



**2014-2015
Officers**

Geraldine T. O'Shea, DO
President

Anna Z. Hayden, DO
Vice-President

Ernest Miller, DO
Secretary-Treasurer

Dana Shaffer, DO
Immediate Past President

**ANNUAL SUMMIT MEETING
MILLENNIUM BILTMORE HOTEL ■ LOS ANGELES, CA
January 9 - 10, 2015**

FRIDAY, JANUARY 9

Location: Emerald Ballroom

2:45 p.m. **Joint Session with AOA CME Sponsors Conference**

State Mandated CME Requirements for Relicensure

Nicholas A. Schilligo, MS - Associate Vice President, State Government Affairs, AOA
Geraldine T. O'Shea, DO - President, AAOE
Ronald R. Burns, DO - Past Chair, Florida Board of Osteopathic Medicine
James Griffin, DO - Member, Rhode Island Board of Medical Licensure and Discipline

Location: Heinsbergen Room

3:45 p.m. **Welcome Remarks**
Geraldine T. O'Shea, DO - President, AAOE

3:50 p.m. **Interstate Medical Licensure Compact Update**
Lisa A. Robin, MLA - Chief Advocacy Officer, Federation of State Medical Boards

4:30 p.m. **Regulation of the Assistant Physician**
Brian Bowles, MEd -Executive Director, Missouri Association of Osteopathic Physicians & Surgeons
David Tannehill, DO - Member, Missouri Board of Registration for the Healing Arts

6:30 p.m. **Group Dinner***

SATURDAY, JANUARY 10

Location: Heinsbergen Room

8:30 a.m. **American Osteopathic Association Leadership Welcome**
Adrienne White-Faines, MPA - AOA Executive Director and CEO

8:45 a.m. **Changes in Assessment for Licensure of Osteopathic Physicians**
John R. Gimpel, DO, MEd – President & CEO, NBOME
Sandra Waters - Vice President, Collaborative Initiatives, NBOME

Moderator: Ernest Miller, DO – Secretary/Treasurer, AAOE

***Note: Friday, January 9– 6:30 p.m. - Dinner Reservation: Engine Co. Number 28 - 644 S. Figueroa Street, Los Angeles, CA. Each attendee will be responsible for the cost of their own meal.**



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9:15 a.m. **ADA Requirements for High Stakes Testing Accommodations**
Jed Magen, DO – NBOME ADA Testing Accommodations Committee
Sandra Waters, MEM - Vice President, Collaborative Initiatives, NBOME

Moderator: Anna Hayden, DO – Vice President, AAOE

9:45 a.m. **Break**

Location: Crystal Ballroom

Joint Session with AOA OME Leadership Conference

10:00 a.m. **Council on Postdoctoral Training Update**
Clint E. Adams, DO, MPA – Chair, COPT

10:30 a.m. **NBOME and COMLEX-USA Update**
John R. Gimpel, DO, MEd – President & CEO, NBOME

11:00 a.m. **AACOM Update**
Stephen C. Shannon, DO, MPH – President & CEO, AACOM

11:45 a.m. **Break**

Location: Heinsbergen Room

12:15 p.m. **Working Lunch: Blue Ribbon Commission Update**
Boyd R. Buser, DO – Co-Chair, Blue Ribbon Commission

1:15 p.m. **Managing Chronic Pain**
Michael Finley, DO – Associate Dean, Western University of Health
Sciences, College of Osteopathic Medicine of the Pacific

Moderator: Dana Shaffer, DO – Immediate Past President, AAOE

2:15 p.m. **Break**

2:30 p.m. **AAOE Annual Business Meeting (Fellows Only)**

4:30 p.m. **Adjourn**

****CME: Attendees are eligible for up to 11 credits of AOA Category 1-B for participation in this program.**



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ANNUAL SUMMIT MEETING
MILLENIUM BILTMORE HOTEL ▪ LOS ANGELES, CA
January 9-10, 2015

List of Attendees

- Brian Bowles, MEd – Executive Director, Missouri Association of Osteopathic Physicians & Surgeons
- Ronald R. Burns, DO – Florida Board of Osteopathic Medicine
- Boyd R. Buser, DO – Kentucky Board of Medical Licensure
- Mary Jo Capodice, DO – Wisconsin Medical Licensing Board
- Wayne Carlsen, DO - Vice Chair, National Board of Osteopathic Medical Examiners
- David Connett, DO - Past President, Osteopathic Medical Board of California
- Michael Finley, DO - Associate Dean, Western University of Health Sciences, College of Osteopathic Medicine of the Pacific
- Catherine Galligan, RN, MM, CPA – Chief Operating Officer, American Osteopathic Association
- John R. Gimpel, DO – President & CEO, National Board of Osteopathic Medical Examiners
- James F. Griffin, DO – Rhode Island Board of Medical Licensure and Discipline
- Anna Hayden, DO – Vice President, AAOE
- Linda Mascheri – Vice President, State, Affiliate and Affairs, American Osteopathic Association
- Jed Megan, DO – ADA Testing Accommodations Committee, National Board of Osteopathic Medical Examiners
- Ernest Miller, DO –Secretary-Treasurer, AAOE
- Karen O'Mara, DO - Illinois State Medical Disciplinary Board
- Geraldine O'Shea, DO –President, AAOE
- C. Michael Ogle, DO - Oklahoma State Board of Osteopathic Examiners
- Donald Polk, DO – Chair-elect, Federation of State Medical Boards
- Wayne Reynolds, DO - President, Virginia Board of Medicine
- Lisa Robin, MLA - Chief Advocacy Officer, Federation of State Medical Boards
- Joel Rose, DO – Chairman, Florida Board of Osteopathic Medicine
- Nicholas A. Schilligo, MS – Associate Vice President, AOA State Government Affairs and AAOE Liaison
- Dana C. Shaffer, DO – Immediate Past President, AAOE
- Gary Slick, DO, MA - Executive Committee, National Board of Osteopathic Medical Examiners
- Anita Steinbergh, DO – President, State Medical Board of Ohio
- Scott Steingard, DO – President, Arizona Board of Osteopathic Examiners in Medicine and Surgery
- David Tannehill, DO - Missouri State Board of Registration for the Healing Arts
- Barbara E. Walker, DO - North Carolina Medical Board
- Sandra Waters, MEM – Vice President, Collaborative Initiatives, National Board of Osteopathic Medical Examiners
- Adrienne White-Faines, MPA - Executive Director & CEO, American Osteopathic Association
- Michael Wieting, DO - Tennessee Board of Osteopathic Examiners
- Joseph Willett, DO - Minnesota Board of Medical Practice
- Jane Xenos, DO - Osteopathic Medical Board of California
- Joseph A. Zummatto, DO – President, Osteopathic Medical Board of California



2015 AAOE Annual Summit Meeting - Speaker Biographies

Clint E. Adams, DO, MPA

Dr. Adams is a Professor of Family Medicine and former Dean (2005-2012 - COMP-Pamona) at Western University of Health Sciences, College of Osteopathic Medicine of the Pacific. He is a graduate of Midwestern University, Chicago College of Osteopathic Medicine. He earned a Master's of Public Administration at the University of Oklahoma. Currently he is a member of American College of Osteopathic Family Physicians (ACOFP), Osteopathic Physicians and Surgeons of California and California State Association of Osteopathic Family Physicians. Dr. Adams served proudly in the United States Navy and rose to the rank of Rear Admiral in 2001 and retired in 2005.

Speaker: Saturday, January 10, 2015 - 10:00 am - Council on Postdoctoral Training Update

Brian Bowles, MEd

Mr. Bowles is the Executive Director of the Missouri Association of Osteopathic Physicians and Surgeons (MAOPS). He represents MAOPS at all local, state and federal meetings, as well as with the AOA, and directs legislative and regulatory advocacy efforts. He is also the staff liaison for both colleges of osteopathic medicine in the state, and he serves as the staff liaison to the Legislative; Bylaws and Strategic Planning; Rules and Regulations; and Physician Health Committees

Speaker: Friday, January 9, 2015 - 4:30 pm - Regulation of Assistant Physician

Ron Burns, DO

Dr. Burns is an AOA board-certified family physician who serves on the board of the NBOME and is a member of the ACOFP. He has also served the Florida Osteopathic Medical Association (FOMA) in many capacities, including being president from 2004-2005.

Dr. Burns has been an active member of the AOA Board of Trustees since 2007. Currently he is Chair, Department of Governmental Affairs and has served as chair of the Bureau of Osteopathic Clinical Education and Research and received FOMA's Physician of the Year award in 2002, as well as its Distinguished Service Award in 2007. Dr. Burns completed his osteopathic medicine degree from what is now the OU-HCOM Athens, OH. Following completion of his degree, he completed his postdoctoral medical training at the Doctors Hospital of Stark County in Massillon, OH and the Florida Hospital – East Orlando.

Speaker: Friday, January 9, 2015 - 2:45 pm - State Mandated CME Requirements for Relicensure

Boyd Buser, DO

Dr. Buser is Vice President for Health Affairs and Dean of the University of Pikeville's Kentucky College of Osteopathic Medicine in Pikeville, Kentucky; he also holds the rank of Professor of Osteopathic Principles and Practice and Professor of Family Medicine.

Dr. Buser is a graduate of Des Moines University College of Osteopathic Medicine, dually board certified in Osteopathic Manipulative Medicine and Family Medicine, and is a Fellow of ACOFP. He is currently a member of the Executive Committee of the AOA Board of Trustees, chairs the AOA's Bureau of OGME Development and is co-chair of the AOA/AACOM Blue Ribbon Commission on the Advancement of Osteopathic Medical Education. He is also a member of the Kentucky Institute of Medicine and the Kentucky Board of Medical Licensure.

Speaker: Saturday, January 10, 2015 - 12:15 pm - Blue Ribbon Commission Update

Michael Finley, DO

Dr. Finley is the Associate Dean for Graduate Medical Education, an Associate Professor of Internal Medicine and Chief Academic Officer, OPTI-West at Western University of Health Sciences, College of Osteopathic Medicine of the Pacific. He is a graduate of Chicago College of Osteopathic Medicine.

Speaker: Saturday, January 10, 2015 - 1:15 pm - Managing Chronic Pain

John Gimpel, DO

Dr. Gimpel is President and Chief Executive Officer (CEO) of the NBOME and has served in this position since 2009. He has been affiliated with the NBOME since 1995, including former roles of Board Member and Vice President for Clinical Skills Testing.

After earning a B.A. in Biology and being awarded the outstanding senior in the Biology Department from La Salle University, Dr. Gimpel graduated with the Doctor of Osteopathic Medicine degree from PCOM in 1988. Dr. Gimpel completed a rotating internship and family medicine residency training at the Hospital of PCOM/Saint Agnes Medical Center and the Chestnut Hill Hospital/Thomas Jefferson University program. He has a Master's Degree in Education from La Salle University. Board certified and recertified in Family Medicine, Dr. Gimpel has served as Director of Predoctoral Education and Associate Professor of Family Medicine at Georgetown University School of Medicine, and he is the former Dean and Vice President for Health Services at the University of the New England College of Osteopathic Medicine (UNECOM) in Biddeford, Maine. Dr. Gimpel is also a Fellow of ACOFP and the American Academy of Family Physicians.

*Speaker: Saturday, January 10, 2015 - 8:45 am - Changes in Assessment for Licensure of Osteopathic Physicians
10:30 am - NBOME and COMLEX-USA Update*

James Griffin, DO

Dr. Griffin is dually boarded physician in internal medicine and anesthesiology. He serves as President of the Rhode Island Society of Osteopathic Physicians and Surgeons, and is a member of the Rhode Island Board of Medical Licensure and Discipline.

Dr. Griffin is a graduate of University of Health Sciences; College of Osteopathic Medicine, Kansas City, MO. He completed his Internal Medicine residency and Anesthesiology residency at Albany Medical Center Hospital (New York).

Speaker: Friday, January 9, 2015 - 2:45 pm - State Mandated CME Requirements for Relicensure

Jed Magen, DO

Dr. Magen is Chair of the Department of Psychiatry in the College of Osteopathic Medicine and the College of Human Medicine at Michigan State University. He graduated from Des Moines University College of Osteopathic Medicine and did a rotating internship at Botsford General Hospital in Farmington Hills, MI. He then spent 3 years as a commissioned officer in the US Public Health Service, Indian Health Service. He did a general psychiatry residency and child and adolescent psychiatry fellowship at the University of Michigan and a research fellowship at the Institute for Social Research.

Dr. Magen is a former president of the American Osteopathic College of Neurologists and Psychiatrists and the Michigan Psychiatric Society. He served two terms on the American Osteopathic Board of Psychiatry and Neurology. He is a representative to the Council of Academic Societies of the Association of American Medical Colleges and has been elected to membership in the American College of Psychiatrists.

He has a Master's Degree in Health Care Management from the University of Texas at Dallas. He writes on graduate medical education financing, a subject on which he is a national resource for psychiatry educators and chairs.

Speaker: Saturday, January 10, 2015 - 9:15 am - ADA Requirements for High Stakes Testing Accommodations

Geraldine O'Shea, DO

Dr. O'Shea is the President of the American Association of Osteopathic Examiners (AAOE) and an osteopathic internist from Jackson, CA. She is currently the Medical Director of Foothills Women's Medical Center in Jackson and a member of the AOA Board of Trustees. Prior to joining the AOA Board, Dr. O'Shea served the AOA in many capacities, including Chair of the Bureau of Scientific Affairs and Public Health, Vice Chair of the Bureau on Federal Health Programs and Vice Chair of the Council of Women's Health Issues.

A Past President of the Osteopathic Physicians and Surgeons of California (OPSC), Dr. O'Shea has served as chair of the California delegation to the AOA's House of Delegates since 2006. Additionally, Dr. O'Shea is a member of the NBOME Board of Directors and currently serves on the board's executive committee.

After earning her osteopathic medical degree from the Western University of Health Sciences College of Osteopathic Medicine of the Pacific in Pomona, CA; Dr. O'Shea completed a rotating internship and an internal medicine residency at Maricopa Medical Center in Phoenix.

*Speaker: Friday, January 9, 2015 - 2:45 pm - State Mandated CME Requirements for Relicensure
3:45 pm - Welcome Remarks*

Lisa A. Robin, MLA

Ms. Robin is the FSMB's Chief Advocacy Officer and oversees their Washington DC office. During her long tenure at the FSMB, Ms. Robin has been active in policy analysis, development and promulgation on issues including license portability, telemedicine, pain and addiction policy, scope of practice, professional conduct and ethics, and Internet prescribing. She represents the position of state medical boards to Congress and the Administration and supports individual boards to achieve their state legislative agendas. In her current position, she oversees the FSMB's education services, federal and state legislative and policy

services, and public affairs. She also provides support to the FSMB Foundation and its grant programs. Ms. Robin earned her bachelor's and master's degrees from Texas Christian University in Fort Worth, TX.

Speaker: Friday, January 9, 2015 - 3:50 pm - Interstate Medical Licensure Compact Update

Nicholas Schilligo, MS

Mr. Schilligo is the Associate Vice President of State Government Affairs with AOA. He oversees the AOA's interactions in the state legislative and regulatory arenas and works with state licensing and regulatory boards to ensure that the osteopathic medical profession is represented in their activities. This work includes helping DOs resolve licensing application issues and CME reporting discrepancies. Prior to joining the AOA, he worked for six years at the North American Spine Society where he oversaw all aspects of the organizations advocacy and political activities.

