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THE VOICE OF PHYSICIANS IN NORTHERN OHIO

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AMCNO Members Share Insights with Medical Students

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) hosted a medical school student networking event, with second-year Case Western Reserve University (CWRU) School of Medicine medical students, on Sept. 24. This was the first year for the event, called PALS (or Physicians Are Linked with Students), and it was very well-received by all attendees.

Held in the school's Thwing Atrium, the event began with a light dinner and opening remarks from AMCNO President Dr. Matthew Levy, who explained the logistics. During the event, physicians were invited to sit at a numbered table in the room; a placard indicated the physician's name and specialty. Students were then invited to fill in the tables in groups of threes. After an 8-minute conversation at one table, groups moved to the next numbered

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Dr. Matthew Levy, AMCNO President, welcomes the medical students to the networking session.

AMEF and AMCNO Join with MetroHealth to Sponsor Session on Opioid Use

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and the Academy of Medicine Education Foundation (AMEF) were pleased to join MetroHealth's Project DAWN (Deaths Avoided with Naloxone) and the Cuyahoga County Board of Health in sponsoring a timely session for physicians and healthcare staff on the topic of opioid use. The session, entitled "Opioid Use Disorder, Associated Stigma and How to Utilize Key Prevention Tools," was held at MetroHealth, and more than 200 participants attended the event, including representatives from the AMCNO staff and board of directors.

Following a brief introduction by Dr. Al Connors, the chief quality officer at MetroHealth, the event began with a presentation by Cuyahoga County Medical Examiner Dr. Thomas Gilson, who provided an overview of the opioid problem in Cuyahoga County. He described the current and recent data on the extent of opioid mortality in the region, noting that the county is seeing a rise in opioid deaths due to fentanyl — which has been manufactured and brought into the community and is not being diverted from medical facilities. He also noted that 73% of heroin overdose victims had a file with the OARRS system, meaning within two years of death 3 of 4 heroin fatalities had received a legal prescription for some type of controlled substance.

Dr. Christina Delos Reyes from University Hospitals provided an overview of opioid use

Dr. Joan Papp delivers her remarks about Project DAWN during the session at MetroHealth.

disorder and discussed the different models for understanding substance use disorders and the disease of addiction, including the medical

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AMCNO Members Share Insights with Medical Students *(Continued from page 1)*

table for another 8 minutes, and so on, until all of the groups met with each physician.

The physicians in attendance represented several different specialties, including cardiovascular medicine, obstetrics/gynecology, anesthesiology, rheumatology, family practice, internal medicine, vascular surgery, general surgery and gastroenterology. The students were given sample questions before the event, to help start a conversation, but they were also encouraged to ask questions of their own. Some of their questions included the following:

- What is a typical day/week like?
- How did you choose your specialty? What drew you to it?
- Did you always know you wanted to go into this particular field?
- What do you like most/least about your profession?
- Do you think you would have been happier in a different field?
- What do you think of the changing healthcare environment, with regard to payment models?
- How do you manage family life with work?

Dr. Fred Jorgensen, a family medicine physician, and an AMCNO board member and officer, told one group of students that primary care physicians are in demand, which will work out well for the students once they get to that point, especially when it comes to negotiating salaries. But, he advised against choosing the field solely based on that. "Pick what you like because you like it," he said. "You're going to be doing your job for a long time."

Students spend time at each table talking to a physician about their experience.

After the event, students and the physicians were asked to fill out an evaluation form. Both groups unanimously agreed that their evening was time well spent.

One physician indicated that it was "nice to interact with the students and hear what they are concerned about." Other physicians noted that what they liked most about the program was seeing the students' enthusiasm, sharing their knowledge about the practice of medicine and introducing different specialties to the students.

Dr. Fred Jorgensen, AMCNO board member and officer, provides his comments to several medical students.

All of the physicians agreed that the students were receptive to what they had to say, and one indicated that the students asked great questions and were interested in the answers. Alternately, the students had mostly positive comments about the program, with one indicating that it was good to hear from the physicians, especially those he might not otherwise meet.

The physicians were asked what they thought the students gained from them during their brief interactions. Dr. Lawrence Kent, AMCNO past president, said that the students likely gained "more of an idea on how to navigate their medical school careers," and Dr. Ronald Savrin, also an AMCNO past president, suggested that the students gained a "realistic understanding of being a medical doctor."

Sheena Tsai, one of the students and event coordinators, said, "One of the best pieces of advice I received at the event was that no matter what specialty we as medical students end up choosing, the most important thing is to love and enjoy life." She also was thankful that several physicians offered their contact information, so that the students could contact them with questions in the future or for shadowing opportunities.

She added, "It was fascinating (and relieving) to see that these individuals, our role models, all had some doubt and confusion at some point in their medical career, but still were able to find their way and accomplish so much."

The AMCNO would like to thank everyone who participated in the event. This interaction helped students gain a better understanding about various specialties and the practice of medicine, right from the physicians' point of view, which should assist them as they continue on in their studies. It also helped the physicians, too—they remembered why they joined the profession in the first place, and one physician noted that it is a physician's responsibility to the profession, to teach those coming into the field after him.

To see more photos from the event go to the AMCNO Twitter feed and Facebook page. ■

AMEF and AMCNO Join with MetroHealth to Sponsor Session on Opioid Use *(Continued from page 1)*

model. She also outlined the symptoms, major clinical manifestations and diagnostic criteria for opioid use disorder. She noted that addiction is a chronic and treatable brain disease and the most successful treatments combine behavioral therapy with medications. One of her final comments for the day was that we need to start treating addiction the way we treat other diseases — when someone else has any other disease we all rally around them and try to help if we can. With addiction, people that have it do not want to talk about it because they are embarrassed and others do not know what do to. We need to change the culture, she said.

Dr. Jason Jerry from the Cleveland Clinic described evidence-based treatments for opioid use disorders and noted that treatment for addiction is not a "one-size-fits-all" proposition. He also described the deficiencies in the system that block access to effective care. He provided a detailed history of drug use and treatment plans and the treatments utilized for addiction such as medication-assisted treatments.

