

Healthcare Reform Takes Center Stage at the 2017 AMCNO/CMBA Medical Legal Summit

Gail Wilensky, PhD, delivered the keynote address, "The Future of the Affordable Care Act and Medicare Payment Reform," at the 2017 Medical Legal Summit—an annual event co-sponsored by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), the Academy of Medicine Education Foundation, and the Cleveland Metropolitan Bar Association (CMBA). It was held March 24-25 at the CMBA Conference Center.

Prior to Dr. Wilensky's keynote presentation, opening remarks were provided by **Dr. Robert E. Hobbs**, AMCNO President and Summit Co-Chair, and **Marlene Franklin, Esq.**, Associate General Counsel at MetroHealth Medical Center and Summit Co-Chair. The

Health Care Law Update took place earlier in the afternoon, prior to the keynote presentation. Among the topics covered during that session were: "Safety Net Providers: Law and Public Policy," and "Managing Risk in Employing Foreign



Dr. Gail Wilensky (center right) stands with a few 2017 Medical Legal Summit planning committee members (from left to right—Dr. Fred Jorgensen, Marlene Franklin, and Dr. Robert Hobbs).

Nationals: At the Crossroads of Health Care, Labor and Employment, and Immigration," which was presented by **Isabelle Bibet-Kalinyak**, McDonald Hopkins LLC.

(Continued on page 2)

The American Health Care Act (AHCA)

GOP Efforts to Repeal and Replace the Affordable Care Act—What Can Healthcare Providers Anticipate Moving Forward?

By Elizabeth Sullivan, Esq., and Isabelle Bibet-Kalinyak, Esq., McDonald Hopkins LLC

On Monday, March 6, 2017, House Republicans released the American Health Care Act (AHCA)—the long-awaited plan to repeal and replace the Affordable Care Act (ACA). After a few weeks of intense activity, including passage of the legislation in the House Ways and Means Committee and the House Energy and Commerce Committee, the AHCA fell short of passage in the House. Republican proponents pulled the AHCA bill from consideration on Friday, March 24, 2017, due to concerns that sufficient support did not exist within the Republican Party to pass the bill. More uncertainty awaited the legislation in the Senate.

Even though the AHCA is currently tabled, the Trump administration and Republicans have not given up efforts to replace the ACA. In the past few weeks, meetings between the administration and various coalitions of Republicans have taken place, showing the continued interest in replacing the ACA.

Without new draft legislation, at this point, the real question is what the recent efforts to pass the AHCA tell us about future proposals for healthcare reform. Though the authors do not pretend to have a crystal ball, the dialogue surrounding the AHCA provides some insight into future legislation. While many things may change in subsequent

efforts, several foundational elements appear to emerge and are likely to stick.

Initial Efforts to Repeal and Replace—The AHCA

When the ACA was enacted in March 2010, major themes included expansion of coverage, improving the efficiency and quality of health care, and lowering the overall cost of insurance. While the goal for Republicans over the past 7 years has been to repeal the ACA, the AHCA left much of the existing ACA themes in place. Untouched were a number of the most popular aspects of the ACA,

(Continued on page 5)

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INSIDE THIS ISSUE

AMCNO President's Message	Page 7
Legislative Update	Page 9
AMCNO Community Health Activities	Page 14

Healthcare Reform Takes Center Stage at the 2017 AMCNO/CMBA Medical Legal Summit *(Continued from page 1)*

Ms. Bibet-Kalinyak had recently written an article on this topic for the AMCNO's March/April *Northern Ohio Physician* magazine.

At the time of the Summit, the American Health Care Act (AHCA) was still being debated. Keynote speaker Dr. Wilensky stressed that regardless of the outcome, there is still a need for bipartisan support for passing any type of legislation. She discussed the unique makeup of the new governing body—Republicans now control Congress and the White House, but they are without a filibuster-proof majority in the Senate. This means that the Republicans need some Democratic support, or they will have to use the budget reconciliation process, which comes with challenges as well. Her advice to the Senate Republicans, especially concerning the Affordable Care Act (ACA), is to find something that they think could garner bipartisan support, and work on that.



Dr. Wilensky talks about healthcare reform during her keynote presentation.

It is clear that the ACA needs to change, Dr. Wilensky said, stressing that in year 4, “exchanges are still in churn, and one-third of counties in America are left with one insurer in the exchange.” And, the Congressional Budget Office (CBO) had predicted 18 million enrollees in exchanges by 2017; so far this year only 12.1 million have signed up. She did say that “the unsung hero” has been the success of Medicaid expansion plans that have pulled in numbers of the uninsured. And “this population has been absorbed without the churn and without stress in the system,” she said.

Dr. Wilensky said she sees many “mistakes” related to ACA policy. “As a public policy person, I’m not going to trash anything that substantially increases people with insurance coverage—that is a good thing.” But mistakes have happened along the way in previous administrations, she said, where Republicans had opportunities that they did not follow through on, such as limiting the age-band to 3:1 instead of 5:1; allowing

26-year-olds to stay on their parents’ policy after Jan. 1, 2014; guaranteeing future coverage without penalties; and lenient “special enrollment” rules.

One strategy is to repair or reform the ACA, she said. Politics never allowed this as an option—Republicans spent 2010-2016 vowing to repeal and replace it, particularly conservative Republicans. Legislation that is passed on a partisan basis is rarely stable, however, she said. Medicare was passed with bipartisan support, even though conservative Republicans and southern Democrats were against it. The new legislation, however, has a deep political partisan divide.

Republications have adopted a “three-bucket strategy,” Dr. Wilensky said, one of which is fast-track a bill, as they did with the AHCA. She said a better strategy, however, would have been to let both the Senate and the House pass something and then come to a reconciliation later. The other strategy is changing regulations and other administrative changes. The Administrative Procedures Act puts in many safeguards and processes to be followed in changing regulation and has to be consistent with the statute Congress is trying to implement. The Centers for Medicare & Medicaid Services (CMS) has to write rules and regulations, which is not a fast process. And the final strategy is a separate legislative package for other changes, such as malpractice reform, selling insurance across states, etc. This strategy requires 60 Senate votes.

She discussed proposed legislation introduced by Senators Bill Cassidy (R-LA) and Susan Collins (R-ME), which would keep some ACA provisions but not all. States would have three options:

1. Continue with the ACA, with the same funding for Medicaid (95% of premium subsidies).
2. Receive 95% of federal funding. Direct deposit/refundable tax credits in health savings accounts, paired with high-deductible plans.
3. Create their own solution but without federal funding.

Four Republican governors who expanded Medicaid in their respective states, including Ohio Gov. John Kasich, also proposed legislation focusing on Medicaid reforms, wanting to maintain support for their expanded Medicaid programs. They proposed that states should be offered two options:

convert federal funding to a per capita grant or funding for nondisabled/nonelderly to a block grant, or keep the current system but reduce the federal share.

The real problem, Dr. Wilensky said, is that no Democrats support the AHCA; and some Democrats have denounced Sens. Cassidy and Collins. But, she stressed that it is clear that stable legislation needs to have bipartisan support. “If the Republicans jam through a bill without the Democrats, it will be no more successful or stable than the ACA,” she concluded.

