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AMCNO Joins Effort to Address Opioid and Substance Misuse Epidemic

Rx Abuse Leadership Initiative (RALI) of Ohio Will Support Effective Programs for Prevention, Treatment and Recovery

An alliance of local, state, and national organizations have come together to form the Rx Abuse Leadership Initiative (RALI) of Ohio. RALI Ohio will address the challenges and needs of the state's opioid and substance misuse epidemic through a diverse partnership that includes health care, business, veteran, farmer, community, and drug prevention organizations. This initiative will support effective prevention, education, treatment, and recovery programs. By partnering with a broad range of leading groups, RALI Ohio aims to reach people in every part of the state. It includes a wide variety of groups, and the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is now a partner as well.

This new coalition is focusing on ways different entities across the state can collaborate in the fight against opioid addiction. RALI Ohio is designed to elevate the good work of many organizations in Ohio who are already making an effort to fight substance abuse and addiction in our state. RALI Ohio has begun working with a variety of groups, including donating kits that allow for the safe disposal of prescription drugs.

RALI Ohio is also looking to identify gaps in support for vital programs that help those struggling with substance use disorder and those at risk for opioid misuse. The partnership has begun educating communities about proper disposal options for unused medications, providing tools to facilitate in-home disposal, and raising awareness of addiction prevention and education programs led by organizations throughout the state.

Jenny Camper of Lesic & Camper Communications kicks off the RALI Ohio event at the Ohio Statehouse.

Moving forward, RALI Ohio will continue to build on this foundation of support in partnership with its member organizations.

About RALI Ohio:
The Rx Abuse Leadership Initiative (RALI) of Ohio is an alliance of local, state and national organizations committed to addressing the epidemic of substance misuse in the state through support for effective education, prevention, treatment and recovery programs. For more information about RALI Ohio, visit ralioh.org. ■

Overview of the New Board Rules for Chronic Pain Opioid Prescriptions

By Kathryn Hickner, Partner, Kohrman, Jackson & Krantz LLP

On December 23, 2018, Ohio physicians became subject to new rules governing the prescription of opioids to address chronic pain (the "New Rules").[1] The New Rules do not set *limits* for the dispensing of opioids but instead set up certain *"safety checkpoints"* based upon dosages to facilitate further review and communication by physicians.

It is imperative that Ohio physicians understand the New Rules and then implement any necessary changes within their practices to ensure compliance. To support physicians in this effort, this article broadly summarizes the new requirements and identifies certain resources available to physicians who desire more information and support.

Overview of Crisis and Regulatory Landscape

For many years, Ohio has been considered to be at the epicenter of the opioid crisis. Prescription opioids are considered by many to be a key contributor to the epidemic.

Although the availability of prescription opioids for illicit purposes and prescription opioid-related overdose deaths both appear to be decreasing in Ohio, the prevention of illicit prescription opioid use and overdoses through the reduction of prescription

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Overview of the New Board Rules for Chronic Pain Opioid Prescriptions

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opioids remains a priority for state and industry leaders. Examples of Ohio initiatives that have been adopted to decrease the availability of prescription opioids include the Ohio Automated Rx Reporting System ("OARRS"), Ohio's Prescription Drug Monitoring Program ("PDMP") and the various prescribing guidelines and related resources that have been promulgated.

The State Medical Board of Ohio (the "Board") continues to fight the opioid crisis by bolstering opioid prescribing requirements intended to help prevent patients from becoming addicted to prescription opioids. The New Rules are the latest example of such efforts.

Summary of New Rules

Applicability

The New Rules govern Ohio physicians' prescriptions of opioids for the treatment of chronic pain (lasting 12 weeks or more) and subacute pain (lasting between six and 12 weeks). However, note that the New Rules do not apply to opioid prescriptions by physicians to patients in hospice care, inpatients in a hospital, patients with terminal cancer or patients with another terminal condition.

Limiting Prescriptions to the Minimum Necessary

The New Rules require physicians to consider and document non-medication and non-opioid treatment options before treating, or continuing to treat, subacute or chronic pain with an opioid. In the event that the physician determines through a history and physical examination that an opioid prescription is required, the physician must prescribe only the minimum quantity and potency needed to treat the expected duration of pain and improve the patient's ability to function.

General Documentation Requirements

Before providing an opioid prescription for subacute or chronic pain, Ohio physicians must complete or update the patient record to reflect the following assessment activities:

- History and physical examination (including review of previous treatment and response to treatment, patient's adherence to medication and non-medication treatment, and screening for substance misuse or substance use disorder);
- Laboratory or diagnostic testing or documented review of any available relevant laboratory or diagnostic test results (note that, if evidence of substance misuse or substance use disorder exists, diagnostic testing shall include urine drug screening);
- Review the results of an OARRS check;
- A functional pain assessment which includes the patient's ability to engage in work or other purposeful activities, the pain intensity and its interference with daily activities, quality of family life and social activities, and the patient's physical activity;
- A treatment plan based upon the clinical information obtained, to include all of the following components: (a) diagnosis, (b) objective goals for treatment, (c) rationale for the medication choice and dosage, and (d) planned treatment duration and steps for further assessment and follow-up; and
- Discussion with the patient regarding: (a) benefits and risks of the medication (including potential for addiction and risk of overdose), and (b) the patient's responsibility to safely store and appropriately dispose of the medication.

