Report on Actions Taken by the
2011 House of Delegates

Submitted by Jon F. Wills
Executive Director

Explanatory Note: The following actions were taken by last year's House of Delegates. Any activity related to a resolution is noted in bold following the resolution.

Bylaws Amendments. The 2011 OOA House of Delegates approved five amendments to the OOA Constitution and Bylaws that dealt with Governance issues. The amendments:

- Reduced the size of the OOA House of Delegates, effective with the 2012 House.
- Reduced the size of the OOA Executive Committee to five voting members plus the Executive Director, who serves without vote, effective with last year's election.
- Deleted specific references to the original OOA Districts, which will allow the OOA House of Delegates to redistrict without amending the bylaws every time a change is made.
- Changed the formula for electing AOA Delegates, by making all members of the OOA Board of Trustees automatically members of the Delegation to the AOA House if they plan on attending. If a board member is unable to serve, an alternate will be selected to go in his/her place.

OOA Strategic Plan 2011-2013. The House of Delegates approved the OOA Strategic Plan for 2011-2013. The complete plan is available on-line at the OOA website (www.ooanet.org).

New or Substitute Resolutions Adopted. The following resolutions were adopted by the 2011 OOA House of Delegates. Any activity taken during the past year that is related to a specific resolution appears in bold. A complete report covering all actions of the 2011 OOA House of Delegates was published in the *Buckeye Osteopathic Physician* (Summer 2011)

Providing Exceptions for the Medicare
Three-Day Qualifying Policy for SNF

WHEREAS, the current Medicare guidelines require a 3 day (3-night) stay at a hospital in order to qualify for care at a skilled nursing facility; and

WHEREAS, there are some patients whose medical clearance/care can be achieved in an overnight stay or observation care; and

WHEREAS, there is an incredible amount of wasted resources and increased healthcare cost as delineated by the current criteria; and

WHEREAS, advances in medicine and better overall healthcare has reduced this need; and

WHEREAS, it is more prudent to participate in preventative or proactive care (such as with sub-acute patients that could benefit from skilled nursing care prior to requiring a full admission); now, therefore, be it

RESOLVED, that the OOA petition the Centers for Medicare & Medicaid Services and insurance agencies with similar rules to develop exception guidelines to these rules that will facilitate care to be given to appropriate patients in a less intense setting, without having to fulfill the three-day rule; and, be it further

RESOLVED, that the OOA forward this resolution to the AOA House of Delegates for its consideration.

ACTION RELATED TO THIS RESOLUTION. The OOA delegation took this resolution to the 2011 AOA House of Delegates as directed, where it was amended and approved.

Ohio Automated Rx Reporting System (OARRS) and HB 93

WHEREAS, the Ohio Automated Rx Reporting System (OARRS) was established by the Ohio State Board of Pharmacy (OSBP) to enable prescribers and distributors of controlled substances to access a database to help identify patients who are misusing or diverting substances of abuse, or who may be "doctor shopping"; and

WHEREAS, Ohio House Bill 93 of the 129th General Assembly requires the OSBP to adopt rules that establish standards and procedures to be followed by physicians regarding the review of patient information available through the drug database; and

WHEREAS, OARRS can help doctors feel confident that they are treating "real patients with real pain"; and

WHEREAS, the OARRS is currently underutilized by primary care physicians in Ohio; now, therefore, be it

RESOLVED, that osteopathic physicians in Ohio become familiar with OARRS and utilize it when they deem it appropriate; and, be it further

RESOLVED, that the Ohio Osteopathic Association (OOA) play an active role in the Ohio State Medical Board (OSMB) development of regulations requiring physicians to interact with OARRS to assure that these regulations are not cumbersome and overly demanding of a physician's time; and, be it further

RESOLVED, that the OOA work with the Ohio State Board of Pharmacy to update OARRS and improve ease of access and utilization.

ACTION RELATED TO THIS RESOLUTION. HB 93 was signed into law by Governor Kasich and became effective May 20, 2011. The OOA participated on the Ohio State Medical Board committee that developed the OARRS rules. We are also participating in an E-Prescribing Task Force that is being coordinated by the Ohio Health Information Partnership (The Partnership). One of the goals is "to explore the interoperability of the OARRS with the e-prescribing process." Currently, OARRS requires duplication of work for prescribers to report to OARRS.

