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AMEF Sponsors The Free Clinic's Forum on the Effects of Violence

In June, the Academy of Medicine Education Foundation (AMEF) provided support for The Free Clinic's community forum on exploring the intersection of violence, public health and the economy. The event was held at Cuyahoga Community College's East campus.

Danny Williams, JD, Executive Director of The Free Clinic, began the forum with welcome remarks and a short, interactive audience response session to gauge the audience's knowledge of violence statistics. He then introduced the first speaker, **George Rodrigue**, an editor with *The Plain Dealer*. Rodrigue relayed the newspaper's desire to make the community better, to ask questions, to see what we all can do to change the occurrence of violence. The problem, he said, is finding a way to create a plan, fund it and make it sustainable, but added that it is something that we as a community need to work on.

AMCNO President Dr. Robert Hobbs introduced the opening speaker, **Cheryl Wills, MD**, who is an assistant professor of psychiatry at the CWRU School of Medicine. She presented on "Early Trauma: A Precursor to Violence." Her talk focused on the spectrum of trauma, a historical perspective of protecting children in the United States, research studies, and what works to help curb violence.

AMCNO President Dr. Robert Hobbs introduces the opening speaker at The Free Clinic event.

The consequences for victims and society are linked to public health, public policy, psychological, social, medical and financial

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Recent Amendments to Ohio's Affidavit of Merit Rule

A Helpful Tune-up, But No Additional Teeth Yet

By Edward E. Taber and Laura A. Supple, Tucker Ellis LLP

In Ohio, an affidavit of merit is usually required to initiate a medical malpractice lawsuit. The purpose of an affidavit of merit is to prevent medical malpractice claims from being filed unless and until a qualified physician has reviewed the case and deemed the claim to have merit. The affidavit of merit requirement is helpful because it theoretically screens out at least some percentage of frivolous medical malpractice lawsuits.

The affidavit of merit requirement was added to the Ohio Rules of Civil Procedure in 2005 as Civil Rule 10(D)(2). In practice over the last ten years, however, this requirement has been plagued by inconsistent application and ambiguity. This has prompted various efforts to add more "teeth" and clarity to it.

Although the affidavit of merit rule seems simple and straightforward at first glance, it is complicated by its connection to other Ohio rules and statutes. For example, the affidavit of merit rule is found in the Ohio Rules of Civil Procedure (Civ.R.) but it also references medical malpractice statutes from the Ohio Revised Code (R.C.) and rules from the Ohio Rules of Evidence (Evid.R.). The recent amendments are thus multilayered, and incorporate both Rules of Procedure, Rules of

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AMEF Sponsors The Free Clinic's Forum on the Effects of Violence *(Continued from page 1)*

issues, Dr. Wills stated. She said that "the home is the most violent place in America." And, several studies show that an increased exposure to violent acts in the media among our youth has contributed to increased aggression and antisocial behavior. It also desensitizes children to future violence.

Dr. Wills noted that in 1962, researchers identified "battered child syndrome." In 1971, a Senate Subcommittee on Children and Youth was created. That same year, experts provided testimony on diagnosing and reporting battered child syndrome. In 1973, mandatory reporting statutes were formed for every state.

Around this time, researchers started to take a look at how children developed. John Bowlby, a British psychologist, believed that behavioral problems could be attributed to early childhood, and explained through his attachment theory in 1969 that a strong attachment or bond promotes a child's survival and will affect how the child will behave in and perceive relationships throughout his or her life. An insecure attachment is associated with criminal behavior (even in the absence of a mental disorder), such as violent and non-violent offenses, domestic violence and sexual offenses.

In a 2001 study, researchers looked at maltreatment outcomes. Abuse and neglect led to an increased risk for trauma and victimization. For girls, there was an increased risk of emotional distress (ie, anger, depression, anxiety, and post-traumatic stress [PTS] symptoms) and violent and non-violent delinquency. For boys, there was a 2.5-3.5 increase in depression, PTS symptoms and overt dissociation, and there was an increase in threatening behavior or physical abuse against dating partners.

What works, Dr. Wills said, is early identification of at-risk youths using the Adverse Childhood Experience Index. The more adverse experiences children experience, the greater the risk of them becoming offenders. Dr. Wills said that the identification and research of therapeutic programs that target impulsivity, urgency and lack of premeditation can work as well.

She also suggested screening parents for stress, parent-child conflict, substance use disorders, other mental disorders, and trauma history to help limit violence, through trauma-informed care, treatment of mental disorders or multisystemic therapy.

Dr. Wills discussed firearms during her presentation and said that in one study, 73% of children knew where guns were stored in the house, and 36% admitted to handling the gun. Only 39% of their parents said their child knew where the gun was kept, and 22% said their child never handled the gun. These results help illustrate that parent education is key, Dr. Wills said, and according to the American Academy of Pediatrics, "physician counseling, when linked with the distribution of gun cable locks, has been demonstrated to increase safer home storage of firearms."

Danny Williams, Executive Director of The Free Clinic, gauges the audience's knowledge of violence statistics.

Following her presentation was a panel discussion on "The Facts about Mental Illness and Violence." Panelists were: **Anisha Durve**, acupuncturist, author and domestic violence survivor; **Dr. Mark Munetz**, professor and chairman of psychiatry at the Northeast Ohio Medical University; and the **Honorable José Villanueva**, Cuyahoga County Mental Health Court. The moderator was **Dr. Phillip Resnick**, professor of psychiatry at the CWRU School of Medicine.

Following are some statistics that were cited before the discussion began:

- The United States has the highest rate of homicide internationally (40 per 100,000 people).
- Most people who are mentally ill are not violent.
- Victims are rarely strangers.
- In violent crimes, 41% is attributed to someone under the influence of alcohol, and 36% to illegal drugs.

Durve discussed domestic violence. She said that, according to the United Nations, one of every 3 women around the world (1 in 4 women in the United States) will be beaten, raped or otherwise abused during her lifetime. Women account for 85% of domestic violence incidences. And, 275 million children worldwide are exposed to violence in the home, according to a U.N. Secretary-General's study.

Women experience 2 million injuries from intimate partner violence yearly in the United States, according to the Centers for Disease Control and Prevention, and a quarter of emergency room (ER) visits by women are due to domestic violence.