Mr. Schilligo holds a Bachelor's Degree in Business Administration from the University of Missouri and Master's Degree in Public Policy and Public Service Management from DePaul University.

Speaker: Friday, January 9, 2015 - 2:45 pm - State Mandated CME Requirements for Relicensure

Stephen C. Shannon, DO, MPH

Dr. Shannon currently serves as President and CEO of AACOM since January 2006. In this role, he serves as spokesperson on behalf of the nation's colleges of osteopathic medicine, articulating the community's priorities and positions in a variety of national and international settings. Dr. Shannon also guides the association in fulfilling its vision and mission, and in positively influencing state, federal, and executive branch policy formulation relative to medical education. Dr. Shannon has previously served as Vice President for Health Services and Dean of the College of Osteopathic Medicine at the University of New England since 1995 and served as Chair of the AACOM Board of Deans from July 2003 to June 2005.

Dr. Shannon earned his Doctor of Osteopathic Medicine degree in 1986 from the University of New England College of Osteopathic Medicine in Biddeford, ME, and his Master of Public Health degree in 1990 from the Harvard University School of Public Health. He is board certified in osteopathic family practice and preventive medicine. He also holds BA and MA degrees in American History from the University of Maryland. Dr. Shannon has strong professional interests in public health and preventive medicine, and in major research areas of clinical outcomes study, occupational and environmental health, health promotion and disease prevention, health professions workforce, rural health and medical school curriculum.

Speaker: Saturday, January 10, 2015 - 11:00 am - AACOM Update

Sandra Waters, MEM

Sandra Waters, MEM is Vice President for Collaborative Initiatives at the NBOME. In this role, Ms. Waters facilitates relationships with key stakeholder groups as the "Chief Collaborative Officer" for the organization. She has been instrumental in developing strategy, improving operations and leading innovation in diverse organizations and industries. Ms. Waters earned a Master of Engineering Management degree from Northwestern University where she serves on Advisory Boards to two programs.

*Speaker: Saturday, January 10, 2015 - 8:45 am - Changes in Assessment for Licensure of Osteopathic Physicians
9:15 am - ADA Requirements for High Stakes Testing Accommodations*

Adrienne White-Faines, MPA

Ms. White-Faines, MPA is the Executive Director and CEO of the AOA. In this position, she is in charge of carrying out the AOA's strategic agenda supporting the organization's physician and student members and its commitment to promoting public health; advancing scientific research; and serving as the accrediting agency for osteopathic medical schools, hospitals and health care facilities.

For 10 years prior to joining the AOA, White-Faines served as vice president of health initiatives and advocacy at the American Cancer Society (ACS), Illinois Division, where she was accountable for cancer research, education, advocacy, and patient service programs. Prior to employment at ACS, she served as chief operating officer at Chicago-based Renwal Emergency Medical Services, a health care management consulting firm for hospitals and physicians, and at Chicago's Northwestern Memorial Hospital, where she oversaw a \$600 million hospital redevelopment project. She also worked as a health strategist with the New York City Health and Hospitals Corporation, and as a practice administrator for a large physician group practice in Whittier, Calif.

She holds a master's of public administration from the University of Southern California in Los Angeles and a bachelor's of arts from Amherst (Massachusetts) College.

Speaker: Saturday, January 10, 2015 - 8:30 am - American Osteopathic Association Leadership Welcome

State Mandated CME Requirements for Relicensure

Nicholas A. Schilligo, MS
Associate Vice President
State Government Affairs
American Osteopathic Association



CME Mandates

- ✓ Relicensure Requirement
- ✓ Remain Up to Date with Advancements
- ✓ Assure Competency
- ✓ Protect the Public



Significant Variation

- Colorado, Indiana, Montana, and South Dakota
- New York
- Everyone Else



The Varying Requirements

- Number of Credits/Hours
- Type of CME
 - (AOA vs. AMA)
 - Category 1, 1-A, 2, etc.
- Subject Specific
- Length of Term



Trends in CME Mandates

- Addressing public health concerns
- Promoting changes in health care delivery



Addressing Public Health Concerns

- ✓ Infectious Disease
- ✓ AIDS/HIV
- ✓ Suicide
- ✓ Child and Dependent Adult Abuse
- ✓ Prescription Drug Abuse



Promoting Changes in Health Care Delivery

Massachusetts: Certifying Proficiency in Electronic Health Records



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

AOA Position

H278-A/04

MANDATORY CME COURSE REQUIREMENTS

The American Osteopathic Association opposes any federal attempts to impose any specific continuing medical education (CME) course requirements and will assist any component societies in opposing additional specific CME course requirements. 2004; reaffirmed 2009



AOA Resources

- US Licensure Summary

<http://www.osteopathic.org/inside-aoa/development/licensure/Pages/us-licensure.aspx>

- AOA Staff

- nschilligo@osteopathic.org

- (312) 202-8185



Thank You!



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

Protecting
Advocating
Serving

Expanding Access, Protecting Patients: The Interstate Medical Licensure Compact

Lisa Robin

Chief Advocacy Officer

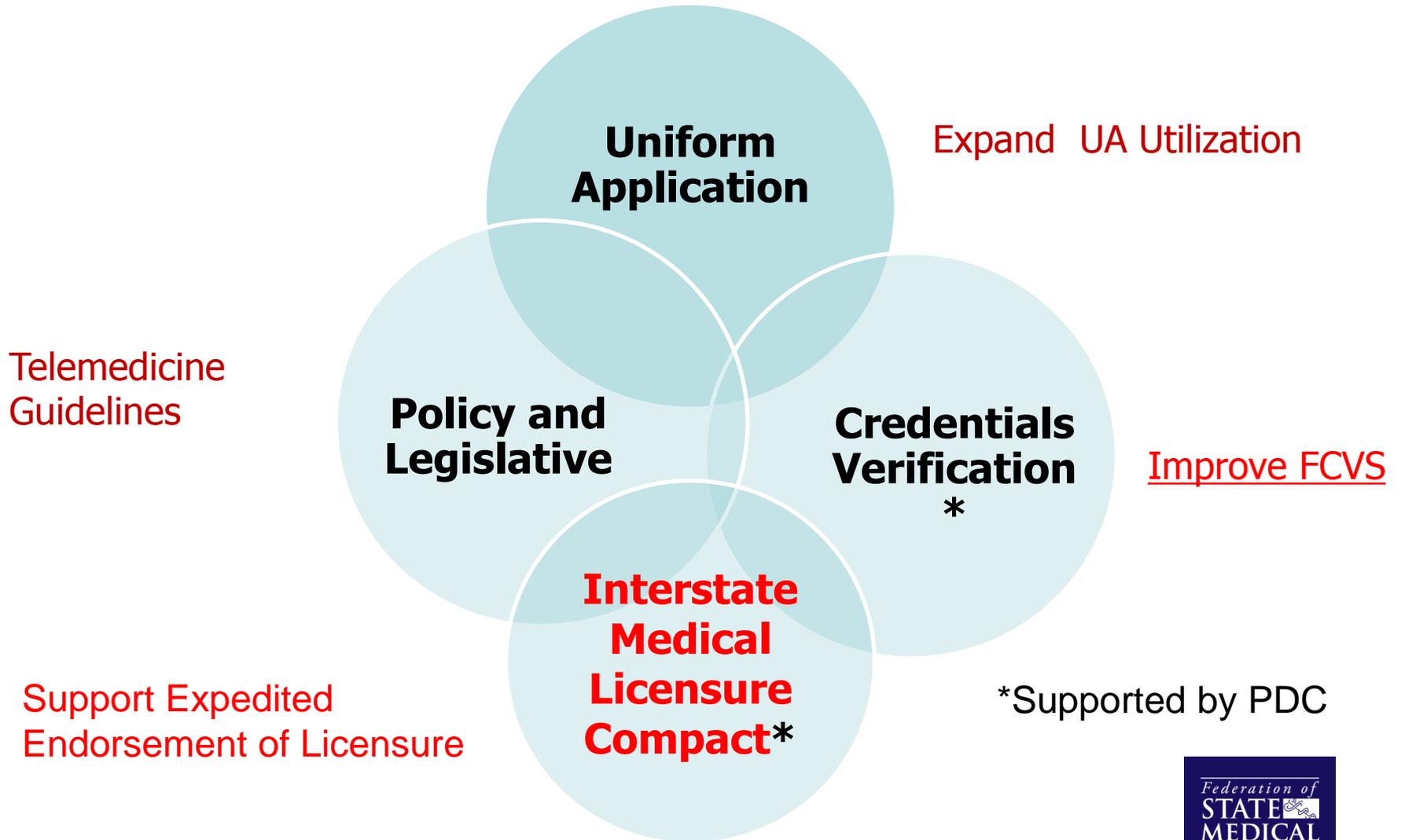
Federation of State Medical Boards (FSMB)

Federation of
STATE
MEDICAL
BOARDS

The Need for License Portability

- **Health care rapidly changing**
 - Rise of telemedicine and new technology
 - The *Affordable Care Act* and need for greater access to care
 - Integration of health care delivery systems
 - Increase in multi-state practice
 - 16% of physicians are licensed in 2 states
 - 6% of physicians are licensed in 3 or more
- **Goal: Facilitate multi-state practice without compromising patient safety or quality**

FSMB's License Portability Initiatives



Current Regulatory Environment

- **Combating Aggressive Push for a 'National' License**
 - Legislation in Congress calling for “nationalized” licensure system
 - Proposals tie licensure to federal health programs (i.e. Medicare)
- **Need for a Nationwide Solution, Implemented by the States, without Federalizing Licensure**
 - State solution would preserve proven regulatory approach
 - State solution does not require overhaul or new federal program
 - Licensing is constitutionally a state power
- **Options for interstate cooperation**
 - Uniform Law?
 - Interstate Compact?

What is an Interstate Compact?

- **A contract between compact states**
- **Constitutionally authorized**
- **Retains state sovereignty on issues traditionally reserved to state jurisdictions**
- **Commission established to coordinate cooperation**

Interstate Compact HOD Directive in 2013

- FSMB House of Delegates unanimously adopted ***Resolution 13-5: Development of an Interstate Compact to Expedite Medical Licensure and Facilitate Multi-State Practice (HOD 2013)***
- Directed FSMB to study the feasibility of an Interstate Compact model to facilitate license portability

Interstate Compact Key Principles

- **Participation voluntary for both physicians and state boards of medicine**
- **Creates another pathway for licensure, but does not otherwise change a state's existing *Medical Practice Act***
- **Regulatory authority remains with the participating state medical boards**

Interstate Compact Key Principles

- **The practice of medicine occurs where the patient is located**
- **Compliance with the statutes, rules and regulations of state where patient located**
- **State boards aware of physicians practicing in the state**

Interstate Compact Key Principles

- **Improved sharing of complaint and investigative information between medical boards**
- **The license to practice medicine may be revoked by member state once issued**
- **The ability of boards to assess fees will not be compromised**

Compact Eligibility Requirements

- **Not all Physicians will be eligible**
- **Must meet the following requirements:**
 - Successfully passed USMLE or COMLEX-USA
 - Successful completion of a GME program
 - Specialty certification or a time-unlimited certificate
 - No discipline on any state medical license
 - No discipline related to controlled substances
 - Not under investigation by any agency

State of Principal License

- **Entry point for eligible physicians**
 - State must be a Compact State
 - Physician must obtain (or hold) a full and unrestricted license
- **What state can serve as State of Principal License?**
 - State of physician's primary residence
 - State where 25% of medical practice occurs
 - Location of physician's employer
 - State designated for federal income taxes

Proposed Interstate Compact Pathway

Step 1

- **Eligible Physician is/becomes licensed in a Compact State (State of Principal License)**

Step 2

- **Eligible Physician applies for expedited licensure in other Compact states via State of Principal License**
- **State of Principal License verifies eligibility**

Step 3

- **State of Principal License sends attestation to an Interstate Commission**
- **Eligible physician transmits fees to Interstate Commission**

Proposed Licensure Pathway

Step 4

- **Interstate Commission sends fees and physician information to other Compact states selected by Physician**

Step 5

- **Selected member states issue physician a license**

Step 6

- **ONGOING: Commission is used as a clearinghouse for shared discipline and investigatory information, renewals**

Impact of Disciplinary Actions

Action by State of Principal License – Effect on License(s) Granted Under Compact:

| State of Principal License Action | Major Action | Minor Action |
|-----------------------------------|---|---|
| Initial Action | Other license(s) immediately placed on identical status w/o additional action by other member board | Member board(s) may: (1) Deem factual findings to be <i>res judicata</i> and impose same or lesser sanction(s); OR (2) Pursue separate disciplinary action under its respective medical or osteopathic practice act |
| Reinstatement | Other license(s) remains on encumbered status pending action by other member board | |

Impact of Disciplinary Actions

Action by Member State – Effect on Licenses Issued in Other Member States:

| Member State Action | Major Action | Minor Action |
|---------------------|---|--|
| Initial Action | Other licenses immediately suspended for 90 days automatically and without additional action necessary by other member board; however, the other board may lift or otherwise change the suspension prior to the completion of 90 days | Other member licensing board(s) may: (1) Deem factual findings to be <i>res judicata</i> and impose same or lesser sanction(s); OR (2) Take separate action under its respective medical or osteopathic practice act |
| Reinstatement | Other license(s) remains on encumbered status pending action by other member board | |

Joint Investigations

- **Member Boards may participate with other member boards in joint investigations of physicians licensed by the member boards**
- **Boards may share information and other materials**
- **Subpoenas issued by member states enforceable in other member states**

Coordinated Information System

- **Commission to establish database of all physicians who apply or are licensed through Compact**
- **Member Boards will report complaint/disciplinary information to the Commission**
- **Increased permissive sharing of complaints and other investigatory information**

Interstate Compact Commission

- **State Boards retain licensing authority, participate as Commission members**
- **Administrative Role Only**
 - Coordinate education and training
 - Empowered to determine when a state has breached its obligations under Compact
 - Can raise own funds to remain budget neutral

Interstate Compact Commission

- **Each member state would appoint two representatives to serve**
- **Rulemaking authority crucial to success**
- **Substantive changes to Compact must be unanimous**

Funding and Fees

- **Budget not envisioned to be substantial**
- **Each member board retains power to set licensing fees**
- **Commission would assess user fee**
 - Similar to a 'convenience fee' for online ticketing
- **Commission can seek grants**

Interstate Compact: Next Steps

- **Must be enacted as statute by state legislatures**
- **Growing interest among states for adoption**
 - 21 boards have formally endorsed (as of 1/5/15)
 - Growing support from medical and hospital associations
 - American Medical Association
 - At least 10 introductions likely in 2015
- **Late Summer 2015 projected for first meeting**

Available Resources

- <http://www.fsmb.org/policy/interstate-model-compact>
- **Talking Points**
- **Endorsements**
 - State Medical and Osteopathic Boards
 - National and state medical associations
 - Specialty Societies
 - Health Care Delivery Systems

Questions / Discussion / Contact Us

Lisa Robin

Chief Advocacy Officer

FEDERATION OF STATE MEDICAL BOARDS

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ASSISTANT PHYSICIANS IN MISSOURI...