During the course of treatment with an opioid prescription with an average dose of less than 50 MED per day, the physician shall provide periodic follow-up assessment and documentation of: (a) the patient's functional status, (b) the patient's progress toward treatment objectives, (c) indicators of possible addiction, and (d) drug abuse or drug diversion and the notation of any adverse drug effects.

During the course of treatment with an opioid prescription with an average dose equal to or greater than 50 MED per day, an Ohio physician must complete and document the following in the patient record at least every three months:

- Review of the course of treatment and the patient's response and adherence to treatment;
- Review of any complications or exacerbation of the underlying condition causing the pain through appropriate interval history, physical examination, any appropriate diagnostic tests, and specific treatments to address the findings;
- Assessment of the patient's adherence to treatment including any prescribed non-pharmacological and non-opioid treatment modalities;
- Rationale for continuing opioid treatment and nature of continued benefit, if present;
- Results of an OARRS check;
- Screening for medication misuse or substance use disorder; and
- Evaluation of other forms of treatment and the tapering of opioid medication if continued benefit cannot be established.

Safety Checkpoints

50 MED or More

Before increasing an opioid prescription to a daily average of 50 MED or greater, Ohio physicians need to complete and document each of the following:

- Review and update the assessment activities described above, if not already completed;
- Update or formulate a new treatment plan, if needed; and
- Obtain a written informed consent, including (a) the benefits and risks of the medication (including potential for addiction and risk of overdose), and (b) the patient's responsibility to safely store and appropriately dispose of the medication.

Further, unless the patient was prescribed an average daily dosage that exceeded 50 MED before December 23, 2018, the physician must document consideration of each of the following: (a) consultation with a specialist in the area of the body affected by the pain; (b) consultation with a pain management specialist; (b) obtaining a medication therapy management review by a pharmacist; and (d) consultation with a specialist in addiction medicine or addiction psychiatry, if medication misuse or substance use disorder are noted.

The physician is also required to consider offering a prescription for naloxone to mitigate risk of overdose.

80 MED or More

Before increasing an opioid prescription to a daily average of 80 MED or greater, Ohio physicians also need to complete each of the following:

- Enter into a written pain treatment agreement with the patient that outlines the physician's and patient's responsibilities during treatment and requires the patient's agreement to each of the following provisions:
    - o Permission for drug screening and release to speak with other practitioners concerning the patient's condition or treatment;
    - o Cooperation with pill counts or other checks designed to assure compliance with the treatment plan and to minimize the risk of misuse or diversion;
    - o The understanding that the patient shall only receive opioid medications from the physician treating the chronic pain unless there is written agreement among all of the prescribers of opioids outlining the responsibilities and boundaries of prescribing for the patient; and
    - o The understanding that the dosage may be tapered if not effective or if the patient does not abide by the treatment agreement.

A template pain management agreement that can be utilized for this purpose can be found on the Board website.

Further, unless the patient was prescribed an average daily dosage that exceeded 80 MED before December 23, 2018, Ohio physicians must also obtain at least one of the following:

- Consultation with a specialist in the body area affected by the pain;
- Consultation with a pain management specialist;
- A medication therapy management review; or
- Consultation with a specialist in addiction medicine or addiction psychiatry if medication misuse or substance use disorder is present.

120 MED or More

Ohio physicians are prohibited from prescribing a dosage that exceeds an average of 120 MED per day, unless one of the following circumstances applies:

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- The physician holds board certification in pain medicine or in hospice and palliative care;
- The physician has received a written recommendation for a dosage in excess of an average of 120 MED per day from a board certified pain medicine physician or hospice and palliative care physician who based the recommendation on a face-to-face visit and examination of the patient (and the prescribing physician shall maintain the written recommendation in the patient's record); or
- The patient was receiving an average daily dose of 120 MED or more prior to December 23, 2018. However, note that, in the event that a physician escalates the patient's dose, the physician has to again obtain and document the written recommendation in accordance with the prior bullet point.

Naloxone Prescriptions

Finally, note that Ohio physicians are required to offer a naloxone prescription to patients receiving an opioid prescription under any of the following circumstances: (a) the patient has a history of prior opioid overdose; (b) the dosage prescribed exceeds a daily average of 80 MED or at lower doses if the patient is co-prescribed a benzodiazepine, sedative hypnotic drug, carisprodal, tramadol, or gabapentin; or (c) the patient has a concurrent substance use disorder.

Conclusion

Because federal and state opioid prescribing requirements, and the guidance with respect to the government's enforcement of those laws, is continually growing and changing, physicians must stay abreast of developments in this area. It's imperative that Ohio physicians understand the New Rule and implement changes to their clinical and documentation protocols and other procedures as necessary to ensure compliance. The Board, the Centers for Disease Control and Prevention ("CDC"), the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), other professional associations and legal advisors are all excellent sources of continuing medical education, template documents and other educational information regarding the prescription of opioids for chronic pain. ■

References

1. https://med.ohio.gov/Portals/0/Laws%20%26%20Rules/Newly%20Adopted%20and%20Proposed%20Rules/4731-11-01%2C%204731-11-02%2C%204731-11-14.pdf. See also https://med.ohio.gov/Overview-Regulations-for-Chronic-and-Subacute-Opioid-Prescriptions.