Dr. Munetz talked about the Crisis Intervention Team (CIT) Model, which is a community partnership to improve community safety. Dr. Munetz said that most violent acts are committed by individuals who are not mentally ill. But, encounters between law enforcement and people with serious mental illness can have adverse outcomes. The CIT Model involves intensively training select volunteer patrol officers, with an emphasis placed on verbal de-escalation. These CIT officers respond to calls 24/7 involving those with mental illness, which is about 7-10% of all calls. Officers are encouraged to refer people to treatment when it is an appropriate alternative to incarceration.

Judge Villanueva discussed the Mental Health and Developmental Disabilities (MHDD) Court. The goals of this court are to increase community safety, improve continuum of programming, continue collaboration with community agencies, continue to increase the early identification and engagement process, improve a defendant's supervision engagement and compliance, and improve a defendant's long-term participation with behavioral health agencies.

Mental health courts were created in response to the increasing numbers of defendants with serious mental illness who are placed in the criminal justice system. An estimated 800,000 people with serious mental illness are admitted to U.S. jails each year. In Ohio, more than 10,500 inmates suffer from mental illness. There are 10 times as many mentally ill inmates than there are patients in Ohio's six psychiatric hospitals.

Six judges oversee the MHDD court on a volunteer basis in addition to carrying their regular criminal and civil case workloads, and defendants must meet certain requirements to be eligible for the MHDD court. A treatment model approach is used by the court, which monitors a defendant's performance and progress through judicial interactions and therapeutic approaches.

The next panel discussion was moderated by **Harry Boomer**, anchor/reporter for Cleveland 19 News. Panelists were **Andrés González**, Chief of Police for the Cleveland Metropolitan Housing Authority; **Sharyna Cloud**, Director of Cleveland Peacemaker's Alliance; and **Khalid Samad**, CEO of Peace in the Hood.

Boomer started the discussion by saying that crime is on the move, and that we have to find solutions to these problems before they occur. A child is involved in a domestic violence incident 65% of the time, and in Cleveland, it's 85% of the time. It's important to intervene with that child, and officers are trained to recognize the symptoms of trauma to provide some form of intervention.

Boomer then asked the panel what can be done to break the cycle of violence. Cloud said that the Alliance targets those who are aged 15-24 and are considered to be at risk. Men and women from the neighborhood volunteer to work with this group to help them in various ways, such as to find a job, create healthy relationships, and raise their self-esteem. Many of the volunteers themselves have transitioned from gangs or other negative situations. They stress to these youths that they have to become invested in the community, and they let them know that they see a future in each of them.

Physicians and hospital representatives were recognized as being involved in the fight to curb violence, too. There is an effort to coordinate efforts on the trauma level (in trauma centers) and on the holistic level to ensure violence doesn't re-occur.

The panel also said that they are trying to get families involved by hosting family days and educating parents on how to give their child a better life. They also encourage children to use social media in constructive ways, instead of posting violent acts for "15 minutes of fame."

The final panel discussion was moderated by **Daniel Flannery, PhD**, Director of the Begun Center for Violence Prevention Research and Education at CWRU. Panelists were **Lisa Bottoms**, Program Director for Human Services, Child and Youth Development at The Cleveland Foundation; **Debra Lewis-Curlee**, MS, Transformation Consulting Services, LLC; and **Dr. Donald Malone, Jr.**, Cleveland Clinic Foundation. The panel discussed "Promising Anti-Violence Strategies."

Bottoms said that in 2007, the Foundation wanted to bridge the gap between childhood and workforce-ready adults. The Foundation

Dr. Cheryl Wills discusses how early trauma can be a precursor to violence.

views youth violence as something that is preventable, she said, and they know that the likelihood of engaging in violence is influenced by a child's relationships and the community in which he or she lives.

The Foundation focuses on intervention-type programming. Early care and education offers home visiting models and high-quality preschool sites, so that kids start school on time and ready to learn. Youth development connects kids to adults for mentoring opportunities and career awareness. They are also looking at education reform and workforce development (creating training programs).

Lewis-Curlee works with Cleveland residents and said that they have an invested interest in their community, but they don't always know that resources are available to them. Many residents are seniors and they don't have or use computers, so it can be a challenge to find ways to reach out to them. Community outreach is very important, she said, because it allows residents to speak and to be heard, and it allows organizations to relay the message of what resources are available to residents and connect them to those services.

Following the opening presentation, panelists talk about the facts behind mental illness and violence.

Malone talked about healthcare and workplace violence. Law enforcement is ranked first in workplace violence, and health care is ranked second, with 70% of workplace violence taking place in the healthcare setting. Last year, 61% of healthcare workers were assaulted, and 100% were verbally assaulted in the ER. The Clinic now has mental health providers in the ER who are trained on de-escalation techniques. Drug use is far more predictive of violent behavior than mental illness, Malone said. Not many detox facilities are available in the community and this needs to be addressed, he said. Treatment is important, and the community needs to be involved.

The panel agreed that we are moving in the right direction to help decrease violence but it can be a challenge to sustain those efforts. They offered several suggestions. Services have to be based in communities where people live—they have to own it. Having young people involved should also be part of the process. Establish programs that can talk to each other and allow people to talk to each other. Change how systems work, especially in relation to information sharing and gathering.

The keynote speaker was Dr. Ted Miller from the Pacific Institute for Research and Evaluation. He presented on "The Bite Violence Takes from our Wallets."

In 2010, violence cost the U.S. almost a trillion dollars. Assault accounted for 43.2% of those costs, sexual assault 42.5%, DWI 12.1%, robbery 2.1%, and arson 0.2%. In a risk assessment, the cost of violence per person, per age group, in 2010 was $7,000 for 15-19 and 25-29 year olds, $8,000 for 20-24 year olds (the highest costs among all age groups), and $6,000 for 30-34 year olds. The costs declined following this age group by $1,000 per group.

Dr. Miller discussed firearm injuries, saying that Americans own more guns than passenger vehicles—270 million vs. 239 million. Nationally, firearm injury costs $238 billion per year, which equates to $695 per gun, per resident—$513 for quality of life, $156 for work, $16 for criminal justice, and $10 for medical. In Ohio, the annual cost is $8.4 billion, or $729 per resident.