POSITIVES, NEGATIVES, AND UNKNOWNNS

DAVID TANNEHILL, D.O., MISSOURI BOARD OF HEALING ARTS MEMBER

BRIAN BOWLES, MAOPS EXECUTIVE DIRECTOR



SB 716

- **OMNIBUS BILL WITH THE FOLLOWING COMPONENTS:**
 - **MANDATORY MENINGOCOCCAL VACCINE FOR PUBLIC UNIVERSITIES**
 - **STATE COURIER SERVICE FOR UMBILICAL BLOOD**
 - **BENCHMARKING OF DIABETES DATA TO IMPROVE CARE**
 - **SHOW-ME ECHO PROGRAM**
 - **SHOW-ME HEALTHY BABIES PROGRAM**
 - **ASSISTANT PHYSICIAN**

WHAT IS AN “AP”?

- **MEDICAL SCHOOL GRADUATE**
- **COMPLETED STEP 1 AND 2 OF THE USMLE OR EQUIVALENT**
- **HAS NOT COMPLETED AN APPROVED RESIDENCY**
- **PROFICIENCY IN ENGLISH**
- **IS IN A COLLABORATIVE ARRANGEMENT WITH A LICENSED MISSOURI PHYSICIAN**
- **PROVIDES PRIMARY CARE SERVICES IN MEDICALLY UNDERSERVED AREAS**

ORIGIN OF THE IDEA

- **MISSOURI STATE MEDICAL ASSOCIATION**
- **SPONSORED BY REPRESENTATIVE KEITH FREDERICK, D.O.**
- **HEARD IN COMMITTEE BUT NEVER VOTED ON**
- **TACKED ON TO SEVERAL OMNIBUS BILLS DURING THE LAST WEEKS OF SESSION AND PASSED ON ALL OF THEM!**
- **ORIGINAL IDEA WAS TO MAKE THIS A TIME-LIMITED LICENSE...LANGUAGE NEVER MADE IT INTO THE BILL**

REASONING BEHIND THE LAW

- **SOLVE THE “ACCESS TO CARE” ISSUES?**
- **ALLOW MEDICALLY TRAINED INDIVIDUALS THE OPPORTUNITY TO SHARPEN SKILLS RATHER THAN SIMPLY NOT PRACTICE**
- **PROVIDE A PHYSICIAN WITH AN ALTERNATIVE TO AN APRN OR PA**
- **ORIGINAL LANGUAGE WOULD HAVE PUT APRN’S UNDER THE BOARD OF HEALING ARTS**

CONCERNS OF AOA AND OTHERS

- **TWO-TIERED PHYSICIAN SYSTEM (DOCTORS WITH RESIDENCY TRAINING AND THOSE WITHOUT)**
- **TRANSPARENCY/PATIENT CONFUSION**
- **ESTABLISHES RESTRICTIONS ON A PHYSICIAN'S ABILITY TO PRACTICE**
- **LOWERS THE BAR FOR PROVIDERS**
- **POSSIBLE INFLUX OF "LOWER PERFORMING" GRADUATES WHO HAVE NOT MATCHED**
- **NO TIME LIMIT WAS INCLUDED-INITIALLY DISCUSSED 18 MONTHS**

POSITIVE POLITICAL OUTCOMES

- **LEGISLATORS LIKED THE IDEA BECAUSE IT PROVIDED A “SOLUTION” WHEN NO OTHERS WERE BEING OFFERED**
- **ESTABLISHES A “GEOGRAPHIC PROXIMITY” FOR AP’S, SOMETHING THE APRN’S HAVE BEEN TRYING TO REPEAL.**
- **MADE NURSES GO ON RECORD OPPOSING A PLAN TO HELP SOLVE THE ACCESS TO CARE ISSUE**
- **EMPHASIZES OUR STANCE THAT FULLY TRAINED PHYSICIANS OFFER SUPERIOR CARE; OTHERWISE THEY NEED TO BE IN COLLABORATIVE AGREEMENTS**

REGULATORY ISSUES

- **PROMULGATION OF RULES TO DEFINE REQUIREMENTS OF AP COLLABORATIVE PRACTICE AGREEMENT MUST OCCUR**
- **OTHER TERMS IN THE LAW MUST BE CLARIFIED BY RULE (IE. “EMERGENCY SITUATION”)**
- **PROBLEMS INHERENT IN THE LANGUAGE HAVE TO BE LEGISLATIVELY FIXED**

CONCERNS OF BOHA - TECHNICALITIES

- **DEFINITION OF AN AP IS PROBLEMATIC IN TERMS OF “RESIDENT ALIEN”**
- **TIMING OF STEP 1 AND 2 COULD BE PROBLEMATIC FOR LICENSURE IN CERTAIN INSTANCES**
- **CONTRADICTORY LANGUAGE REGARDING EXACTLY WHAT STAGE OF TRAINING QUALIFIES FOR AP LICENSE**
- **FOREIGN MEDICAL GRADUATES – CURRENT LANGUAGE IMPLIES ONLY GRADUATES OF AOA AND LCME QUALIFY, BUT IT IS NOT ABSOLUTELY CLEAR IF THIS IS THE INTENT.**
- **LAW LIMITS AP TO PRIMARY CARE IN MEDICALLY UNDERSERVED AREAS, BUT NEITHER IS CLEARLY DEFINED**

CONCERNS OF BOHA - FEDERAL LAW

- **“FOR A PHYSICIAN-ASSISTANT PHYSICIAN TEAM WORKING IN A RURAL HEALTH CLINIC UNDER THE FEDERAL RURAL HEALTH CLINIC SERVICES ACT AN AP SHALL BE CONSIDERED A PHYSICIAN ASSISTANT FOR THE PURPOSES OF REGULATIONS OF CMS,” AND**
- **“NO SUPERVISION REQUIREMENTS IN ADDITION TO THE MINIMUM FEDERAL LAW SHALL BE REQUIRED”**
- **STATE LAW CANNOT DEFINE FEDERAL LAW**
- **CMS UNLIKELY TO AMEND RULES TO ACCOMMODATE AP PAYMENT**
- **SINCE AP’S ARE NOT RECOGNIZED UNDER FEDERAL LAW THIS SECTION MAY THEORETICALLY ALLOW THEM TO PRACTICE WITH NO SUPERVISION AT ALL**

CONCERNS OF BOHA - TRANSPARENCY

- **LAW ALLOWS AP'S TO CALL THEMSELVES "DOCTOR" – TWO-TIERED PHYSICIAN SYSTEM**
- **ALLOWS AP'S TO PRACTICE WITHOUT COLLABORATION IN "EMERGENCY SITUATIONS"**

CONFUSION WITH PATIENTS

WHAT CONSTITUTES AN EMERGENCY SITUATION?

CONCERNS OF BOHA - LIABILITY

“THE COLLABORATING PHYSICIAN IS RESPONSIBLE AT ALL TIMES FOR THE OVERSIGHT OF THE ACTIVITIES OF AND ACCEPTS RESPONSIBILITY FOR PRIMARY CARE SERVICES RENDERED BY THE ASSISTANT PHYSICIAN”

IMPLIES CIVIL LIABILITY AND DISCIPLINE RESPONSIBILITY

BUT ANOTHER SECTION CONTRADICTS THIS AND ABSOLVES THE PHYSICIAN FROM RESPONSIBILITY...

CURRENT SITUATION IN MISSOURI

THERE ARE NO LICENSED ASSISTANT PHYSICIANS IN MISSOURI AT THIS TIME

FUTURE

- **CLEAN-UP LEGISLATION**
- **PROMULGATION OF RULES**
- **ISSUING LICENSES**
- **EDUCATION OF PHYSICIANS, PATIENTS, AND GENERAL PUBLIC**



NBOME
NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

January 10, 2015

AAOE ANNUAL SUMMIT MEETING: ADA REQUIREMENTS FOR HIGH STAKES TESTING ACCOMMODATIONS

Jed Magen, DO MS

Sandra Waters, MEM

NBOME Test Accommodations Committee Chair

NBOME Vice President for Collaborative Initiatives

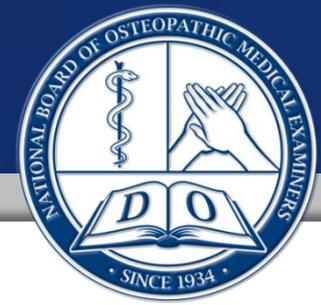
NBOME

NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

OVERVIEW

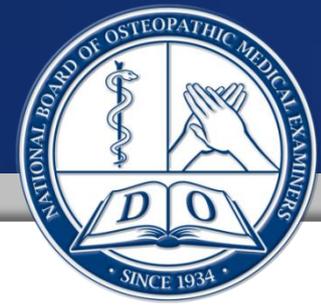
Jed Magen, DO MS



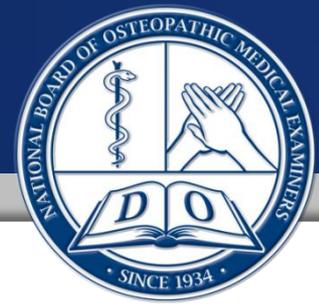


Topics that will be addressed include:

- **Americans with Disabilities Act of 1990, as amended (ADA)**
- **Committee Composition and Responsibilities**
- **Principles of Case Review**
- **How much documentation is enough?**



- **Common Disability Categories and Accommodations**
- **Overview of Application Process and Possible Outcomes**
- **Courtesy Requests/Personal Item Exemptions**



A well designed process is designed to:

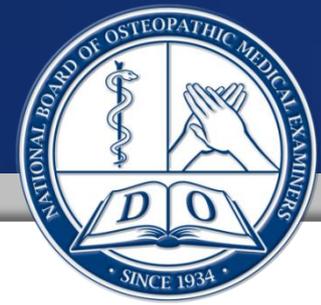
- **Protect the public**
- **Support the students**
- **Follow federal regulations and court rulings**
- **Set the standard in test accommodations among high-stakes testing organizations**



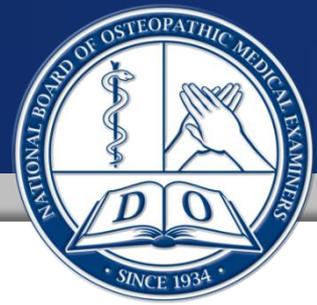
**AMERICANS WITH
DISABILITIES ACT OF 1990,
AS AMENDED (ADAAA)**

Jed Magen, DO MS



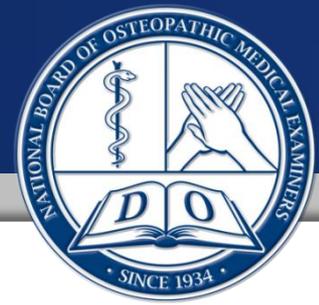


- **42 U.S.C. § 12189 (Title III)**
NBOME must offer its examinations “in a place and manner accessible to persons with disabilities...”



Candidates have the burden to demonstrate that he or she is a “person with disabilities.”:

“a mental or physical impairment” (medical condition) that “substantially limits” (as compared to most people in the general population, not others or own capacity) one or more “major life activities (reading, thinking, etc.)



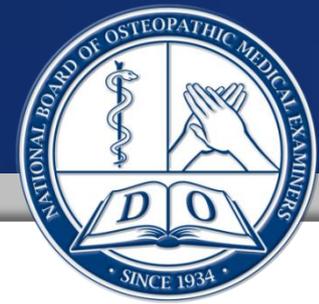
- **ADA Guarantees “Access” Not “Success”**
 - “best ensure” that measuring candidate’s knowledge or skill, not his or her disability
 - Accommodations provided may not “fundamentally alter” what NBOME is measuring
 - e.g., **COMLEX-USA Level 2-PE**
 - Accommodations not required if causes “undue burden” to NBOME



COMMITTEE COMPOSITION AND RESPONSIBILITIES

Jed Magen, DO MS





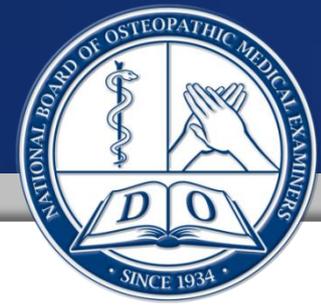
- **physicians and other professionals:**
 - **Variety of specialties**
- **Supported by:**
 - **Administrative staff**
 - **Legal counsel**
 - **Independent and expert consultants**
- **Able to commit Each Month to:**
 - **Review applications and consultant reports prior to meeting**
 - **Meet via teleconference for as long as required to review applications**



PRINCIPLES OF CASE REVIEW

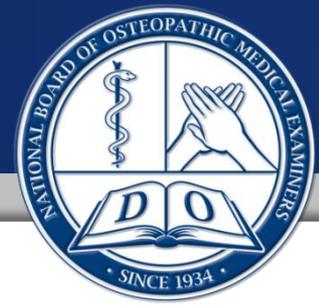
Jed Magen, DO MS





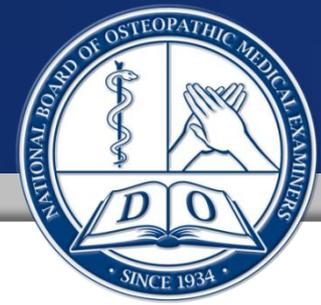
Accommodation Request

A second year student applies for accommodation on COMLEX Level II CE. He has a personal statement, psychometric testing and a physicians statement indicating that he has been diagnosed with ADHD. He is requesting double time and a single room to decrease distraction in the environment.



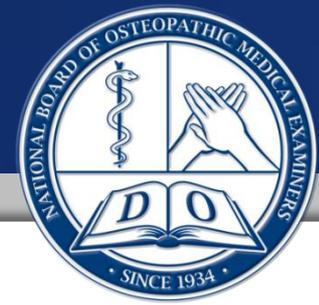
Accommodation Request

A second year student applies for accommodation on COMLEX Level II CE. She reports a diagnosis of diabetes mellitus for which she takes insulin. She has a physician statement and is requesting extra breaks to take food and check her blood glucose.



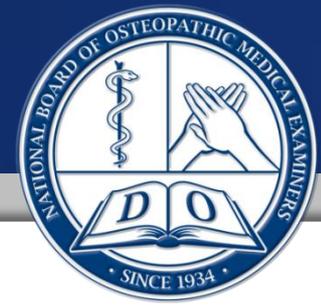
Case Review

- **Comprehensive analysis of multiple data sources**
Psychometric, Historical, Clinical
- **Current functioning**
Candidate statement, testing report
- **Formal diagnosis**
Testing report, physician statement, candidate statement



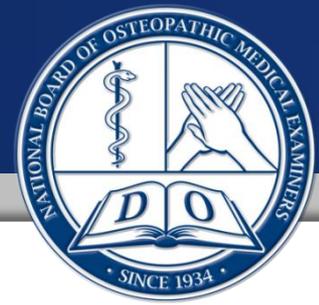
Case Review

- **Rationale for diagnosis**
Current, research-based, complete
- **Prior accommodations (MCAT, medical school, etc)**
“considerable weight” but not conclusive
- **Opinion of candidate’s “qualified professional”**
Must consider (if not accepted, must explain why)



Case Review

- **NBOME's expert consultant's evaluation**
- **Candidate's self reporting**
 - May be useful, but insufficient if not accompanied by other professional data



- **Diagnosis \neq Disability; no accommodation without disability**
- **Insufficient Information**
- **Sufficient information but no disability**
- **Sufficient information to document disability**

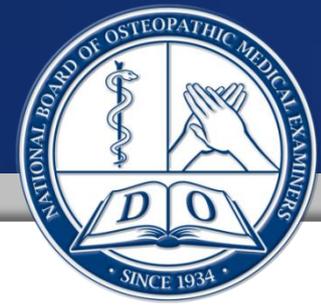


HOW MUCH DOCUMENTATION IS ENOUGH?