Addressing Ohio's Pain Problem Through Improved Physician Education on Pain Management

WHEREAS, former Ohio Governor Ted Strickland convened the Ohio Prescription Drug Abuse Task Force in response to the catastrophic incidence of opioid prescription related overdose and death in the state; and

WHEREAS, members of the task force representing 26 agencies and professional organizations examined the origins and causes of the problem and with counsel from many experts developed consensus on 26 recommendations which were accepted by the Governor on October 1, 2010; and

WHEREAS, these recommendations include the imperative for improved education on pain management for physicians and physician extenders; and

WHEREAS, the Ohio Compassionate Care Task Force identified nearly one million Ohioans who are under-treated for pain or have no access to pain management; and

WHEREAS, the Compassionate Care Task Force recommended attention to the need for improved knowledge of pain management among prescribers; and

WHEREAS, knowledge of good pain management can decrease the need for prescribing opioids in order to treat pain; and

WHEREAS, education on addiction and prevention of diversion and abuse can help the physician to manage patient issues in this area; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association work with the Ohio State Medical Association and the Ohio State Medical Board to develop prescriber education on pain management, addiction prevention and intervention and prevention of diversion in the clinical setting; and, be it further

RESOLVED, that the Ohio Osteopathic Association encourage Ohio University College of Osteopathic Medicine to continue to support basic clinical education in pain management and the prevention of addiction, diversion and abuse in Ohio.

ACTION RELATED TO THIS RESOLUTION. The OOA worked with the Ohio State Medical Association and the Ohio State Medical Board to develop rules pertaining to the regulation of pain clinics. The Kasich administration also invited the OOA to participate in the Governor's Ohio Cabinet Opiate Action Team (GOCAT) Professional Education Work Group. Three cabinet members are leading the top-level initiative: Ted Wymyslo, MD, director of the Department of Health; Bonnie Kantor-Burman, ScD, director of the Department of Aging, and Orman Hall, director of the Department of Alcohol and Drug Addiction Services. OOA Executive Director Jon F. Wills and Cleanne Cass, DO, are participating in meetings. Prescription opioids were involved in about 40 percent of all fatal drug overdoses in Ohio in 2000, more than heroin and cocaine combined. On average, from 2007-2009 there were 19 Emergency Department visits per day in Ohio for unintentional drug overdoses, totaling 2,000 per year; about 20 percent were related to opioids. The Professional Education Group has identified the development of emergency department prescribing protocols and a white paper defining best practices for prescribing controlled-substance pain medicine in all practices as top priorities. Three other workgroups are addressing Enforcement, Treatment, and Public Education.

Prescription Drug Bill (HB 93) and Care of the Terminally Ill

WHEREAS, Ohio House Bill 93 of the 129th General Assembly appropriately addresses the serious concerns of prescription drug abuse and diversion in Ohio; and

WHEREAS, Ohio House Bill 187, "The Intractable Pain Law of 1997" specifically excluded from regulatory oversight prescribers utilizing prescription drugs for the treatment of patients with a terminal illness and patients with a progressive illness that may in the course of progression be expected to become terminal, and excluded treatment for pain with medications that do not exert their action at the level of the central nervous system; and

WHEREAS, the definitions of chronic and intractable pain are changed in the new law; and

WHEREAS, HB 93 specifically excludes hospices from the definition of "pain clinic"; and

WHEREAS, hospice and palliative care patients deserve to receive care from the physicians of their choice; and

WHEREAS, HB 93 may seek to limit the quantity of an opioid or other substance that can be prescribed in a given time interval; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association support rules promulgated to enact HB 93 that specifically and clearly exclude terminally ill patients and patients that may be expected to become terminally ill in the course of their illness.

ACTION RELATED TO THIS RESOLUTION. The OOA was involved with the drafting of the OARRS rules as noted previously. Hospice was specifically exempted from OARRS checking requirements.