Crime by juveniles under the age of 18 cost the U.S. $150 million in 2010. Violence was attributed to 85.6% of the costs, and property

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Members are Needed for AMCNO's Annual Mini-Internship Program

The AMCNO will hold its annual Mini-Internship program October 17-19. The program, which was established in 1989, is designed to improve understanding and communication between the medical profession and those in the community who influence, establish and report on healthcare policy in Northeast Ohio. During the two-day program, interns have the opportunity to spend time with four physicians, accompanying them through their daily work schedule, which can include office visits and surgery.

The goal of the program is to create an information exchange to help broaden the perspectives of all participants. Through the experience, interns can witness first-hand the demands and rewards of the medical profession during a typical physician workday.

AMCNO member Dr. Anthony Bacevice recently sat down with the program's lead physician and facilitator, Dr. William Seitz, to talk about the program. You can view the video on our website www.amcno.org.

The AMCNO is asking its members to participate in the program and act as faculty for the interns. If you are interested in participating in this year's event, contact Abby Bell at (216) 520-1000, ext. 101, or email her at abell@amcno.org.

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(7.2%), public order (6.4%) and DWI (0.8%) accounted for the rest. The cost of sexual violence is $470 billion, and other family violence (including child maltreatment) is $275 billion. When divided by a Sensible Exposure Measure, sexual violence cost $1,520 per U.S. resident in 2010, other child maltreatment cost $2,035 per child ($2,510 including child sexual abuse), and intimate partner violence cost $485 per adult. Sexual violence costs 3.5 times as much as drunk driving in the U.S.—$469 billion vs. $134 billion, respectively.

The AMEF was pleased to be a sponsor of this informative event. The Free Clinic has posted a video and background information about this conference on their website at www.thefreeclinic.org. ■

Recent Amendments to Ohio's Affidavit of Merit Rule

(Continued from page 1)

Evidence, and statutes from the Revised Code. The overall significance of the recent amendments makes the affidavit of merit rule more clear and therefore easier and more efficient to apply. However, these amendments do not meet the oft-cited goal of "putting more teeth" into the affidavit of merit requirement.

The Amendments

The recent amendments to the affidavit of merit rule became effective July 1, 2016. The first amendment clarified the qualifications required for an expert to author an affidavit of merit for certain types of medical claims. The second amendment clarified a Rule of Evidence that is referenced in the affidavit of merit rule. This second change should make the Rule more uniformly interpreted. Each amendment is addressed in detail below.

Change 1: Expert Requirements Based on Type of Medical Claim

Prior to the 2016 amendment, the affidavit of merit rule was unclear about the qualifications the person providing the affidavit (or "affiant") must have when providing an affidavit of merit for different types of medical claims. The affidavit of merit rule seemed to require all affiants to meet the requirements of a specific Rule of Evidence, Evid.R. 601(D).

In reality, however, the only affiants that must meet Evid.R. 601(D) are those that are affiants in lawsuits against doctors, hospitals, and podiatrists. Affiants in other types of medical claims, like those against dentists, optometrists, or chiropractors, are subject to an entirely different Rule of Evidence, Evid.R. 702.

Because Evid.R. 601(D) and 702 contain different requirements for witnesses providing an affidavit of merit, it was important that the discrepancy was fixed in the amendment. Changing the title of the affidavit of merit and incorporating a reference to Evid.R 702 fixed the problem.

Change 2: Amount of Time Expert Must Devote to the Practice of Medicine

The second amendment changed Evid.R. 601(D). As explained above, Evid.R. 601(D) contains requirements for expert witnesses in medical malpractice cases involving doctors, hospitals, and podiatrists. Before Evid.R. 601(D)'s 2016 amendment, a statute from the Revised Code, R.C. 2743.43, also laid out requirements for expert witnesses in medical claims against physicians, hospitals, and podiatrists. Unfortunately, the requirements of Evid.R. 601(D) and R.C. 2743.43 were inconsistent. For example, R.C. 2743.43 required that physician expert witnesses devote at least ¾ of their time to the practice of medicine, while Evid.R. 601(D) requires ½ time.

The solution to this problem was easy. One legal rule of thumb is that when rules and statutes are inconsistent, the rule prevails over the statute. So, Evid.R. 601(D) is now structured more like R.C. 2743.43 and includes some of its language, but the ½ time requirement for experts remains the same. Additionally, R.C. 2743.43 is no longer relevant and has been entirely superseded by the Evid.R. 601(D) amendment.

Conclusion

The recent amendments surrounding the affidavit of merit rule are largely procedural but still important for physicians to note. After these amendments, potential physician affiants can be more confident in the requirements they must meet before providing an affidavit of merit in various types of medical malpractice cases. Additionally, physicians who are subject to medical malpractice lawsuits will benefit because the ambiguity in this requirement has been eliminated, which should reduce litigation costs. ■

SAVE THE DATE!

2017 Medical/Legal Summit

MARCH 24-25, 2017

Cleveland's Medical/Legal Summit will be co-sponsored by the Cleveland Metropolitan Bar Association, Academy of Medicine Education Foundation, and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO).

Co-Chairs:

- Marlene Franklin, Esq. , Associate General Counsel, MetroHealth Medical Center
- Robert E. Hobbs, MD, AMCNO President

The Summit is intended to bring together doctors, lawyers, health care professionals and others who work in allied professions for education, lively discussion and opportunities to socialize.

For more information, call the CMBA at (216) 696-3525 or AMCNO at (216) 520-1000.

SUMMIT DETAILS

March 24 – CME, CLE TBD

March 25 – CME, CLE TBD

FRIDAY, MARCH 24, 2017

Friday evening Plenary Address and Q&A followed by a networking reception

SATURDAY, MARCH 25, 2017

Continental Breakfast followed by a half day of Plenary Sessions and Breakouts

Location:
ONE CLEVELAND CENTER
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REGISTRATION RATES

$75 CMBA members, AMCNO members and other healthcare providers

$125 Non-Members

$15 Students and Residents

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Better Health Partnership Update

By Diane Solov, Better Health Partnership

Better Health Partnership introduced itself to the community and presented its first report in June 2008, at a time when healthcare reform was the hottest policy issue on both major political parties' platforms.

Before a diverse audience at ideastream's Westfield studio, Better Health debuted its first report on the quality of care and outcomes delivered to 26,000 Northeast Ohioans with diabetes. With that it laid the foundation for a data-based, collaborative approach to improving chronic disease management within clinics and across populations. The goal was to improve care and health, eliminate disparities and reduce costs, targeting costly common chronic disease managed in primary care practices.