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Legalization of Medical Marijuana in Ohio – Fact Sheet (02/2019)

By Isabelle Bibet-Kalinyak, Esq., McDonald Hopkins LLC

Medical Marijuana is now legal in Ohio. As dispensaries begin to flourish, medical providers and all employers need to take proactive steps to decide whether they will accommodate patients and employees who desire to use Medical Marijuana on their worksites. This fact sheet provides a brief summary of Ohio law applicable to Medical Marijuana and non-exhaustive list of practical considerations for all employers.

Summary of Ohio Law Legalizing Medical Marijuana

1. **Effective date**: September 8, 2016 – Ohio adopts Medical Marijuana law, HB 523 (RC 3796.01 et. seq.).
2. **Effective date of Medical Marijuana Program:** September 8, 2018. Dispensaries are now open.
3. **Scope:** Permits individuals (including minors, subject to parental or authorized representative consent) who suffer from covered medical conditions (and their official caregivers) to purchase and use Medical Marijuana that will be cultivated and processed in Ohio without state criminal prosecution.
4. **Qualifying Conditions:** Medical Marijuana is only legal for individuals with either AIDS/HIV, Alzheimer's disease, ALS, cancer, chronic traumatic encephalopathy, Crohn's disease, epilepsy and other seizure disorders, fibromyalgia, glaucoma, hepatitis C, inflammatory bowel disease, intractable or chronic and severe pain, multiple sclerosis, Parkinson's disease, PTSD, sickle cell anemia, spinal cord disease and injury, Tourette syndrome, traumatic brain injury, and ulcerative colitis.
5. **Who can *prescribe* Medical Marijuana?** No one. It is still illegal at the federal level.
6. **Who may *recommend* Medical Marijuana?** Certified physicians (M.D. and D.O.), provided they obtain a certificate to recommend (CTR)[1] from the State Medical Board (the "Board"). CTRs renew with medical licenses after the initial grant by the Board. The list of providers with a CTR is available on the Board's website.[2]
7. **Which types of providers may <u>not</u> recommend Medical Marijuana:** All other providers, including Physician Assistants, Nurse Practitioners, podiatrists, chiropractors, massage therapists, etc.
8. **Patients and caregivers:** Patients and caregivers must first visit a certified physician who will enter them into the Patient and Caregiver Registry upon verification of eligibility. They will then have to pay a registration fee online to obtain their individual Medical Marijuana card. The annual fee is $50 for patients and $25 for caregivers.
9. **Acceptable forms and routes of administration:** (a) oral administration: oil, tincture, capsule, or edible form; (b) vaporization: metered oil, solid preparation, or plant material (with use of vaporizing devices); (c) transdermal: patches; and (d) topical: lotions, creams, or ointments.
10. **Illegal forms and routes of administration:** (a) smoking; (b) forms considered "attractive to children" (i.e. edibles, candy, etc.); and (c) cannot grow for self-consumption.
11. **How much is permissible:** The amount of Medical Marijuana possessed by a registered patient or caregiver must not exceed a 90-day supply.
12. **Official resources and updates for physicians:** Available at https://www.medicalmarijuana.ohio.gov/

Requirements for Physicians to Obtain a Certificate to Recommend Medical Marijuana[3]

1. Unrestricted active Ohio medical license.
2. OARRS database access.
3. Active DEA registration.
4. Never have been denied a license to prescribe, possess, dispense, administer, supply or sell a controlled substance by the DEA due to the physician's inappropriate prescribing, furnishing, dispensing, administering, supplying or selling a controlled substance, or never have had a DEA or state prescribing license restricted for the same.
5. Never have been subject to disciplinary action by any licensing entity based on the physician's prescribing, furnishing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug.
6. At least two hours of continuing medical education (CME) in courses that assist in the diagnosing and treatment of a qualifying medical condition for Medical Marijuana.
7. No ownership or investment interest in or compensation agreement with a Medical Marijuana entity licensed or seeking licensure in Ohio.

Standard of Care and Documentation[4]

1. Physicians must establish and maintain a bona fide physician-patient relationship including an initial in-person visit (not via telemedicine) and ongoing care.
2. Documentation in medical records (minimum statutory requirements):
   a. Patient's name and dates of office visits.
   b. Description of current medical condition.
   c. Medical, prescriptive, and substance use disorder history.
   d. Review of diagnostic test results, prior treatment and current medications.
   e. Drug screen at physician's discretion if evidence of drug abuse.
   f. Physical exam and diagnosis of the patient's medical condition.
   g. Diagnosis or confirmation of prior diagnosis of a qualifying medical condition for Medical Marijuana.
3. Proper documentation of the medical diagnostic in the medical records (record retention period – 3 years minimum), including supporting evidence, is defined by law as follows:
   a. Treatment plan.
   b. Access OARRS report covering at least the preceding 12 months.
   c. Discussion with the patient regarding possible abuse or drug diversion of any drugs listed in OARRS report.
   d. Explanation of the risks and benefits of Medical Marijuana treatment.
   e. Patient's consent (or consent of a legal representative).
   f. Whether the patient needs a caregiver to assist in the administration of Medical Marijuana.
   g. Confirm patient's active registration with Board of Pharmacy registry.
   h. Plan for follow-up care to assess efficacy.