Health Literacy

WHEREAS, an estimated 21 million Americans simply cannot read; and

WHEREAS, reading abilities are typically three to five grade levels below the last year of school completed; and

WHEREAS, more than 10 million Americans have graduated from high school reading at a 7th or 8th grade level and one in five high school graduates cannot read their diplomas; and

WHEREAS, the US Department of Health and Human Services report Healthy People 2010 states health literacy is the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions; and

WHEREAS, more than one-half of all Americans have health literacy issues; and

WHEREAS, two-thirds of US adults age 60 and over have inadequate or marginal literacy skills; and

WHEREAS, 81 percent of patients age 60 and older cannot read or understand basic materials such as prescription labels and 85 percent of unwed mothers are illiterate; and

WHEREAS, approximately half of all Medicare/Medicaid recipients read below the fifth-grade level; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association strongly support the campaign for health literacy; and, be it further

RESOLVED, that the OOA strongly encourage all practitioners and medical facilities to create a shame-free environment where low-literate patients can seek help without feeling stigmatized; and, be it further

RESOLVED, that this resolution be forwarded to the American Osteopathic Association's House of Delegates for consideration at its 2011 annual meeting.

ACTION RELATED TO THIS RESOLUTION. The OOA delegation took this resolution to the 2011 AOA House of Delegates as directed, where it was amended and approved. The OOA continues to be engaged in Medical Home activities in Ohio, which encompass engaged consumer participation as an essential part of the model.

Prescriptions for Over-the-Counter Medications

WHEREAS, the Affordable Care Act Section 9003 established new rules for reimbursing the cost of over-the-counter medicines and drugs from health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs) as of January 1, 2011; and

WHEREAS, this legislation mandates that distributions from health FSAs and HRAs will be allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription; and

WHEREAS, the United States Food and Drug Administration (FDA), defines over-the-counter medications as drugs that are safe and effective for use without a prescription by a licensed medical practitioner; and

WHEREAS, data from the 2007 National Health Interview Survey (NHIS) Alternative Medicine Supplement showed that 17.7 percent of US adults had used natural products in the previous year, including herbs and other naturally occurring non botanical supplements; and

WHEREAS, health care providers commonly suggest over-the-counter medications, herbals and supplements be used for treatment of various medical conditions; and

WHEREAS, the writing of over the counter prescriptions for patients: 1) places a significant financial and time burden on health care providers in researching patient medical histories, looking for drug interactions, writing a prescription for each medicine encounter, and then retaining a copy for patient records, and 2) needlessly increases the medicolegal responsibilities of the health care provider; and

WHEREAS, the American Osteopathic Association declares in its policy statement (H234-A/07) in matters concerning the regulation of health care: "Where the need for (health care) regulation has been demonstrated, it should emanate from the lowest applicable level of government;" now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association support the repeal of Section 9003 of the Affordable Care Act requiring prescriptions for over-the-counter medications for reimbursement from health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs) due to the significant burden placed on health care providers in the writing of these prescriptions; and be it further

RESOLVED, that upon successful passage of this resolution, a copy be sent to the American Osteopathic Association House of Delegates for consideration and discussion at its 2011 annual meeting.

ACTION RELATED TO THIS RESOLUTION. The OOA delegation took this resolution to the 2011 AOA House of Delegates as directed, where it was amended and approved. This topic was addressed with Ohio's Congressional Delegation as part of the 2012 DO Day on the Hill visits.

Repeal of Resolution 29
(AOA Approval of ACGME Residency in an Option-1 Specialty)

WHEREAS, osteopathic physicians are responsible to the public as providing assurance of the quality and integrity of osteopathic training for osteopathic physicians who hold osteopathic certification; and

WHEREAS, the Ohio Osteopathic Association, serves the members of the Ohio osteopathic family as the representative in not only professional but educational affairs; and

WHEREAS, Ohio is an influential state in both osteopathic (DO) and allopathic (MD) professions and has a tradition in providing quality medical education; and

WHEREAS, AOA Resolution 29, as approved at the July 15, 2010, AOA Board of Trustees meeting and at the 2010 AOA House of Delegates, as currently written exerts a potential negative effect on the ongoing stability and future of AOA accredited residency programs that are both purely osteopathic and dually-accredited; and

WHEREAS, AOA Resolution 29 may have the unintended consequence of the closure of existing osteopathic accredited graduate medical education (OGME) programs; and

WHEREAS, AOA Resolution 29 grants AOA approval of Accreditation Council for Graduate Medical Education (ACGME) training for osteopathic physicians by a nominal application process, minimal evidence of parity between AOA and ACGME training, and no input from specialty colleges; and

WHEREAS, AOA Resolution 29 grants AOA approval to ACGME training for osteopathic physicians that may have different lengths of training, may contain no training in osteopathic principles and practice (OP&P) and different curricula than comparable AOA training programs; and