The Saturday sessions began with a plenary session on MACRA (or, the Medicare Access and CHIP Reauthorization Act of 2015). The speakers were **Cathy Costello, JD**, Director, CliniSyncPLUS Consulting, Ohio Health Information Partnership; **Dr. Howard Pitluk**, Health Services Advisory Group (HSAG), Vice President for Medical Affairs and Chief Medical Officer; and **Dr. Robert Furno**, Chief Medical Officer at CMS (via Skype).



Moderator Dr. Bruce Cameron (left) stands with panel speakers Dr. Howard Pitluk and Ms. Cathy Costello.

Ms. Costello discussed several items, including reporting timelines and Meaningful Use (MU) measures for 2017-18 for MACRA, the Merit-based Incentive Payment System (MIPS) and reporting options, the significance of the Composite Performance Score (CPS), and the Advanced Alternative Payment Models (APMs).

Dr. Pitluk talked about how HSAG is a partner in improving healthcare quality. Nearly 25% of the nation’s Medicare beneficiaries fall under the HSAG’s Quality Innovation Network-Quality Improvement Organization (QIN-QIO) territory. He discussed how research indicates that quality has improved through electronic health records and MU reporting. Advancing Care Improvement has replaced MU, and it is not “all or nothing.” Dr. Pitluk also talked about health information technology and its impact.

AMCNO MEDICAL LEGAL ACTIVITIES



Dr. Cameron introduces Dr. Robert Furno, who spoke via Skype.

Dr. Furno focused on the Quality Payment Program, which will reform Medicare Part B payments for more than 600,000 clinicians, and improve care across the entire healthcare delivery system. He then discussed the two tracks, MIPS and Advanced APMS, in more detail.

The next plenary session addressed the opioid crisis in Ohio. Panelists were **Dr. Nicole Labor**, Addiction Specialist, SUMMA Health Systems; **Marisa Darden**, Assistant United States Attorney, Northern District of Ohio; and **Hugh Shannon**, Administrator, Cuyahoga County Medical Examiner.



Dr. Nicole Labor gives a presentation outlining how addiction is a brain disease.

Mr. Shannon shared information on overdose deaths from 2006-2017 for all categories. In 2014, fentanyl was introduced into Cuyahoga County. There was a “catastrophic rise” in deaths in 2016, he said, and only 2 months into 2017, the projections are very high for deaths this year compared to last year. Ninety-five percent of all fatalities involve more than one drug and/or alcohol. He mentioned that Project DAWN, spearheaded by AMCNO member Dr. Joan Papp, has increased the number of lives saved.

Dr. Labor talked about how addiction is a brain disease, and she gave an easy-to-understand description of how each part of the brain is

affected by addiction. She said that medical providers, law enforcement and others are focusing on the drug, not the disease. The goal of treatment should be to restore the frontal cortex—where behavioral therapy works—once it’s been “hijacked” by the midbrain, where the drugs and alcohol work. She said she would like to see a shift in the current crisis—to treat the disease of addiction and work on prevention.



Panelists address the opioid crisis in Ohio (left to right: Ms. Marisa Darden, Mr. Hugh Shannon and Dr. Nicole Labor).

Ms. Darden discussed the Organized Crime Drug Enforcement Task Force Unit, which was created in 2013, and is a four-point model: law enforcement, education and prevention, healthcare policy and treatment. She said her office focuses on “big players,” such as drug dealers and cartels. Not many prosecutors are taking on these cases, but the Cleveland unit is. The penalties are stiff to send a message to drug dealers who are ruining communities and lives, she said. She also said the task force is placing an emphasis and resources on prevention, talking to schools and parents, for example, on the effects of drugs.

The final plenary session was about lawsuits—how to avoid or survive them, from a medical/legal perspective. Panelists were AMCNO member **Dr. John Bastulli**, St. Vincent Charity Medical Center; **The Honorable Nancy McDonnell**, Cuyahoga Co. Court of Common Pleas; and **R. Eric Kennedy**, Esq., Weisman, Kennedy & Berris Co, LPA.



Panelists from three different professions discuss lawsuits from their points of view: (l-r) The Honorable Nancy McDonnell, Mr. R. Eric Kennedy, and Dr. John Bastulli.

Dr. Bastulli, who is also the AMCNO’s VP of Legislative Affairs, said that the medical community promotes a culture of safety. “We have made strides in the last 15 years in

reducing medical errors,” he said. Malpractice suits can be stressful for physicians, but he offered a few suggestions in the event a physician is summoned for a case, such as don’t contact the patient and don’t alter the medical record. He said injured patients should be compensated fairly if they are truly harmed.

Mr. Kennedy has been asked to represent physicians in addition to the one that is hired by a physician’s insurance company. He tells physicians to “take [the case] personally”—they must decide whether they were right or wrong, if they met the standard of care. He also tells them “not to take it personally”—they’re going to have bad results, it’s nature, it’s medicine.

He added that medical malpractice filings are down—about 25% of what they were 10 years ago. Judge McDonnell said that malpractice cases in the county are down as well. The panelists agreed that tort reform has had a major impact.

The panelists also agreed that practice guidelines and standard of care are more important in lawsuits, rather than policies.

Following the final plenary on Saturday was a breakout session with two options: “Medical Marijuana,” or “Legal Issues in the Care of the ‘Vulnerable Patient.’”



Dr. Hobbs and Ms. Isabelle Bibet-Kalinyak stand at the podium to introduce panelists Ms. Cassandra Manna and Dr. Jerry Mitchell.

The Medical Marijuana session was moderated by Dr. Hobbs and Ms. Bibet-Kalinyak, and featured two presenters: **Dr. Jerry Mitchell**, a member of the Ohio Medical Marijuana Advisory Panel, and **Ms. Cassandra L. Manna**, Esq., from Roetzel & Andress, LPA.

Dr. Mitchell provided information on the known effects of marijuana, and he noted that there have been no randomized trials done on marijuana because it is classified as a Schedule I drug. He also provided background on HB 532, which was signed into law in Ohio in

(Continued on page 4)

AMCNO MEDICAL LEGAL ACTIVITIES

Healthcare Reform Takes Center Stage at the 2017 AMCNO/CMBA Medical Legal Summit *(Continued from page 3)*

2016. This law established a framework for marijuana cultivation, processing, dispensing and recommending marijuana. He stated that rules are currently being written for this legislation by the Departments of Commerce, Pharmacy and the State Medical Board.

Ms. Manna provided an overview on some of the legal aspects of the new law. She noted that a key point for physicians to remember is that if they are recommending medical marijuana to patients, they are issuing a "recommendation" versus a prescription. This was done because if a physician were to write a prescription for marijuana, they would be writing a prescription for a Schedule I drug, and under federal law, the Drug Enforcement Administration could revoke their license. Medical marijuana can be recommended for 21 qualified medical conditions, and there is a statute that allows for other medical conditions to be added to the list, so the list can expand in the future.

Ms. Manna also briefly discussed how employers do not have to permit or accommodate an employee's use of medical marijuana, and that employers may wish to consider establishing a zero-tolerance policy so they have one in place. She also indicated that all of the rules have to be



Summit participants listen to panelists speak during a breakout session.

completed by Sept. 8, 2017, so that may be a good time to review what is in the rules and then look at what policies hospitals and physician offices have in place.