For the past nine years, Better Health's member healthcare organizations have opened a window to the information needed to improve the health of patients and populations. Knowing where we stand on the path to a healthier community helps us see what challenges remain and opportunities exist.

Better Health's 17th report to the community in June 2016 highlights its growth, fruits born of the regional collaborative and looks ahead to new initiatives that will address children's health and associated non-medical determinants.

More providers, more patients. The latest report offers quality data on more patients and primary care clinics than ever before. It documents the care of 191,142 patients with diabetes, heart failure, hypertension and depression cared for by 717 primary care clinicians in 72 practices of 9 Northeast Ohio health systems. Fifty-one percent of them receive care in safety-net practices, a jump from 33% three years ago—the result of Ohio's expansion of Medicaid, a post-2008 health reform program that has had an impact on the region, which Better Health has documented.

In 2015, Better Health welcomed 13 new outpatient clinics of the Northeast Ohio VA Healthcare System, the only VA system in the country that participates in a regional healthcare improvement collaborative. Also welcomed is the return of six clinics of Northeast Ohio Neighborhood Health Services, also known as NEON, to Better Health reports, as well as new sites of NEON and Neighborhood Family Practice.

Overall, primary care providers participating in Better Health care for an estimated 75% of patients in Cuyahoga County with chronic disease. Its reach and stratification of patient attributes—race/ethnicity, preferred language, insurance type (including uninsured), income, education and gender—provide a lens on challenges and opportunities at the population level.

Overall, more patients are receiving evidence-based and equitable care for diabetes, and more have their high blood pressure under control. The improvements are greatest for the most disadvantaged people in our community.

Getting control of hypertension. The care and outcomes of more than 181,000 adults living with high blood pressure were included in Better Health's report on 2015 data, which come from partners' electronic health records. Better Health has been reporting and driving improvements in blood pressure since 2009. In 2012, a "bright spot" in hypertension results at the former Kaiser Permanente Ohio practices was identified in the course of the Better Health Data Center's routine analysis. Kaiser's achievement were the result of a protocol that included a simplified medication algorithm and communications training. Better Health physician leaders adapted the protocol to ease adoption by its diverse member practices. Since then, Better Health coaches have been helping implementation in safety-net clinics, with striking results. Across 35 sites that have reported data in the last five biannual reports, rates of good control—140/90—rose from 65.7% in 2014 to 67.3% in 2015. The nine top-improving sites, all safety-net practices, have been working with Better Health staff to adopt the practice. The result is 1,608 more patients in these practices who have gotten their high blood pressure in control in the past year. Figure 1 shows the year-over-year change.

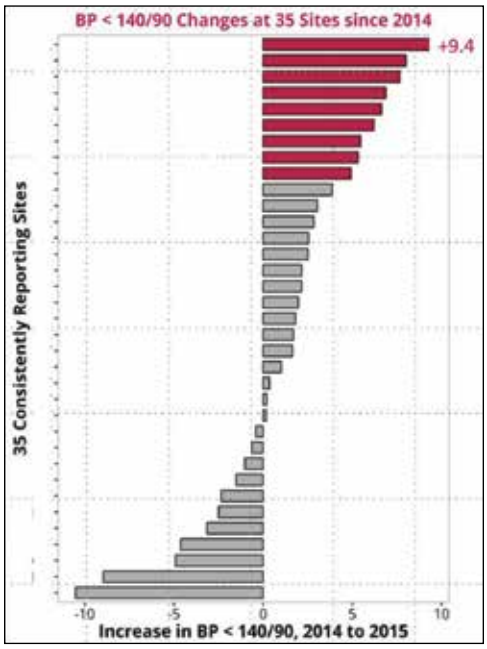

Figure 1. Safety-net practices that adopted the hypertension best practice with Better Health help topped the list of improvement in high blood pressure control rates from 2014 to 2015.

Better Health Partnership Snapshot

Modus operandi: Focus on common chronic problems; reach consensus on metrics; collect quality data from electronic records; measure & motivate by publicly reporting outcomes of care; analyze and mine data to identify uber-achieving clinics; document "best practice." If replicable, disseminate. Repeat twice yearly.

Public reports: Shine a spotlight on quality of care for adults with common chronic conditions cared for in primary care clinics.

Peer-to-peer learning: Twice yearly Learning Collaborative Summits facilitate learning across health systems, accelerating improvement as providers learn from peers with the most successful outcomes.

Impact: Since 2009, over 66,000 more patients with hypertension have their blood pressure under control, and over 12,000 more patients with diabetes receive recommended care than they did in 2007.

Health Equity: Improvements benefit vulnerable patients most: The gap in patients who receive recommended diabetes care has virtually vanished across racial and ethnic groups. Gaps in vaccination rates for pneumonia among diabetes patients with different income levels have closed, saving an estimated $7 million in averted hospitalizations over a five-year period.

Children's Health Initiative. Every child deserves a chance to thrive. In Northeast Ohio, too many children already have serious health conditions and risk factors that affect all spheres of their lives and will accompany them into adulthood. In 2015, Better Health launched its Children's Health Initiative, which initially will focus on the region's high rates of childhood obesity and asthma.

The need to address obesity is clear. In Cuyahoga County, 51% of poor children aged 12-17 are overweight or obese, and the rates of overweight and obese students rose 4.4% to 37.3% between 2009 and 2015, according to the Youth Risk Behavioral Health survey of 6,197 high school students in 26 Cleveland Metropolitan School District schools.

Weight problems are linked to limited access to healthy food and easy access to inexpensive low-nutrition food, as well as sedentary lifestyles. The 2015 survey of Cleveland high school students found that 35% of them ate fast food three or four days a week, just 30% met recommended activity levels and 28% reported no physical activity in 2015.

Under the co-leadership of Heidi Gullett, MD, MPH, family practitioner and co-chair of HIP-Cuyahoga, and Michelle Medina, MD, Interim Chair, Department of Community & General Pediatrics at Cleveland Clinic, a group of health providers for children has selected standards for overweight and obese children for Better Health's measurement and public reporting. A pilot report is targeted by the end of 2016.