WHEREAS, AOA approval of ACGME certification of osteopathic physicians is confusing in presentation and lacks checks and balances; and

WHEREAS, the membership of the Association of Osteopathic Directors and Medical Educators (AODME) at the AODME's General Membership Meeting on April 14, 2011, in Baltimore, Maryland, voiced concern regarding AOA Resolution 29; and

WHEREAS, at the April 2011 AODME general membership meeting, the members voted in the affirmative to repeal Resolution 29, that a moratorium be placed on petitions pending under AOA Resolution 29 and that the AOA modify existing resolutions or write a new resolution to replace AOA Resolution 29; and

WHEREAS, it is a necessity to have an appropriate mechanism of AOA approval of ACGME training and the current AOA Resolution 29 may have unintended consequences; now, therefore, be it

RESOLVED, that the Ohio Osteopathic Association (OOA) support the recommendations that AOA Resolution 29 be repealed; a one-year moratorium be placed on any petitions under Resolution 29 and be replaced with an appropriate, functional resolution that assures the integrity of the AOA approval of ACGME training of osteopathic physicians; and be it further

RESOLVED, that the OOA support the AODME's recommendation that the Bureau of Osteopathic Medical Educators (BOME) produce a white paper evaluating the AOA approval of ACGME residency training; and be it further

RESOLVED, that the OOA forward this resolution to the 2011 AOA House of Delegates for its consideration.

ACTION RELATED TO THIS RESOLUTION. The OOA delegation took this resolution to the 2011 AOA House of Delegates as directed, where it was taken into consideration by the AOA Board of Trustees and referred to the Educational Policies and Procedures Review Committee (EPPRC-III).

Ohio Bureau of Workers Compensation
Health Partnership Program
(Substitute Position Statement)

WHEREAS, osteopathic physicians have traditionally provided care for injured workers in the State of Ohio; and

WHEREAS, the Ohio Osteopathic Association, business representatives, organized labor, other health care provider organizations, and the Bureau of Workers Compensation jointly created the Health Partnership Program (HPP) as a unique managed-care system to meet customers' needs for years to come; and

WHEREAS, HPP is truly a partnership, where the private-sector managed care organizations (MCOs) are working together with the BWC to provide comprehensive claims-management and medical-management services for the employers and employees of Ohio; now therefore, be it

RESOLVED, that the OOA, through its Bureau of Workers Compensation representatives continue to actively participate in ongoing efforts to maintain and improve the Health Partnership Program (HPP), as an efficient process for Ohio's injured workers and the osteopathic physicians who provide care for them.

ACTION RELATED TO THIS RESOLUTION. Paul T. Scheatzle, DO represents the OOA on the BWC Quality Committee. The OOA regularly attends Stakeholder meetings and reviews rules pertaining to the Health Partnership Program, which are reviewed every five years.

Photo IDs for Scheduled Drug Prescriptions

RESOLVED, that the Ohio Osteopathic Association encourages pharmacists through the Ohio Pharmacists Association, to request photo IDs from individuals who present a prescription or pick up the prescribed medication when the pharmacist has concerns about the identity of that individual.

Drug Enforcement Administration Numbers

RESOLVED, that the Ohio Osteopathic Association urges all third party payers to maintain the confidentiality of all Drug Enforcement Administration Numbers and not require them for insurance billing purposes.

Third Party Payors, Osteopathic Representation

RESOLVED, that the Ohio Osteopathic Association continue to encourage all third party payers to appoint medical policy panels which include osteopathic representation.

OOA Physician Placement Information Service

RESOLVED, that the Ohio Osteopathic Association encourage physicians to advertise practice opportunity information by utilizing osteopathic publications, OSTEOFAX, and the OOA website; and be it further

RESOLVED, that the Ohio Osteopathic Association continues to support Medical Opportunities in Ohio (MOO) as a centralized, comprehensive statewide career source for use by osteopathic residents and OOA members seeking employment opportunities; and be it further

RESOLVED, that the OOA encourage Ohio's hospitals and other institutional healthcare employers to become members of MOO.

Diagnostic, Therapeutic, and Reimbursement Options

RESOLVED, that the Ohio Osteopathic Association (OOA) continue to oppose any managed care policy which interferes with a healthcare professional's ability to freely discuss diagnostic, therapeutic and reimbursement options with patients.