In the other breakout session, **Chuck Corea**, In-House Attorney at the Cuyahoga County Board of Developmental Disabilities, discussed "vulnerable patients." He said 40% of patients have a disability or behavioral health issue. He talked about applicable Ohio Revised Code sections and definitions that cover this population, such as competent, incompetent, neglect, abuse, and emergency guardianships. He also discussed supported decision-making, which is an alternative to guardianship and involves the use of friends, family members, and professionals to help these patients understand the medical situations and choices

they face. The discussion concluded with case scenarios.

More than 250 Northern Ohio physicians and attorneys registered for this annual event, and both organizations appreciate their attendance. The AMCNO and CMBA especially thank the event sponsors for their generous support, as well as the planning committee and presenters for their hard work and sharing their expertise.

The planning committee will be meeting in the near future to discuss next year's agenda. AMCNO members are encouraged to participate, submit topics and suggest presenters for the Summit. Contact Elayne Biddlestone at ebiddlestone@amcnoma.org or (216) 520-1000, ext. 100, for more information. ■

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The American Health Care Act (AHCA) *(Continued from page 1)*

relating to the group health plan coverage requirements, including but not limited to:

- Coverage of children up to age 26;
- Prohibition on insurers denying coverage based on pre-existing conditions;
- Cap on out-of-pocket expenses;
- Guaranteed availability and renewability of coverage;
- Prohibition on maximum lifetime and annual limits; and
- No discrimination based on disability, age, or sex.

The underlying reason the AHCA did not attempt to repeal more of the ACA stems from the process invoked by Republicans to pass the bill: budget reconciliation. The advantage of passing the AHCA legislation as a reconciliation bill is that only a simple Senate majority is required for passage. This is the same mechanism that was used to enact parts of the ACA in 2010. The downside to using budget reconciliation is that it must be revenue neutral, meaning that any reduction in federal revenue (i.e., tax cuts) must be offset by reduction in credits or spending. In addition, only legislation that is germane to the management of the budget is allowed to be passed using the fast-track method. This explains why the technical components of the ACA, in particular its provisions affecting the healthcare delivery system through quality initiatives and program integrity, were left unscathed in the AHCA. Overall, much of the AHCA focused on changes to the Medicaid program and the healthcare insurance market for individual consumers.

Aspects of the AHCA Likely to Reappear Changes to the State Medicaid Programs

Included in the AHCA was a “freezing” of the ACA’s Medicaid expansion program within 3 years. In 2020, the state Medicaid programs would be able to continue serving then-current enrollees, but would not be able to accept new applicants into the programs. In addition, the Medicaid’s funding model would have shifted from an open-ended commitment by the federal government to each state, to a set annual amount provided to each state, either in the form of a block grant or capitated model related to the number of Medicaid beneficiaries. As negotiations within the Republican Party progressed, some of the accommodations intended to trigger additional Republican support included the addition of a work requirement for certain Medicaid beneficiaries and requiring Medicaid expansion beneficiaries to re-register every 6 months. Furthermore, the AHCA would have eliminated the requirement that Medicaid plans include the 10 “essential benefits” required by every plan under the ACA as follows:

- Ambulatory patient services;
- Emergency services;

- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Because of the interest in program savings, it is likely that many of the aspects of Medicaid reform contained in the AHCA and discussed during related negotiations will reappear in the future. In particular, the concept of the federal government providing states with a fixed amount of funding for the Medicaid program each year has been a constant of prior Republican repeal-and-replace efforts and is likely to be a feature of any future proposals. Consequently, it seems probable that future proposals to reduce Medicaid spending will result in a reduction of the total number of beneficiaries. Providers and facilities that routinely treat the uninsured and Medicaid patients are likely to be the first to feel the impact of such reduced coverage.

Individual Healthcare Insurance Market

The AHCA also proposed a number of changes to the individual healthcare insurance market. Under the AHCA, the ACA individual penalty for lack of healthcare coverage would be replaced by continuous coverage incentives that would make health insurance more expensive for individuals who lost coverage and later decided to reapply for insurance. Instead of premium subsidies based on income, the AHCA proposed tax credits based on age. The AHCA would have also permitted insurers to implement maximum risk ratios of 5 to 1 rather than 3 to 1 as required by the ACA.

During the negotiation of the AHCA, one of the issues raised by House members on the fence or against the bill was the fact that the AHCA would not cause premiums to fall for individuals purchasing insurance on the open market and that premiums would likely increase, at least in the short term. Another proposal was the elimination of the requirement that all health plans include the 10 essential health benefits in exchange for more reasonably priced coverage. Critics, however, worried that health plans would be stripped by insurers without the desired impact of significant reduction in premiums if the essential health benefits were no longer required.

Down but not Out

Repealing and replacing the ACA remains a top priority of the new administration and the Republican Party. As recently as early April, Vice President Mike Pence met with House

Speaker Paul Ryan and other House Republicans to discuss a path forward. While the elimination of the 10 essential health benefits for all health plans was reportedly off the table, the concept of a waiver program that would permit states to eliminate the requirement that insurers comply with the ACA’s community rating requirements was purportedly discussed. Such a change could negatively impact high-risk individuals and those with pre-existing conditions.

Most recently, on April 6, 2017, an amendment to the AHCA was submitted to the House Rules Committee, reintroducing the AHCA for consideration by the House, together with a new amendment that created a \$15 billion fund establishing an invisible risk-sharing program that would help states subsidize claims from high-risk individuals. Critics responded that the program would not have a meaningful impact and individuals would still feel the effects of the other contemplated changes, including the high propensity for increased premiums based on risk or age.

Efforts to repeal and replace the ACA will expectedly continue along partisan lines. Such efforts will be supported by Health and Human Services Secretary Tom Price, MD, the former Republican House Representative who issued his own repeal and replace plan in 2015 and reportedly consulted with House Speaker Ryan in assembling the AHCA. However, the lack of alignment among Republican critics of the AHCA presents unique challenges for the White House and congressional Republicans to find a way forward. In crafting and embracing more common ground with moderate critics, the White House and the Republicans already on board risk alienating the more conservative base and vice versa. These internal divisions make predicting which individual coverage elements will survive very difficult. While moderate Republicans and Democrats worry about individuals losing coverage, conservative Republicans remain concerned that the AHCA does not go far enough to curb costs. Amidst the dissensions, one constant remains: Supporters of the AHCA appear ready to continue to fight and vow to repeal the ACA. In the coming days, weeks, and perhaps months, we will need to continue to monitor the progress of repeal-and-replace legislation. While some clues exist, the final shape of the next healthcare reform legislation is anyone’s guess. ■

Elizabeth Sullivan, Esq., and Isabelle Bibet-Kalinyak, Esq., are business attorneys with the law firm of McDonald Hopkins LLC (www.McDonaldHopkins.com). Elizabeth’s practice is focused on regulatory and transactional support for healthcare clients. Isabelle’s practice focuses on healthcare law (transactions and compliance) and business immigration, primarily in healthcare settings.



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Outgoing President's Message: Robert E. Hobbs, MD

April 11, 2017



Robert E. Hobbs, MD

It was an honor to serve as President of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) for 2016-2017. The year was filled with a variety of advocacy, community, and educational activities. The AMCNO remained strong and fully active as the collective voice of physicians in Cleveland and Northern Ohio, and will continue to do so. The AMCNO focuses on several areas: legislative and medical-legal advocacy, communication and education, and community activities; a review of each follows.