The keynote speaker for the event was Sam Quinones, a Los Angeles-based freelance journalist and author of *Dreamland: The True Tale of America's Opiate Epidemic.* To write the book, Quinones traveled across the United States, and the book focuses on the drug epidemic in a small Ohio town.

Quinones' book illustrates how addiction affected the Portsmouth, Ohio, community and shows how the prescribing of pain medications and addictive painkillers, along with the influx of black tar heroin from one small county in Mexico, impacted small towns and cities like Portsmouth.

Quinones described how certain factors gave rise to more painkillers being prescribed over the last few decades: A study published in the early 1980s outlined that addiction was rare when patients were given narcotics while hospitalized, and the Joint Commission decided that pain is a fifth vital sign and began judging hospitals on how well they treat pain. He also noted that the manner in which doctors were judged by patients — along with patients believing that they were entitled to a life free of pain — led to the frequent prescribing of narcotics, which added to the

Dr. Jason Jerry discusses evidence-based treatment for addiction.

problem. At the same time this was going on pharmaceutical companies began to aggressively market oxycontin as "non-addictive" — which resulted in doctors thinking that these drugs could be prescribed without any risk.

The outcome of this prescribing practice has been a rise in the amount of prescription painkillers available to the public. One town that felt the brunt of this was Portsmouth, Ohio — starting with the town becoming the pill mill capital of the country. A doctor set up a pill mill in the area and soon others set up pill mills as well, and it became a lucrative cash business. Portsmouth developed a mentality where you could buy anything in that city with oxycontin. The town lost businesses, and many of the citizens became addicted.

It was also about this time that drug traffickers from a small town in Mexico moved into cities like Portsmouth and began selling heroin — preying on addicts already hooked on pain pills — since heroin was cheaper than the painkillers. They realized that if you follow the pills sooner or later there will be a heroin market. Quinones described how the drug trade works, noting that Mexican traffickers have focused on a less-processed form of heroin called black tar because of how it looks when processed. Black tar is cheap to make and purchase, resulting in more people becoming addicted.

Ohio passed a pill mill bill in 2011 and since they have closed, Portsmouth has started to make a comeback. There have been some economic and business changes in their community, and the citizens have begun to turn away from drug dependency. Quinones stated that he believes the community is the antidote to heroin — there is still a drug problem in this country and we need to come together as a community to address these issues.

Quinones was followed by Dr. Joan Papp, the Medical Director for the MetroHealth Project DAWN program. Dr. Papp discussed how to identify patients who are at risk for opioid overdose and would benefit from take-home naloxone. She also outlined the changes in Ohio law that impact naloxone prescribing and provided information on how to incorporate prescription naloxone into a practice environment. Dr. Papp also presented information on MetroHealth's controlled substance prescribing policy, which replaced the current departmental policies with a system-wide policy for prescribing controlled substances — incorporating recent changes in the Ohio Revised Code and the State Medical Board of Ohio guidelines for prescribing opioids for the treatment of chronic, non-terminal pain.

Sam Quinones delivers the keynote speech at the MetroHealth session.

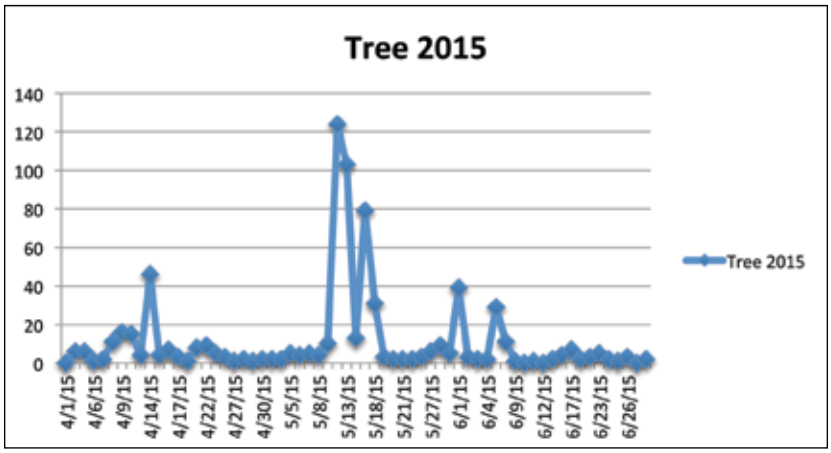
The event also included presentations from clinicians and others who provided stories of recovery and how to recognize the stigma associated with opioid use disorder — as well as the steps involved in prevention, abuse, recovery and relapse — along with a detailed presentation on how to approach patients who abuse substances and provide constructive feedback to these patients on how to reduce or stop their substance abuse. Cameron McNamee from the Ohio Board of Pharmacy also provided a detailed presentation on OARRS — how to register for it and utilize the data available on the database.

The full-day event was most informative, and the feedback from all of the participants was very positive. The slides from this event can be accessed at http://www.metrohealth.org/dawn-conference. Quinones did not have a slide presentation, but more information about his book can be obtained at http://www.samquinones.com/books/dreamland/ ■

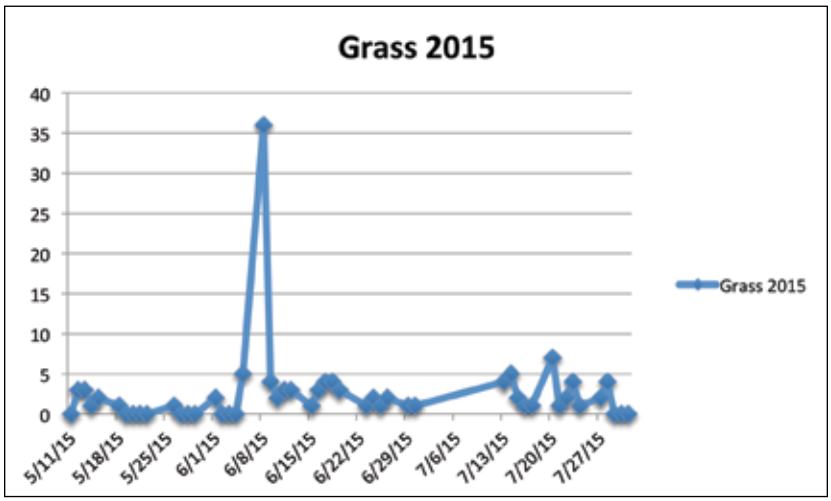
AMCNO Pollen Line – 2015 Recap

Brian P Peppers, DO, PhD; John Frith, DO; Chelsea Michaud, DO; Theodore Sher, MD; Haig Tcheurekdjian, MD; and Robert Hostoffer, DO