Physician Signatures, Reduction of Unnecessary

RESOLVED, that the Ohio Osteopathic Association (OOA) continue to study the issue of signature burden, identify areas of potentially unnecessary signature requirements, and seek a reduction in same with the appropriate agencies and institutions doing business in the State of Ohio.

Home Health Care, Physician Reimbursement

RESOLVED, that the Ohio Osteopathic Association continue to seek adequate third party reimbursement for physicians supervising and certifying Home Health Services.

Hospital Medical Staff Discrimination

RESOLVED, that the Ohio Osteopathic Association continue to be vigilant and monitor for discrimination against osteopathic physicians and advocate for equal recognition of AOA specialty certification by hospitals, free-standing medical and surgical centers and third party payers. *(original 1991)*

Safe Prescriptions and Drug Diversion Tactics

RESOLVED, that the Ohio Osteopathic Association (OOA) encourages colleges of osteopathic medicine to educate students about common diversionary tactics used to obtain scheduled drugs; and, be it further

RESOLVED, that the OOA periodically publish information and/or provide continuing medical education on best practices in order to reduce medication errors and prevent drug diversion in physician practices.

School Health Policies and Childhood Obesity

RESOLVED, that the Ohio Osteopathic Association (OOA) supports programs that advocate physical fitness in private and public schools for Ohio's youths; and be it further

RESOLVED, that the OOA support healthier food and drinks in public and private schools; and be it further

RESOLVED, that the Ohio Osteopathic Association continues to encourage its physician members to educate and caution their patients, school superintendents, and members of school boards across Ohio about the health consequences of consuming carbonated soft drinks and urge them to eliminate the sale of these products on school property; and be it further

RESOLVED, that the Ohio Osteopathic Association continue to support school health initiatives and campaigns to prevent childhood obesity.

Existing Policy Statements Deleted. The following position statements were deleted, under the five-year policy review, because they were no longer pertinent, were incorporated into other existing policies, or the original intent was accomplished.

- **Patient Care at Assisted or Independent Living Facilities**
- **Health Savings Accounts**
- **Staffing Requirements at Extended Care Facilities**
- **Ohio Bureau of Worker's Compensation Quality and Efficiency of Providers**
- **Anorectic Medications, Use for the Treatment of Obesity**
- **Human Immunodeficiency Virus (HIV)**
- **Counterfeit Medications**
- **Improving End of Life Directives in Ohio**
- **Managed Care, Access to Care in Rural Areas**
- **Managed Care Plans, Drive Thru Delivery**
- **Prepaid Health Plans, Osteopathic Participation**

Resolutions Defeated, Referred, or Withdrawn. The Cleveland Academy of Osteopathic Medicine withdrew Resolution 2011-16: Patient Medical Care Expense Control.

Frequently Asked Questions

Rule 4731-11-11
Standards and Procedures for Accessing OARRS

STATE MEDICAL BOARD OF OHIO
30 EAST BROAD STREET, 3RD FLOOR
COLUMBUS, OHIO 43215
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Rule 4731-11-11, Ohio Administrative Code
Standards and Procedures for Accessing OARRS
FREQUENTLY ASKED QUESTIONS

Background and purpose:

The Ohio Automated Rx Reporting System (OARRS) was established in 2006 as a tool to assist healthcare professionals in providing improved and safer treatment for patients. House Bill 93 of the 129th General Assembly authorized the Board to adopt Ohio Administrative Code (OAC) Rule 4731-11-11, Standards and Procedures for Accessing OARRS, in an effort to encourage prescribers to access OARRS. An OARRS Prescription History Report can assist in assuring that a patient is getting the appropriate drug therapy, is taking their medication as prescribed, and may alert prescribers to signs of possible misuse or diversion of controlled substances. The system serves a secondary purpose to enhance the monitoring of the misuse and diversion of controlled substances.

A prescriber is authorized to request an OARRS Prescription History Report on an individual **only if**: (1) the request is for the purpose of providing medical treatment and (2) the prescriber has a current prescriber-patient relationship with the individual named in the request. Please note that unauthorized accessing of an OARRS Report may be in violation of Board of Pharmacy laws.

Question 1: How do I register for OARRS?

A: The Ohio Board of Pharmacy maintains and operates the OARRS system. Information on registering with OARRS, acceptable use policies, and assigning delegates can be obtained by contacting the Ohio Board of Pharmacy.