In terms of legislative initiatives, the AMCNO supported reforms in prior authorization this year, which were subsequently signed into law by Governor John Kasich. We continued to advocate for a physician-led, team-based approach to patient care and opposed independent practice authority for allied health personnel. We continued to support efforts to curb the opiate epidemic plaguing Ohio, including use of the Ohio Automated Rx Reporting System (OARRS), treatment guidelines for acute and chronic pain, naloxone to save lives, and the "Good Samaritan Law" for calling 911 in the event of an overdose. The AMCNO continued to advocate for the continuation of Medicaid expansion, which has benefitted 700,000 Ohioans. In fact, the Board of Directors sent a letter to Congress stating their position on healthcare reform and the continuation of Medicaid, and emphasizing that the AMCNO is committed to working with congressional leaders to work toward efficient health system reform initiatives.

We will face new and ongoing legislative issues in 2017, including items in the state budget, tort reform (HB 7), step-therapy, price transparency, preservation of Medicaid expansion, surprise non-coverage, scope of practice, controlled substance dispensing regulations, one-bite rule, non-compete clauses, medical marijuana, and Graduate Medical Education funding.

The AMCNO Medical-Legal Liaison Committee consists of a team of physicians and attorneys that reviews legal decisions in the courts likely to impact the practice of medicine. This year the committee filed amicus curiae briefs with the Ohio Supreme Court on cases involving the statute of repose, the cap on noneconomic damages, the definition of a medical record,

access to patient information, interlocutory appeals, and the apology statute. Our track record in supporting these cases has been excellent, based on the final Supreme Court rulings.

The AMCNO joined a lawsuit with the Ohio Hospital Association and other medical associations against the State of Ohio seeking to block the Price Transparency Law from going into effect on Jan. 1, 2017. This legislation was introduced as part of a budget bill in 2015 without any preliminary committee hearings. The law was later deemed unworkable by hospital and physician groups. Despite using the best computer modeling, physicians and hospitals would be unable to provide patients with accurate and timely financial data prior to rendering service or performing a procedure. Discussions on price transparency will continue this year.

In terms of education, the AMCNO and the Cleveland Metropolitan Bar Association organized the annual Medical-Legal Summit, which featured Gail Wilensky, PhD, who discussed the future of healthcare. Other topics included the Medicare Access and CHIP Reauthorization Act (MACRA), medical malpractice lawsuits, medical marijuana, and managing vulnerable patients. The AMCNO also organized a seminar that highlighted the financial and legal aspects of medical practice.

The AMEF is the charitable arm of the AMCNO. It provided financial assistance for scholarships, educational forums, and community initiatives. The AMEF supported the Business of Medicine seminar, Immunize Ohio event, Violence Forum, Medical-Legal Summit, PALS (or, Physicians Are Linked with Students) medical student event, Doc Opera, Ohio Infant Mortality Summit, and the Annual

Golf Outing fundraiser. In addition, the AMEF awarded two grant requests, assisting students with career choices and developing an online educational program on controlled substance prescribing. Additionally, the AMEF granted seven scholarships to students attending Northern Ohio medical schools.

Community activities attempt to tackle difficult societal problems. With that in mind, the AMCNO co-sponsored a regional forum on violence with the Free Clinic of Cleveland, held a panel discussion on drug addiction at the Ohio Healthcare Trade Faire, and joined coalitions to address public health issues of chronic diseases, infant mortality, opiate addiction and lead poisoning. The solutions to these problems are never easy, and a multifaceted approach seems to work best.

Politically, the AMCNO endorsed Pat Fischer and Pat DeWine as candidates for the Ohio Supreme Court. Both justices indicated they would abide by the constitution and uphold tort reforms, and both were subsequently elected. The AMCNO's Political Action Committee, NOMPAC, participated in fundraisers for Supreme Court candidates and Ohio Senators. AMCNO members conducted candidate interviews among applicants seeking election to the Ohio legislature and partnered with the Ohio State Medical Association in providing endorsements.

I have had a busy but fulfilling year serving as President of the AMCNO. I am grateful to many individuals for their assistance and guidance—in particular I am most appreciative of the AMCNO EVP/CEO Elayne Biddlestone, who provided experience, wisdom and management skills that made my job easier. I am indebted to the Executive Committee for helping me make tough decisions. I thank the Board of Directors for their involvement, input, and insight. I also thank the AMCNO staff, Abby Bell and Tara Camera, for daily management of the Academy.

I am confident that our new President, Fred Jorgensen, MD, will lead the AMCNO effectively to face the challenges of the practice of medicine and embrace new opportunities for the organization. ■

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Gov. Kasich Releases Proposed Rules Aimed at Reducing Opioid Prescriptions—Legislators Introduce Legislation on Similar Path

Governor John Kasich and the state's medical licensing boards have announced proposed rules for acute pain prescribing, with the goal of reducing the number of opiate painkillers that are distributed to patients. For short-term pain, the rules would limit the amount of prescription opioids to no more than seven days for adults and five days for minors. The prescriptions cannot exceed an average of 30 morphine equivalent doses (MED) per day. Also, physicians would be required to provide a specific diagnosis and procedure code for every painkiller prescription they write, to be entered into the Ohio Automated Rx Reporting System (OARRS). Healthcare providers can prescribe opiates in excess of the new limits only if they provide a specific reason in the patient's medical record. The limits would not apply to care for cancer, palliative care, end-of-life or hospice care, or medication-assisted treatment for addiction. The administration estimated that the new rules would reduce the number of opiate doses by 109 million per year.

In addition to the governor's announcement regarding new rules, lawmakers in both the Ohio House and Senate announced legislation—SB 119 and HB 167—to require physicians to adhere to guidelines from the federal Centers for Disease Control and Prevention. The legislation would tighten regulations for opioid prescriptions from doctors and dentists by mandating alternative treatments and education for professionals who exceed federal guidelines.

The governor's proposal for physicians would be a Medical Board rule which would allow for more flexibility should changes or modifications be needed, whereas, the legislative proposal would be law complete with inflexible mandates for physicians. In addition, the governor's proposal contains a process by which physicians can use their professional discretion to exceed the prescribing limits if appropriate for a patient, whereas, the legislative proposal does not and will potentially lock all doctors into inflexible treatment options. The rules announced by the governor don't require new legislation.

The Ohio Board of Pharmacy (BOP) has sent out their proposed rules for Prescription Manner of Issuance and OARRS Reporting Rules for public comment. A copy of the proposed rules may be viewed on the BOP website at www.pharmacy.ohio.gov.