Jed Magen, DO MS

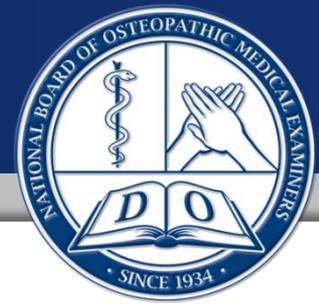


How Much Documentation is Enough?



Required for complete evaluation:

- Testing reports and/or physician statement
- Candidates statement



Problems include:

- **Insufficient information to document diagnosis or disability**
- **Inappropriate/irrelevant data**
- **Testing that claims to document disability but does not**

DSM-5 criteria

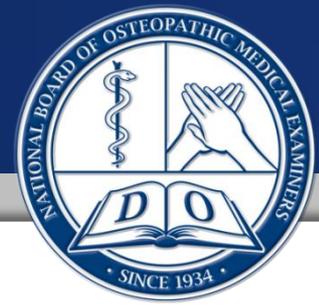
“other specified” replaces NOS and is not generally sufficient diagnosis for disability



COMMON DISABILITY CATEGORIES AND ACCOMMODATIONS

Jed Magen, DO MS





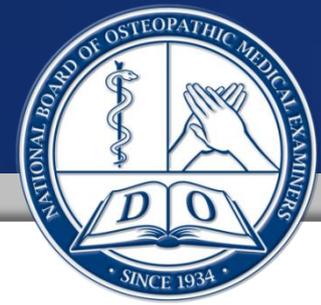
Neurodevelopmental Disorders

- Documented history of impairment
- School and other records, deficits on testing

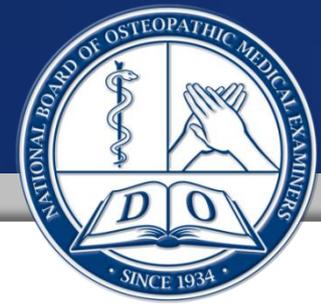
Specific Learning Disorder with Impairment in Reading

Attention-Deficit/Hyperactivity Disorder (ADHD)

Common Disability Categories



- **Other psychiatric disorders**
 - Anxiety Disorders**
- **Physical disabilities**
 - Diabetes, Autoimmune Disorders**
- **Visual or auditory impairments**



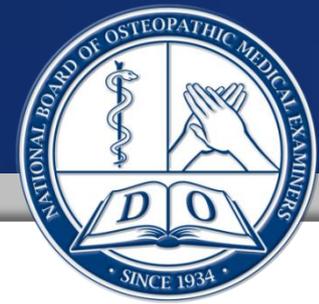
- **Case-by-case determination**
- **No set accommodations for particular conditions**
- **Commonly requested accommodations**
 - **Extra time**
 - **Private, low-distraction room**
 - **Reader**
 - **Larger monitor**
 - **Enlarged text (Zoomtext, etc.)**
 - **Screen reader/ text-to-speech (Jaws, etc.)**



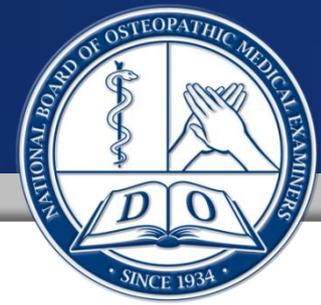
OVERVIEW OF APPLICATION PROCESS AND POSSIBLE OUTCOMES

Sandra Waters, MEM

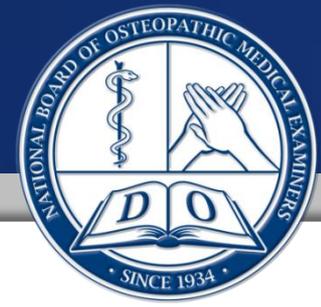




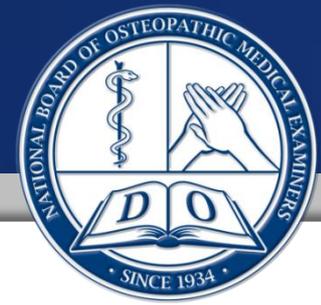
- **Student's Role**
 - **Register and apply early; process can take up to 60 days**
 - **Candidate should consider desired examination window and submit complete application 90 days prior**
 - **Candidate should aim to submit application within the first week of a month to have it reviewed that same month**
 - **Applications available on the website; separate applications for CBT and PE examinations**
 - **NBOME prefers the candidate not schedule an examination until decision letter is received**



- **Client Services' Role**
 - Support student throughout process
 - Function in an administrative capacity; staff are not subject matter experts
 - Attend and support monthly meeting
 - Draft and send decision letters
 - Assist with scheduling accommodated examinations



- **Consultant's Role**
 - Serve as outside subject matter expert
 - Review applications, evaluate and return recommendations
 - Present applications at monthly meeting
- **Committee's Role**
 - Review applications
 - Discuss and debate the merits of each case
 - Reach a decision by vote



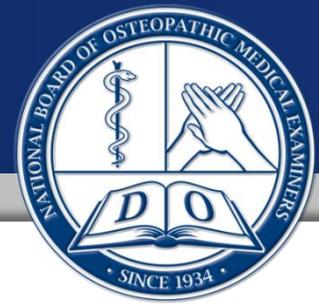
- **Possible Outcomes**
 - **Approved, as requested or with modifications**
 - **Not approved, disability not demonstrated or no appropriate accommodation**
 - **Insufficient documentation, may submit additional information**



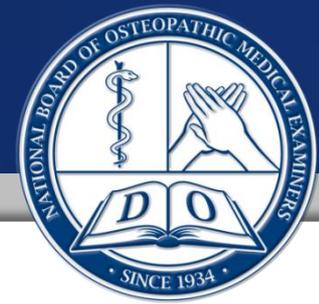
COURTESY REQUESTS/PERSONAL ITEM EXEMPTIONS

Sandra Waters, MEM





- **Requests which do not require an alteration in examination administration itself**
 - Inhaler, medication
 - Insulin pumps, glucose tablets and glucose meters
 - Technical aids, pillows, comfort items
 - Ergonomic chair
 - Seating near door
- **Require written request at least 2 weeks prior to examination date**
- **Staff will review, forward to Prometric and send confirmation to student**



- **Items requiring Committee approval:**
 - Candidate provided electronic stethoscope, magnifying glass, otoscope/ophthalmoscope attachments
- **Items allowed on self in exam hall or break areas (no prior authorization required):**
 - Cane, crutches, walker, emergent medication (given to proctor), eye drops (given to proctor), hearing aids, insulin pump, etc.
- **Items allowed in break areas (no prior authorization required):**
 - Breast pump, diabetic supplies, mouthwash, sweater, sugar drink, water, etc.

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SUMMARY

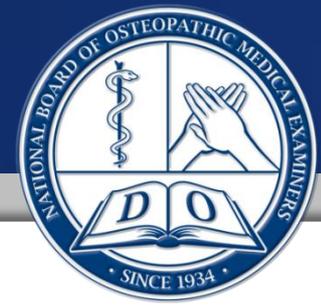
Jed Magen, DO MS





The process should be designed to:

- **Protect the public**
- **Support the students**
- **Follow federal regulations and court rulings**
- **Set the standard in test accommodations among high-stakes testing organizations**



Topics that were addressed:

- **Americans with Disabilities Act of 1990, as amended (ADA)**
- **Committee Composition and Responsibilities**
- **Principles of Case Review**
- **How much documentation is enough?**
- **Common Disability Categories and Accommodations**
- **Overview of Application Process and Possible Outcomes**
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QUESTIONS?



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NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

THANK YOU.

CONTACT NBOME

Client Services: 866-479-6828 / clientservices@nbome.org

**BUILDING THE FUTURE:
Educating the 21st Century Physician**

**Report of the
Blue Ribbon Commission for the
Advancement of Osteopathic Medical Education**

Boyd R. Buser, D.O. Co-Chairs: Marc B. Hahn, D.O.



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS



AMERICAN ASSOCIATION OF
COLLEGES OF OSTEOPATHIC MEDICINE

The Blue Ribbon Commission on the Advancement of Osteopathic Medical Education

- Joint project of the AOA and AACOM
- Additional funding support provided by the Josiah Macy, Jr. Foundation

The Charge

In 2011, the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine established the ***Blue Ribbon Commission for the Advancement of Osteopathic Medical Education (BRC)***.

The BRC was created in response to calls from legislators, foundations, and other stakeholders for reform in both undergraduate medical education (UME) and graduate medical education (GME). The charge of the BRC was to:

- assess the evolving U.S. health care environment and envision the future health care needs of the American public;
- articulate a vision of a contemporary, 21st Century osteopathic physician who is positioned to meet the needs of the evolving U.S. health care environment;
- identify the competencies that this physician would possess; and to
- envision a new educational *Pathway* to prepare the 21st Century physician.

BRC Members

- Boyd R. Buser, DO*
- Marc B. Hahn, DO*
- John W. Becher, DO
- Dale W. Bratzler, DO
- John B. Bulger, DO, MBA
- Robert A. Cain, DO
- John B. Crosby, JD*
- Tyler Cymet, DO*
- Kenneth H. Johnson, DO
- Robert S. Juhasz, DO
- Isaac J. Kirstein, DO
- Janice A. Knebl, DO, MBA
- Harald Lausen, DO
- Martin S. Levine, DO, MPH
- Creagh Milford, DO
- Karen J. Nichols, DO*
- Sonbol Shahid-Salles, DO
- Stephen C. Shannon, DO, MPH*
- Ray E. Stowers, DO
- Elizabeth Varadian, DO
- Kenneth J. Veit, DO, MBA
- Norman E. Vinn, DO
- D. Keith Watson, DO
- Cole A. Zanetti, DO



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS



AMERICAN ASSOCIATION OF
COLLEGES OF OSTEOPATHIC MEDICINE

Environmental Assessment

- Aging population
- Chronic disease epidemic
- Increasing costs
- Increasing emphasis on quality of health care
- Physician shortages/mal-distribution
- Transformation of delivery systems underway: ACA implementation, ACOs, PCMH
- Technological changes: IT, data management, AI
- Calls for reform of medical education system (especially GME)



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AMERICAN ASSOCIATION OF
COLLEGES OF OSTEOPATHIC MEDICINE

Calls for Reform

Revisiting the Medical School
Educational Mission
at a Time of Expansion

*Proceedings of a Conference
Chaired by Jordan J. Cohen, M.D.*

Edited by Mary Hager and Sue Russell

WHO WILL PROVIDE
PRIMARY CARE
AND HOW WILL
THEY BE TRAINED?

Proceedings of a conference chaired by
Linda Cronenwett, Ph.D., R.N., FAAN
and Victor J. Dzau, M.D.

Josiah Macy, Jr. Foundation
April 2010



AMERICAN OSTEOPATHIC ASSOCIATION

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AMERICAN ASSOCIATION OF
COLLEGES OF OSTEOPATHIC MEDICINE

Calls for Reform



Ensuring an Effective Physician Workforce for America
 Recommendations for an Accountable Graduate Medical Education System

Proceedings of a Conference Chaired by **Michael M.E. Johns, MD**
 October 2010 | Atlanta, Georgia

April 2011



CONFERENCE SUMMARY

May 2011 | Atlanta, Georgia

Ensuring an Effective Physician Workforce for the United States: Recommendations for Reforming Graduate Medical Education to Meet the Needs of the Public

The Second of Two Conferences—The Content and Format of GME



AMERICAN OSTEOPATHIC ASSOCIATION

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AMERICAN ASSOCIATION OF
COLLEGES OF OSTEOPATHIC MEDICINE

Calls for Reform

Letter from **COGME** to AACOM and AAMC:

Organizations should jointly convene and pursue

- Streamlining of physician training
- Acceleration of the time frame for physician education
- Improving the quality of medical education
- Development of competency-based evaluation
- Increasing the number of physicians being trained
- Developing new approaches to team-based training



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COLLEGES OF OSTEOPATHIC MEDICINE

IOM Committee on Governance and Finance of GME

- Seven US Senators (bi-partisan) sent letter to IOM in December 2011 requesting the Institute to “...conduct an independent review of the governance and financing of our system of graduate medical education...and potential GME reforms.”
 - Results published in September 2014
 - BRC report mentioned **ten times**

The Process

- BRC established in Spring 2011:
 - Membership broadly representative of osteopathic medicine, reflecting the practice community, professional organizations, medical colleges, accreditation, and state licensure boards; includes physicians in training.
- Interviews with 19 key opinion leaders
- Review of existing programs, reports and calls for reform
- Four BRC meetings
 - June 2011, January 2012, June 2012 and January 2013.
- Monthly steering committee meetings
- Final report released in November 2013

Disclaimer

As an independent commission, the opinions and recommendations presented in the report reflect the discussions of the members of the Blue Ribbon Commission and do not necessarily express the views of the American Osteopathic Association or the American Association of Colleges of Osteopathic Medicine.

The Recommendation

The creation of a new educational *Pathway* to produce board-eligible, practice-ready Osteopathic Physicians who possess the competencies needed for success in today's high-quality, high-value health care environment, such as Accountable Care Organizations and Patient-Centered Medical Homes, and are ready to serve as leaders of the interprofessional health care team.

The *Pathway* consists of a **competency-based** integrated educational *Pathway*, with a seamless transition between undergraduate and graduate medical education.

Characteristics of The Pathway

- 1. It will prepare osteopathic physicians for primary care practice** and will incorporate traditional Osteopathic principles and practices;
- 2. It will consist of a continuous, longitudinal educational experience.** The UME experience will be seamlessly integrated with a GME experience delivered predominately in clinics and ambulatory settings;
- 3. It will be built upon a competency-based curriculum** centered on the biomedical, behavioral, and clinical sciences foundations of osteopathic primary care medical practice; a highly qualified student may be able to complete the program in as little as five years;

Characteristics of The Pathway

- 4. It will be co-managed by the Colleges of Osteopathic Medicine** and their residency program partners, such as integrated health care systems, hospitals, and community health centers;
- 5. It will include a focus on health care delivery science** including principles of high-quality, high-value health care, health care team leadership, business principles, health policy, population health, health information technology, quality assurance, and patient safety.

The End Result

Upon completion of the *Pathway*, the graduating physician will be ready for practice as a community-based, comprehensive primary care physician and leader of the interprofessional health care team.

It is understood that some graduates may elect to participate in additional specialty training, and the *Pathway* experience should position them well for continued training.

As one BRC member noted, “As a profession, we would prepare better specialists if all physicians had a stronger foundation in primary care and population health.”