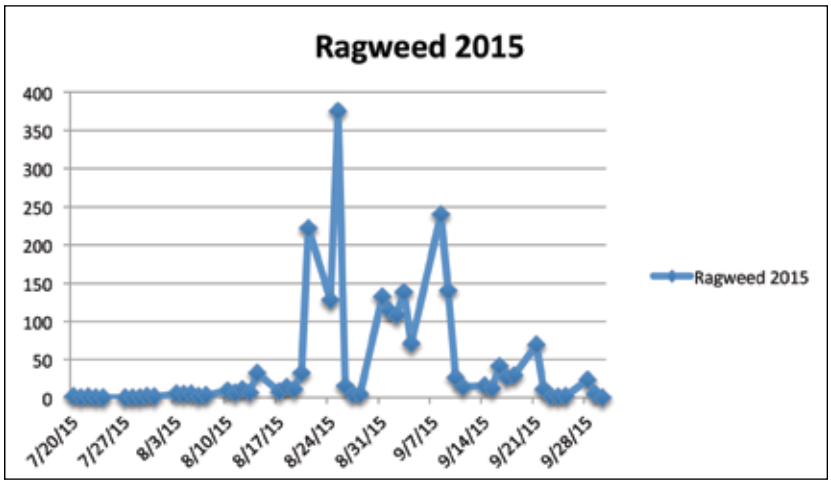
Allergy/Immunology Associates has been dedicated to serving patients of the Greater Cleveland area through the use of the Pollen Line. As in years past, we have used a Rotorod Aeroallergen device to obtain and then count the pollen levels daily throughout the 2015 pollen season. These pollen counts not only provide insight to patients, but allow allergists and physicians to have an extra tool to better direct therapy for their patients to achieve symptom relief. For those who suffer from allergic rhinitis, allergic conjunctivitis and asthma, the pollen season can be miserable. By following yearly trends, we can predict the timing of certain allergens and prepare our patients so that their quality of life can be maximized.



In the Greater Cleveland area, the pollen season begins with trees in April. Compared to last year, tree pollen levels peaked around the same time but raw numbers were less. Although total counts differ, we were able to identify the peaks in each season, which correlate reasonably with years past.



Grass pollen is known to be the main offender during the summer months. It was on the rise in early-mid June this year, similar to last year. Compared with last year, it peaked in the first week of June and then fell off quickly. These dramatic changes in grass pollen counts may have been in part due to unusual weather patterns involving rainy spells.



As the temperature starts to cool, we move into fall, also known as ragweed season. Ragweed appeared around the same time as last year. However, the values were much higher this year than last year. Last year's peak value was 50; this year we saw values of over 100 on multiple occasions, with a peak value of 375. With the Rotorod Aeroallergen device changing location and undergoing maintenance, several issues have come up. It is possible that last year's counts could be low if the device was starting to malfunction at the end of last season, if the new location was apt to get more ragweed then the previous location, or if, more likely, this year was just much worse for ragweed in general. We do tend to see ragweed every year around August 15 and it continues to climb from there until it starts a downward slope over the first two weeks of September. The ragweed pollen had a second peak in the first week of September this year. But like previous years, levels trailed off by the end of September.

Each year, Allergy/Immunology Associates, in coordination with the AMCNO, is proud to provide the pollen count for the Greater Cleveland area from April 1 to September 30. The counts are made available to the Pollen Line at (216) 520-1050, as well as www.amcno.org. Stay healthy and warm this winter, and we look forward to helping you prepare for next year's pollen season on April 1, 2016! ■

AMEF and AMCNO Sponsor Immunize Ohio Event

Through the generous support of the Academy of Medicine Education Foundation (AMEF) and others, Immunize Ohio hosted a one-day, CME-credited immunization symposium on Sept. 10 at the Embassy Suites in Dublin, Ohio.

The goal of the 2015 Statewide Immunization Conference was to provide a global perspective utilizing science-based strategies to effectively meet emerging challenges. Best practices were presented to facilitate timely, age-appropriate immunizations. The conference, "Global Exposure – Local Effect," drew participants from around the state and focused on new adult vaccination standards, global infectious disease threats and the status of possible vaccines; the true cost to Ohio for not vaccinating; adolescent vaccines, environmental survey results on HPV vaccination with hopeful strategies; and a keynote address outlining when religious beliefs can undermine modern medicine.

Cindy Modie delivers the opening remarks at the Immunize Ohio session.

Opening remarks were provided by the Ohio Chapter of the American Academy of Pediatrics, and presentations were provided by representatives from PFIZER Vaccine, Case Western Reserve University (CWRU), the Ohio Department of Health (ODH), the Centers for Disease Control and Prevention (CDC), the Ohio State University (OSU) and Children's Hospital of Philadelphia.

The first presenter was John McLaughlin, PhD, MSPH, from PFIZER Vaccine. Dr. McLaughlin discussed the cost of not vaccinating, pointing to the results of a recent report which estimated the economic impact to Ohio of the four major adult vaccine-preventable diseases (influenza, pneumococcal, herpes zoster and pertussis) was considerable and that broadening adult immunizations efforts beyond influenza may help reduce the economic burden of disease. He also noted that there is a need to address the barriers of adult vaccination at the patient and provider level and discussed the need to establish a public health rationale for improving awareness of adult vaccine-preventable disease in Ohio.

Dr. Heidi Gullett discusses how to increase HPV vaccinations.