The State Medical Board of Ohio (SMBO) policy committee discussed additional rules during their April policy committee meeting. The SMBO rules would do the following:

For the treatment of acute pain, the physician shall comply with the following:

- (1) Extended-release or long-acting opioid analgesics shall not be prescribed for treatment of acute pain;
- (2) Before prescribing an opioid analgesic, the physician shall first consider non-opioid treatment options. If opioid analgesic medications are required as determined by a history and physical examination, the physician shall prescribe for the minimum quantity and potency needed to treat the expected duration of pain, with a presumption that a three-day supply or less is frequently sufficient;
- (3) In all circumstances where opioid analgesics are prescribed for acute pain:
 - (a) The duration of the first opioid analgesic prescription for the treatment of an episode of acute pain shall be:
 - (i) For adults, not more than a seven-day supply with no refills;
 - (ii) For minors, not more than a five-day supply with no refills. A physician shall comply with section 3719.061 of the Revised Code, including but not limited to obtaining the parent or guardian's written consent prior to prescribing an opioid analgesic to a minor;
 - (iii) The seven-day limit for adults and five-day limit for minors may be exceeded for pain that is expected to persist for longer than seven days based on the pathology causing the pain. In this circumstance, the reason that the limits are being exceeded and the reason that a non-opioid medication was not

appropriate to treat the patient's conditions shall be documented in the patient's medical record; and

- (iv) If a patient is allergic to or otherwise unable to tolerate the initially prescribed opioid medication, a prescription for a different, appropriate opioid may be issued at any time during the initial seven or five-day dosing period and shall be subject to all other provisions of this rule. The allergy and/or intolerance shall be documented in the patient's medical record. The patient or the minor patients, parent, guardian or other responsible adult must be provided education of the safe disposal of the unused medication.
- (b) The patient, or a minor's parent or guardian, shall be advised of the benefits and risks of the opioid analgesic, including the potential for addiction, and the advice shall be documented in the patient's medical record; and
- (c) The total MED of a prescription for opioid analgesics for treatment of acute pain shall not exceed an average of thirty MED per day.

This rule does not apply when an opioid analgesic is prescribed to an individual who is a hospice patient or in a hospice care program; to an individual receiving palliative care; to an individual who has been diagnosed with a terminal condition; or to an individual who has cancer or another condition associated with the individual's cancer or history of cancer. In addition, the rule does not apply to prescriptions for opioid analgesics for the treatment of opioid addiction utilizing a Schedule III, IV or V controlled substance narcotic that is approved by the U.S. Food & Drug Administration for opioid detoxification or maintenance treatment, and the rule does not apply to inpatient prescriptions.

The SMBO proposed rules have now been sent out for comment and will then proceed into Ohio's standard rule review and adoption

(Continued on page 10)

(Continued from page 9)

process. The AMCNO is reviewing the rule and will be providing comments. Further information and specific prescribing information will be provided by the SMBO once the rules are finalized, but before they become effective.

Ohio Board of Pharmacy Releases Guidance Documents for New Licensing Requirements Specific to Certain Physicians

Three Ohio Board of Pharmacy (BOP) licensing requirements take effect this year for physicians in certain settings, and the BOP recently released guidance documents concerning the new laws. Following are summaries of the new requirements; physicians can also view the full documents—and obtain further information about them—on the BOP website: www.pharmacy.ohio.gov.

The first new law, effective April 1, is Terminal Distributor of Dangerous Drugs (TDDD) Requirements for Prescribers Possessing Compounded Drugs or Engaging in Drug Compounding. All prescribers that possess compounded drugs or engage in compounding of dangerous drugs (including previously exempted prescriber practices) must obtain a license as a TDDD. The BOP defines compounding as “the preparation, mixing, assembling, packaging, and labeling of one or more drugs. Compounding includes the combining, admixing, mixing, diluting, reconstituting, or otherwise altering of a drug or bulk drug substance.”

The second law is the TDDD Requirements for Controlled Substances, effective April 6. All locations that possess controlled substances (including previously exempted prescriber practices) are required to obtain licensure as a category III TDDD. Controlled substances include anything designated as Schedule I-V. On or after April 6, 2017, any facility possessing controlled substances without being properly licensed as a terminal distributor will be in violation of Ohio law. Also, any facility that is not licensed as a terminal distributor will not be able to purchase any controlled substance medications from an Ohio-licensed wholesaler.

And, the final law is Office-Based Opioid Treatment, which will take effect August 4. All locations that treat more than 30 individuals for opioid dependence or addiction using a controlled substance are required to obtain a license as a TDDD with an office-based opioid treatment classification; however, there are some exemptions, which can also be viewed on the BOP's website: www.pharmacy.ohio.gov.

HPIO Releases Health Value Dashboard

The Health Policy Institute of Ohio (HPIO) has released the latest edition of its *Health Value Dashboard*, which ranks states and the District of Columbia on a combination of population health and healthcare spending metrics. According to the *Dashboard*, Ohio ranks 46th in the nation in health value.

The *Dashboard* is unique in its emphasis on “health value,” rather than on population health outcomes alone. No other national rankings factor in the impact of healthcare spending. The *Dashboard* also takes a more comprehensive approach in looking at health by evaluating social, economic and physical environments—which are significant contributors to overall health. The *Dashboard* provides in-depth data on 118 metrics.

The HPIO *Health Value Dashboard* shows that Ohioans live less healthy lives (43rd in population health) and spend more on health care (31st in healthcare spending) than other states.

Like most states, Ohio's performance is moving in the right direction, with more metrics that improved than worsened in recent years. However, there are a number of metrics in which Ohio ranked in the bottom quartile. To view the *Dashboard* go to www.hprio.org.

AMCNO Participation in American Heart Association (AHA) Advocacy Day

Dr. Robert Hobbs and Ms. Elayne Biddlestone participated in an advocacy day event in March sponsored by the American Heart Association (AHA). Several issues were discussed with legislators during the event including the tobacco excise tax, which is



AMCNO President Dr. Robert Hobbs and staff joined AHA representatives to discuss healthy initiatives with Senator John Eklund (second from right).

outlined in the current biennial budget, a request for additional funding in the budget to assist the Healthy Food Program for Ohio, and stroke facility recognition.

AMCNO representatives met with several legislators including Senator John Eklund, Senator Sandra Williams, Representative Janine Boyd and the aide for Representative Sarah LaTourette.

On the topic of the tobacco excise tax we outlined how the governor's proposed tobacco tax increases are a step in the right direction, but we believe that Ohio can do better. We'd like to see a higher increase in the cigarette tax which would save lives and generate more revenue for the state, and we asked the legislators to support an increase in the cigarette tax from \$0.65 to \$1.00 per pack. And, we asked them to keep the other tobacco products parity as well. We informed legislators that the projected new annual revenue from the \$1.00 per pack increase is \$313.08 million and that increasing the price of tobacco products through tax increases is one of the most effective ways to keep youth from starting to use tobacco products and prompting tobacco users to quit.



During the AHA-sponsored advocacy day event at the Statehouse, AMCNO staff met with several legislators to talk about important issues. (l-r: Dr. Hobbs, Elayne Biddlestone, and Rep. Janine Boyd).

AMCNO LEGISLATIVE UPDATE

Another topic of discussion was healthy food financing. We noted that too many communities—and kids—lack access to a nearby grocery store that provides them with healthier food options. Over two million Ohio residents lack local access to fresh, affordable food, contributing to a health crisis among lower-income communities from diet-related diseases. Ohio is home to nearly 500,000 children who do not have access to healthy food options.

We advised legislators that we have to do better for our children and for ourselves. Healthy food financing puts healthy foods in the communities where options don't exist. Our ask to legislators was to consider including a \$15 million line item in the state biennial budget for the Healthy Food for Ohio program.