BRC and AMA Comparisons

October 2014

| | OP&P | COMPETENCY BASED | SEAMLESS UME/GME | COM LED | Healthcare Delivery Competencies | Accelerated Training |
|---------------------------|------|---------------------|---------------------|---------|--|-------------------------|
| BLUE RIBBON COMMISSION | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Indiana vHS | | | | ✓ | ✓ | |
| Mayo Medical School | | ✓ | | ✓ | ✓ | |
| NYU Healthcare by Numbers | | ✓ | | ✓ | ✓ | ✓ |
| Oregon HSU SOM | | ✓ | | ✓ | ✓ | ✓ |
| Penn State COM SyNC | | ✓ | | ✓ | ✓ | |
| Eastern Carolina Brody | | | | ✓ | ✓ | |
| Brown Univ Alpert | | | | ✓ | ✓ | |
| UC--Davis | | ✓ | ✓ | ✓ | | ✓ |
| UC -- San Francisco | | | | ✓ | ✓ | |
| Univ Michigan | | | | ✓ | | ✓ |
| Vanderbilt | | ✓ | | ✓ | ✓ | |

Timeline of the BRC Report

December 2012:

- Shared the draft report with the IOM Committee on Governance and Finance of GME

March 2013:

- BRC report endorsed by AOA Board of Trustees at their mid-year meeting in March

April 2013:

- AACOM Board of Deans expressed support at their annual meeting
- Presentation to the broader OME Community

July 2013

- Presentation to AOA House of Delegates

November 2013

- Public release of report

Final Steps in the BRC Report

November 2013

- “A New Pathway For Medical Education”
– Published in *Health Affairs*

Reform Proposals

By Stephen C. Shannon, Boyd R. Buser, Marc B. Hahn, John B. Crosby, Tyler Cymet, Joshua S. Mintz, and Karen J. Nichols

A New Pathway For Medical Education

ABSTRACT Physician education in the United States must change to meet the primary care needs of a rapidly transforming health care delivery system. Yet medical schools continue to produce a disproportionate number of hospital-based specialists through a high-cost, time-intensive educational model. In response, the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine established a blue-ribbon commission to recommend changes needed to prepare primary care physicians for the evolving system. The commission recommends that medical schools, in collaboration with their graduate medical education partners, create a new education model that is based on achievement of competencies without a prescribed number of months of study and incorporates the knowledge and skills needed for a twenty-first-century primary care practice. The course of study would occur within a longitudinal clinical training environment that allows for seamless transition from medical school through residency training.

In a changing health care delivery system that purports to be shifting away from disease care and toward a focus on population-based prevention and care management, new models of comprehensive health care delivery, based on inter-professional teams led by primary care physicians, are emerging as an innovative response. For years, evidence¹ has shown that the availability of primary care physicians improves health care outcomes² and lowers costs.³ Unfortunately, most health experts have concluded that there is an inadequate supply of primary care physicians,

compensation relative to that provided for specialty care, and primary care workloads that impinge upon preferred lifestyles. New models of care may enhance primary care compensation, improve the work environment, and improve the attractiveness of careers in primary care medicine. But the ability to train physicians for these new models is limited.¹⁰

Osteopathic physicians are an important part of our nation's health care system. Today there are 82,500 osteopathic physicians in the United States; 60 percent practice primary care, many of them in rural locations.¹¹ More than 20 per-

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Challenges

- Licensure
- Accreditation
- Governance and Board Certification
- Financial Considerations
- Regulatory Environment
- Public Relations

Building the Future:

Educating the 21st Century Physician

Report of the Blue Ribbon Commission
for the Advancement of
Osteopathic Medical Education

Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy (REMS)

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Affiliation:

NBOME Board of Directors

OPTI West Educational Consortium

*WesternU College of Osteopathic
Medicine*

Faculty Disclosure

Nothing to Disclose

Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy

An Accredited Continuing Medical Education Activity



Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy (REMS)

METHOD OF PARTICIPATION / HOW TO RECEIVE CREDIT

1. There are no fees for participating in and receiving credit for this activity.
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3. Complete the CME activity.
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SPONSORSHIP

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TARGET AUDIENCE

This activity is intended for health care professionals who prescribe ER/LA opioids.

STATEMENT OF NEED

Chronic pain is a major public health problem in the United States and has been estimated to affect up to a third of Americans. However, after a decade of standard setting and research on pain control, health care practitioner assessment and management of patient pain continues to be inadequate. Evidence-based guidelines emphasize thorough patient assessment, prompt recognition of patient pain, frequent monitoring, multimodal analgesic therapies, and patient input; yet, there are persistent gaps in clinicians' knowledge and practice around key areas of chronic pain management. Additionally, rates of misuse and abuse of nonprescription medications have not abated over the past decade, resulting in addiction, drug poisoning, and overdose death. Despite these concerns, appropriate use of opioids can improve a patient's quality of life. Thus, education on best practices for opioid safe use is critical for all clinicians managing patients with chronic pain.

Extended-Release and Long-Acting Opioid Analgesics REMS

- Target Audience
 - This activity is intended for health care professionals who prescribe ER/LA opioids.
- Statement of Need
 - Chronic pain is a major public health problem estimated to affect up to 1/3 of Americans
 - decade of standard setting and research on pain control, health care practitioner assessment and mgmt of patient pain continues to be inadequate.
 - Evidence-based guidelines emphasize thorough patient assessment, prompt recognition of patient pain, frequent monitoring, multimodal analgesic therapies, and patient input
 - persistent gaps in clinicians' knowledge & practice around key areas of chronic pain mgmt.
 - rates of misuse and abuse of nonprescription medications have not < over the past decade, resulting in addiction, drug poisoning, and overdose death.
 - Despite these concerns, appropriate use of opioids can improve a pts QOL
 - Thus, education on best practices for opioid safe use is critical for all clinicians managing patients with chronic pain.

Extended-Release and Long-Acting Opioid Analgesics REMS

- Learning Objectives
- Upon completion of this course, the participants should be able to:
 - Appropriately assess patients for the treatment of pain with ER/LA opioid analgesics, including analyzing risks versus potential benefits
 - Assess patient’s risk of abuse, including substance use and psychiatric history
 - Identify state and federal regulations on opioid prescribing
 - Incorporate strategies to effectively initiate therapy, modify dosing or discontinue use of ER/LA opioid analgesics in patients with pain
 - Manage ongoing therapy with ER/LA opioid analgesics
 - Incorporate effective counseling for patients and caregivers about the safe use of ER/LA opioid analgesics
 - Discuss general and product-specific drug information related to ER/LA opioid analgesics

Thank you for your participation today!

**Please take the pretest now –
The pretest is part of the
stapled paper handout you
received**

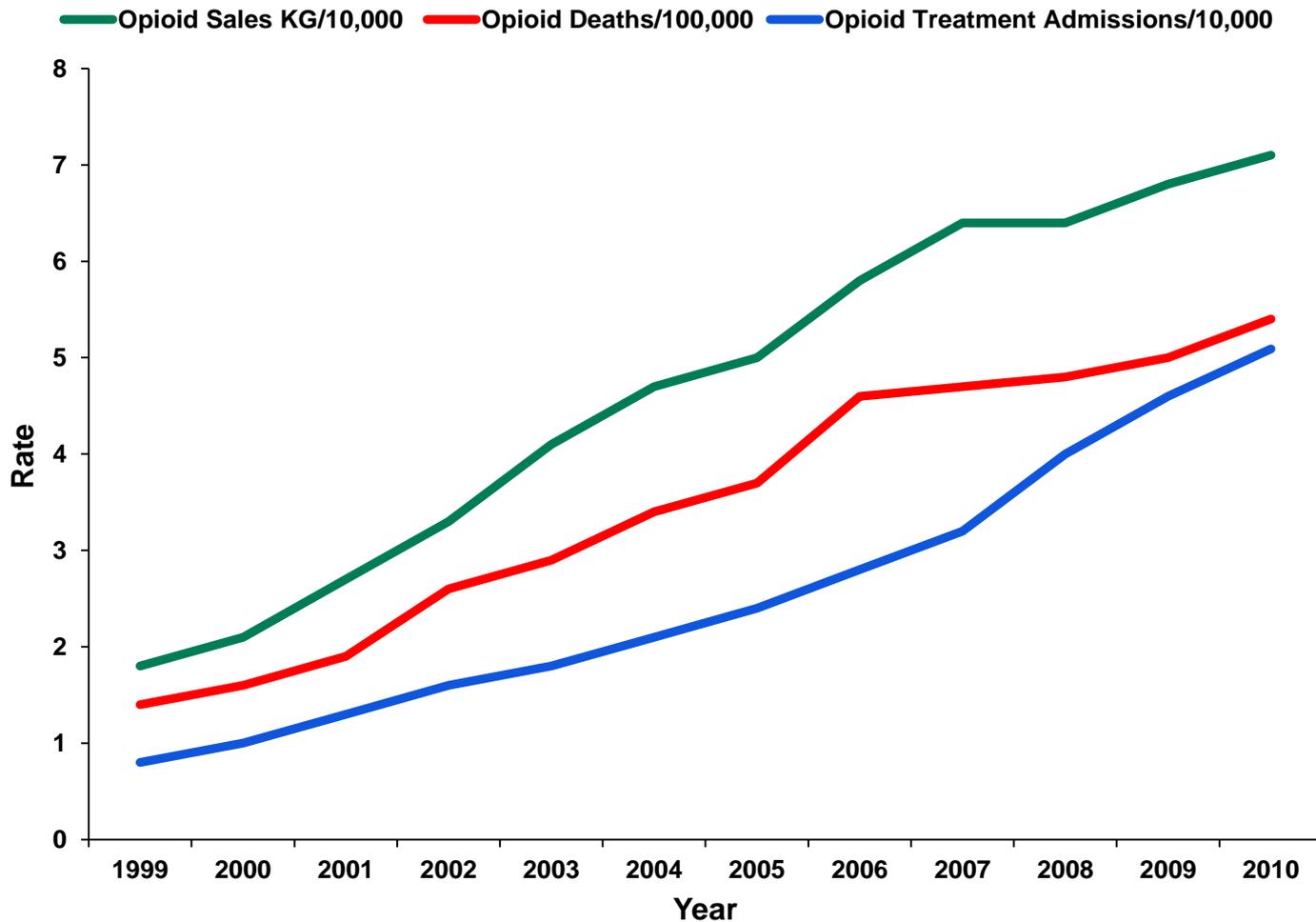
Assessing Patients for Treatment with ER/LA Opioid Analgesic Therapy

Module 1

Learning Objectives

- Appropriately assess patients for the treatment of pain with ER/LA opioid analgesics, including analyzing risks versus potential benefits
- Assess patient's risk of abuse, including substance use and psychiatric history
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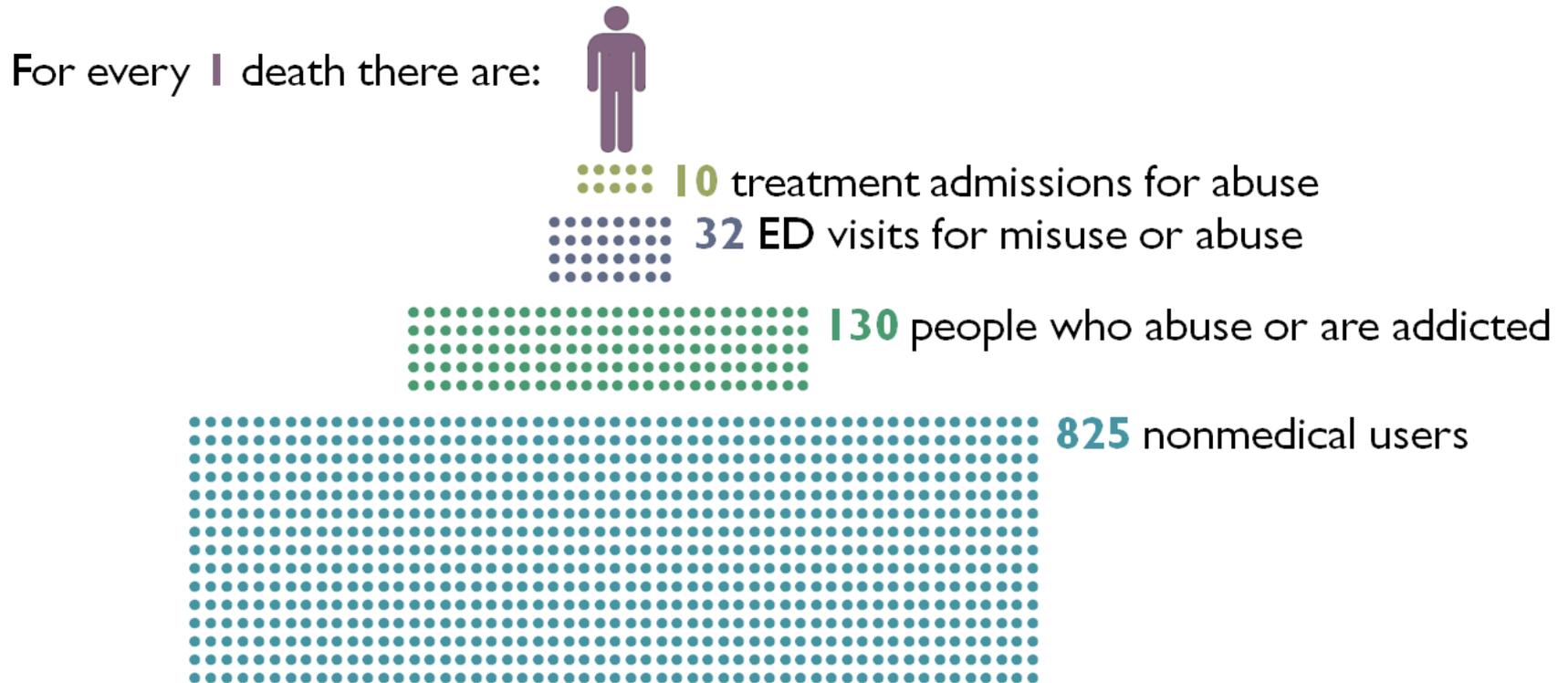
Rates of Opioid Overdose Deaths, Sales, and Treatment Admissions, United States, 1999–2010



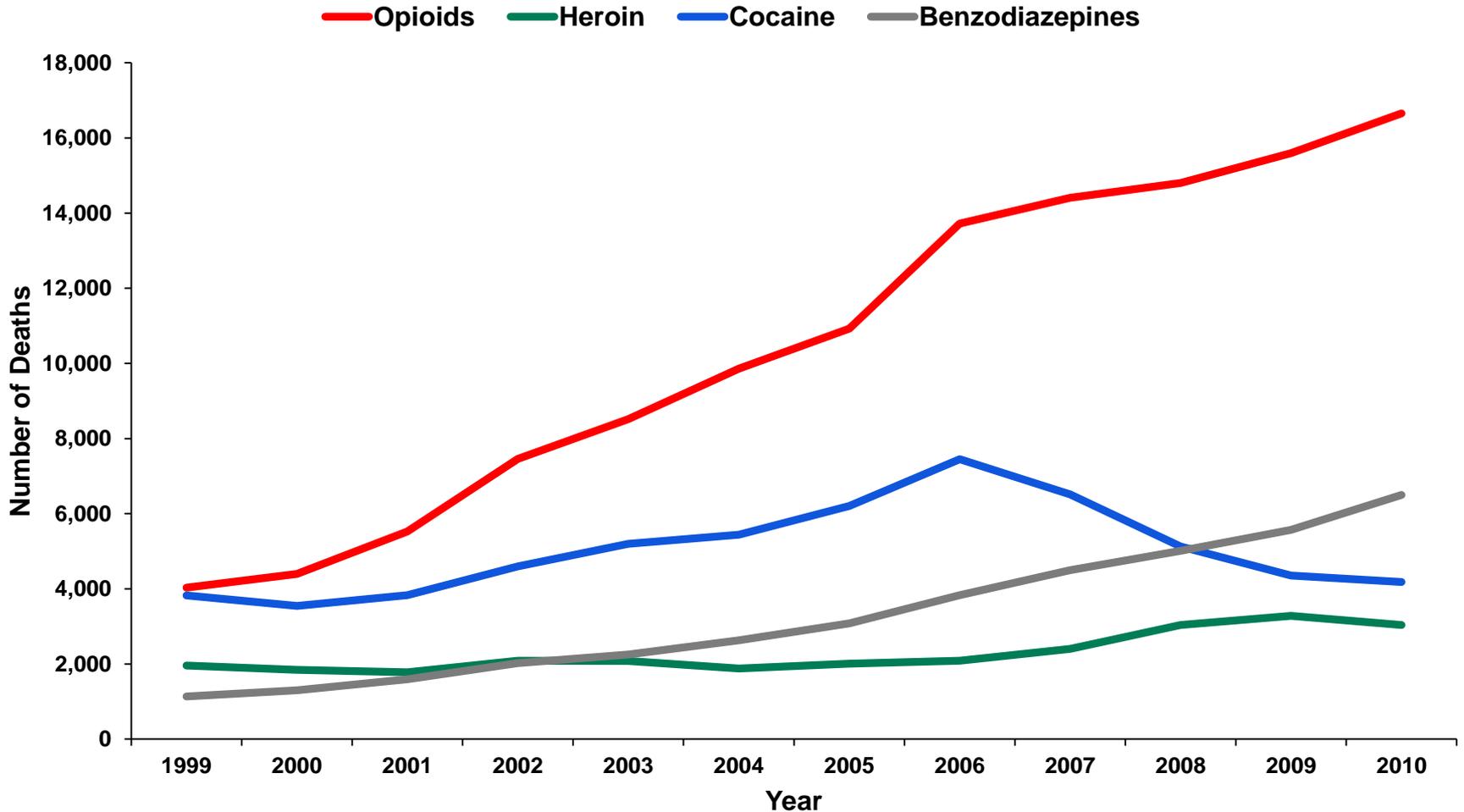
CDC. *MMWR* 2011. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm60e1101a1.htm?s_cid=mm60e1101a1_w. Updated with 2009 mortality and 2010 treatment admission data.