Question 2: Can I have my office staff access OARRS on my behalf?

A: Yes. Licensed individuals, such as nurses and physician assistants may obtain an account from the Board of Pharmacy to access OARRS on your behalf. Under House Bill 93, a physician may also name non-licensed staff such as medical assistants or other office personnel, as delegates to access OARRS on the physician's behalf. The Board of Pharmacy limits the number of non-licensed delegates to three per physician. For more information please contact the Ohio Board of Pharmacy.

Question 3: What types of drugs are reported to OARRS?

A: Currently controlled substances in schedules II, III, IV, V, and all dangerous drug products containing carisoprodol or tramadol are required to be reported to OARRS. These drugs are referred to as "reported drugs" in Rule 4731-11-11.

Question 4: Does the OARRS rule apply to drugs <u>administered</u> in an in-patient or office based setting?

A: No. Rule 4731-11-11 only applies to instances when you either prescribe or personally furnish controlled substances, carisoprodol, or tramadol to a patient and does not apply to the administration of drugs in an in-patient or office based setting. An example of administering drugs in an in-patient or office based setting would be the filling or refilling of morphine pumps, in this situation you would not be required by rule to check OARRS, though you may still choose to do an OARRS check based upon your professional discretion. Furthermore, if you are either providing or

furnishing drugs for a patient to take home or providing a written prescription then you should be checking OARRS under the appropriate circumstances.

Question 5: When do I need to check OARRS?

A: Rule 4731-11-11 outlines situations for accessing OARRS prior to prescribing or personally furnishing a controlled substance, tramadol or carisoprodol which include the following:

a. If a patient is exhibiting signs of drug abuse or diversion;
b. When you have a reason to believe the treatment of a patient with the above listed drugs will continue for twelve weeks or more; and
c. At least once a year for patients thereafter for patients receiving treatment with the above listed drugs for twelve weeks or more.

Question 6: What signs of drug abuse or diversion require an OARRS Report?

A: The following signs of drug abuse or diversion require a physician to access an OARRS report prior to prescribing or personally furnishing a controlled substance, carisoprodol, or tramadol:

***REQUIRED* OARRS REPORT**	
Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen	Increasing the dosage of reported drugs in amounts that exceed the prescribed amount
Forging or altering a prescription	Selling prescription drugs
Stealing or borrowing reported drugs	Receiving reported drugs from multiple prescribers, without clinical basis
Having been arrested, convicted or received diversion, or intervention in lieu of conviction for a drug related offense while under the physician's care	Having a family member, friend, law enforcement officer, or health care professional express concern related to the patient's use of illegal or reported drugs

Question 7: Are there other instances where a physician may consider checking OARRS?

A: Yes. A physician may consider checking OARRS prior to prescribing or personally furnishing controlled substances, carisoprodol, or tramadol to a patient exhibiting the following signs of possible drug abuse or diversion. Please note this list is not all inclusive and there may be other legitimate basis for checking OARRS:

***OPTIONAL* OARRS REPORT**	
A known history of chemical abuse or dependency	Frequently requesting early refills of reported drugs
Appearing impaired or overly sedated during an office visit or exam	Frequently losing prescriptions for reported drugs
Requesting reported drugs by specific name, street name, color, or identifying marks	Recurring emergency department visits to obtain reported drugs
A history of illegal drug use	Sharing reported drugs with another person

Question 8: When I run an OARRS report is it required to cover a specific time period?

A: Yes. An initial report should cover a time period of at least one year from the current date (though personal discretion and circumstances related to the type or number of signs of abuse or diversion may suggest a report covering a longer time period of up to two years). Subsequent reports should cover the period from the date of the last report to present.

Question 9: Should a copy of an OARRS report be maintained in a patient's medical record?

A: The preferred method of documenting the receipt and assessment of an OARRS report is to notate the date the report was requested and received, as well as any pertinent findings in the patient's medical record. A notation suggests that you or your delegate did not just take the report and file it. If you do maintain a copy of the actual OARRS report in the patient's medical record it should be in a non-reproducible portion of the record.

Please note that unauthorized disclosure of an OARRS Report may be in violation of Board of Pharmacy laws and/or federal privacy laws such as HIPAA. As with all medical records, take the necessary steps to maintain confidentiality. For more information please contact the Ohio Board of Pharmacy.