The final item of discussion with legislators was stroke facility recognition. The AHA and the American Stroke Association are a part of a national effort to ensure needed standards are in place that recognize a hospital's "stroke-ready" capability along with the effective coordination of emergency responders to transport stroke patients to the most appropriate facility in the shortest amount of time. The AHA plans to pursue the introduction and passage of stroke facility recognition legislation in Ohio that would establish a system of recognition for Comprehensive Stroke Centers, Primary Stroke Centers, and Acute Stroke Ready Centers throughout Ohio. The AMCNO representatives told legislators that we plan to review the language in the bill after it is introduced and consider our position at that time.

Immunization Event Highlights **New App**

The AMCNO was on hand during an event held at the Ohio Statehouse by the Immunization Advocacy Network of Ohio (IANO). IANO is a network of immunization providers and supporters who share information, best practices and serve as a collective voice educating and advocating for vaccines in Ohio.

During the event, presentations were provided highlighting the work being done in the field to ensure the health and well-being of all Ohioans, including improving access to vaccines and the public benefit of them. One key point addressed during the event was the launch of a new mobile application by the Ohio Chapter of the American Academy of Pediatrics. This new app was funded in part by the Ohio Department of Health, and it was developed to educate parents and provide them with trusted, credible and useful information about childhood immunizations. The app includes a series of videos recorded by a pediatrician, an interactive immunization schedule customized by the child's age, news alerts on research, and the ability to share information with others. The app also includes a provider login with a link to continuing medical education opportunities and information to use when talking to patients and caregivers. More information is available at www.OhioAAP.org/FVF.

AMCNO Continues to Support Step Therapy Reform; Promotes New Website

The AMCNO advocacy staff and representatives from more than 45 patient and provider groups across Ohio are working to raise awareness of the insurance industry practice known as "fail first" or "step therapy." Step therapy protocols can be harmful to patients both financially and physically, causing an undue wait for the proper treatment, and, in some cases, a worsening of a person's medical condition. Under step therapy, a patient must try one or more drugs chosen by his or her insurer—usually based on financial, not medical, considerations—before coverage is granted for the drug prescribed by the patient's healthcare provider.

The Ohio Physicians for Step Therapy Reform website was recently launched and includes information which physicians can use to learn more about the proposed legislation (SB 56 and HB 72), share their patients' step therapy stories, and send messages of support to their state Senator and Representative through the "Take Action" option on the site. Visit www.ooanet.org/reform.

In addition to launching the new website, supporters of SB 56 and HB 72, including several doctors and representatives from medical and patient groups, testified before the Senate Health, Human Services and Medicaid Committee and the House Health Committee. Testimony was provided from the medical community that step therapy has its place, but that exceptions should be provided for stable patients with ongoing conditions and in cases of known drug interactions. Physicians also noted that step therapy is primarily a method of saving money for insurance companies, and the legislation would increase transparency and eliminate red tape for patients.

It was also noted that insurance companies' lists of preferred drugs to be used in step therapy change from year to year and they are not consistent with one another. More than a dozen pieces of written proponent testimony were submitted to both committees—including letters of support from the AMCNO.

Biennial Budget Discussion Continues

As noted in our last issue, Governor Kasich has introduced his last two-year budget proposal, which includes tax proposals from previous budgets as well as ideas to increase the quality of health and human services. At press time, the budget discussion was nearing completion in the Ohio House with discussions to begin in the Senate in May—the budget is to be sent to the governor for his signature by the end of June.

The governor's budget plan includes many Medicaid-related proposals, including initiatives to modernize Medicaid, streamline health and human services, and improve population health. The AMCNO Board of Directors strongly supported Medicaid expansion in Ohio—and the AMCNO continues to support the modernization of Medicaid. We are part of a broad-based statewide coalition that agrees that Medicaid expansion in Ohio should remain intact. At this time it is still not clear how the debate at the federal level could impact Medicaid funding in the future. For more information on the discussions at the federal level see the cover story on the American Health Care Act.

(Continued on page 12)

AMCNO LEGISLATIVE UPDATE

(Continued from page 11)

Update on One-Bite Legislation

HB 145—Confidential Treatment was recently introduced in the Ohio House by Reps. Steve Huffman and Robert Sprague. The legislation will provide for the establishment of a confidential program for the treatment of certain impaired practitioners. The language in this legislation was developed in part by a medical advisory committee made up of various medical associations—including the AMCNO and the Ohio Physicians Health Program (OPHP). The legislation will require confidential reporting of all peers, treatment centers, and the Board regarding impairment concerns to the “monitoring organization” conducting the confidential program (instead of reporting to the Medical Board). It enacts three new sections to establish criteria for the monitoring organization, confidential program criteria, and immunity. It also identifies the eligibility criteria of who qualifies for the confidential program and contains an immunity clause for the monitoring organization. The AMCNO strongly supports HB 145 and we will continue to monitor the debate on this issue as the bill moves through the legislature. ■

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On March 6, 2017, the AMCNO president and staff attended an OSMAPAC fundraiser held at Moxie in Beachwood. A special guest at the fundraiser was Congressman David Joyce—who provided the physicians present with his thoughts on the AHCA. He was introduced by Dr. Daniel Sullivan (on the left).



Pictured—left to right, Dr. Jeffrey Cameron, Congressman Joyce and R. Bruce Cameron, AMCNO President-Elect.

The Ohio Supreme Court Refuses to Consider Whether a Medical Provider is Vicariously Liable for a Rogue Employee's Unauthorized Use of a Patient's Medical Record

By Bret C. Perry, Esq., and Jason A. Paskan, Esq., Attorneys with Bonezzi Switzer Polito & Hupp Co. L.P.A.

The AMCNO Medical Legal Liaison Committee tracks cases for the AMCNO Board of Directors that come before the Ohio Supreme Court (OSC) and could impact or change the law in Ohio concerning our physician members. As a result, the AMCNO became aware of such a case and we have filed an amicus brief on behalf of our members in the case described below.

The OSC recently declined to consider an appeal from the Tenth District Court of Appeals wherein the appellate court determined a non-treating employee's decision to access a patient's medical records, and communicate his opinions regarding the same to third-party individuals, is binding on the employer in a subsequent medical malpractice action. The Tenth District Court of Appeals concluded that the unauthorized access of the medical records for the purpose of getting "to the bottom" of what transpired was within the scope of the employment and, therefore, the hearsay statements regarding the employee's opinions were admissible at trial.

In support of the appeal, the AMCNO filed an amicus brief urging the OSC to consider this appeal because the decision of the appellate court has expanded the "scope of employment" for healthcare professionals to now include the willful violation of the Health Insurance Portability and Accountability Act (HIPAA) or the unauthorized access of patient information. Despite the adverse impact the decision of the Tenth District could have on healthcare providers involved in litigation, the OSC declined to consider this appeal and further denied a subsequent motion to reconsider its original denial. This decision will now potentially subject hospitals, physicians, nursing homes or other medical provider employers to civil liability, and potential criminal charges, under a strict liability analysis in contravention of well-established Ohio law.