James Kazura, MD, from CWRU, discussed the evolution and emergence of human infectious disease, citing global infectious disease threats and discussing the potential vaccine solutions to emerging diseases. Following Dr. Kazura was Carolyn Bridges, MD, from the CDC, who described for the audience the barriers to increase adult vaccinations as well as the barriers for patients and providers to fully immunize adults. She further outlined the burden of vaccine-preventable disease and illness, a list of recommended adult vaccines and current adult vaccination rates. Her presentation also covered an update on Tdap and influenza vaccination of pregnant women, a review of "Practice Standards for Adult Immunization" and resources for both physicians and patients to assist in implementing these standards. Just before the afternoon break, Alexandra Thornton, MPH, representing the ODH, provided an overview of the Assessment, Feedback, Incentive, eXchange (AFIX) Awards and congratulated this year's recipients.

Heidi Gullett, MD, MPH, from CWRU, and Toyin Sokari, MPH, from OSU, began the afternoon session discussing how to increase HPV vaccinations. They provided information on a national environmental scan to understand the issues impacting rates of HPV vaccine uptake and reviewed findings from HPV environmental scans conducted across Ohio and within Cuyahoga County. Both presenters also discussed multi-level strategies for increasing HPV vaccine uptake across Ohio in various settings, noting that every year we delay increasing vaccination rates, more women are at risk of developing cervical cancer.

The final presenter was Paul Offit, MD, from Children's Hospital of Philadelphia. Dr. Offit provided attendees with a copy of his new book, *Bad Faith – When Religious Belief Undermines Modern Medicine,* and discussed the challenges resulting from the anti-vaccine movement while describing strategies to increase vaccination rates.

The AMEF and the AMCNO were pleased to be sponsors of this important program. ■

A capacity crowd was on hand to learn more about immunization issues.

ICD-10 Has Arrived…Now What?

By Tamiya Williams, CMPE, Senior Manager, Medic Management Group, LLC

The long-awaited transition from ICD-9 to ICD-10 finally took place on October 1, 2015, and you may be wondering as a provider or administrator what you should be doing in your practice now.

In the months leading up to the transition date you were probably informed to do the following: Crosswalk your top 25-50 diagnosis codes, take steps to improve clinical documentation, make sure revenue cycle staff has adequate training, make sure you have enough cash on hand to cover expenses, and most importantly, make sure that your billing software and clearinghouse are ICD-10 ready. If you have taken the time to do all of those things, you probably consider your practice to be in pretty good shape and you probably are. With all those things being said, however, there is still more work to be done.

There is probably a sense of relief among providers, clinical support staff, and revenue cycle staff everywhere, but we are still in the land of the unknown. We should all keep focused on the following:

- Am I doing everything in my power to help cash flow?
- Is my documentation and coding to the highest specificity possible?
- Will I understand and know how to process the various denial reasons?
- Is there a delay in the processing of claims?
- Should I be conducting ongoing chart audits?

Surviving the last quarter of 2015 may not be an easy task for some practices as it pertains to cash flow. It is important that the patient registration process is ironclad. Obtaining complete and accurate demographic information along with complete and accurate insurance information are important. It is very beneficial for a practice to verify insurance prior to the patient's appointment time so the front desk staff can be prepared to collect copays, deductible amounts, and any outstanding balances owed. It will also be beneficial for practices to avoid huge cash expenditures during the last quarter of 2015 to help maintain cash flow.

Before claims are sent out the door it is a good idea to have a coder take a second look to see if there is any missing documentation and the claim is coded using the highest specificity. CMS announced that claims will not be denied for level of specificity for 12 months after the ICD-10 transition date, but that does not mean that other payers won't. Coders and providers should have open lines of communication during this time so that there is not a delay in the billing process. It may also be advantageous for a practice to nominate a "Physician Champion" for ICD-10 for peer-to-peer education.

Denial management is another key component that practices should pay attention to. It is important to do thorough research when a claim is denied for ICD-10. If the denial reason is not clear, it is imperative that someone from your billing department calls the payer to get clarification on what is needed in order to correct the claim. Denials can be used to train physicians and clinical support staff on documentation and coding requirements. It is also important to look at the big picture when it comes to denials to see if trends and root causes can be identified. All denials should be addressed immediately to prevent future denials that can and will impact cash flow.

Accounts Receivable management should also be a focus point for your practice's billing department. Once claims submission has taken place it is important to confirm that the number of claims you submitted were accepted by the clearinghouse and the payer. If a claim falls out and does not go through the submission process successfully, it should be due to a claims edit that was created and should be reviewed immediately. Claim acceptance can be verified by using the EDI report (Claim Status), which can be obtained from your clearinghouse. Ohio has a prompt pay law, meaning you should know if a claim is being denied or paid within 15-30 days. Best practice is for the A/R team to start calling on claims between 20-30 days. This practice will also serve as a double check to confirm that the payer has the claim on file, which in turn will help the practice avoid timely filing denials.

It is also important for practices to perform ongoing chart audits to ensure that all billing providers are using the correct ICD-10 codes. All chart audits should be performed by a Certified Professional Coder that has had ICD-10 training. Feedback and education should always be a part of the audit process. Documentation of the audit findings and provider education should be kept on file for reference in the future.

The world of healthcare is ever-changing, or I should say the requirements put on providers by CMS and the government are ever-changing. With all of the new healthcare requirements and guidelines, it is imperative that physicians and support staff form a partnership with one goal in mind — to provide the best patient care possible while meeting CMS requirements. ICD-10 requires a more collaborative effort with patients due to the level of detail that we need to obtain from them. At the beginning this will require patient education on why this type of detailed information is needed. The one thing that will never change is that this world will always need physicians to facilitate and guide patients through their medical journey and on to a healthier life…welcome to the world of ICD-10. ■

Center for Medicare & Medicaid Services Convenes Region V Medical Society Meeting

In September, staff from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) participated in the Center for Medicare & Medicaid Services (CMS) Region V State Medical Society quarterly meeting. Also attending this meeting were representatives from state medical associations representing Ohio, Michigan, Indiana, and Illinois. Some of the topics covered were the ICD-10 roll out, the two-midnight rule, and the Medicare Access and CHIP Reauthorization Act (MACRA).

