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AMCNO Active in Tobacco-Free Youth Initiative

The AMCNO has become an active participant in a new legislative initiative known as the Investing in Tobacco-Free Youth Coalition campaign. The group is dedicated to reducing the problem of non-cigarette tobacco products, called "other tobacco products" (OTP).

AMCNO physician and staff representatives met with legislators in Columbus recently to discuss the campaign. The AMCNO also spent time discussing this initiative with the *Plain Dealer* editorial board. The AMCNO has joined hundreds of advocates from around the state to urge the legislature to support tobacco prevention and cessation. The coalition is asking the legislature to correct the inequity between the "other tobacco products" tax and the cigarette tax. (The "other tobacco products tax" includes non-cigarette forms of tobacco

products, including smokeless tobacco). This correction is especially urgent given these new forms of tobacco and the increased emphasis on marketing. When legislators raised the cigarette taxes in the past, they failed to raise the "other tobacco products" tax, which includes all tobacco products that aren't cigarettes. So, now the tax on these products is less than half the tax on cigarettes, making them cheap and easily attainable. The coalition is asking the legislature to correct this inequity and dedicate the revenue to youth prevention



Rep. Matt Dolan (left) spends a moment with AMCNO board member Dr. John Clough after a meeting with representatives from the Coalition.

and community programs that help our kids not start using tobacco; and to cessation programs so that addicted users can get the help they need to quit. The Coalition is

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AMCNO Legal Issues Seminar Offers Useful Updates

The Academy of Medicine of Cleveland and Northern Ohio (AMCNO) and the Academy of Medicine Education Foundation (AMEF) sponsored legal seminars held on April 2 and April 9 were well attended by physicians and physician office staff. Presenters included Brant Poling, Esq. from Sutter, O'Connell and Farchione Co., L.P.A., Edward Taber, Esq. from Tucker, Ellis & West LLP, Amy Leopard, Esq. from Walter & Haverfield LLP, and Heidi Carroll, Esq. from Reminger & Reminger Co., L.P.A. with AMCNO members Dr. Anthony Bacevice and Dr. Paul Janicki each facilitating a session. The presenters informed the audience of the legal issues currently impacting physicians in their practices and offered means to ensure that legal compliance consistently was met.

The first session regarding current trends in malpractice allegations and risk management began with Mr. Poling offering a snapshot view of the current trends in medical

malpractice cases, which point downward in frequency yet upward in the severity of

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Dr. Anthony Bacevice, AMCNO board member provided the opening remarks at the AMCNO legal seminar at Lakewood Country Club.

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AMCNO Active in Tobacco-Free Youth Initiative

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asking that the resulting funds be dedicated to tobacco prevention and cessation programs so that the Ohio Tobacco Prevention Foundation (OTPF) can counteract manipulative advertising by the tobacco companies.

Current tobacco funds to be used to fund the state job stimulus package

While the AMCNO and the Coalition for Investing in Tobacco-Free Youth were asking Ohio legislators to consider supporting legislation to correct the other tobacco products tax and provide additional funding for the OTPF, the legislature and the Governor were working on a \$1.57 billion bipartisan job stimulus package. This package, which was unveiled by state leaders has tapped numerous other funding sources — including most of the money currently held by the

Ohio Tobacco Prevention Foundation (OTPF).

When it was set up by the state in 1999, OATF was projected to receive \$1 billion for an endowment to continuously fund antismoking and cessation efforts. Funding, however, stalled at more than \$300 million, and last year the state sold its future payments from Big Tobacco for a lump sum of about \$5.5 billion — most of which was earmarked for school facility projects. Saying the statewide smoking ban has curbed tobacco use across Ohio in recent months, and that Ohio has spent significant money on health care upgrades, Gov. Ted Strickland said OTPF would have to be prudent with its remaining funds and raise private money through the authority it was granted last year. The AMCNO will continue to monitor this issue and report back to our membership. (For more information on the OTPF issue see the AMCNO legislative report on page 10.) ■

AMCNO Legal Issues Seminar Offers Useful Updates

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Mr. Brant Poling, Esq., of Sutter, O'Connor and Farchione, Co., LPA provides the attendees with information on "how to avoid the courthouse."

payment both in Ohio and nationally. Mr. Poling stated that from 2004 – 2006 the Ohio Department of Insurance shows a substantial downward trend in the number of claims reported yet the amount of indemnity payments has grown with Northeast Ohio having the largest payout in the state. Mr. Poling opined that tort reform is working to contain the number of cases; however, specifics were shared on how damages are being expanded. Proactive ways to prevent claims and resulting litigation were offered as well as specific problems that could be avoided with appropriate documentation.