For the purposes of background, in the matter *Pontius v. Riverside Radiology, et al.*, 10th Dist. Franklin No. 15AP-906, 2016-Ohio-1515, the Tenth District Court of Appeals reversed a jury verdict in favor of the defendants. In *Pontius*, the mother of the decedent requested that a non-party physician employed by the defendant radiology group review a CT scan performed on her son. This non-party physician had no involvement in the care of the decedent or the review of the CT scan at issue during the events in question; apparently,

he was social friends with the decedent through the local country club. The purported review was performed by this non-party employee at the request of the decedent's mother and for his own curiosity. He did not review the CT scan for any purpose to promote or facilitate the defendants' business, nor was he participating in the official peer-review process for this patient.

As part of this review, the non-party physician allegedly advised the plaintiff and friends of the decedent that after reviewing the CT scan, he believed that the film evidenced a clot which was not appreciated by the defendant physician who interpreted the film, and that the decedent died due to a pulmonary embolism. Further, the plaintiff claimed that the non-party physician advised her of his opinion that "they blew it."

At trial, the plaintiff sought to testify as to the communications she had with this non-party physician. The trial court prevented the plaintiff's attempts, finding that any communications constituted hearsay statements that did not fall under the party-opponent admission exception to the hearsay rule. It was the defendants' position that since the non-party's alleged statements were a result of unauthorized access to the films, done on a volunteer basis, absent a patient-physician relationship and under no circumstance related to his employment, that the statements could not be related to any acts within the scope of his employment as to impute liability upon the defendants.

On appeal, the Tenth District reversed the jury's verdict in favor of the defendants, finding that the lower court erred in refusing the permit testimony related to statements allegedly made by the non-party physician. The Tenth District concluded that his actions fell within the course and scope of his employment and his statements should have been considered by the jury as an exception to the hearsay rule. The Tenth District essentially held that any action taken by an employee,

despite the absence of any beneficial interest for the employer, falls within the definition of the "scope of employment."

The AMCNO is the only organization that filed an amicus brief, at the jurisdictional stage, urging the OSC to accept and consider the decision of the Tenth District Court of Appeals. The amicus brief encouraged the Court to accept the defendants' appeal, and reverse the decision of the appellate court, because the "scope of employment" for healthcare professionals does not include the willful violation of HIPAA or the unauthorized access of patient information. The AMCNO argued that the most concerning aspect of the Tenth District Court of Appeals' analysis is that so long as a medical provider has access to medical records and utilizes the same for legitimate business purposes as part of their duties and responsibilities to the employer, their own self-serving acts, or actions that are detrimental to the employer, would also fall within the "scope of employment," thereby subjecting the employer to civil liability or criminal penalty. This conclusion is contrary to Ohio and federal law, particularly in the realm of healthcare and protected health information, and would subject employers of all types to strict liability when their employees act in a manner that has a tenuous connection with their job description, but is rather unsanctioned, self-serving or even harmful to the employer's interests.

By irreparably damaging well-established precedent pertaining to vicarious liability, Ohio employers are now left without protection from individuals who abuse their ability to access information for their own purposes. In declining to accept jurisdiction, the OSC left undisturbed the Tenth District's conclusion that a non-treating physician's review of a decedent's medical chart, on his own time without knowledge or authorization from his employer, constitutes conduct within the "scope of his employment." This type of conduct is undoubtedly against policy and in clear violation of HIPAA laws enacted to protect a patient's right to privacy. The Tenth District Court of Appeals' decision ostensibly condones unauthorized, unsanctioned and

(Continued on page 15)

Ohio Project puts Naloxone in Right Hands at Right Time

By Troy Parks, Reprinted from AMA Wire®, <http://wire.ama-assn.org/>

An emergency medicine physician working in the beating heart of the opioid overdose epidemic creates a naloxone-distribution program from the ground up.

Leslie Dawn Cooper of Portsmouth, Ohio, died at age 34 of an opioid overdose. She did not die alone, but no one with her had the antidote that could have saved her life. A project started in Cooper's name gives people who witness an overdose the ability and training to administer that antidote, naloxone.

The Ohio Department of Health started Project Deaths Avoided With Naloxone (DAWN) in Scioto County in 2013, and shortly thereafter a program for Cuyahoga County was founded by Joan Papp, MD, an emergency physician at MetroHealth in Cleveland. Project DAWN is an opioid overdose education and naloxone-distribution program designed to find a more efficient way to ensure naloxone is available to those who need it most.

Since 2013, Project DAWN Cuyahoga County has distributed more than 5,000 overdose-prevention kits, with five walk-in sites, a jail program, and take-home kits available to patients in the emergency department, inpatient units, primary care clinics and available at all MetroHealth pharmacies behind the counter without a prescription. The program's impact is most deeply felt in one number: the 740 opioid overdoses reversed so far through use of the Project DAWN kits.

Emergency physicians typically do not have expertise in addiction, Dr. Papp said. Yet emergency physicians take care of patients who struggle with addiction every day. "We reverse their overdoses. We manage their withdrawal. We treat them when they are seeking help or have complications from their drug use," she said.

However, emergency medicine is not the kind of profession that allows a lot of extra time for pursuing projects. Yet Dr. Papp felt compelled to go beyond her typical duties to develop Project DAWN.

Dr. Papp has experienced addiction up close and personal. She had family members throughout her life who struggled with the disease. "I felt like I am in a unique position to do something and this is something that desperately needs to be done," she said. "I think there are few specialties that use naloxone more than emergency medicine."

"To be perfectly honest, this kind of hit home for me," Dr. Papp said. "Sometimes we forget that the patient in front of us isn't just a patient; they're part of the community."

"They're a father or a mother, a sibling, a son or a daughter," she said. And when they walk into the emergency department, they are looking for help not just from a physician but from a fellow human being."

Between 2014 and 2015, the state saw an increase of 21.5 percent in drug overdose deaths, according to the Centers for Disease Control and Prevention.

With Project DAWN, Dr. Papp takes on the role of community educator. The project holds small-group and community-education events with speakers such as law enforcement, judges, recovering patients, parents of overdose victims, and the county medical examiner. Together, Project DAWN can paint a "broad picture of what's going on in the community," Dr. Papp said.

"I was actually quite surprised, when we started our program, by how much support we got from the health department and from the county," Dr. Papp said. "One of the things that helped us most in starting our program was collaborating with our medical examiner, because nothing is more powerful than having an advocate who can give you all the numbers of overdoses in real-time trends in what's going on."

Cuyahoga County's medical examiner provides Dr. Papp and Project DAWN with updates monthly, at the very least. These updates show the project "what's going on, what are the trends, is there a fentanyl outbreak, are we seeing an increase in cocaine deaths?" Dr. Papp said. "It really helps us to not only advocate, but also helps us to change our approach when we notice that there's a batch of a stronger or different drug out there."

So how important is naloxone in the emergency department?

"Unfortunately, it's becoming more common," Dr. Papp said. But treating a patient with naloxone in the emergency setting allows for a good opportunity to intervene. "We know that individuals who have recovered or

survived an overdose, about 26 percent of those will go on to seek treatment in the next 30 days. That really gives us an opportunity to step in ... we're pretty lucky to have access to that population."

Giving a rough estimate based on her firsthand experience, Dr. Papp said about half of patients are willing to accept an overdose-prevention kit when they are given. "Sometimes people are just not in the mindset to accept new information or accept help at that particular moment," she said. "But it is a very important time to try to intervene."