Representatives from CMS discussed the rollout of ICD-10-CM, stating that ICD-10 should be used by all providers in every healthcare setting, and claims for dates of service on or after October 1, 2015, must be coded in ICD-10. No claim can contain both ICD-9 and ICD-10 codes. CMS has provided guidance on how to handle claims that span the October 1 transition date. CMS has also established an ombudsman department to address problems and issues with the new coding set. They have a full office dedicated to questions and these queries will be tracked and followed until completion. They are also working on other resources that will be made available soon. It is important to remember that Medicare claims take a couple of days to process and they may take a couple of weeks before they are paid. If physicians want to check the status of a claim, they can go to their MAC portal. CMS presenters also encouraged the medical society representatives in attendance to have their members go to the Road to ICD-10 website for more information — this website was developed by CMS with the help and input from practicing physicians. The website was developed because physicians asked for a "one-stop shop" to get their questions answered. The website includes provider-inspired fact sheets; the top 25 codes by specialty, information on how to contact the new CMS ombudsman department, quick start guides and other information. The website is https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

CMS representatives discussed the two midnight rule, noting that the rule includes the need to have documentation to justify the stay. In addition, the benchmark applies to the admitting practitioner and the benchmark is when a physician orders an inpatient admission if the patient is expected to need hospital care (outpatient and inpatient) for at least two midnights. The presumption applies to the medical reviewer — inpatient stays longer than the two midnights will be presumed medically necessary absent evidence of gaming or fraud and abuse. Special circumstances include patient death, transfer, or left against medical advice. CMS has heard from both the hospital and physician community that in many instances CMS removed physician judgment in these circumstances — therefore, in the proposed rule they are providing more of a role for physician judgment. Further changes to the rule have been proposed for 2016 — such as stays expected to last <2 midnights: exception based on the judgment of the physician rather than national guidance, and still rare and unusual for an inpatient admission for a minor surgical procedure or treatment expected in the hospital for only a few hours and not overnight. For stays expecting to last >/=2 midnights: no change. Medical review: the first review will be done by the quality improvement organization, and there will be a referral to the recovery audit contractors where there is repeated non-compliance with the rule. Comments are being sent in on the proposed rule and the final rule will be out by November 2015.

The presentation regarding MACRA covered an overview of the new law. There will be a lot of rules and information developed in the next couple of years to implement the law. As previously reported in the *Northern Ohio Physician,* MACRA repealed the 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) update and will change the Medicaid PFS payments to a merit-based incentive payment system (MIPS), with incentives to participate in an alternate payment model (APM). This is currently under comment through a request for information through November 2015. MIPS and APMs will drive payment from 2019 onward. Separate application of payment adjustments under PQRS, value modifiers, and electronic health records/meaningful use will sunset as of December 31, 2018. Beginning in January 2019, MIPS and APM payments will begin, and eligible providers can participate in MIPs or meet requirements to be a qualifying APM participant. MIPS participants can receive positive, negative or zero payment adjustment, and if criteria are met, APM participants can receive 5% incentive payments for 6 years. CMS will propose the initial policies for the MIPS in CY2017 PFS Rule Making — with the proposed rule to be published in June 2016. As part of MIPs, CMS must make available timely confidential feedback reports to each MIPs eligible provider by July 1, 2017. Information about the performance of MIPs EPs must also be made available on the Physician Compare website.

APM model incentive payments will begin in 2019, and for 6 years there will be a 5% incentive payment for eligible professionals or groups of EPs who participate in certain types of APMs and meet specified payment thresholds. Payments will be made in a lump sum on an annual basis and EPs or groups of EPs who meet the criteria to receive APM incentive payments are excluded from the MIPs requirements.

There was a lot of information contained in the MACRA law and even the CMS representatives noted that patients and providers alike will need assistance to implement the law. An item contained in MACRA will impact Medicare beneficiaries — the new Medicare cards will not display Social Security numbers. For more than a decade the Department of Health and Human Services (HHS) has recommended taking the SSNs off of Medicare cards in order to reduce the potential for identity theft. MACRA includes funding and instructions for HHS to consult with the Social Security Administration to establish cost-effective procedures to modernize Medicare cards.

There will be more information on MIPs and APMs and the entire MACRA law from CMS in the coming months. The information will be made available through the CMS website, the Medicare Learning Network and other resources. CMS representatives will also make materials available to the medical societies, including the AMCNO, for dissemination to our members. ■

Call for 2016 AMCNO Honorees

We invite you to nominate an individual who is an AMCNO member and who you believe is deserving of special recognition by the AMCNO. Any physician who wishes to nominate an individual for one or more of the following awards should complete the form below and mail it to Elayne Biddlestone at the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, OH, 44131. You may also FAX your nominations to Elayne Biddlestone at (216) 520-0999 OR you may call her at (216) 520-1000, ext. 100, to provide your honoree nominations over the phone. Deadline for submission:12/31/15.

- JOHN H. BUDD, MD, DISTINGUISHED MEMBERSHIP –
  This award is bestowed upon a member of the AMCNO who has brought special distinction and honor to the medical profession, to our community and to our physician association as a result of his or her outstanding accomplishments in biomedical research, clinical practice or professional leadership. Often, such an individual has already gained national and/or international recognition because of the importance of his or her contributions to medicine.

- CHARLES L. HUDSON, MD, DISTINGUISHED SERVICE –
  Awarded to a physician whom the AMCNO deems worthy of special honor because of notable service to and long activity in the interest of organized medicine.

- CLINICIAN OF THE YEAR –
  Awarded to a physician whose primary contribution is in clinical medicine and whose service to his/her patients over many years has reflected the highest ideals and ethics of, and personal devotion to, the medical profession.

- Your Name: _____
- Your Nomination: _____
- Nominated for the following award: _____

Please include an explanation as to why you are nominating this individual: _____

_____

_____

_____

_____

Are you Interested in Running for the AMCNO Board of Directors in 2016?
Directors are elected to represent their district, which is determined by primary hospital affiliation or at-large for a two-year term. Members of the Board are responsible for addressing issues of importance to physicians and the patients we serve, and setting policy for the AMCNO. If you are interested in running for the AMCNO Board of Directors please return this form with your name and contact information to the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, OH, 44131. You may also FAX your information to Elayne Biddlestone at (216) 520-0999 OR call her at (216) 520-1000, ext. 100. Deadline: 12/31/15.

