



Officers

President
Ryan D. Kauffman, MD, Bellefontaine

Immediate Past President
Thomas P. Houston, MD, Dublin

President-Elect
Donald O. Mack, MD, Columbus

Vice President
Stanley R. Anderson, MD, North Canton

Treasurer
Anna M. McMaster, MD, Napoleon

Speaker
Michael Sevilla, MD, Salem

Vice Speaker
Doug W. Harley, DO, Akron

Executive Vice President
Ann M. Spicer, Columbus

Delegates

AAFP Delegate
Jeffrey D. Bachtel, MD, Tallmadge

AAFP Delegate
Renee L. Markovich, MD, Akron

AAFP Alternate Delegate
Sarah L. Sams, MD, Hilliard

AAFP Alternate Delegate
Elisabeth L. Righter, MD, Dayton

OSMA Delegate
Melissa Jefferis, MD, Lewis Center

OSMA Alternate Delegate
Jeffrey A. Harwood, MD, New London

Ex Officio

AAFP Delegate to AMA
Colette R. Willins, MD, Westlake

Regional Directors

Central Region
Bryan W. Ghiloni, MD, Gahanna

East Central Region
John A. DiSabato, MD, Stow

Northeast Region
Patricia Kellner, MD, Cleveland

Northwest Region
Kathleen Meehan-de la Cruz, MD, Norwalk

Southeast Region
Stephen C. Ulrich, MD, New Lexington

Southwest Region
William P. Sawyer, MD, Cincinnati

West Central Region
Teresa W. Zryd, MD, Dayton

At-Large Directors

Sanford Kimmel, MD, Eaton

Mary E. Krebs, MD, Xenia

W. Fred Miser, MD, Powell

Brian L. Bachelder, MD, Akron

Residents

Marcus A. Wing, DO, Westerville

Valerie F. Good, MD, Columbus

Students

Jessica Tucker, Reynoldsburg

Anna Askari, Upper Arlington

April 27, 2017

Ohio Representatives and Senators
Columbus, OH 43215

Dear Representatives and Senators,

House Bill 167 and Senate Bill 119 are deeply flawed pieces of legislation that attempt to address Ohio's opioid crisis in a piecemeal, haphazard approach that will significantly inhibit a physician's ability to provide quality, timely and appropriate care to patients suffering from chronic pain.

The number of opioids prescribed by doctors and dispensed to patients decreased in 2016 for the fourth consecutive year. Data shows physicians are doing their part to curb doctor shopping and overprescribing but we continue to be the focus of a seemingly very one-dimensional campaign to fight Ohio's opioid crisis. Restricting/reducing opioid prescriptions over the past two years has driven overdose deaths through the roof. Please help us understand how further restricting the legitimate prescribing of these medications will now have the opposite effect?

On behalf of the 4,900 family physician, family medicine resident and medical student members of the Ohio Academy of Family Physicians, we write to outline our numerous concerns with HB 167 and SB 119. We will attempt to outline our concerns as concisely as possible in hopes that future, in-person conversations will allow further elaboration.

Treats Primary Care Physicians Differently Than All Other Physicians:

Of all the objectionable parts to HB 167 and SB 119, singling out primary care physicians and treating them differently than all other physicians is the most alarming. Standards need to be applied uniformly to all physicians; primary care physicians should not be singled out to meet different or more extensive requirements than other physicians or prescribers. Primary care physicians are not "second class" physicians and should not be treated as such. Primary care is an essential component of patient health and wellness. According to the

American Academy of Family Physicians (AAFP), primary care is care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern not limited by problem origin, organ system, or diagnosis. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.

Family medicine, a board-certified specialty, makes up the largest component of primary care. Family physicians complete four years of undergraduate study, four years of medical school and at least three years of training after medical school in an accredited family medicine residency program. In order to maintain board-certification, family physicians must complete at least 150 hours of continuing medical education every three years, pass a re-certification exam every seven to ten years and demonstrate continued competencies annually. Family physicians are career-long learners continuously updating themselves on advances and developments in medicine.

While the legislation gives the State Medical Board the authority to define primary care, it should be pointed out that a physician's specialty is self-identified and self-reported to the medical board.

Opioid Prescribing Dependent Upon Opioid Dependence or Addiction Treatment:

In its assault on primary care, the legislation specifies that primary care physicians can only treat chronic pain if they comply with a series of requirements that include offering opioid dependence or addiction treatment in the practice. Even general dentists have more ability to treat chronic pain than do primary care physicians because dentists can refer patients to treatment for opioid dependence or addiction treatment. Under the legislation as introduced, primary care physicians have to provide opioid dependence or addiction treatment if they treat chronic pain.