Every conversation Dr. Papp has about naloxone and the overdose-prevention kits includes information about treatment options in the community for the patient. But, "the sad truth is they're inadequate," she said. "I can give a person information about treatment, but there is inadequate availability of methadone for medication assisted therapy, there is inadequate availability of public housing or other services in the community."

"It may be 30 days before they get into treatment. They may not be able to find a person who is able to prescribe suboxone," she said. "That is truly where we are failing our patients."

Project DAWN has distributed more than a thousand kits of the life-saving overdose antidote. And those kits are critical in her state, which saw the most opioid-related overdose deaths of any state in 2014, according to the Kaiser Family Foundation.

"It's very gratifying to save somebody's life, no matter what the cause," Dr. Papp said. "With that, we are lucky that we have such a good antidote ... I wish we didn't have as much opportunity to use it."

The AMA has long advocated for expanded access to naloxone and, to date, nearly every state has legislation that allows for greater access to the life-saving antidote. The AMA Task Force to Reduce Prescription Opioid Abuse is leading these efforts. ■

Editor's Note: The AMA contacted us looking for a physician to interview who is an expert on the opioid crisis/naloxone, and we suggested AMCNO member Dr. Joan Papp. We are pleased that Dr. Papp provided her input for this article, and we thank her for her contributions to the community.

AMCNO LEGAL ACTIVITIES

The Ohio Supreme Court Refuses to Consider Whether a Medical Provider is Vicariously Liable for a Rogue Employee's Unauthorized Use of a Patient's Medical Record

(Continued from page 13)

self-serving actions and places the same within the scope of employment will result in an erroneous expansion of the definition of "scope of employment."

This decision is troublesome and wholly inconsistent with Ohio's longstanding law that correctly defines the "scope of employment." It cannot be emphasized enough the grave ramifications of the Tenth District's expansion of the definition of the "scope of employment," to the point that all unauthorized and unsanctioned actions of rogue employees, especially hospital and physician group employees, will be imputed to an employer and hold the employer strictly responsible and accountable for that employee's actions.

Based upon the conclusion of the Tenth District Court of Appeals, and the Supreme Court of Ohio's decision to not review the *Pontius* matter, healthcare employers must now be as vigilant as ever regarding the unauthorized access of medical records. Further, efforts should be made to reiterate to employees and others with potential access to protected patient information, that under state and federal law, such records are only to be utilized for patient care. ■

SAVE THE DATE!

The 14th Annual Marissa Rose Biddlestone Golf Outing to benefit the Academy of Medicine Education Foundation (AMEF) is planned for **Monday, August 7, 2017**, at Chagrin Valley Country Club.

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AMCNO Partners with *Healthcare Informatics* for its 2017 Cleveland Health IT Summit Series

The AMCNO once again served as a partner of the 2017 Health Information Technology Summit Series (formerly known as the Institute for Health Technology Transformation, or iHT2, Health IT Summits), to connect and promote improvements in the quality, safety and efficiency of healthcare through information and IT. The 2017 series featured discussions on a wide variety of topics, including cybersecurity, data analytics, clinical workflow, telehealth, and policy. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was also a point of interest.

The event was held March 23-24 at the Hilton Downtown Cleveland. The conference co-chairs were **Greg Rosencrance, MD**, Chairman of the Medicine Institute, Cleveland Clinic, and **David Kaelber, MD**, Internist and Pediatrician, Chief Medical Informatics Officer (CMIO) and Vice President of Health Informatics, The MetroHealth System.

The two-day Summit began on Thursday with a keynote presentation by **Robert Schwartz, MD**, Principal, Chartis Group, titled “MACRA: The Latest Accelerant to Value-Based Care—Are You Ready?” Dr. Schwartz, a practicing emergency physician, discussed the near-term implications of MACRA for providers post-election, provided an overview of the legislation, examined the elements of an effective MACRA strategy, and discussed IT’s role in preparing a “no-regrets” strategy. He stated that MACRA is here to stay; time is of the essence, quality is paramount, a MACRA strategy must be developed, and capabilities are needed to support patient care and reporting.

Panel discussions followed the keynote. One focused on “HHS, MACRA, Mandatory Bundled Payments, and IT as a Difference Maker.” **Mark Hagland**, Editor-in-Chief, *Healthcare Informatics*, served as moderator. It has been reported that only 20% of private practices are ready for MACRA. They stressed that successful organizations have a CMIO in their leadership suite, and that physicians need to be involved from the beginning in the process of creating strategies and workflows for improved care.

The other panel discussion focused on “Managing the HIE Relationship: Navigating the Data Exchange Partnership.” **Dan Paoletti**, Executive Officer of CliniSync/Ohio Health Information Partnership—of which the AMCNO is a partner—served on this panel and shared how Health Information Exchanges (HIEs) such as CliniSync are driving change, particularly in Ohio, by jumping into the payment reform models. He added that they are looking at how HIE systems can be interoperable—not just collecting volumes of

data—and how the information can easily fit into providers’ workflows. Another panelist, Dr. Kaelber, said he viewed HIEs as clinical support—needing and having the information at the right time to take proper care of a patient.

Another session focused on “Understanding the Next Generation of Cybersecurity Threats.” The panel discussed how health care is vulnerable to cyber threats and terrorists, because hacking into systems and devices carry life-or-death risks for patients, and the threats change constantly. It can be difficult to protect healthcare technology because there is a wide variety of products and their “ages” differ. There is also the human factor—the system may be secure, but an employee can compromise data. The panelists agreed that there is not one solution that is going to solve all the problems associated with cybersecurity, but several steps can be taken to help protect data, such as installing firewalls, monitoring information, and controlling access to the data.

The other Thursday sessions focused on: “Avoiding the Five Pain Points of Data Protection in Healthcare,” “Changing the Enterprise from the Data Up: Exploring Data Governance and Business Intelligence

Initiatives at the Cleveland Clinic,” “Keys to Repelling Ransomware,” and “Automating and Stratifying Risk through Effective Population Health Registries.”

The Friday sessions began with a T2 Talk: “2017 Cyber Threat Forecast and Sharing Strategies to Defend Your Networks,” presented by **Josh Singletary**, Chief Information Officer, National Health Information Sharing and Analysis Center (NH-ISAC). He discussed how the NH-ISAC was created in 2010 to allow non-profit and for-profit healthcare stakeholders to share their cyber and physical security threat indicators, best practices and mitigation strategies. The organization also hosts webinars, conferences and workshops concerning cyber threats to keep providers up-to-date.

The remaining Friday sessions covered the following topics: “Health IT’s Role in Combatting the Zika and Ebola Menaces,” “Beating the MSSP Expectations: How Scottsdale Health Partners’ ACO Has Thrived,” “Effectively Using Sociodemographic Data in Healthcare Analytics,” “Automating Quality: The Advanced Metrics, Data and Strategy Behind the Paperless ED,” “Building Integrated Clinical Dashboards Using FHIR,” “Leveraging Actionable Data to Combat Sepsis,” “Imaging IT and Healthcare IT Interoperability,” and “Analytics Behind Understanding Clinical Decision Making.”

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Participants listen to a panel discussion on “Managing the HIE Relationship: Navigating the Data Exchange Partnership.”