Widespread Abuse and Misuse of Opioids

In 2008, there were 14,800 prescription painkiller deaths



Drug Overdose Deaths by Major Drug Type, United States, 1999–2010



CDC, National Center for Health Statistics, National Vital Statistics System, CDC Wonder. Updated with 2010 mortality data.

Critical Vocabulary

- **Aberrant drug-related behavior**: Conduct outside the boundaries of the agreed upon treatment plan
- **Abuse**: Any use of an illegal drug, or a medication for a nonmedical purpose
- **Addiction**: Impaired control over drug use, compulsive use, continued use despite harm, and/or craving
- **Diversion**: The intentional transfer of a controlled substance from legitimate distribution and dispensing channels
- **Misuse**: Use of a medication other than as directed or as indicated
- **Physical dependence**: A state of biologic adaptation manifested by a withdrawal syndrome produced by decreasing blood levels of the drug
- **Tolerance**: A state of physiologic adaptation in which exposure to a drug induces a diminution of one or more opioid effects over time

REMS Education

On July 9, 2012, the FDA approved a **Risk Evaluation and Mitigation Strategy (REMS) for extended-release (ER) and long-acting (LA) opioid medications**

What Drugs Are Covered by This REMS?

Brand Name Products

- Avinza[®] morphine sulfate ER capsules
- Butrans[®] buprenorphine transdermal system
- Dolophine[®] methadone hydrochloride tablets
- Duragesic[®] fentanyl transdermal system
- Embeda[®] morphine sulfate/naltrexone ER capsules*
- Exalgo[®] hydromorphone hydrochloride ER tablets
- Kadian[®] morphine sulfate ER capsules
- Methadose[™] methadone hydrochloride tablets
- MS Contin[®] morphine sulfate CR tablets
- Nucynta[®] ER tapentadol ER tablets
- Opana[®] ER oxymorphone hydrochloride ER tablets
- OxyContin[®] oxycodone hydrochloride CR tablets
- Palladone[®] hydromorphone hydrochloride ER capsules[†]
- Zohydro[™] ER hydrocodone bitartrate ER capsules

Generics

- Fentanyl ER transdermal systems
- Methadone hydrochloride tablets
- Methadone hydrochloride oral concentrate
- Methadone hydrochloride oral solution
- Morphine sulfate ER tablets
- Morphine sulfate ER capsules
- Oxycodone hydrochloride ER tablets

*Not currently available due to voluntary recall (still approved)

[†]No longer marketed (still approved)

Risks of ER/LA Opioid Analgesics

- Overdose with ER/LA formulations
- Abuse by patient or household contacts
 - Especially adolescent children
- Inadvertent exposure by household contacts
- Misuse and addiction
- Physical dependence and tolerance
- Interactions with other medications and substances
 - Medication reconciliation
- Financial (diverting drugs for illegal sale)

Your Patient Complains of Pain: Where to Start

- Consider source or etiology of pain
- In most circumstances, use a non-opioid pain medication first



Clinical Interview: Getting Started

- **Complete history**
 - Family history of substance abuse (does not preclude treatment with ER/LA opioid)
 - Family history of psychiatric disorders
 - Social history, including criminal record
- **Complete physical examination**
- **Use a screening tool**
 - ORT, SOAPP, DIRE

Clinical Interview: Description and Impact of Pain

Description of current pain complaint

- Location
- Intensity
- Quality
- Onset/Duration
- Patterns

What causes or increases pain?

Effects of pain on physical, emotional, and psychosocial function

Patient's pain and functional goals

Clinical Interview: Pain Coping Strategies

Pain Medications

Past use

Current use

- Query state **PDMP** where available to confirm patient report
- Contact past providers and obtain prior medical records
- Conduct Urine Drug Test (**UDT**)

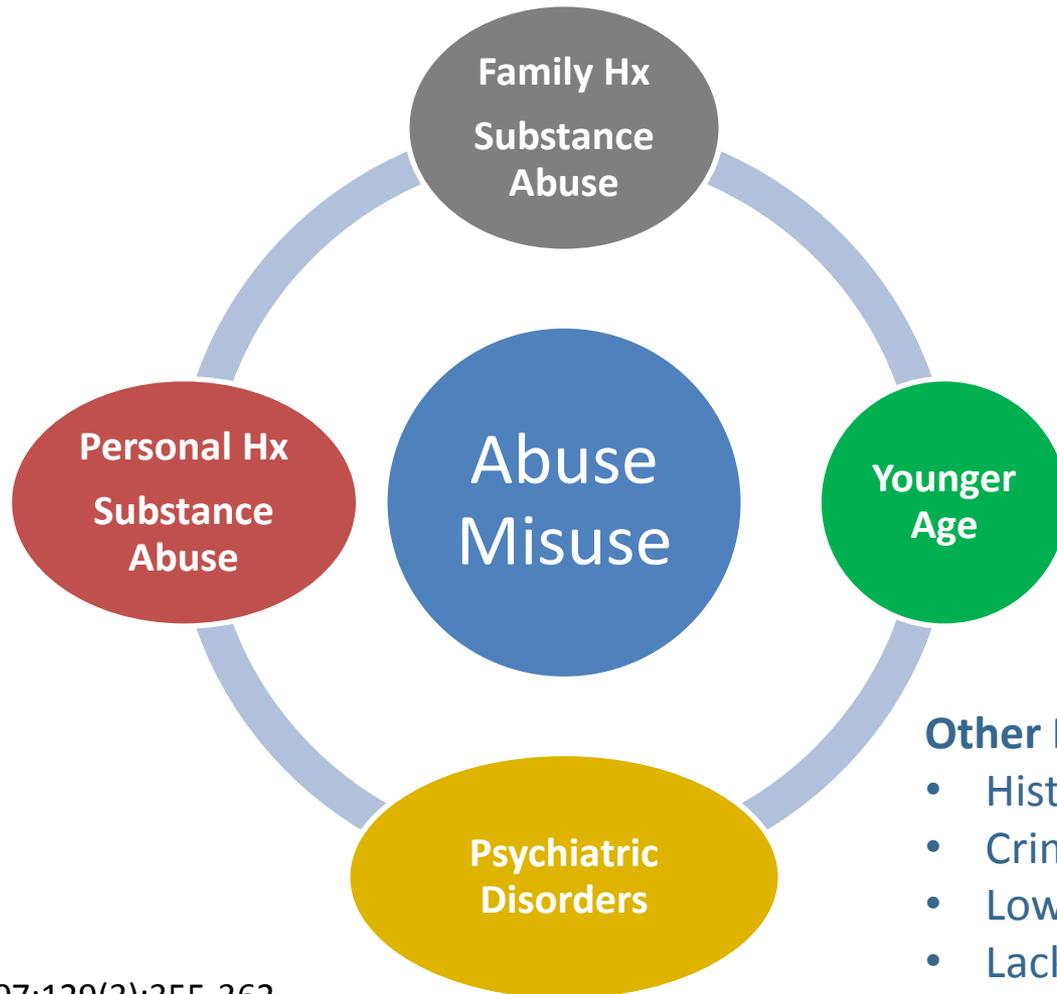
Dosage

- For opioid currently prescribed: opioid, dose, regimen, and duration
 - Important to determine if patient is **opioid tolerant**

General Effectiveness

Nonpharmacologic strategies and effectiveness

Risk Factors for Aberrant Drug-related Behaviors



Other Factors:

- History of sexual abuse
- Criminal record
- Low reliability
- Lack of social support
- Smoking

Edlund MJ, et al. *Pain*. 2007;129(3):355-362.

Chou R, et al. *J Pain*. 2009;10(2):113-130.

Fishbain DA, et al. *Pain Med*. 2012;13(9):1212-1226.

What Were They Thinking?

- Is this patient really in pain?
- Is he/she seeking opioids?
- Is he/she an abuser?
- Is he/she addicted?

- Is the doctor taking my pain seriously?
- Should I reveal my history?
- Should I reveal my home life?



Validated Questionnaires

| | |
|-------|---|
| ORT | Opioid Risk Tool |
| SOAPP | Screener & Opioid Assessment for Patients with Pain |
| DIRE | Diagnosis, Intractability, Risk, and Efficacy inventory |
| STAR | Screening Tool for Addiction Risk |
| SISAP | Screening Instrument for Substance Abuse Potential |
| PDUQ | Prescription Drug Use Questionnaire |

- No “gold standard”
- Lack of rigorous testing

Opioid Risk Tool (ORT)

Mark each box that applies

Female

Male

| 1. Family Hx of substance abuse | | Female | Male |
|-------------------------------------|----------------------------------|----------------------------|----------------------------|
| | Alcohol | <input type="checkbox"/> 1 | <input type="checkbox"/> 3 |
| | Illegal drugs | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| | Prescription drugs | <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |
| 2. Personal Hx of substance abuse | | Female | Male |
| | Alcohol | <input type="checkbox"/> 3 | <input type="checkbox"/> 3 |
| | Illegal drugs | <input type="checkbox"/> 4 | <input type="checkbox"/> 4 |
| | Prescription drugs | <input type="checkbox"/> 5 | <input type="checkbox"/> 5 |
| 3. Age between 16 & 45 yrs | | Female | Male |
| | | <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |
| 4. Hx of preadolescent sexual abuse | | Female | Male |
| | | <input type="checkbox"/> 3 | <input type="checkbox"/> 0 |
| 5. Psychologic disease | | Female | Male |
| | ADD, OCD, bipolar, schizophrenia | <input type="checkbox"/> 2 | <input type="checkbox"/> 2 |
| | Depression | <input type="checkbox"/> 1 | <input type="checkbox"/> 1 |

Scoring Totals:

Administer

On initial visit

Prior to opioid therapy

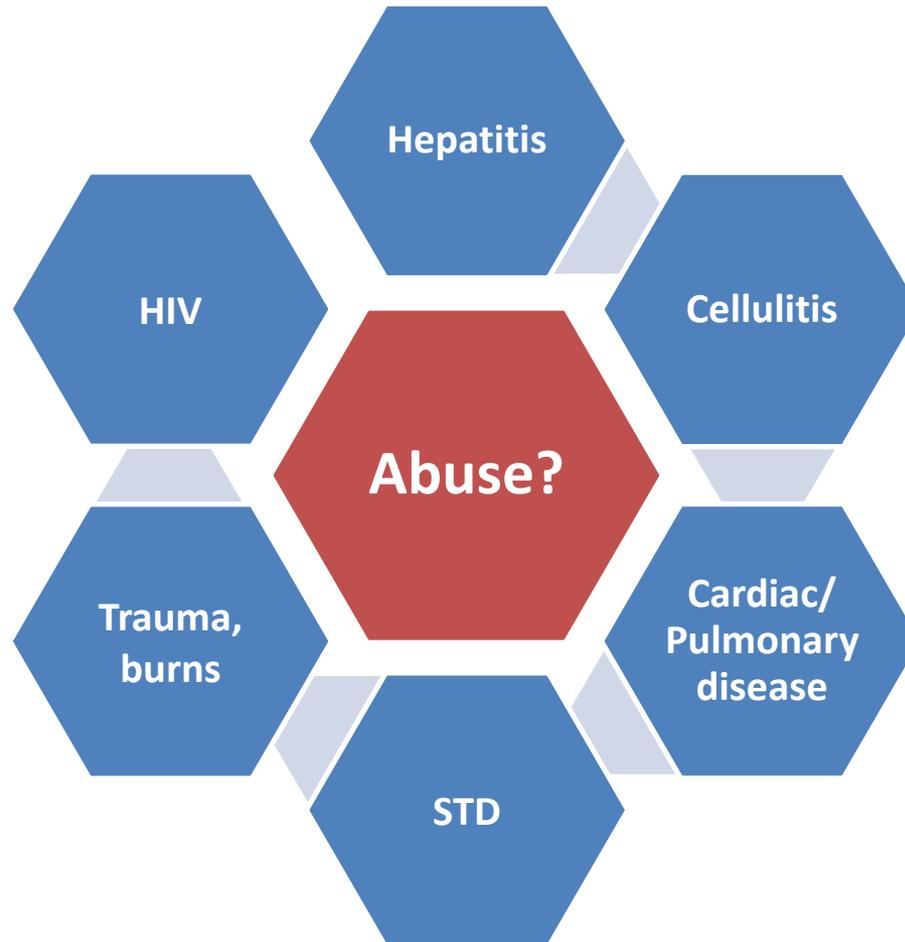
Scoring (*risk*)