Health systems whose primary care providers care for an estimated 85% of children in Northeast Ohio have joined the effort. All are committed to health improvement for the region's youngest residents.

More than a clinical problem. Attending to non-medical factors that affect health requires collaboration with strategic partners outside of health systems. Better Health joins the growing number of healthcare leaders who recognize the need to combine the care and expertise of pediatric clinicians with connections to resources in the community that can help achieve better health outcomes.

As in the adult population, Better Health will measure, publicly report and apply its "positive deviance" approach to identify, verify, share and accelerate dissemination of best practices. Our peer-to-peer and community-directed events, including biannual Learning Collaborative Summits and Reports to the Community, will expand to include more learning opportunities related to children's health.

Better Health will use its data capabilities to provide detailed maps that providers, community organizations, government agencies and funders can use to identify "hot spots," allocate resources and monitor progress. We are testing a potentially effective and scalable approach to enable clinicians to easily refer patients to vetted community resources and services to help achieve health goals.

Better Health also is working with United Way of Greater Cleveland to leverage its 2-1-1 Help Center, which helps people find, understand and access community resources for improving their health. Together, we will design and test linkages drawing on clinicians' and 2-1-1's resources and partnerships to improve health. A key objective is bidirectional data-sharing between clinics and 2-1-1 navigators to support follow-up in both the clinic and the community. ■

Editor's Note: *The AMCNO has been a participant in the Better Health Partnership since its inception, with physician representation from the AMCNO on several BHP key committees.*

AMCNO Opposes VA Proposal to Give Full Practice Authority to APRNs

The U.S. Department of Veterans Affairs (VA) recently published a proposed rule that would allow the VA to grant full practice authority for advanced practice registered nurses (APRNs), regardless of state practice acts.

The AMCNO submitted comments to the VA on its proposal to amend its medical regulations to give full practice authority to APRNs, which would include certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and certified nurse-midwives.

It is the understanding of the AMCNO that "full practice authority" means that an APRN working within the scope of VA employment would be authorized to provide services without the clinical oversight of a physician, regardless of state or local law restrictions on that authority.

The AMCNO opposes this proposed rule, as we support the use of patient-centered, team-based care. A team-based approach includes physicians and other healthcare professionals working together, sharing information and making decisions—for the patient's well-being. Each member of the healthcare team plays a critical role. Nurses, therapists, pharmacists, and others do their part in a team led by a physician. In our letter, we asked the VA to reconsider implementation of this proposal.

Board of Pharmacy Releases New Hazardous Drug Compounding Rule/Information

At their July meeting, the Ohio Board of Pharmacy voted to retract and redraft the dangerous drug rule (OAC 4729-16-04), and they created a new rule (OAC 4729-16-13) specifically dealing with an immediate-use provision.

The latest iteration of the rule provides for a more lenient immediate-use time than the USP immediate-use provision. The draft rule gives providers 6 hours to administer a compounded drug without the need for an ISO 5 environment, while USP limits the use to a one-hour time frame. There will be no changes to the hazardous drugs compounding rule (OAC 4729-16-11)—they were in effect as of May 1, 2016; however, the necessity for providers to obtain a Terminal Distributor of Dangerous Drugs license for the purpose of compounding dangerous drugs will be delayed until April 2017. Additional documents on this issue may be viewed on the Board of Pharmacy website at www.pharmacy.ohio.gov.

The new rules are now in the official rules review process, so there will be opportunities to comment. A pharmacy board rules hearing will be scheduled within the next few months. The AMCNO sent a comment letter on these revised rules and outlined our concerns. The letter stated that the AMCNO has significant concerns about the proposed rules' impact on the ability of physicians to provide high-quality patient care in the most efficient and cost-effective manner. We believe that the rules will negatively affect patients' access to care, potentially create inconsistency with federal regulations and unnecessarily increase the cost of medical care in some clinical areas without a significant improvement in patient safety.

The AMCNO will continue to update our members on this important issue.

Medical Board Plans to Cut Initial Licensure Fee

The State Medical Board of Ohio (SMBO) is looking to create financial incentives to encourage new physicians to stay in Ohio. Ohio's initial physician licensing fee is already among the least expensive in the country. Recently, the SMBO approved a further reduction from $335 to $305, and is awaiting legislative approval to implement this fee change.

AMCNO Agrees with HHS Action Plans to Combat Opioid Epidemic

The U.S. Department of Health and Human Services (HHS) is taking several new steps to tackle the nation's opioid epidemic, according to an announcement made by HHS Secretary Sylvia M. Burwell.

The new actions build on the HHS Opioid Initiative that launched in March 2015 and is focused on three key priorities:

- Improving opioid prescribing practices;
- Expanding access to medication-assisted treatment (MAT) for opioid use disorder; and
- Increasing the use of naloxone to reverse opioid overdoses.

These actions also build on the National Pain Strategy, which is the federal government's first coordinated plan to reduce the burden of chronic pain in the United States.

Of particular note is that the Centers for Medicare & Medicaid Services (CMS) is proposing to remove the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey pain management questions from the hospital payment scoring calculation. Many clinicians have reported that they feel pressured to overprescribe opioids because scores on the survey are tied to Medicare payments to hospitals. Those payments, however, currently have a very limited connection to the pain management questions on the HCAHPS survey. In the proposed rule, hospitals would continue to use the survey to assess patients' pain, but the questions would not affect the level of payment hospitals receive. The AMCNO has long advocated for this change, and we are pleased to see that it is being addressed by CMS.

Another action of note is the Buprenorphine Final Rule. Buprenorphine is one of the drugs frequently used for MAT for opioid use disorders. The finalized rule by the Substance Abuse and Mental Health Services Administration allows practitioners who have had a waiver to prescribe the drug for up to 100 patients for a year or more to obtain a waiver to treat up to 275 patients. This rule became effective August 5, 2016.

The other action steps the HHS is planning to take are:

- A requirement for Indian Health Service opioid prescribers and pharmacists to check their state Prescription Drug Monitoring Program database prior to prescribing or dispensing any opioid for more than 7 days
- More than a dozen new scientific studies on opioid misuse and pain treatment that will be launched by the HHS
- Provide prescribers with access to the education and training they need to make informed decisions

For more information on the other actions the HHS has been working on to address the opioid problem, go to their website at www.hhs.gov.