Office-based Opioid Treatment:

There are a number of regulatory and legislative barriers to physicians doing office-based opioid treatment. The Ohio General Assembly, as recently as last December, added to those barriers with passage of SB 319 of the 131st Ohio General Assembly which required office-based opioid treatment providers to get a special terminal distributor of dangerous drugs (TDDD) license which includes the requirement that the prescriber and everyone in the prescriber's office complete background checks and be fingerprinted. DEA has a number of restrictions on managing patients with buprenorphine including waivers relative to the maximum number of patients a provider can treat per year. The reality is that if all waived physicians prescribed buprenorphine to the fullest extent possible, the workforce would only be able to treat 1.4 million of the patients who have a diagnosis of opioid dependence. If barriers were adequately addressed, more physicians would be able to provide office-based opioid treatment but dictating a physician's practice through legislation is not appropriate.

CME Requirements:

The Ohio Academy of Family Physicians and its national organization, the American Academy of Family Physicians, have long opposed mandatory, subject-specific continuing medical education as a condition of licensure or as a condition for prescribing specific drugs, such as opioids. Both House Bill 167 and Senate Bill 119 require 8 hours of continuing medical education (CME) in treating chronic pain plus two hours of CME annually on prescribing controlled substances. Continuing medical education is the process by which family physicians and other health professionals engage in activities designed to support their continuing professional development. Activities are derived from multiple instructional domains, are learner centered, and support the ability of those professionals to provide high-quality, comprehensive, and continuous patient care and service to the public and their profession. CME subjects should not be dictated by legislation or regulation and, instead, should be determined by the medical professional based on learner's needs, patient population and practice parameters.

EHR System Tied to OARRS:

This is a complicated and expensive requirement to implement and is something that EHR vendors will charge prescribers to do even though it can be argued that systems should provide this feature automatically as part of a standard EHR package. If required, electronic health record/electronic medical record vendors should be subject to penalties if their products fail to interface properly with OARRS. Prescribers should not be responsible for paying vendors to implement this interface.

Non-Medicinal Treatments:

Payers incentivize the use of prescriptions first because that is what they pay for. When physicians recommend treatments (physical therapy, massage, acupuncture, non-narcotic medication) that aren't covered by insurance plans, people can't afford those treatments and therefore want something else. When you eliminate medication options for treatment of pain, give us something else to work with. Insurance typically only covers pain medication and, to a much lesser extent if at all, physical therapy or other effective means to seek pain relief. Make coverage of other treatments for pain mandatory.

Required Tapering of Opioid Treatment:

HB 167 and SB 119 require tapering of opioid treatment in accordance with CDC guidelines. It should be noted that 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain were based on a review of contextual evidence using inconsistent inclusion and exclusion criteria for different pain management therapies. Because of these inconsistencies in methodology, and because strong recommendations were made on the basis of low-quality or insufficient evidence, the American Academy of Family Physicians (AAFP) did not endorse the CDC guideline.

Additional Prescribers:

In the midst of this crisis, it should be noted that the Ohio General Assembly saw fit to extend prescriptive authority for controlled substances to APRNs. So while complaining about overprescribing, the legislature authorized more prescribers to prescribe controlled substances.

In closing, we disagree with the argument that since primary care physicians are responsible for about half of the opioid pain relievers dispensed, the need for specific restrictions on primary care physicians to prescribe controlled substances is justified. Primary care physicians are actively managing chronic pain patients because post-surgery, post-injury patients are returned to them within the context of the medical home. As one of our physicians stated, "The buck stops with the family doctor. When the surgeon or the rheumatologist or the pain management physician tells my patient they have nothing else to offer them for their pain, the patient comes back to me. I accept responsibility for meeting that patient's needs until death or change of insurance do us part. When the patient cannot afford the \$50 per visit co-pay for three days a week of physical therapy, insurance won't cover Lidoderm patches, acupuncture or massage, or payers drag out the MRI approval for weeks on end, I have little to offer through no fault of my own. Tylenol only does so much for severe pain."

Opioid prescriptions have declined as the state has increased prescription reporting and cracked down on pill mills and doctor shopping. The state is turning a corner with prescriptions and should focus on making addiction treatment more available. The problem has shifted to heroin, fentanyl and even stronger drugs.

The Ohio Academy of Family Physicians is very willing to continue working with the Ohio General Assembly on this situation, but HB 167 and SB 119 are not answers; they are problems for patients who experience chronic pain.

Sincerely,

A handwritten signature in cursive script that reads "Ryan Kauffman MD". The signature is written in dark ink and is positioned above the typed name.

Ryan Kauffman, MD
President