Yes, I am interested in running as a candidate for the AMCNO Board of Directors

Name and contact information: _____

The AMCNO Weighs in on Important Tort-Reform Issue before Ohio Supreme Court

By Susan M. Audey, Attorney, Tucker Ellis, LLP

One of the many ways the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) furthers the interests of its members is by making their voices known on important issues of tort reform that are before the Supreme Court of Ohio. One such tort-reform issue — caps on noneconomic or "pain and suffering" damages — is right there at the top. And right now before the Court is a case challenging the constitutionality of a damage-cap statute very similar to the statute that limits the same kind of damages in medical-malpractice cases.

The case is *Simpkins v. Grace Brethren Church of Delaware, Ohio,* and the AMCNO made its interests and positions known by filing an amicus "friend of the court" brief. The case involves the statute capping noneconomic damages for general torts, R.C. 2315.18. The general tort in *Simpkins* — negligence against a church for promoting a pastor who ultimately raped 15-year-old Jessica Simpkins during a church "counseling" session — is similar to the medical-malpractice statute capping noneconomic damages, R.C. 2323.43. Both statutes cap noneconomic damages at the greater of $250,000 or an amount equal to three times the economic loss to a maximum of $350,000 for each plaintiff or a maximum of $500,000 for each occurrence. The jury in *Simpkins* awarded the plaintiff $3.5 million in total noneconomic damages and $150,000 in economic damages. Although the plaintiff argued the damage-cap statute was unconstitutional "as applied" to her, the trial court disagreed and entered judgment for the capped amount: $500,000, which consisted of the $350,000 cap for noneconomic loss (based on three times the $150,000 noneconomic loss) and $150,000 for economic loss. The court found no reason for any different result based on its earlier decision in *Arbino v. Johnson & Johnson,* which upheld the constitutionality of the damage-cap statute "on its face" back in 2008. The Fifth District Court of Appeals agreed on that issue and affirmed that part of the trial court's judgment. The Supreme Court of Ohio agreed to hear the issue of whether the damage-cap statute is unconstitutional "as applied" to minor victims of sexual assault.

The importance of this case is two-fold. The constitutionality of a statute is typically challenged in one of two ways: either "facially" or "as applied" to a certain set of facts. A successful "facial" challenge effectively invalidates the statute challenged for anyone under any set of facts. An "as applied" challenge, on the other hand, invalidates the statute only as that particular plaintiff under a particular set of facts. Recall that *Arbino* — the seminal case on the constitutionality of this statute and the basis upon which constitutionality is measured in Ohio — had already found the damage-cap statute constitutional "on its face." Plaintiffs would have a hard time getting around that clear pronouncement of the law. Consequently, plaintiffs have been increasingly challenging the constitutionality of tort-reform statutes "as applied," even though they appear to raise the very same arguments that would be raised in a facial challenge. Of course, the Supreme Court of the United States has not been entirely clear in its analyses of these kinds of challenges either, which has only furthered the confusion in the analyses there and in state courts. What the AMCNO did in its brief, however, was to offer the Court a clearer path to analyzing "as applied" challenges, especially when the Court has already determined the same statute is constitutional "on its face." As an alternative, it urged a very narrow carve-out for victims of sexual assault that would limit *Simpkins* to its facts.

The analysis the Court ultimately adopts is also important for a second reason. *Simpkins* also argued that the "occurrence" language in the damage-cap statute should be read so that the caps apply to each act of rape—here, vaginal and oral—as they would be considered in the criminal context. Of concern to the medical community is that plaintiffs would use this same language from the medical-malpractice statute to say that each visit to a medical provider is an "occurrence" and thus each visit would be entitled to a separate damage cap. The AMCNO pointed out in its amicus brief the faulty reasoning for such a construction because that language speaks to multiple plaintiffs not multiple acts.

The AMCNO's brief supporting the Church was only recently filed and *Simpkins* has the opportunity to respond with one more brief. The Court will likely hear arguments sometime in the first half of 2016 and a decision would be forthcoming sometime after.

As always, the AMCNO is working hard to protect its members' interests in upholding commonsense interpretations of tort-reform law as that law is enacted by those we elect into the Ohio General Assembly. The AMCNO is happy to discuss this case in more detail with anyone interested. A link to the AMCNO's brief can be found on their website www.amcno.org. ■

Ohio House Healthcare Efficiencies Committee Reviews New Payment Models, Medicaid and Graduate Medical Education Issues

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was on hand at the first meeting of the Ohio House Healthcare Efficiencies Study Committee, chaired by Rep. Stephen Huffman (R-Tipp City). The purpose of this study committee is to examine healthcare efficiencies that lead to better health outcomes at a lower cost to Ohioans. Speaker Cliff Rosenberger (R-Clarksville) created this committee to examine healthcare models across Ohio that the House can help support and promote. The findings of the committee could potentially be used in legislation to be introduced later in the General Assembly.

This first meeting of the committee focused on graduate medical education (GME) funding in Ohio. Rep. Huffman, a physician, said it's important to understand the educational process that medical professionals go through as lawmakers consider legislation that aims to keep graduates in the state who intend to work in underserved areas.

Several physicians testified before the committee outlining why maintaining GME funding is important to the state. Testimony addressed how GME works—with both federal and state funds used by teaching hospitals to pay for the cost of educating residents through direct GME payments, which reimburse hospitals for the costs of salaries and benefits paid to residents and teaching faculty; and indirect GME payments, which are added on to patient care reimbursement rates to compensate teaching hospitals. Testimony also addressed how Medicare and Medicaid reimburse teaching hospitals for their direct and indirect shares for training residents—with additional information provided on how Ohio Medicaid pays hospitals for the percentage of GME costs.