Key Considerations for Health Care Providers

1. **Permission to recommend:** Health care providers have to decide whether they will permit their respective owners, employees, or medical staff to "recommend" Medical Marijuana. Prior to doing so, they should contact their professional liability carrier or broker to ensure that their medical malpractice coverage includes Medical Marijuana. Most insurance policies do not include coverage for this risk and will need to be updated.
2. **Patients, caregivers and visitors:** Health care providers must decide whether to authorize patients, caregivers, and visitors to possess and/or use Medical Marijuana on their premises. Communication is paramount. Solicit staff input and try to anticipate potential scenarios to best prepare everyone. After updating internal policies, first start by training staff to roll out implementation smoothly. Advise patients upon admission (e.g., by using a modified version of your informed consent form) <u>and</u> during the History & Physical examination (H&P), and document in the medical records. Use signage in facilities, waiting rooms, treatment rooms, etc. Implementation must be systematic to avoid discrimination claims based on other factors such as race, age, etc.
4. **Inpatient facilities:** Hospitals, nursing homes, and other inpatient facilities must

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determine if they will let patients bring in their own supply of Medical Marijuana (similar to when they bring their own medications) and how they will handle compliance and enforcement. Some forms or Medical Marijuana may be difficult to spot and/or identify (e.g., oils and ointments). On the flip side, inpatient providers must also ensure that employees, medical staff, and independent contractors do not divert patients' Medical Marijuana if it is permitted onsite. All applicable policies should be updated to place employees on notice of the potential disciplinary consequences. In addition, consider updating the medical staff bylaws and standard contractual terms with outside providers, including physicians or physician groups providing medical services on an independent contractor basis.

Key Considerations for All Employers, Including Health Care Providers

1. **All or none:** Employers need to decide whether they will endorse and accommodate Medical Marijuana generally, i.e. for all the medical conditions listed in the statute. They cannot pick and choose which condition(s) they will accommodate as this may open them up to some discrimination claims.
2. **Drug policies:** Employers are under no legal obligation to endorse, permit, or accommodate an employee's use, possession, or distribution of Medical Marijuana in the workplace. However, they must still accommodate employees with a disability, as defined under the Americans with Disabilities Act (ADA). Importantly, unless they take action and update all applicable internal policies, employers may have a hard time disciplining employees that are using Medical Marijuana at work. A "Zero Tolerance" drug policy is not sufficient. Such drug policy should explicitly state that employees in possession or, and/or using Medical Marijuana with a valid physician certificate and/or Medical Marijuana card are not exempt from the drug policy and will be subject to all the provisions of the drug policy. In addition, the drug policy should affirmatively list Medical Marijuana in the definition of "illegal drugs." Updating H.R. policies will be essential for employers dealing with unemployment benefits or workers compensation claims.
3. **Unemployment compensation:** An individual terminated from employment because of Medical Marijuana use will be deemed terminated for just cause if the use was in clear violation of the employer's drug-free workplace policy, zero-tolerance policy, or other formal program or policy that includes Medical Marijuana as a prohibited substance. If the policy does not explicitly prohibit Medical Marijuana use, the employee may be entitled to unemployment compensation.
4. **Workers compensation:** Ohio law[5] permits employers with a clear drug policy to reject workers compensation claims involving a positive drug screen and places the burden on claimants to rebut that presumption. A positive drug test may support rejecting a claim if the employer's H.R. policies then in place explicitly prohibit Medical Marijuana. The claimant may still argue that he or she was not impaired and that the Medical Marijuana was not the proximate cause of the injury but he or she will bear the burden of proving so.
5. **OSHA:** OSHA regulations are another factor employers need to consider. OSHA regulations obligate employers to provide a workplace "free from recognized hazards that are causing or are likely to cause death or serious physical harm." Consequently, since Medical Marijuana may affect the rate of work injuries, it may also expose employers to additional OSHA violations.
6. **Insurance:** Employers should consult their insurance carriers or brokers prior to deciding whether to accommodate Medical Marijuana in the workplace. Additional riders may be required to extend coverage.

Ohio employers are facing new risks due to the legalization of Medical Marijuana. A proactive assessment of such risks is strongly recommended for employers of all types, especially health care providers who may quickly find themselves caught between patient satisfaction and increased risk of liability.

For additional information, please contact Isabelle Bibet-Kalinyak, Esq., at (330) 554-4133 or IBK@McDonaldHopkins.com. ■

References

1. OAC 4731-32-02, available at http://codes.ohio.gov/oac/4731-32-02, see also video explaining how to apply for a CTR available at https://www.youtube.com/watch?v=xz25rW1tnMI.
2. Roster of providers with CTR, available at https://med.ohio.gov/Publications/Rosters
3. *Id*.
4. OAC 4731-32-02, available at http://codes.ohio.gov/oac/4731-32-02.
5. Ohio Revised Code Section 4123.54(B).