Question 10: What do I do if an OARRS report is not immediately available?

A: In the event an OARRS report is not immediately available a physician should document the reason why the report was unavailable. Examples may include network outages or a report being held for review by OARRS. It may be necessary for follow-up to obtain the report based upon personal discretion and circumstances related to the type or signs of drug abuse or diversion.

Question 11: Does Rule 4731-11-11 apply to hospice patients?

A: NO. Rule 4731-11-11 provides an exception for prescribing to hospice patients who are in a hospice program.

Question 12: Can a physician assistant supervisory plan or an advanced practice nurse collaborative agreement include guidelines for checking OARRS?

A: Yes. As part of either the supervisory plan with a physician assistant or the standard care arrangement (collaborative agreement) with an advanced practice nurse a physician and the practitioners with whom they are working may establish guidelines for the circumstances and degree of collaboration necessary for checking OARRS or consultation prior to prescribing or personally furnishing drugs to a patient.

For More Information:

State Medical Board of Ohio

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Ohio Board of Pharmacy

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4731-11-11 **Standards and procedures for review of Ohio Automated Rx Reporting System (OARRS)**

(A) For purposes of this rule:

(1) "OARRS" means the "Ohio Automated Rx Reporting Sysytem" drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(2) "OARRS report" means a report of information related to a specified patient generated by the drug database established and maintained pursuant to section 4729.75 of the Revised Code.

(3) "Personally furnish" means the distribution of drugs by a prescriber to the prescriber's patients for use outside the prescriber's practice setting.

(4) "Protracted basis" means a period in excess of twelve continuous weeks.

(5) "Reported drugs" means all the drugs listed in rule 4729-37-02 of the Administrative Code that are required to be reported to the drug database established and maintained pursuant to section 4729.75 of the Revised Code, including:

(a) Controlled substances in schedules II, III, IV, and V, and

(b) All dangerous drug products containing carisoprodol or tramadol.

(B) If a physician believes or has reason to believe that a patient may be abusing or diverting drugs, the physician shall use sound clinical judgment in determining whether or not the reported drug should be prescribed or personally furnished to the patient under the circumstances.

(1) To assist in this determination, the physician shall access OARRS and document receipt and assessment of the information received if the patient exhibits the following signs of drug abuse or diversion:

(a) Selling prescription drugs;

(b) Forging or altering a prescription;

(c) Stealing or borrowing reported drugs;

(d) Increasing the dosage of reported drugs in amounts that exceed the prescribed amount;

(e) Having a drug screen result that is inconsistent with the treatment plan or refusing to participate in a drug screen;

(f) Having been arressted, convicted or received diversion, or intervention in lieu of conviction for a drug related offesne while under the physician's care;

(g) Receiving reported drugs from multiple prescribers, without clinical basis; or

(h) Having a family member, friend, law enforcement officer, or health care professional express concern related to the patient's use of illegal or reported drugs.

(2) Other signs of possible abuse or diversion which may necessitate accessing OARRS include, but are not limited to the following:

(a) A known history of chemical abuse or dependency;

(b) Appearing impaired or overly sedated during an office visit or exam;

(c) Requesting reported drugs by specific name, street name, color, or identifying marks;

(d) Frequently requesting early refills of reported drugs;

(e) Frequently losing prescriptions for reported drugs;

(f) A history of illegal drug use;

(g) Sharing reported drugs with another person; or

(h) Recurring emergency department visits to obtain reported drugs.

(C) A physician prescribing or personally furnishing reported drugs to treat a patient on a protracted basis shall, at a minimum, document receipt and assessment of an OARRS report in the following circumstances:

(1) Once the physician has reason to believe that the treatment will be required on a protracted basis; and

(2) At least once annually, therafter.

(D) A physician shall document receipt and assessment of all OARRS reports in the patient record.

(1) Initial reports requested in compliance with this rule shall cover a time period of at least one year;

(2) Subsequent reports requested in compliance with this rule shall, at a minimum, cover the period from the date of the last report to present.

(E) In the event an OARRS report is not available prior to writing a prescription for a reported drug or personally furnishing the reported drug, a physician shall document in the patient record why the the OARRS report was not available.

(F) Paragraph (C) of this rule does not apply to a hospice patient in a hospice care program as those terms are defined in section 3712.01 of the Revised Code.