(Continued on page 10)

(Continued from page 9)

Legislation Requiring Alignment of Hospital and Public Health District Assessments Becomes Law

Gov. John Kasich recently signed legislation to coordinate local health assessments and improvement plans. Under the new law (ORC 3701.981), tax-exempt hospitals and local health districts are required to submit their existing community health improvement plans to the state to post online beginning in July 2017. And, the law requires these hospitals to complete future assessments and plans in alignment every 3 years beginning in 2020.

With this legislation, it will be easier for local communities to set priorities that improve the health of their citizens. And, it has the potential for significant cost savings over time, as it offers the opportunity to conduct one shared assessment for every health district and hospital in a county instead of paying for multiple separate assessments.

According to the Governor's Office of Health Transformation (OHT), this alignment will make it simpler for hospitals and local public health officials to work together on setting healthcare priorities. Hospitals have already been conducting their health assessments in three-year cycles, but local health districts have been doing so on five-year cycles. The change eliminates one of the barriers to cooperation between hospitals and local health districts.

The assessments look at a number of health factors affecting their communities, including rates of smoking, chronic conditions, risk factors and infectious diseases. According to the OHT, this new concept is part of a state goal to align health assessments and planning to affect overall population health outcomes. That state goal is to include a state health assessment and a state health improvement plan.

The AMCNO has long advocated for the coordination of these assessments and improvement plans and we are pleased to see this legislation become law. ■

Physician Leaders Conduct Candidate Interviews

Over the summer months, physician leaders from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and the AMCNO PAC—the Northern Ohio Medical Political Action Committee (NOMPAC)—participated in several Northern Ohio state legislator candidate interviews. The Ohio State Medical Association sent out a survey to candidates that contained specific questions related to several topics such as tort reform, scope of practice issues, what healthcare-related issues they would focus on if elected, the opioid crisis, health insurance issues, etc. The physicians conducting the interviews focused on these questions to obtain some insight about the candidates. Pictured: Interview with Matt Dolan (top) and Dave Greenspan (bottom).

The NOMPAC will be sending out additional information regarding the candidates running in Northern Ohio in the near future.

Ohio Supreme Court Candidates Meet with Physicians

The Ohio Supreme Court (OSC) candidates pose with OSC Chief Justice Maureen O'Connor (l to r – Pat DeWine, Chief Justice Maureen O'Connor and Pat Fischer.)

Over the summer months, the AMCNO (through our political action committee—NOMPAC), participated in a fundraiser for Ohio Supreme Court candidates at the home of AMCNO member Dr. John Bastulli. Candidates Judge Pat Fischer and Judge Pat DeWine met with attendees during the event. Chief Justice Maureen O'Connor—who is running unopposed—also attended the event.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO), through our PAC—the Northern Ohio Medical Political Action Committee (NOMPAC)—has endorsed **Judge Pat Fischer, Judge Pat DeWine** and **Chief Justice Maureen O'Connor** for the Ohio Supreme Court.

As we have done in previous elections, the NOMPAC seeks to endorse candidates for the Ohio Supreme Court who understand judicial restraint, will interpret Ohio law (not rewrite it), and will maintain stability and balance in the Ohio Supreme Court. Judges Fischer and DeWine and Chief Justice O'Connor follow this judicial philosophy. To learn more about these and other judicial races go to www.judicialvotescount.org and click on the "Who's Running for Judge" link.

AMCNO physician leadership spend a moment with the candidates and Chief Justice (l to r – Dr. Robert Hobbs, AMCNO President; Pat DeWine; Maureen O'Connor; Pat Fischer; and Dr. John Bastulli, AMCNO Vice President of Legislative Affairs.)

Ohio Medical Marijuana Law to Take Effect in September

By Cassandra Manna, JD, Roetzel and Andress, LPA

Ohio's new medical marijuana bill (HB 523) becomes effective on September 6, 2016. Passed by the Ohio General Assembly at the end of May and signed by Governor Kasich on June 6, the law makes Ohio the 25th state to pass a medical marijuana bill. The new law will have far-reaching effects on the business community but it is silent on many issues that concern employers.

Below is a summary of the law. We have listed facts for ease of reference; issues not fully addressed by the law are also noted.

Who can legally use medical marijuana?

1. Only people with the following medical conditions can legally use medical marijuana:
2. HIV/AIDS
3. ALS – Amyotrophic Lateral Sclerosis
4. Alzheimer's Disease
5. Cancer
6. CTE – Chronic Traumatic Encephalopathy
7. Crohn's Disease
8. Epilepsy or other seizure disorders
9. Fibromyalgia
10. Glaucoma
11. Hepatitis C
12. Inflammatory Bowel Disease
13. Multiple Sclerosis
14. Pain – chronic, and severe or intractable
15. Parkinson's Disease
16. PTSD – Post-Traumatic Stress Disorder
17. Sickle Cell Anemia
18. Spinal Cord Disease or injury
19. Tourette's Syndrome
20. Traumatic Brain Injury
21. Ulcerative Colitis

How and where do patients get medical marijuana?

Patients will need a recommendation from a doctor to receive a medical marijuana prescription. They must have an ongoing relationship with the doctor. The bill does not say where patients will get medical marijuana. Patients will have to receive the marijuana from states with legal dispensaries or will have to obtain it in other manners.

What are the rules and regulations for medical marijuana?

The bill is silent on direct rules and regulations. The bill calls for the formation of a bipartisan Medical Marijuana Advisory Committee within the Board of Pharmacy. The Committee must include two pharmacists, two physicians, a nurse, a researcher, and a member from each of a listed interest group. The committee will issue recommendation related to the Medical Marijuana Control Program.

Additionally, the Department of Commerce, Ohio State Pharmacy Board, and Ohio State Medical Board will need to determine how many licenses to issue and the guidelines for writing a marijuana prescription and filling that prescription.

What are the rules for and the steps to receiving a license?

No rules for or steps to receive a license have been established at this time. The rules, standards, and regulations will be established by the Medical Marijuana Control Program (the Program). The Program will be housed within the department of commerce and the board of pharmacy. The Program will issue four different licenses. First, a party can obtain a cultivator license for growing medical marijuana. Second, a party can obtain a processor license for processing the marijuana plant into a legal consumable form. Third, a party can obtain a laboratory license for testing and research purposes. Finally, a party can obtain a retail dispensary license for distributing the medical marijuana to registered patients and caregivers. The department of commerce will adopt the rules establishing standards and procedures for the Program for cultivators, processors, and laboratories. The board of pharmacy will adopt rules establishing standards and procedures for the retail dispensaries.