0-3: low

4-7: moderate

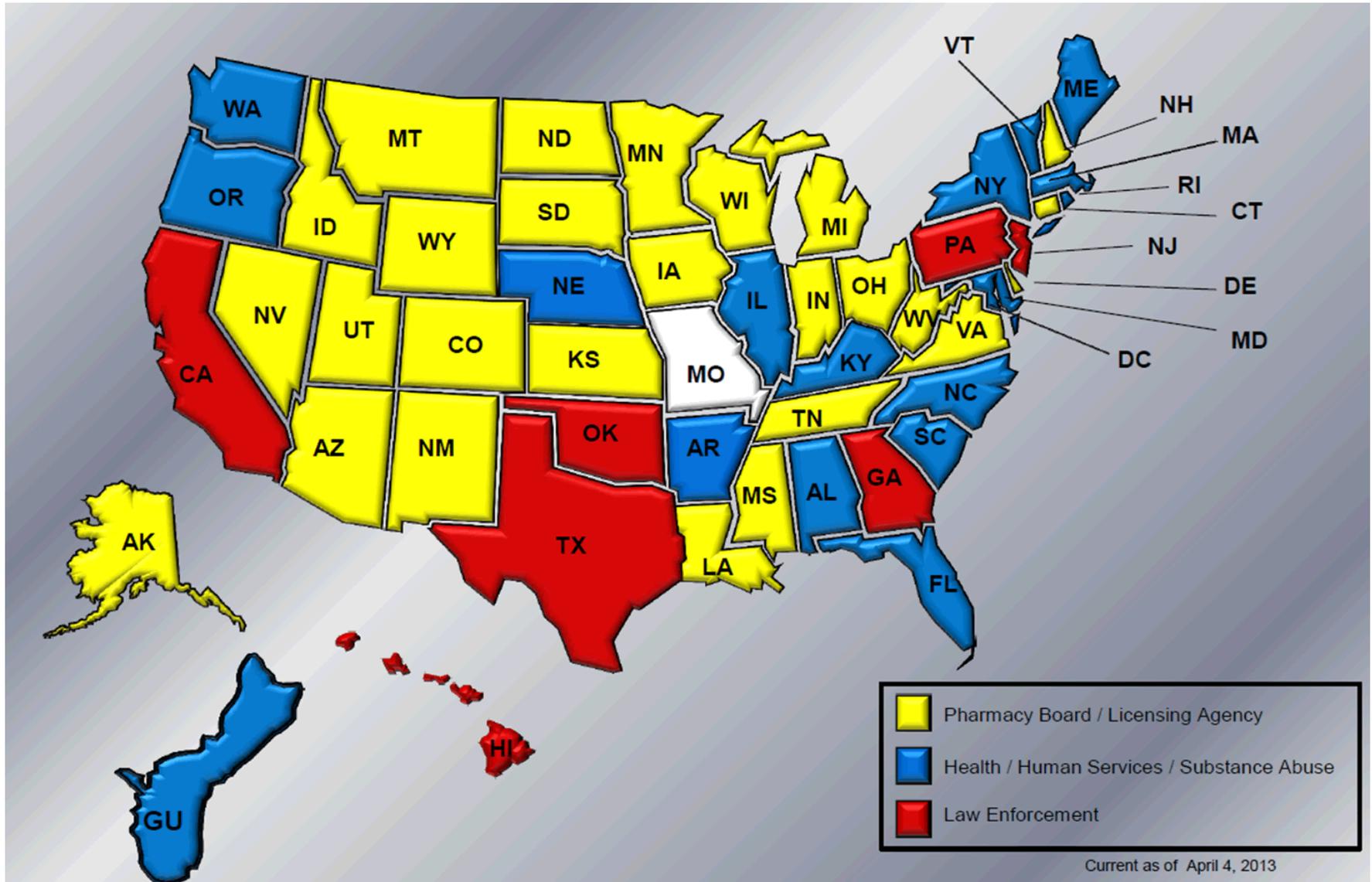
≥ 8: high

Clinical Interview: Conditions Suggestive of Abuse



Chou R, et al. *J Pain*. 2009;10:113-130. Zacharoff KL, et al. *Managing Chronic Pain with Opioids in Primary Care*. 2nd ed. Newton, MA: Inflexion, Inc., 2010. Department of Veterans Affairs, Department of Defense. *VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*. 2010.

Prescription Drug Monitoring Programs



Rationale for Urine Drug Testing (UDT)

Prior to Therapy

- Prior drug use
- Other drug use

During Therapy

- Adherence
- Legal requirement
- Grounds for referral
- Frequency per provider

Patient Presentation



- A 38-year-old divorced mother of three teenagers presents with complaints of lower back pain since an MVA 4 years ago
- She describes the pain as constant, intense, and encompassing her whole lower back area. She relates that it is exacerbated by walking, bending, and lifting. The pain makes activities of daily life difficult
- She would like to have her pain reduced to a tolerable level

Patient Work-Up



- Medical Hx
 - Prior physical therapy and medication have failed
- Social Hx
 - Remote history of marijuana use
 - Once convicted of writing bad checks
- Family Hx
 - Father abused alcohol
 - Recent break-up with an abusive boyfriend with a drug problem
- Exam
 - While describing the severity of her pain and her limitations, she does not appear to be in pain
 - Lower back demonstrates tenderness with some wincing
 - Gait is normal

Referring High-Risk Patients

Prescribers should

Understand when to appropriately refer high-risk patients to pain management or addiction specialists

Regularly check your state's regulations for requirements

Documentation

- A risk/benefit evaluation
 - History
 - Physical exam
 - Diagnostic testing
- Patient interactions
- Previous health records, including prescriptions, MRI, CT
- Patient permission to obtain records from other providers
- Provider communication with other providers
- Treatment plan, patient/provider agreement, informed consent (module 3)
- Aberrant drug-related behavior



Module 1 Key Messages

- ER/LA opioids can be effective for pain management
- Benefit must be weighed against risk
- Medical and behavioral factors influence risk of abuse or misuse
- Patients should be regularly assessed
- Documentation of assessments, patient interactions, treatment plans, aberrant drug-related behavior, and involvement of other providers is critical

Assessment and Improvement Modules

NBOME's Goal with OPAIMs:

- To partner with AOA specialty boards, colleges and stakeholders in developing practice assessment programs that are:
 - Convenient
 - User-friendly
 - Practical
 - Relevant
 - Affordable
 - Osteopathically distinctive
 - Approved for CME credit and AOA's OCC Component 4 (practice assessment)

Two OPAIM programs have been produced:

- Medication Safety Communication
- OMT for Low Back Pain during Pregnancy

OPAIM



NBOME
NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

Initiating Therapy, Modifying Dosing, and Discontinuing Use of ER/LA Opioid Analgesics

Module 2

Learning Objectives

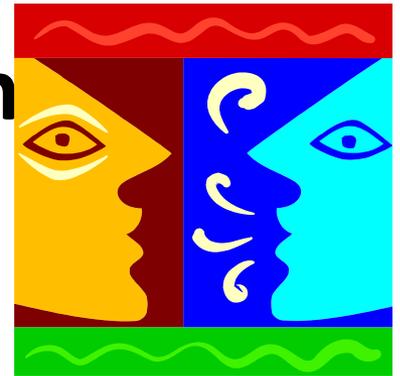
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- Discuss general and product-specific drug information related to ER/LA opioid analgesics

Analgesic and Functional Goals

- **Decrease pain**
 - Treat underlying cause where possible
 - Minimize medication use
- **Restore function**
 - Physical, emotional, social
- **Correct secondary consequences of pain**
 - Postural deficits, weakness, overuse
 - Maladaptive behavior, poor coping

Patient Prescriber Agreement

Informed Consent



Communication process between patient and provider, including:

- Potential risks and benefits
 - Side effects (both short- and long-term)
 - Tolerance and physical dependence
 - Drug interactions and over-sedation
 - Impaired motor skills
 - Misuse, dependence, addiction, and overdose
 - Evidence of benefit
- Physician's prescribing policies and expectations
 - Number and frequency of refills
 - Policy on early refills and replacement of lost or stolen medications
- Specific reasons for changing or discontinuing opioid therapy, including violation of the treatment agreement

Analgesic Selection

Non-opioid approaches should be considered first

- Address underlying condition
- Non-opioid analgesia

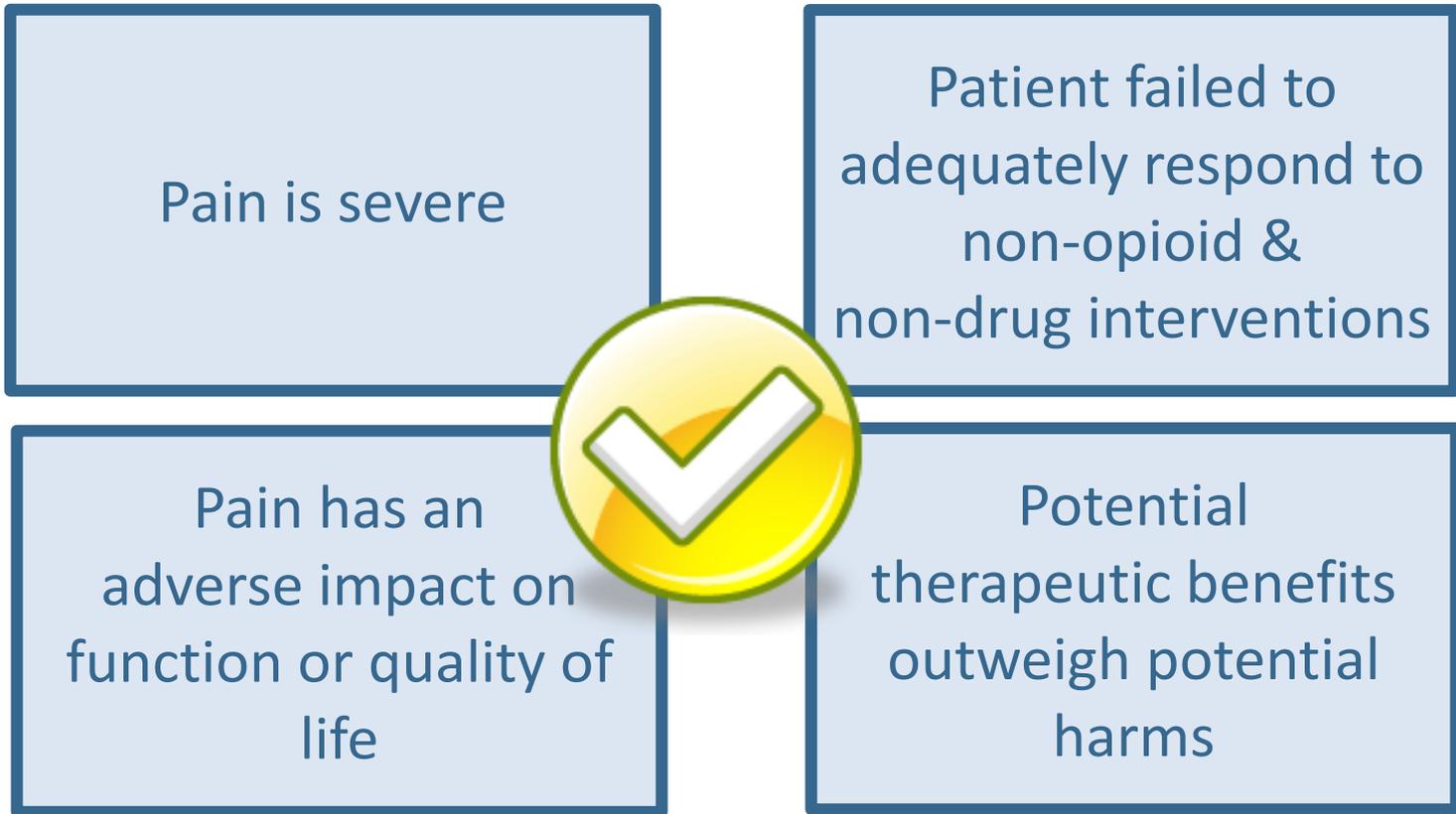
Short-acting opioids are probably safer than ER/LA for initial therapy

- Shorter half-life
- May have a lower risk of inadvertent overdose
- Better for break-through pain

Proposed benefits of long-acting opioids

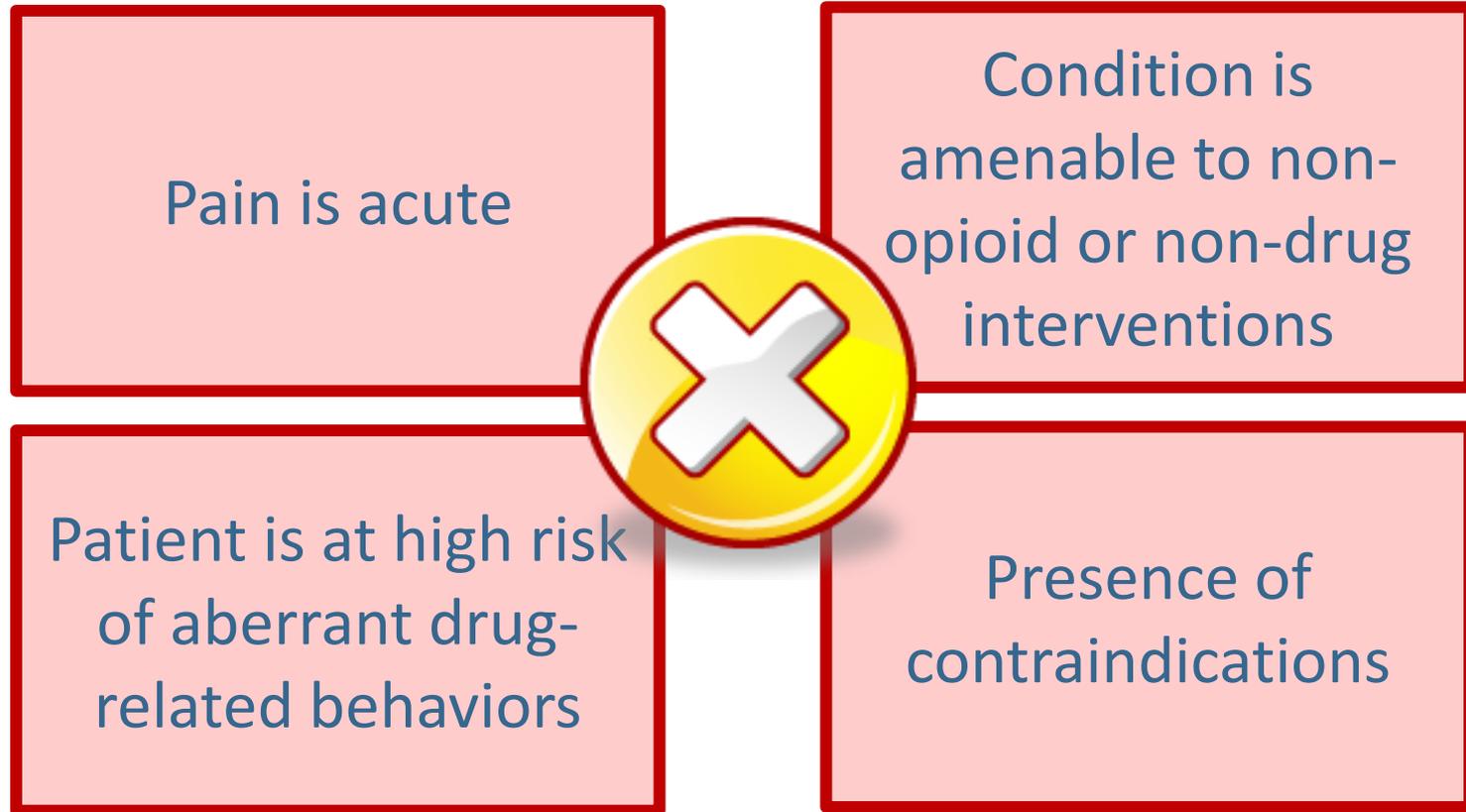
- More consistent control of pain
- Improved adherence
- Lower risk of addiction or abuse

When to Consider a Trial of an ER/LA Opioid



Consider referral to pain or addiction specialist when risks outweigh benefits

When to Not Consider a Trial of an ER/LA Opioid



Initiating & Titrating ER/LA Opioid Analgesics: Opioid-Naïve Patients

Drug/Dose

- For naïve?
- Drug PI

Monitor

- Respiratory Depression
- 24-72 hours

Titrate

- Efficacy
- Tolerability
- Adverse Effects
- Minimum interval → Drug PI

When Analgesia is Inadequate



Reassess/manage underlying condition



Address behaviors that aggravate pain



Apply other non-opioid medications



Escalate opioid dose as a trial



Consider an ER/LA opioid (if using IR opioid)



Consider opioid rotation

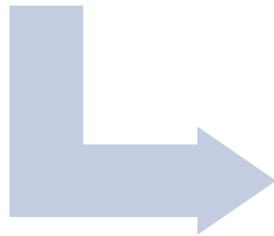
Converting From Immediate Release to ER/LA Opioids

- Safety is primary
- Before conversion to a long-acting opioid, use immediate release preparations to titrate to the appropriate 24 hour dose
- Different approaches
 - A. Use opioid equianalgesic dose table (EDT, conversion table) to switch
 - B. Use cross-titration
 - Slowly decrease old opioid
 - Slowly increase new opioid
 - May take weeks to achieve proper dosing

Switching ER/LA Opioids: Rotation

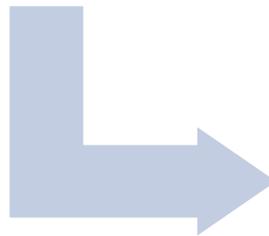
Dissatisfaction

- AE
- Poor efficacy
- Drug interactions
- Route of administration
- Change in clinical status
- Financial or drug-availability



Weigh

- Age and race
- Clinical state
- Comorbidities
- Other medications



Other Drug

- Drug sensitivities
- Convenience
- Improved adherence
- Financial
- Best dose!?!