AMCNO LEGISLATIVE UPDATE

The final months of 2018 saw a flurry of legislative activity during the lame duck session, which lasted almost up until the end of the year. The legislative update in the 2019 January/February issue of the *Northern Ohio Physician* provided information on bills that had been sent to the governor for his signature prior to the end of the lame duck session, such as legislation dealing with tort reform that was signed into law in late December (and included several medical liability reforms that will reduce unnecessary litigation in Ohio), and step therapy legislation that included major reforms to address how step therapy is utilized by health insurers. Step therapy reforms included in this legislation will apply to health plan benefits issued or renewed on and after January 1, 2020.

In addition to the above-referenced bills, several other pieces of legislation that were under review by the AMCNO were signed into law. Following is an overview of some of this activity.

Substitute House Bill 131 – Physical Therapy

Originally, the AMCNO had opposed this legislation because it would have given physical therapists the ability to make a medical diagnosis and order certain X-rays and imaging tests. Both of these provisions were removed from the substitute bill and the AMCNO changed its position to neutral. The bill as enacted will:

- Include in the practice of physical therapy the evaluation of a person to determine (1) a physical therapy diagnosis to treat physical impairments, functional limitations, and physical disabilities, (2) a prognosis, and (3) a plan of therapeutic intervention.
- Specifies that "physical therapy diagnosis" does not include a medical diagnosis.

Physical therapy diagnosis is defined by the bill as a judgment made after examining the neuromusculoskeletal system or evaluating or studying its symptoms and that uses physical therapy techniques and science to establish a plan of therapeutic intervention. The bill further specifies that the physical measures a physical therapist may use include not only massage, as provided in current law, but also other manual therapy techniques.

The following activities are currently excluded from the practice of physical therapy and remain expressly excluded under the bill:

- The use of Roentgen rays (X-rays) or radium for diagnostic or therapeutic purposes; or the use of electricity for cauterization or other surgical procedures.

Substitute Senate Bill 119 – Opioid Medication

The AMCNO had opposed this bill as well when it was first introduced because it would have imposed more restrictions on physician prescribing at a time when regulations on this issue have already been put into place in Ohio. Major changes, however, were made to the bill which removed these restrictions and the bill focused on the administration of naloxone; the AMCNO changed its position on the bill to neutral.

In summary, this bill does the following:

- Authorizes a pharmacist to dispense, or in some cases, administer an emergency refill of naltrexone if certain conditions are met;
- Generally grants immunity to each of the following for administering naltrexone by injection under specified circumstances: the person who administers the drug, the person's employer, and the facility at which the drug is administered.
- Requires the dispensing or furnishing of naltrexone to be reported to the State Board of Pharmacy's Ohio Automated Rx Reporting System (OARRS).
- Maintains current law requiring a physician, advanced practice nurse, or physician assistant to provide information about all drugs approved by the U.S. Food and Drug Administration for medication-assisted treatment before initiating a patient's medication-assisted treatment.
- Requires the Ohio Department of Public Safety, if it collects certain information concerning the administration of naloxone by emergency medical service personnel, to report that information to the Ohio Department of Health on a monthly basis.
- Names the act "Daniel's Law" and the "Opioid Data and Communication Expansion Act."

Substitute House Bill 464 – Stroke Patients

The AMCNO strongly supported HB 464, and we are pleased that this bill has been signed into law. The AMCNO provided written testimony in support of HB 464, and we also participated in several advocacy days at the Statehouse, talking to legislators about the importance of this legislation.

HB 464 as passed will:

- Create a process for state recognition of hospitals as comprehensive stroke centers, primary stroke centers, or acute stroke ready hospitals.
- Prohibit a hospital from representing itself as a comprehensive or primary stroke center or acute stroke ready hospital unless it is recognized as such by the Ohio Department of Health.
- Requires the establishment of written protocols for use by emergency medical service personnel when assessing, treating, and transporting stroke patients.

The AMCNO strongly opposed several pieces of legislation, and we worked with other medical associations and coalitions in an effort to see that these were defeated in the legislature. The bills are outlined below.

HB 726 - APRN Independent Practice

Late in the fall of 2018, another bill that would remove the requirement that APRNs collaborate with a physician resurfaced in the legislature. AMCNO members will recall that in 2016 we worked diligently with other medical associations to assure that legislation was passed that made several changes to the APRN scope of practice, but did not include independent practice authority. The issue resurfaced in HB 726, which would have changed how physicians and APRNs work collaboratively. The AMCNO was pleased that HB 726 did not move forward; however, we are certain that this issue will be back before the legislature in the future.