The next presentation on practice pitfalls by Mr. Taber was divided into two parts — the first covered medical privacy litigation and HIPAA compliance, detailing the necessary office operations' practices that will ensure compliance. The second part addressed informed consent and included areas such as not sharing information about potential complications, supervision of residents, failure to disclose material risks and more. It was also explained that consent is a process and not a piece of paper. While good consent forms are important it is wise to consider other means to inform patients such as the use of videos and literature.

The presentation on electronic health records/technology issues and patient communication conducted by Ms. Leopard explored the different types of legal risks associated with Electronic Health Records (EHR). Attendees were provided with detailed information on the specific risks with managing health information technology (IT), intellectual property issues, privacy and security risks, professional liability risks and fraud and abuse issues. At the federal level, favorable policy goals have been set for health IT with the overall goal being to avoid medical errors, reduce costs and improve patient care. Ms. Leopard also discussed the new rules for health IT donations by hospitals and the issues associated with community health information exchange that successful Regional Health Information Organizations (RHIOs) must address.

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The final presentation by Ms. Carroll focused on Stark III compliance and prevention of healthcare fraud and abuse by providing information on the most common forms of fraud in the federal healthcare programs and how they are prosecuted. Of interest were examples of Stark violations by physicians and hospitals and the associated penalties incurred as well as the resultant settlements. Also discussed were the Deficit Reduction Act of 2005 (DRA) promoting individual physicians and groups, Stark exceptions with compensation arrangements, ownership or investment interest and public policy, and physician recruitment by group practices.

Afterwards, a question and answer session was conducted where participants had an opportunity to address their specific concerns and/or issues with the panel. The program did qualify attendees from University Hospitals for two hours of Clinical Risk Management Credit (non-live) towards the required hours for Western Reserve Assurance. The AMCNO plans to offer similar sessions in the future. ■

AMCNO ACTIVITIES

AMCNO Wine Experience

AMCNO members and residents, medical students and their spouses attended this year's wine tasting event held on Sunday, February 17th at La Cave du Vin. Those in attendance thoroughly enjoyed this opportunity to sample wines from California, Italy and Argentina. La Cave du Vin wine sommelier Erich and Tim English of Private Reserve discussed the particular flavors and ingredients of each glass of wine as well as regional stories about each wine and recommended suitable food accompaniments. The venue provided the perfect atmosphere to mingle with fellow AMCNO members and their guests.



Dr. and Mrs. Raymond Scheetz, Jr., were pleased to participate in the event.



Dr. Cristiani Quintini and Teresa Diago, MD, enjoy one of the tastings for the evening.



Dr. and Mrs. Avitsian review the wine tasting list.

AMCNO Hosts Legislative Luncheon at Marymount Hospital

On Friday, March 14th the AMCNO sponsored a Legislative Lunch at Marymount Hospital. A key component of the AMCNO legislative agenda for 2008 is to coordinate meetings with hospitals/groups in the region. These meetings are to educate physicians and legislators on the ongoing impact of medical issues on access to care, physician practice, hospital care and reimbursement issues. Legislators in attendance for the Marymount luncheon were Representatives Kenny Yuko, Tom Patton, and Michael DeBose. Also in attendance were Senators Spada and Miller.

Physicians in attendance voiced concern about the medical liability climate in Northern Ohio, specifically providing information to the legislators that although premiums have leveled off somewhat, physicians in our region continue to pay the highest rates in the state while their practice cannot increase their reimbursement rate under the current

payment system. Participants noted that doctors have taken a big hit on the cost of their medical liability premiums but they cannot pass on their costs. Doctors continue to get harassed by insurance companies regarding contracting and reimbursement issues.