**You have decided to switch ER/LA medications.
At what dose should the second ER/LA opioid
be initiated?**

- Equivalent dose, from the ED table
- 25–50% reduction of equivalent dose
- 75% reduction of equivalent dose
- Initiate as new treatment after wash-out period



Choosing a New Dose

Calculate
equianalgesic
dose of new
opioid from
EDT

Reduce calculated equianalgesic dose

- Generally: 25–50% reduction
- Methadone: 75–90% reduction
- Use clinical judgment

~50% reduction if patient

- Receives a high dose of current opioid
- Elderly or medically frail



~25% reduction if patient

- Is staying on current opioid but switching to a different administration route

Guidelines for Opioid Rotation

If switching to **methadone**:

- Reduce calculated equianalgesic dose by **75–90%**
- For patients on very high opioid doses, be cautious converting to methadone ≥ 100 mg/d
 - Consider inpatient monitoring, including serial EKG

If switching to **transdermal formulation**:

- **Fentanyl**: use equianalgesic dose ratios in the PI
- **Buprenorphine**: follow instructions in the PI

Guidelines for Opioid Rotation

Titrate new opioid dose

Frequently
assess:

Analgesia



AEs

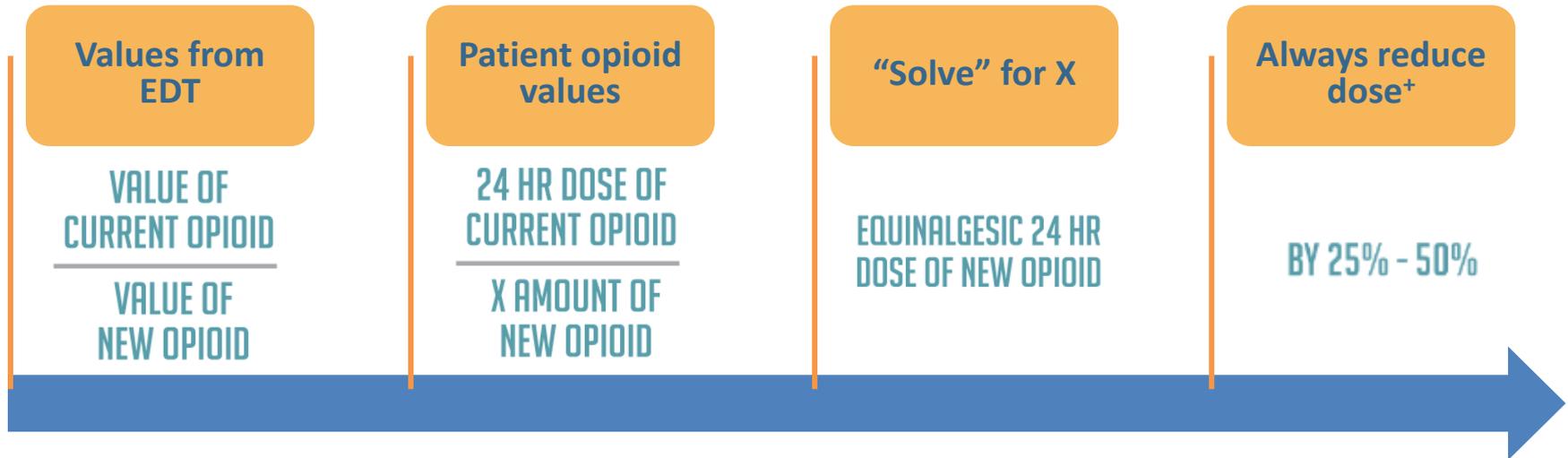


Withdrawal
symptoms

Break Through Pain

- Use a short-acting, immediate release preparation at 5–15% of total daily opioid dose
- If oral transmucosal fentanyl is used for BTP, always begin at lowest dose
- NEVER use ER/LA opioids for BTP

Opioid Rotation: Summary



Frequently assess initial response

Titrate dose of new opioid to optimize outcomes

Calculate supplemental rescue dose used for titration at 5–15% of total daily dose[‡]

[†]If switching to methadone, reduce dose by 75–90%

[‡]If oral transmucosal fentanyl used as rescue, begin at lowest dose irrespective of baseline opioid

ER/LA Opioid-Induced Respiratory Depression

Chief hazard of opioids

- May lead to respiratory arrest & death
- Greatest risk after initiation or dose increase
- Alcohol, sedatives, hypnotics, etc

Reduced urge to breathe & decreased respiration rate

- Shallow breathing
- CO₂ retention can exacerbate opioid sedating effects

Instruct patients/ family

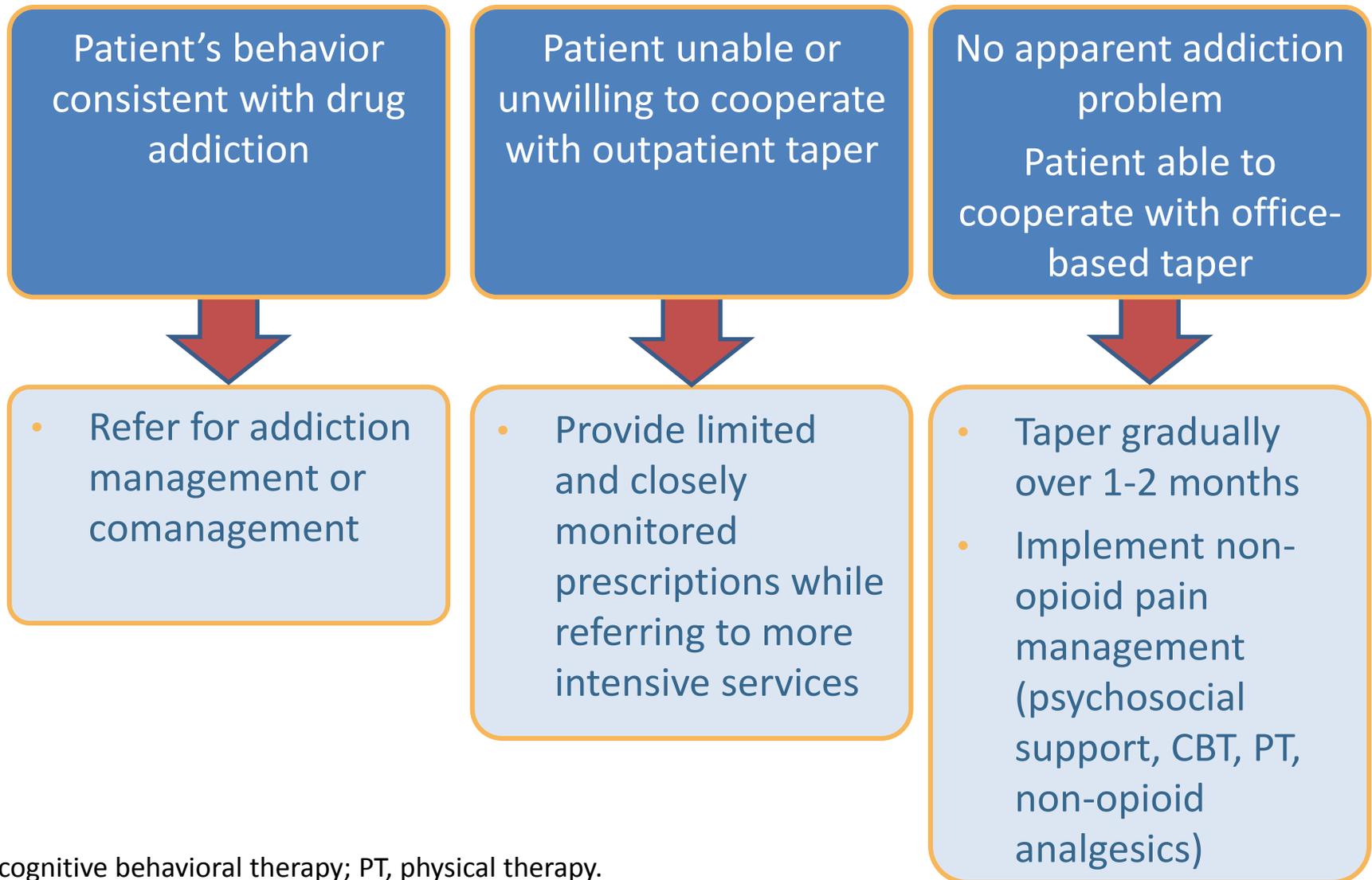
- Symptoms
- Call 911
- Dangerous polypharmacy

Chou R, et al. *J Pain*. 2009;10:113-130.

Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics. 2012.

www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafety/InformationforPatientsandProviders/UCM311290.pdf

Opioid Exit Strategy – Possible Paths



CBT, cognitive behavioral therapy; PT, physical therapy.

Katz, N. *Patient Level Opioid Risk Management: A Supplement to the PainEDU.org Manual*. Newton, MA: Inflexion, Inc; 2007.

Webster LR, Dove B. *Avoiding Opioid Abuse While Managing Pain: A Guideline for Practitioners*. 1st Edition. North Branch, MN: Sunrise Press; 2007.

Taper Dose When Discontinuing

Avoid withdrawal symptoms in opioid dependent patients

Optimal setting

- Outpatient in absence of unstable medical or psychiatric conditions or unsafe patterns of behavior
- Higher risk patients may need a more structured setting

When aberrant drug-related behaviors continue, may need

- Close monitoring and enforced tapering or
- Discontinued prescription and referral to detox or
- Agonist therapy

May use a range of approaches

- Slow...10% dose reduction/week
- Rapid...25–50% reduction every few days

Taper Dose When Discontinuing

Factors that influence the reduction rate:

- Reason for discontinuation
- Medical and psychiatric comorbidities
- Initial weaning rate
 - Faster at high doses (eg, > 200 mg/d morphine equivalent)
 - Slower at low doses (eg, 60-80 mg/d morphine equivalent)
- Monitor withdrawal symptoms

After taper:

- Continue to treat pain with non-opioids
- Treat psychiatric disorders
- Assess for and treat addiction-related aberrant behaviors

Module 2 Key Messages



- Best analgesic choice depends on patient and condition
 - Non-opioid analgesia
 - Immediate-release opioid
 - ER/LA opioid
- Rotation/conversion is not an exact science but protocols give guidance
- ER/LA are not for breakthrough pain
- Respiratory depression is rare but serious
- Opioids should be discontinued by tapering

Thank you for participating!

- Please take the posttest
- Please fill out the evaluation



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This activity has been planned and implemented in accordance with the Accreditation Requirements and Policies of the Accreditation Council for Continuing Medical Education through the joint providership of the University of Nebraska Medical Center, Center for Continuing Education, The France Foundation, the Federation of State Medical Boards, the FSMB Foundation and the American Osteopathic Association of Medical Informatics.



TARGET AUDIENCE

This activity is intended for health care professionals who prescribe ER/LA opioids.

STATEMENT OF NEED

Chronic pain is a major public health problem in the United States and has been estimated to affect up to a third of Americans. However, after a decade of standard setting and research on pain control, health care practitioner assessment and management of patient pain continues to be inadequate. Evidence-based guidelines emphasize thorough patient assessment, prompt recognition of patient pain, frequent monitoring, multimodal analgesic therapies, and patient input; yet, there are persistent gaps in clinicians' knowledge and practice around key areas of chronic pain management. Additionally, rates of misuse and abuse of nonprescription medications have not abated over the past decade, resulting in addiction, drug poisoning, and overdose death. Despite these concerns, appropriate use of opioids can improve a patient's quality of life. Thus, education on best practices for opioid safe use is critical for all clinicians managing patients with chronic pain.

Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy

An Accredited Continuing Medical Education Activity



EDUCATIONAL ACTIVITY LEARNING OBJECTIVES

Upon completion of this course, the participants should be able to:

- Appropriately assess patients for the treatment of pain with ER/LA opioid analgesics, including analyzing risks versus potential benefits
- Assess patient's risk of abuse, including substance use and psychiatric history
- Identify state and federal regulations on opioid prescribing
- Incorporate strategies to effectively initiate therapy, modify dosing or discontinue use of ER/LA opioid analgesics in patients with pain
- Manage ongoing therapy with ER/LA opioid analgesics
- Incorporate effective counseling for patients and caregivers about the safe use of ER/LA opioid analgesics
- Discuss general and product-specific drug information related to ER/LA opioid analgesics

ACCREDITATION STATEMENT

The University of Nebraska Medical Center, Center for Continuing Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

CREDIT DESIGNATION

Physicians

The University of Nebraska Medical Center, Center for Continuing Education designates this live activity for a maximum of 2 *AMA PRA Category 1 Credit(s)*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The American Osteopathic Association Council on Continuing Medical Education, through its accredited CME sponsor, the American Osteopathic Association of Medical Informatics, has designated this live activity for a maximum of 2 AOA Category 2B credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nurses

Nurses who are certified by the American Nurses Credentialing Center (ANCC) may utilize activities that are certified by ACCME-accredited providers toward their requirement for certification renewal by the ANCC. A certificate of attendance will be provided by the University of Nebraska Medical Center, Center for Continuing Education, an ACCME-accredited provider.

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| Release Date | April 2014 |
| Expiration Date | December 16, 2014 |
| Estimated Time to Complete Activity | 2 hours |

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The following faculty has indicated s/he has relationships with industry to disclose relative to the content of this CME activity:

- William L. Harp, MD, is a stock shareholder for UnitedHealth Group Common Stock

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CONTACT INFORMATION

If you have questions about this educational activity, please contact The France Foundation at 860-434-1650 or info@francefoundation.com.