HB 191 - CRNA Scope of Practice

This legislation that would have allowed CRNAs to have an undefined practice authority as well as prescriptive authority in Ohio did not pass through the legislature. The first draft of the bill included independent practice provisions, and although changes were made to the bill, the proposed expansions to CRNA practice authority were not clear, and the AMCNO and other medical associations strongly opposed the bill. Dr. John Bastulli, the AMCNO Vice President of Legislation Affairs, testified in opposition to the bill, noting that there was no need for a change to the scope of practice of CRNAs. He also outlined the concerns about patient safety should this legislation be allowed to pass. A companion bill to HB 191 was introduced in the Senate – SB 301. These bills did not pass, but, once again, the AMCNO is certain that this issue will be back before the legislature in the near future.

HB 450 - Insurance Mandates

The AMCNO joined a large coalition of community organizations and health associations to express our opposition to HB 450, which would have established restrictive requirements relating to mandated health benefits already enacted in state law, as well as any future legislation regarding mandated

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AMCNO Legislative Update

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health benefits. The bill did not pass and hopefully this legislation will not be introduced again in the future.

The 133rd General Assembly will kick-off early in 2019 and the focus for the first part of the year will be on the development of the state budget. We will continue to provide updates to our members on the budget and legislation under review at the Statehouse.

Householder Elected Speaker

Ohio House Democrats helped Speaker Larry Householder retake the chamber's top leadership position and thwart outgoing speaker Rep. Ryan Smith's effort to retain the job.

Rep. Householder (R-Glenford) served as Speaker from 2001-2004 and has now regained this position, earning the support of 52 members to Rep. Smith's 46. The 99-member chamber has one vacancy.

The floor vote followed a flurry of negotiations and political posturing as both Reps. Householder and Smith (R-Bidwell) worked to garner support, particularly among the Democratic caucus's 38 members. In the end, Householder prevailed—earning the support of 26 Democrats, after promising to change the chamber's approach to accepting amendments as well as their approach to human resources.

Governor DeWine Appoints New Cabinet Members

Governor Mike DeWine has chosen directors for several posts that are of interest to the AMCNO and our members. Jillian Froment has been named the Director of the Department of Insurance. Ms. Froment was appointed Director of the Ohio Department of Insurance in 2017 by Ohio Governor John R. Kasich. She serves as a member of the governor's cabinet and is responsible for the overall leadership and direction of the Department of Insurance. She will remain in this position under Gov. DeWine. Kimberly Hall has been named the Director of Job and Family Services. Ms. Hall currently is senior vice president of administration and general counsel at Columbus State Community College. She formerly served as a deputy chief counsel to Gov. DeWine in the attorney general's office.

Lori Criss will become the Director of Mental Health and Addiction Services. Ms. Criss has more than 20 years of experience leading addiction and trauma treatment, including opioid addiction. She will work with Gov. DeWine's "Recovery Ohio" initiative to improve addiction treatment.

Maureen Corcoran has been named the Director of the Ohio Department of Medicaid, replacing Barbara Sears. Ms. Corcoran currently is president of Vorys Health Care Advisors, where she works on healthcare policy issues. She previously was assistant deputy and acting deputy director for Medicaid at the Department of Jobs & Family Services.

Stephanie McCloud has been named the administrator of the Bureau of Workers' Compensation. Ms. McCloud, a lawyer, previously was a staff attorney and fiscal officer at the bureau. She was a deputy legal counsel to former Republican Gov. George V. Voinovich and was chief counsel and senior deputy in the attorney general's office.

The position of the Director of the Ohio Department of Health remains open at this time.

Governor DeWine Begins His Term Signing Executive Orders

Governor Mike DeWine has hit the ground running by signing several executive orders immediately after being sworn in as Ohio's new governor. These Executive Orders will:

- Create an anti-discrimination policy for state employment, extending recently added protections based on gender identity instituted by Gov. John Kasich and adding protections for pregnant women, parents of young children and foster parents.
- Create the Governor's RecoveryOhio Initiative, to focus on the drug epidemic in the state. Gov. DeWine has appointed Alisha Nelson to run the initiative, charged with advancing and coordinating prevention, treatment and recovery services across all levels of government.
- Create the Governor's Children's Initiative that would also have someone who reports directly to the governor coordinating policy affecting children.
- Assist individuals with disabilities and direct the Department of Administrative Services to appoint a State ADA Coordinator, order each state agency to review its hiring practices to identify barriers to the employment of individuals with disabilities, and make other changes designed to encourage the employment of people with disabilities.
- Elevate foster care priorities and direct the Ohio Department of Job and Family Services to have the Office of Families and Children report directly to the director.
- Direct the Ohio Department of Mental Health Services to create a senior level position to lead the Prevention Services Bureau to focus on age and environmentally appropriate drug prevention education for students.

Administrative Update

Medical Association Coalition Sends Comments on SMBO Rule Change

The Medical Association Coalition (MAC), a group of statewide and regional medical and healthcare associations, which includes the AMCNO, sent a letter to the State Medical Board of Ohio (SMBO) stating that we strongly agree with their decision to rescind rule 4731-16-16. The current rule prohibits a licensee from utilizing a controlled substance for the treatment of an opioid dependence. As written, this prohibition has the potential to dissuade physicians who have an opioid use disorder from receiving proper treatment for their condition.