It was also noted that in any other business model if the overhead costs went up 20% that business could charge more to offset those additional costs but that is not the case in a physician's practice. Physicians have overhead costs just like any other business and the insurance companies continue to find ways to ratchet down reimbursement. The legislators were asked to consider the impact this has on a physician practice.



Dr. George Topalsky, AMCNO board member provides opening remarks at the Marymount Legislative Luncheon.



The legislators attending the AMCNO Legislative Lunch at Marymount Hospital spend a moment with several of the attendees. L to R – Rep. Tom Patton, Rep. Michael DeBose, Senator Dale Miller, Rep. Kenny Yuko, Dr. John Clough, William Keckan, Marymount Chief Operating Officer, Dr. Carl Asseff, Senator Robert Spada, Dr. Karl deHaan, and Dr. Shashikant Shah.

Other attendees asked the legislators to provide their opinion on the issue of tax-free status for hospitals. Overall, the legislators in attendance agreed that there are other ways within the State to obtain funding and that this will be an ongoing debate over the next few months. There is a real need to have a debate and open discussion on the issue and the legislators in attendance were willing to have that discussion in the future. Hospitals interested in hosting an AMCNO sponsored legislative lunch may contact E.R. Biddlestone at the AMCNO offices at (216) 520-1000, ext. 100. ■

John Henry Budd, MD

"I was just lucky" was the standard answer John Budd gave anyone who praised him for his enormous accomplishments in his 99 years. No one deserved the praise more than he.

A child prodigy who was an accomplished classical pianist at age four; a hero as an American citizen in the U.S. Army in World War II; a nationally known jazz musician; President of the American Medical Association; President of the Academy of Medicine of Cleveland & Northern Ohio; Honorary President of the state medical association; one of the original inductees into Cleveland's Medical Hall-of-Fame; holder of multiple additional prestigious awards and honors; a physician whose patients revered him; a baseball fanatic and a good friend of a gigantic multitude of people; these are just some of the accomplishments that made him loved, respected, honored and known throughout the national medical community and the old-time jazz community as well.

John Budd was married twice. His first wife, Irma Jackson, was from Alabama. She was also involved in medicine in the new field of radiology. She died in 1982. He married a second time to Katrine Mitchell, who passed away in 2006. In his later years he was cared for by his daughter-in-law, Susan Budd. Susan is the widow of John's son, Charles, who was a well-known orthopedic surgeon in Cleveland. John had two children, eight grandchildren and six great-grandchildren.

John Henry Budd was born in St. Stephen, New Brunswick, Canada on December 6, 1908. Early in life he was recognized as having more talent and ability than most children his age. In his childhood he was an expert in classical music, but as the years rolled on his interests changed to jazz music. John was such a good piano player he played for the silent movies, a job which helped him get through medical school.

He frequently would "tip in" with famous musicians in Chicago, New York and New Orleans late at night as he moved around the nation performing his AMA duties. It was not unusual for John to invite other doctors and their spouses to make the rounds with him to hear him play with

famous jazz artists. He was at his best sitting around the piano playing popular songs for all to sing, which he did at most Academy social events.

John Budd was devoted to medical ethics and never for a moment swerved from the philosophy that whatever was good for the patient was good for medicine. He firmly opposed socialized medicine and debated Ted Kennedy and the Canadian Minister of



Dr. John Budd poses with his newly painted portrait at the AMCNO offices (photo dated 1974).

Health on TV when Canada began their program.

Because of these wonderful contributions to society and the medical profession, John Henry Budd, MD, was not only awarded the Academy's highest honor, "The Distinguished Membership Award" but the award itself was named after him. He also received a very special award, "The Portrait Award," and there is a large portrait of him at the Academy's headquarters. This award has been given only to a handful of physicians since inception many years ago.

In March of 2006, I made a visit to John in his home of sixty some years on Cleveland's West Side. During the visit John took me

down into his basement sanctum sanctorum where he had several old filing cabinets and a banner with the logo of each unit in which he served in the Army. (He also had a gigantic collection of music in every form imaginable and old discs from Count Basie and others whom he knew personally.) He went through many of his records, telling unimaginable stories about events that happened in the Army years previously.