The department of commerce must establish the following standards and procedures for the Program's processor and laboratory licenses by September 6, 2017, and for cultivator licenses by May 4, 2017:

1. Application procedures and fees for licenses and registration
2. All of the following:
   a. Conditions for eligibility for a license
   b. Criminal offenses that disqualify a party from obtaining a license
   c. Criminal offenses that do not disqualify a party from obtaining a license if the offense is more than five years old
3. Number of cultivator licenses allowed at any time
4. Establish license renewal schedule, procedures, and fees
5. Specify reasons license suspended, revoked, or renewal withheld
6. Standards to lift license or registration suspension
7. Determine whether a cultivator or processor that existed at a location before a school, church, public library, public playground, or public park became established within 500 feet of the cultivator or processor may remain in operation, shall relocate, or have license revoked
8. All of the following:
   a. Criminal offenses that disqualify a person from employment with a license holder
   b. Criminal offenses that do not disqualify a person from employment with a license holder if the offense is more than five years old
9. Standards and procedures for testing medical marijuana by a licensed laboratory

The board of pharmacy must establish the following standards and procedures for the Program's retail dispensary licenses by September 6, 2017:

1. Application procedures and fees for licenses and registration
2. All of the following:
   a. Conditions for eligibility for a license
   b. Criminal offenses that disqualify a party from obtaining a license
   c. Criminal offenses that do not disqualify a party from obtaining a license if the offense is more than five years old
3. Number of retail dispensary licenses allowed at any time
4. Establish license renewal schedule, procedures, and fees
5. Specify reasons license suspended, revoked, or renewal withheld
6. Standards to lift license or registration suspension
7. Procedures and requirements for registration of patients and caregivers
8. Training requirements of employees of retail dispensaries
9. Determine whether a retail dispensary that existed at a location before a school, church, public library, public playground, or public park became established within 500 feet of the cultivator or processor may remain in operation, shall relocate, or have license revoked
10. Specify by form and tetrahydrocannabinol content the 90-day supply allowed for possession by a patient
11. Paraphernalia and accessories allowed to administer weed to registered patient
12. Procedures for issuance of patient and caregiver identification cards
13. Forms and methods of medical marijuana use attractive to minor patients
14. All of the following:
    a. Criminal offenses that disqualify a person from employment with a license holder
    b. Criminal offenses that do not disqualify a person from employment with a license holder if the offense is more than five years old
15. Establish a program to assist veterans and indigent patients in obtaining medical marijuana

In addition, the law states that no less than 15% of all licenses available must go to Ohio residents who are also a member of one of the following economically disadvantaged group: Blacks/African Americans, American Indians, Hispanics/Latinos, and Asians.

Again, the rules, standards, and procedures for the Program have not been established. This is an overview and list of the rules, standards, and procedures the Program must develop once it is established and functioning; until then, no licenses are available. Roetzel will continue to provide updates as more information is released but do not hesitate to contact the firm with further questions or concerns. ■

This article was recently featured in Roetzel's Media Alerts, July 2016. Posted with Permission from Roetzel and Andress, LPA – copyright 2016, by Roetzel and Andress.

LEGISLATIVE LEGAL UPDATE

Medical Marijuana Legalization will have Minimal Impact on the BWC

The legalization of medical marijuana will take effect Sept. 8. This new law, however, will not widely affect the Bureau of Workers' Compensation (BWC) business practices. Certain factors will remain unchanged, such as the BWC Drug-free Safety Program, BWC will not be required to pay for patient access to marijuana, and workers' compensation will not be awarded to an employee who is under the influence of marijuana.

In addition, the law continues to protect employers' right. Nothing in the new law requires an employer to accommodate an employee's use of medical marijuana. An employer can refuse to hire someone because of his or her medical marijuana use and can also discharge or take an adverse employment action against a worker for the same reason. If an employee was injured as a result of being under the influence of marijuana, he or she is not eligible for workers' compensation, regardless of whether the marijuana is recommended by a physician. And, although the law does not specifically address reimbursement for medical marijuana recommended for injured workers, Ohio law already has rules and statutes in place that limit what medications are reimbursable by the BWC.

The BWC recommends that employers establish a drug-free workplace, if they haven't done so already or review and update their existing policy, to best protect their workers and themselves. They stress the importance of having a policy because certain sections of the new law reference the use of medical marijuana in violation of an employer's drug-free workplace policy, zero-tolerance policy or other formal program or policy concerning the use of medical marijuana. Employers are encouraged to talk with their human resources or legal department to determine what that means specifically for their workplace.

Medical Marijuana Update from the State Medical Board of Ohio

Governor John R. Kasich signed House Bill 523—which "authorizes the use of marijuana for medical purposes and established the Medical Marijuana Control Program"—into law on June 8, 2016. The legislation goes into effect on Sept. 8, 2016. The Ohio Department of Commerce, State Medical Board of Ohio (SMBO), and Board of Pharmacy will regulate aspects of the legislation.

House Bill 523 authorizes the SMBO to adopt rules in accordance with the Administrative Procedures Act, for the following:

- The procedures when applying for a certificate to recommend;
- The conditions that must be met to be eligible for a certificate to recommend;
- The schedule and procedures for renewing a certificate to recommend;
- The reasons for which a certificate may be suspended or revoked;
- The standards under which a certificate suspension may be lifted;
- The minimal standards of care when recommending treatment with medical marijuana.

The SMBO has one year from the effective date of the bill to adopt the rules.

Website Provides Information About the Development of Ohio's Medical Marijuana Control Program

The Ohio Medical Marijuana Control Program will allow people with certain medical conditions, upon the recommendation of an Ohio-licensed physician certified by the State Medical Board, to purchase and use medical marijuana.