In its letter, the MAC noted that medication-assisted treatment (MAT) is treatment for substance use disorders and includes the use of medication paired with counseling and other support. The opioid addiction treatment community agrees that MAT, when combined with counseling, is a proven path to recovery. The MAC further commented that it is a common misconception that MAT substitutes one drug for another. MAT programs provide a safe and controlled level of medication to overcome the use of an abused opioid. And research has shown that when provided at the proper dose, medications used in MAT have no adverse effects on a person's mental capability, physical functioning or employability.

The MAC applauds the SMBO for appreciating that Ohio physicians are also Ohio patients. All patients in Ohio deserve to receive the most appropriate treatments available. The MAC believes that it is only fair that physicians who are receiving effective treatment for opioid use disorder continue to receive treatment that allows them to return to the practice of medicine when they are ready to do so. ■

Why We Want Every Mom in Ohio to *Count the Kicks*

By Emily Price, Count the Kicks, and Amy Neumann, First Year Cleveland

Earlier this year an African American woman named Dana saw a bright yellow poster inside her OB's office that caught her eye. With a teal Dr. Seuss-looking belly, the poster appeared whimsical but its message was important. It told Dana, in her second trimester of pregnancy, to count her baby's movements, get to know what's normal for her baby, and speak up to her provider if she noticed a change.

Dana downloaded the free *Count the Kicks* app and started tracking her daughter's movements. *Count the Kicks* teaches the method for and importance of tracking fetal movement in the third trimester of pregnancy. Scientific studies show that expectant moms should track their baby's movements once a day in the third trimester and learn how long it normally takes their baby to get to 10 movements. Moms will start to notice a pattern, a normal amount of time it takes their baby to get to 10. If "normal" changes during the third trimester this could be a sign of potential problems and an indication to call their provider.

With a high-risk pregnancy, Dana wanted to do everything she could for a healthy birth and baby. It wasn't long before Dana noticed a change in what was a normal amount of movement for her daughter and took herself to the hospital. After a battery of tests, doctors determined her daughter was in distress and needed to be delivered right away. Nahla (meaning "warrior") is now healthy and home.

"Definitely pay attention to *Count the Kicks*. Had I not, Nahla wouldn't be here," Dana said.

Dana's story is exactly why the Ohio Department of Health wanted to partner with *Count the Kicks*, a proven stillbirth prevention public health campaign. Stillbirth affects every 1 in 167 pregnancies. For African American women in the U.S., it happens in 1 in 94 pregnancies — a public health tragedy that we are trying to address. Ohio vital statistics show that in 2015-2016, there were 1,854 stillborn babies in Ohio. If the numbers in 2019-2020 were hypothetically predicted to be the same, 519 of those babies might be saved if rates decrease by nearly 28%, as has happened in Iowa where the campaign began.

Today, maternal health providers, birthing hospitals and social service agencies throughout Ohio can order free *Count the Kicks* educational materials at www.countthekicks.org to start using these materials in their practices right away. Moms everywhere can download the free *Count the Kicks* app, which is available in the Google Play and iTunes online stores. The app is available in 10 languages, and it allows expectant moms to monitor their baby's movement, record the history, set a daily reminder, and count for single babies and twins.

Dana's doctor says she would have had a different birth outcome if it weren't for the simple and effective method of tracking her baby's movements in the third trimester. This is exactly the kind of success story we want in Ohio — and success to us means saving babies.

Although stillbirths are not counted in infant mortality statistics, which only record deaths of live-born babies in the first year of life, First Year Cleveland hopes that increasing education about stillbirth will save lives.

"*Count the Kicks* is a safe and simple way to help monitor the well-being of a baby," notes First Year Cleveland Executive Director Bernadette Kerrigan. "Using their app every day during the third trimester of a pregnancy to track a baby's movement patterns helps to monitor fetal well-being and is therefore another tool that helps to ensure all our babies celebrate their first birthday."

You can read more stories about *Count the Kicks* at https://www.countthekicks.org/. Learn more and get involved with First Year Cleveland's community movement to reduce infant deaths at https://firstyearcleveland.org/. ■

AMCNO is Partnering with *Healthcare Informatics* on the Health IT Summit in Cleveland: March 19-20, 2019