All of the panel presenters mentioned the physician shortage in Ohio, particularly primary care physicians. It was noted that several factors could worsen the impact of the physician shortage in the future, such as the aging of the baby boomer population, the increase in the newly insured due to the Medicaid expansion, and population growth. In order to address this impending shortage, Ohio medical school enrollment has increased more than 15% in recent years; however, residency slots have not increased. This trend has resulted in more medical students graduating from Ohio schools, but failing to find a residency spot.

Several suggestions were provided to the committee by the panelists that could address these issues, including using GME dollars to incentivize the production of the kinds of physicians needed now and into the future; distributing GME dollars based on outpatient services as well as inpatient services; creating an Ohio GME advisory entity; having the state fund residencies in non-academic settings to promote new delivery models of care; adding residency slots in fields that met workforce demands, and tying GME funding to performance metrics.

The Ohio House Healthcare Efficiencies Summer Study Committee also convened at MetroHealth Medical Center to hear presentations by John McCarthy, Director of the Ohio Department of Medicaid, and Bonnie Kantor-Burman, Director of the Ohio Department of Aging, on Medicaid reform and the aging population in Ohio. Directors or other representatives from local companies, organizations and health systems were also in attendance to testify on how they are working to improve health outcomes through their facilities, while reducing costs. Among the 17 organizations giving testimony, in addition to MetroHealth, were the American Lung Association, Akron Children's Hospital, Diabetes Partnership and University Hospitals Case Medical Center.

Committee Chairman Steve Huffman (R-Tipp City) said he's encouraged by improved healthcare outcomes and reduced costs for the state, but is concerned about the impact on primary care physicians. He and other committee members agreed that they are eager to see how House bill (HB 64), which is seeking a federal waiver mandating all non-disabled adult Medicaid recipients to enroll in a health savings account, will impact the cost and quality of care. The waiver would require recipients to pay 2% of their family income (up to $99 per year) into a health savings account.

There were two other meetings of this committee on the topics of behavioral health and population health management. Its members are now tasked with compiling what they've learned and making recommendations about how Ohio can improve delivery of treatment and decrease costs. The study panel is expected to submit its findings report to the House speaker and members in the coming weeks. Chairman Huffman has said the report will focus on the need for collaboration between healthcare providers and additional GME training as well as emphasize the positive impacts of paying for healthcare outcomes rather than services. As noted above, the findings of the committee could potentially be used in legislation to be introduced later in the General Assembly.

In addition to the above-referenced hearing regarding GME, the recently passed budget legislation (HB 64) also called for the creation of the Graduate Medical Education Study Committee. This committee is to study the Medicaid payments made to hospitals to cover the cost of educating physicians. The committee is also expected to review payments that reward medical school graduates who practice in Ohio for at least five years after graduation. The 15-member committee is chaired by the director of the Office of Health Transformation and will also include the state Medicaid director, state chancellor, presidents and medical deans of Ohio educational institutions, and appointees from four statewide medical associations. The report from this committee is due no later than Dec. 31, 2015.

Infant Mortality Commission Convenes

A new state Commission on Infant Mortality, co-chaired by Sen. Shannon Jones and Rep. Stephanie Kunze, has started their work to identify disparities and develop strategies to reduce the number of Ohio babies who die before their first birthday.

Medicaid Director John McCarthy informed the commission that his department is partnering with other state agencies and local communities to target zip codes with the highest mortality rates, starting with the Akron area. He stated that when he visited the Akron area it appeared that a lack of

communication between local agencies is an issue. He said his team plans to visit all nine of the targeted communities by March 1 and to get financial assistance flowing to local initiatives as soon as possible.

According to statistics from the U.S. Department of Health and Human Services, Ohio ranks 45th in overall infant mortality. The state's rate of infant mortality for black babies (13.57) was the second highest nationally for the 39 states where a rate could be calculated. Only Wisconsin (14) and Kansas (14.18) fared worse and were tied for first.

State Legislators Press for Swift Passage of Mandated Insurance Payment for Abuse-Deterrent Pain Medications

State Reps. Robert Sprague (R-Findlay) and Nickie Antonio (D-Lakewood) participated in a news conference at the Statehouse to urge quick passage of legislation to help fight Ohio's prescription drug abuse epidemic.

Ohio HB 248 mandates insurance companies pay for abuse-deterrent versions of addictive pain medications. Since 2007, drug overdoses have continued to increase and have been the leading cause of accidental death in the state, Rep. Sprague said. Abuse-deterrent formulations of prescription opiates could stymie that trend, he said, pointing to research that shows abusers are more likely to crush up or dissolve opiates to achieve a quick high than take a handful of pills.

Sprague said instances of snorting or injecting abuse-deterrent drugs fell by 70% after the Federal Drug Administration first approved the new product. He said drug overdoses, however, continue to be the leading cause of accidental deaths in Ohio, despite recent initiatives to address the problem. "By making tamper-resistant pain drugs more widely available, we can begin to turn that around," Sprague said.

"People who abuse prescription pain pills are more likely to end up in the hospital and more likely to need outpatient treatment," added Antonio. "If we can prevent abuse, prevent an overdose, we can save those costs. So H.B. 248 is a good financial strategy as well as being a way to help save lives and keep families from suffering the consequences of drug abuse." Rep. Antonio also said that while physicians could likely prescribe opiates without abuse-deterrent mechanisms for those who clearly aren't addicts, it would be best for all opiates to be tamper resistant because they can sometimes end up in the wrong hands. The bill is currently before the House Health and Aging Committee, and the AMCNO supports this legislation.

The Academy of Medicine of Cleveland & Northern Ohio Opposes Issue 3

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Board of Directors has convened and agreed to formally oppose Issue 3, the ballot initiative to legalize marijuana use in the state of Ohio.

Although the AMCNO supports providing avenues in which to educate healthcare professionals and the general public on the issue, its members have taken a stand against legalizing a substance for medicinal purposes before more scientific research has been conducted. While there have been some studies which show the potential benefits of marijuana for some medical conditions, the AMCNO believes that further scientific evidence is necessary in order to support the use of this drug as a suitable alternative for the treatment of certain illnesses. The AMCNO believes that marijuana should be subject to the same research and study as any other type of medicine, and we do not oppose additional clinical research.