He had complete records of almost every soldier he treated in his Army career, many of which were records of soldiers from the German Army! As he explained it, during the Battle of the Bulge in 1944 the American Army was asked by the German Army to send a physician team across no-man's land under a truce to treat British/American prisoners and German soldiers in a hospital captured by the Germans! These were soldiers who had head injuries and the Germans had no neurosurgeon available. His unit was chosen to fulfill this mission.

When the American army was asked to send a doctor across battle lines into German controlled territory, with a guarantee of safety, to deliver a baby for a French woman who was having a particularly difficult delivery — John volunteered. He never hesitated and went into enemy territory to deliver the baby...the patient always came first!

John Henry Budd, MD, was a great friend to all of us. We will miss him sorely. He truly was one in a million. He passed away on March 4, 2008 at age 99. The love of his friends and family was completely evident at his memorial service. He always was proud of his large family, and he was especially proud to have a great-grandchild named after him, John Henry Budd IV!

— Ted Castele, MD

Past President of the Academy of Medicine of Cleveland & Northern Ohio

“Outpatient or Inpatient Care — You Decide”

Giesele R. Greene, MD, CMCE
UnitedHealthcare Clinical Advancement
Health Plan Medical Director for Northern Ohio

Advances in medical technology and support services have transformed medical care over the years, allowing many services that previously required inpatient status and hospitalization to now be performed in outpatient settings. These services are performed as outpatient or ambulatory services or while in observation status. Outpatient or ambulatory status services include many procedures as varied as the administration of blood, medications and other infusion products; invasive and noninvasive diagnostic procedures; invasive treatment procedures; medical therapies, and surgical procedures. Prolonged evaluation and monitoring services for uncertain clinical situations requiring use of a hospital bed are typically referred to as observation status or observation care. Observation care can be appropriate for children, adults, and older adults. Observation status is classified by CMS, Milliman Care Guidelines, InterQual and all insurance payors as a form of outpatient status.

Based on CMS, Milliman, and InterQual classifications, outpatient or ambulatory status is utilized for those procedures and/or treatments that can be anticipated or **scheduled in advance** that would require usual periods of monitoring post procedure or treatment. Examples include infusion of scheduled parenteral medications for chronic disease such as infliximab infusions for inflammatory bowel disease or rheumatoid arthritis; ambulatory diagnostic procedures such as nonemergent endoscopy services or selected elective cardiac diagnostic procedures like cardioversion or catheterization; and elective outpatient surgery such as a laparoscopic cholecystectomy,

Advances in perioperative monitoring have encouraged many physicians performing ambulatory surgeries to order a period of extended observation for postoperative monitoring beyond the 23 hours of postoperative monitoring inherent to an ambulatory surgical procedure. This is especially true if extended observation for recovery facilitates discharge home, rather than admission of the patient to the hospital following uncomplicated surgical procedures in appropriate persons without major comorbid ailments for such surgeries as cervical and lumbar single level discectomy with laminotomy/laminectomy, kyphoplasty; and hernia repair, among others. Ambulatory status for appropriate surgical patients will also facilitate rapid return to home, and may reduce out-of-pocket costs for the insured compared to inpatient admission status.

Ambulatory surgery, with or without an extended observation stay where appropriate, may also help enhance the efficiency of hospital-based care compared to inpatient admission status. Depending on the clinical

setting, both outpatient status and observation status can be acceptable venues for medical care and may entirely eliminate the need for inpatient admission, while preserving the quality of medical care and enhancing the efficiency profile of both the physician and hospital.

Most managed care contracts with hospitals generally support that observation status is determined by the physician's treatment plan and not where the patient is located within the hospital or the length of stay. Observation care begins with a physician order for observation care and ends with a physician order to discharge from observation care or admit to inpatient status.

While a few ambulatory surgeries or procedures performed in an outpatient setting (such as potentially cosmetic services), require advance notification, most do not. Please refer to www.UnitedHealthcareOnline.com for a complete listing of services requiring advance notification.