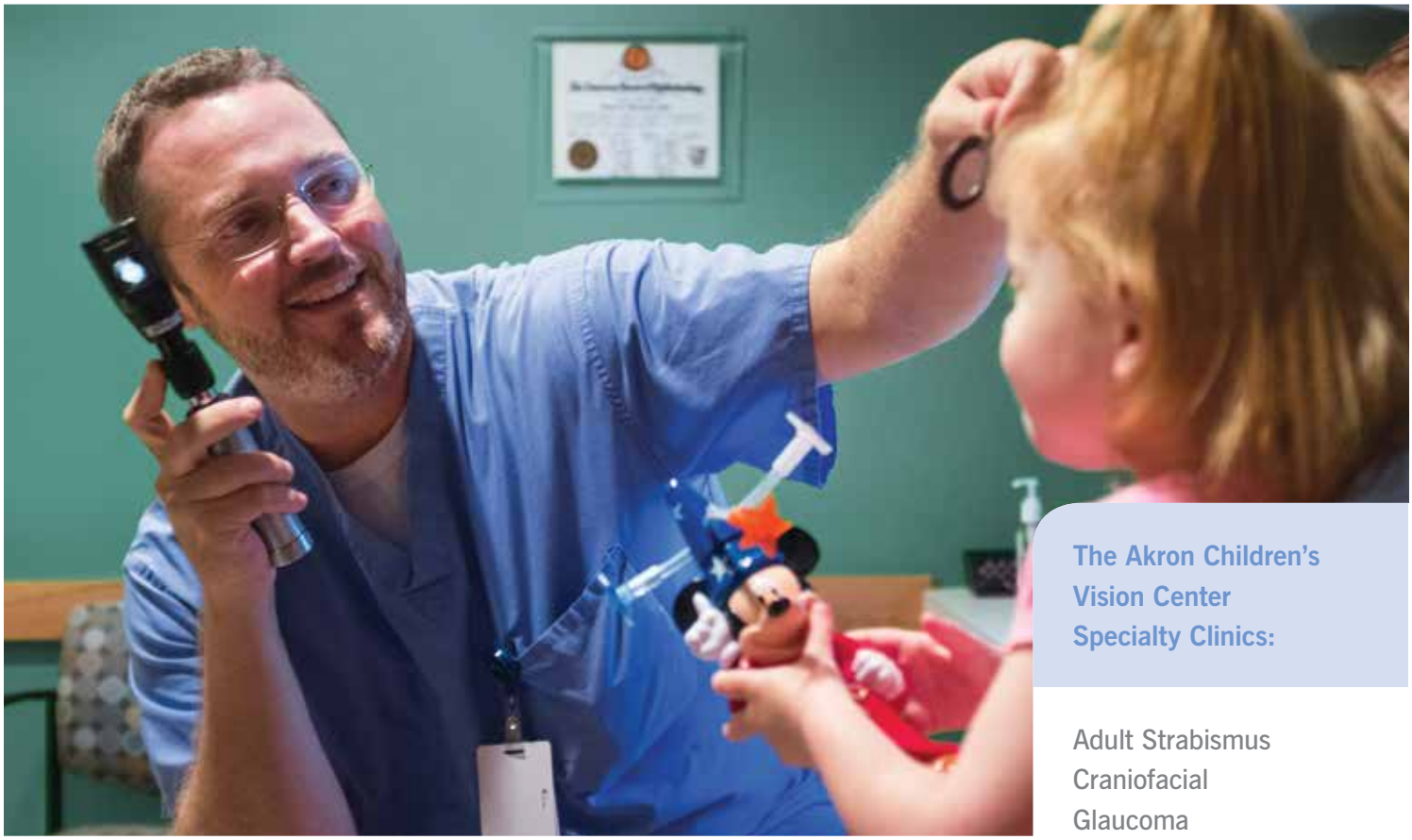
At the Cleveland Health IT Summit, you'll have a chance to hear from innovative health IT leaders, as well as the opportunity to network and speak with them about your own organizational issues. Join keynote speaker Edward Marx, CIO at the Cleveland Clinic, and conference partner AMCNO for two days of interactive discussions.

The full agenda is available at https://vendome.swoogo.com/2019-midwest-health-it-summit/Agenda

As an **Academy of Medicine of Cleveland & Northern Ohio Member**, use code **AMCNOCOMP** to reserve your complimentary seat. To register, visit https://vendome.swoogo.com/2018-cleveland-health-it-summit/begin

For more information about the event, contact Pam Durget at pdurget@vendomegrp.com or (347) 380-2028.

Each child has a unique view of the world. We're here to help preserve it.



The Akron Children's Vision Center Specialty Clinics:

Adult Strabismus
Craniofacial
Glaucoma
Nystagmus
Pediatric Contact Lens
Retinopathy of Prematurity
Traumatic Brain Injury
Uveitis

The Akron Children's Vision Center specializes in the diagnosis and treatment of eye disease and visual system disorders for infants, children and teens.

Our team of pediatric ophthalmologists and optometrists, clinicians and scientists are dedicated to finding solutions specific to kids and their unique anatomy and requirements.

Call 330-543-5290 for 24/7 emergent and urgent care consultation.

Find our Vision Center locations in Akron, Medina, North Canton and Mahoning Valley.

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Akron Children's Hospital

AMCNO Members and Guests Celebrate Valentine's Weekend with a Wine Tasting

AMCNO physician and resident members and their guests gathered for this year's Wine Tasting on February 10 at the Market Avenue Wine Bar.

During the event, attendees sampled various wines from South America, ranging from a Chilean chardonnay to an Argentinian malbec. An assortment of cheeses and dips paired nicely with the wines. Everyone enjoyed the open space, where they were able to easily move around and talk with one another.

Thank you to those who were able to attend this event—it was great to see familiar faces there as well as meet new people. We appreciate you taking the time to spend a fun evening with us, and we hope to see you next year! ■

Rely on the AMCNO Pollen Line this Allergy Season!

The AMCNO welcomes back our member allergists:
Robert W. Hostoffer, DO
Devi K. Jhaveri, DO
Theodore H. Sher, MD
Haig Tcheurekdjian, MD
Allergy/Immunology Associates, Inc.

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