While the legislation set a basic framework for the program, it left the task of establishing specific rules and guidelines for the cultivation, processing, testing, dispensing and medical use of marijuana to different state agencies. A website has been designed to keep Ohioans informed about the development of Ohio's Medical Marijuana Control Program, including important timelines in the rule-making process and the announcement of opportunities for public input: http://medicalmarijuana.ohio.gov/

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Akron Children's Hospital

AMCNO and AMEF Meet and Greet First-Year Medical Students

The AMCNO and Academy of Medicine Education Foundation (AMEF) were pleased to co-host the Case Western Reserve University Society Dean Mixer for first-year medical students. The event was once again held at the Cleveland Botanical Gardens. AMCNO President Dr. Robert Hobbs, Dr. Bruce Cameron and Dr. James Coviello attended this year's event along with AMCNO staff. Staff and the AMCNO physician representatives mingled with the students and society deans. Dr. Hobbs then provided brief comments, and encouraged the medical students to become involved in the organization. He explained that the AMCNO is a group of dedicated physicians who are working to improve quality of care, while providing education and community outreach in our community.

AMCNO President Dr. Robert Hobbs provides brief comments during the Society Dean Mixer.

Medical students check in to the event and register to become AMCNO members.

During the event, the students asked about the activities of the organization and the foundation, and they were pleased to learn that they could participate as medical students. Many expressed interest in the work of the AMCNO and several had questions about their career and specialty choices, while others expressed an interest in volunteering and outreach activities. AMCNO staff was on-hand to provide membership information, and we are pleased to welcome more than 120 new medical student members. ■

Recruitment Efforts Bring New Resident Members into the AMCNO Fold

The AMCNO welcomed more than 400 new resident members into the organization during recent orientation events held around the region. Our congratulations to these new members, who are from the following institutions: The Cleveland Clinic, MetroHealth Medical Center and University Hospitals.

If you know of a resident who would be interested in free AMCNO membership, direct him/her to apply online at www.amcno.org. The application can be found under the Membership tab.

A University Hospitals resident takes a moment to sign up for AMCNO membership.

Academy of Medicine Education Foundation (AMEF) to Sponsor Immunization Conference

The 2016 ImmunizeOhio statewide immunization conference will be held on November 16, 2016, at the Galaxy Banquet Center in Wadsworth, Ohio. ImmunizeOhio brings credible, science-based vaccine education from nationally recognized speakers to physicians and nurses.

Speakers include: Dr. Raymond Strikas, CDC; Dr. Blaise Congeni, Akron Children's Hospital; and Dr. Leonard Friedland, GSK. Topics include adjuvant vaccine technology and the opportunities they bring to improve public health, new vaccines on the horizon, new recommendations, guidelines and mandates to existing vaccines, storage, handling and administration errors with strategies to prevent them, and strategies for bridging the gap between resistance and acceptance of vaccine guidance. The AMEF is pleased to be a sponsor of this important event.

For more information, directions and to register for the conference please visit www.immunizeohio.org

AMCNO Past Presidents are Promoted to New Positions

The AMCNO congratulates two of our Past Presidents on their promotions at the healthcare facilities where they practice medicine.

Anthony E. Bacevice, Jr., MD, has been named Chief Medical Officer for University Hospitals Elyria Medical Center. In his new role, Dr. Bacevice will lead major initiatives, including high-reliability medicine, quality and safety, patient advocacy, and physician relations.

Dr. Bacevice has been practicing medicine in OB/GYN at UH Elyria Medical Center since 1988, after completing his training at Case Western Reserve University (CWRU). He is also an assistant clinical professor in the Reproductive Biology Department at CWRU School of Medicine. He has held numerous positions in medical staff leadership and in hospital medical administration. Dr. Bacevice has also advised and advocated for the transition to the electronic health record implementation and is a member of CliniSync's Clinical Advisory Council, representing UH Elyria and the AMCNO.

George V. Topalsky, MD, has been named Vice President of University Hospitals Primary Care Institute, which is the largest primary care network of physicians in Northeast Ohio. Dr. Topalsky will continue to build on the institute's solid foundation, continuing progress in fostering the most positive outcomes, the highest levels of patient satisfaction, and operational effectiveness. He will also continue to maintain his clinical practice.

Dr. Topalsky joined UH in 2014 and has been serving as the Southwest Regional Medical Director for the Institute since then. Previously, he managed a 10-provider group in the Greater Cleveland area for 25 years. He has also served in various positions within local health systems. He received his medical degree from CWRU School of Medicine and completed his residency in internal medicine at Mt. Sinai Medical Center in Cleveland. He is board-certified in both internal and geriatric medicine.

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2016 AMEF FUNDRAISER

Many Thanks to the 2016 Golf Outing Participants and Sponsors for Another Smashing Success!

AMEF's golf outing will benefit medical students, physicians and the community

On August 8, golfers teed off for the Academy of Medicine Education Foundation's (AMEF) 13th Annual Marissa Rose Biddlestone Memorial Golf Outing.

This year's event was held at the Mayfield Sand Ridge Golf Club. Eager foursomes tested their expertise in a shotgun tournament to raise money for AMEF, which was established for charitable, education and scientific purposes. These monies will be utilized for medical student scholarships, annual CME seminars and grants for health-related programs.

The day went smoothly as golfers registered and dropped off their bags, practiced their shots and enjoyed a leisurely lunch in the warm summer air. The shotgun start was at precisely 1 pm, and the game was on!

Our congratulations to the teams that took home the top prizes:

1st Place Team: William Seitz, Jr., MD; Peter Voudouris; Jacob Ehlers; Lindsey Ehlers

2nd Place Team: Jeff Stanley, DO; Pat O'Brien; Dennis Forchione; Jason Forchione

3rd Place Team: Ed Taber, Dave Valent, Ernest Auciello, Jeff Whitsell

Skill prizes were also awarded:

Closest to the pin: Tom Epps, Nick Trankito, Irwin Mandel, Pat O'Brien

Longest drive: Nate Bayless and Al Page

Longest putt holed: Pat Monahan

Cocktails were enjoyed as everyone relaxed after some challenging holes. Golfers then sat down for a delicious dinner, awards, a great speech by Dr. John Bastulli and a fun prize raffle.

A special **thank you** to Classic Auto Group – Jim Brown and Dr. Victor Bello for sponsoring the hole-in-one contests. And thank you to all the event and hole sponsors who helped make the day such a huge success.

Thank you to the 2016 Event Sponsors:

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SAVE THE DATE for next year's AMEF Golf Outing!

August 7, 2017, at Chagrin Valley Country Club. See you there!