicians are voluntarily using the OARRS system. According to March 2011 data from the Board of Pharmacy (BOP), prescribers/physicians are responsible for 80.4 percent of all OARRS requests, while pharmacists account for 17.7 percent and law enforcement for 1.9 percent. This data is similar to information provided by the BOP in March, 2010 that showed 82.4 percent of the requests were from prescribers/physicians, 15.4 percent were from pharmacists and 2.3 percent were from law enforcement.

In addition, the number of OARRS reports requested has increased by almost *800 percent in five years*, from 178,002 requests in 2007 to 1,415,664 in 2011.

We applaud this activity and would suggest it proves that physicians have voluntarily incorporated the use of OARRS into their practices when they believe it is clinically necessary. For the physicians that have not registered with OARRS, we strongly believe that the adoption of a Board position statement will significantly enhance the voluntary use of OARRS.

This data also shows that pharmacists have experienced only a slight increase in their requests for this information. Pharmacists and prescribers must work together to combat prescription drug abuse and therefore we believe the number of requests from each group should be closer to being equal.

Further, with the restrictions enacted in HB 93 on in-office dispensing of controlled substances, the few physicians that dispensed medications from their offices will no longer be permitted to do so in large quantities and physicians also must now report every controlled substance dispensed from their office to the OARRS database.

Under the changes in HB 93, prescriptions for controlled substances must now be filled through a pharmacy and it would be most beneficial to have the pharmacists review OARRS information prior to filling a prescription.

OARRS Improvements are Necessary before a Mandate is considered

Thanks to the good work of the BOP, Medical Board and Ohio's medical community, our state is years ahead of many other states in the development and use of our prescription drug monitoring program (PDMP). This has happened without any dedicated funding from the state for OARRS and through voluntary participation by the prescriber/physician community. Ohio is a model for how to develop a PDMP with no budget or mandate.

While all of this is commendable, the OARRS program must be improved before OARRS should be considered for mandated use. The BOP has repeatedly stated that the purpose of OARRS is a "tool for prescribers and pharmacists to identify and prevent abuse, misuse or addiction" and in our view, it should remain a clinical tool incorporated into practice when clinically necessary.

There are many reasons that OARRS is considered an imperfect system. There are improvements that could be made immediately that would have a greater impact on the prescription drug abuse epidemic than the proposed mandates. OARRS is a system that the BOP admits "in *most* cases, the patient report is available for viewing in ten seconds…and does not guarantee any report to be accurate or complete." According to the BOP, five percent of OARRS requests take five minutes to an hour to process, Monday thru Friday between 8:00 a.m. and 4:30 p.m.

We believe OARRS must become a more efficient and effective system before considering its mandated use. The system needs dedicated state funding and it should be integrated with electronic medical records, e-prescribing and practice management systems. And the information should be updated in real time, not the current one to 10 day lag from when the medication is dispensed to when it appears in OARRS.

Focusing on the Problem of "Prescriber Shoppers"

We recommend the BOP and Medical Board focus on the 2,800 patients that received prescriptions from 10 or more prescribers and the 430 from 15 or more prescribers and the "Top Ten Prescriber Shoppers" that visited as many as 82 prescribers and 49 pharmacists in 2010. While some of these patients likely suffer from multiple chronic illnesses, some may be "prescriber shoppers" or drug seekers. If that is the case, the BOP should develop a red flag system for these patients so prescribers and pharmacists are notified as soon as they cross a certain threshold of prescribers and pharmacists.

In addition, the OARRS reports should be focused on those narcotics that are highly abused and are frequently found in toxicology reports from autopsies of overdose victims. **We recommend the following drugs be a focus for a red flag system: oxycodone and hydrocodone, carisoprodol and tramadol**.

This focus would ensure Ohio's efforts are more effective in stopping "prescriber shoppers" and overdose deaths, while not impeding access to care for legitimate chronic pain patients.

Conclusion

We commend the Medical Board for taking aggressive and immediate action and strongly recommend that the BOP and other boards follow the Medical Board's lead in developing a position statement that outlines parameters for when pharmacists and other prescribers should review OARRS reports.

The OSMA and undersigned organizations urge the Medical Board to adopt our recommended changes to the proposed OARRS rule. We believe physician review of OARRS information will increase significantly with the establishment of the Medical Board's position statement. A copy of the OSMA's suggested position statement language is attached to this letter and labeled as "Attachment A".

Please contact us if you have any questions or need additional information on our recommended changes.

Kindest regards,

Charles Hickey, MD
President, OSMA

Jeff Smith, JD
Director, Government Relations, OSMA

Ohio Psychiatric Physicians Association
Ohio Orthopaedic Society
Ohio Ophthalmological Society
Ohio Academy of Family Physicians
Ohio Osteopathic Association
Ohio State Society of the American College of Osteopathic Family Physicians
Ohio Society of Interventional Pain Physicians
Ohio Chapter, American Academy of Pediatrics
Ohio Chapter, American College of Emergency Physicians
Ohio State Coroners Association
Ohio Medical Group Management Association
Ohio Society of Anesthesiologists
American Congress of Obstetricians and Gynecologists, Ohio Section
Association of Indian Physicians of Ohio
Ohio Society of Physical Medicine and Rehabilitation
Ohio Hematology Oncology Society