The AMCNO believes that this proposal is not in the best interest of the citizens of Ohio and we join Ohioans Against Marijuana Monopolies to vote NO on Issue 3 in November.

AMCNO Continues to Express Concern Regarding HB 216

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has taken a position of opposition on HB 216, and we have been working with other medical associations around the state to express concern about this legislation to the members of the Ohio legislature. As introduced, HB 216 would allow Advanced Practice Registered Nurses (APRNs) in Ohio to practice independently without a standard care arrangement with a collaborating physician.

The bill would also grant prescriptive authority to certified registered nurse anesthetists and allow all APRNs to prescribe addictive Schedule II drugs in all settings except for retail clinics. Ohio needs greater accountability over prescribing, not less. This drastic change in Ohio law from a collaborative team-based approach to an independent practice model of care for APRNs does not provide adequate patient safety assurances and could threaten the quality of care provided to Ohioans.

The AMCNO believes that APRNs provide a valuable and necessary service when working under the direction of a physician when caring for a patient. Health care works best when there is a team-based approach to patient care, with multiple healthcare professionals working together under the direction of a physician. By permitting APRN independent practice, the team-based approach to care will be further fragmented.

The education and training of physicians are unsurpassed. Physicians have at least 11 years of education and training, while APRNs have 5.5 to 7 years. Although APRNs have a unique and important role in health care, they have not completed medical school and residency training that affords them with the same knowledge, training, experience and skills as those who have completed medical school and residency training.

HB 216 unreasonably expands the scope of practice for APRNs. If HB 216 passes, APRNs would be able to order and interpret diagnostic tests, prescribe addictive narcotics and develop treatment plans without consulting a physician. HB 216 threatens the reliable assurance of safe and appropriate patient care at all times because the bill would change how physicians and APRNs collaborate. The AMCNO learned that a substitute bill is being drafted and we are monitoring this bill closely.

AMCNO Voices Opinion on Mandatory CME for Physicians

The AMCNO joined several other medical associations in voicing concern about Senate

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Bill (SB) 33, a bill that would require certain healthcare professionals to complete instruction in cultural competency.

The AMCNO and other medical associations recognize racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. As such, we support physician cultural awareness initiatives and related consumer education activities as a means to eliminate racial and ethnic disparities in health care.

Our concern with SB 33 however, is that it would ***mandate*** heathcare professionals, including physicians, to take instruction in a content-specific manner. We believe that physicians should be able to determine their initial and continuing education needs based upon their individual areas of expertise, practice type or specialty and the clinical needs of their patient population. We fear mandated content-specific continuing education intrudes on the profession's responsibility to determine appropriate educational requirements.

The AMCNO and the other associations who signed onto the letter to the Senate committee noted that we have always supported efforts to raise awareness about racial and ethnic health disparities. For example, we support the following efforts and recommendations for increasing education on cultural competency:

- Encouraging medical schools to offer courses in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider.
- Assisting physicians in obtaining information about and/or training in culturally effective health care. One example is through the American Medical Association's "Working Together to End Racial and Ethnic Disparities: One Physician at a Time" toolkit, which provides physicians with a broad overview of health disparities among racial and ethnic minority patients and strategies to enhance the services for diverse patients.
- Recommending the study of the integration of cultural competence training in graduate and voluntary continuing medical education and publicizing successful models.

We are interested in working on this important issue with members of the Senate Health Committee, and in finding ways to continue educating health professionals in this area. However, as stated, our concerns for this legislation is in the mandate it will cause for providers.

HHS Names Grant Recipients

The U.S. Department of Health and Human Services (HHS) has announced $685 million in awards to 39 national and regional healthcare networks and supporting organizations to help equip more than 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and reduce costs.

The Transforming Clinical Practice Initiative (TCPI) is one of the largest federal investments designed to support doctors and other clinicians in all 50 states through collaborative and peer-based learning networks.

The TCPI will support efforts among medical group practices, regional healthcare systems, regional extension centers, and national medical professional association networks. These efforts will help clinicians expand their quality improvement capacity, engage in greater peer-to-peer learning, and utilize health data to determine gaps and target intervention needs. The initiative has two major components:

Twenty-nine Practice Transformation Networks (PTNs) will provide technical assistance and peer-level support to assist clinicians in delivering care in a patient-centric and efficient manner. Examples include providing dedicated coaches to help practices better manage chronic diseases, supporting improved patient access to practitioners through emails and other information technology applications, and helping to advance improved access to remote and virtual care.

Ten Support and Alignment Networks (SANs) will focus on such initiatives as creating a collaborative for emergency clinicians to address appropriate utilization of tests and procedures and forming collaboratives between psychiatry and primary care providers so patients can receive basic mental health care from their primary care providers. Many of the SAN grant recipients were national physician organizations. A group of Ohio organizations, including the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), submitted a TCPI application through the Ohio Health Information Partnership, but the proposal did not make the final cut for funding. For more information go to: http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/

Ohio Department of Health Data Shows an Increase in Fentanyl-Related Drug Overdoses

A recent report released by the Ohio Department of Health (ODH) shows a large increase in drug overdoses involving fentanyl. In 2014, there were 502 fentanyl-related drug overdoses, which equates to an almost 500% increase from 2013, when 84 fentanyl-related overdoses were reported. The rise in the use of fentanyl, a synthetic opiate, is thought to be a major driver in the spike in overdose deaths during those years, ODH said. The state saw 2,110 overdose deaths in 2013, which jumped to 2,482 in 2014.

As a result, the state announced it is expanding its efforts to counter the use of fentanyl and other opiates. That includes an additional $500,000 a year to purchase overdose antidote naloxone. In addition, state agencies will work to improve interdiction, raise awareness of the new drug, expand treatment options and reduce inappropriate prescription of pills.

The state is also partnering with the Centers for Disease Control and Prevention to analyze Ohio's growing fentanyl use so that local and state officials, law enforcement and doctors better understand the nature of the fentanyl problem in Ohio and how to address it. ■

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