There is no requirement to notify UnitedHealthcare or precertify observation care in advance. There also is no requirement for the hospital to provide concurrent review information on a patient in observation status unless the patient is admitted to the hospital from observation care rather than discharged.

Observation care may be provided in an emergency department, a dedicated observation unit, a holding or post procedure unit; a hospital location intermingled with inpatients; or in any other hospital-based setting. An overnight stay does not automatically preclude outpatient status. An outpatient procedure or


surgery may be converted to observation care rather than an inpatient admission when unexpected developments in recovery occur, but rapid disposition to home is still anticipated.

In addition to post procedure extended recovery observation care described above, observation care unrelated to elective surgery and procedures may be appropriate for patients requiring short-term evaluation for a condition (e.g., to rule out MI), treatment for a known condition (e.g., asthma), or monitoring for recovery (e.g., drug ingestion) depending on the clinical situation.

Observation care is not for medically stable patients requiring diagnostic testing, or for patients needing a therapeutic procedure typically provided in an outpatient/ambulatory setting. Chemotherapy, blood transfusions, and dialysis are examples of therapeutic care typically provided in an outpatient setting. If extended time for recovery is needed for outpatient therapeutic care, observation status may be implemented when the anticipated length of stay is less than 24 hours and the anticipated final disposition is to discharge the patient.

Observation care is not for patients awaiting nursing home placement; is not to be used as a convenience for the patient, the family, the hospital or the attending physician; and is not to be used routinely for prep or recovery following typical ambulatory diagnostic or surgical services. Observation care may be ordered following ambulatory procedures or surgery if extended time is needed for recovery before rapid discharge to an outpatient setting.

In summary, physicians should consider the individual clinical circumstance of every patient and determine in what clinical setting the medical services can best be provided. Physician and hospital efficiency are improved by the appropriate use of ambulatory care with observation status. Physicians and hospitals have less administrative interaction with UnitedHealthcare, as there are no requirements for notification or concurrent review with observation status. UnitedHealthcare enrollees generally experience less out-of-pocket expense for observation care and benefit as well, whenever the clinical decision appropriately utilizes the outpatient care options. Physicians should give strong consideration to medical care on an ambulatory basis as described above, with the use of observation care, when medically appropriate. This is often the case if the anticipated length of stay for the admission is known to be one day or less. ■



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Board of Governors, The Doctors Company
Past President, American Medical Association

S.B. 281 Noneconomic Damage Caps: Prognosis Guarded Post-*Arbino*

Despite the recent Supreme Court decision of *Arbino v. Johnson & Johnson*, 2007-Ohio-6948, noneconomic damage caps in medical malpractice lawsuits remain at significant risk of constitutional challenge. In *Arbino*, the Court rejected the constitutional challenge to the damage caps of Ohio Revised Code Sec. 2315.19, but the analysis leaves doubt whether the Court would reach the same conclusion if it were called upon to analyze the constitutionality of S.B. 281 (R.C. Sec. 2323.43) caps as applicable to medical liability cases.

In 2006, Plaintiff Melissa Arbino filed suit against Johnson and Johnson, Ortho-McNeil Pharmaceutical, Inc., and Johnson & Johnson Pharmaceutical Research and Development, LLC. This was a simple products liability case regarding the negative effects of the Ortho Evra birth control patch. Arbino challenged the constitutional validity of the Ohio statutes concerning noneconomic damages, collateral source and punitive damages enacted under S.B. 80, (R.C. Secs. 2315.18, 2315.20, 2315.21 respectively). To be successful in her constitutional challenge, Arbino needed to demonstrate there was no set of circumstances under which the statutes would be valid. After a thorough review of Plaintiff's arguments, the Ohio Supreme Court in a 5-2 decision issued on December 27, 2007, upheld the caps on noneconomic and punitive damages under S.B. 80 as facially constitutional.

The Statute At Issue

While there are similarities between the caps at issue in *Arbino* and those set forth under S.B. 281, their differences are significant when it comes to comparative constitutional analysis. The tort/product liability caps analyzed in *Arbino* generally provide:

- (1) No limit on damages for economic loss;
- (2) Noneconomic damages for injury or loss to person or property shall not exceed the greater of \$250,000 or three times the economic damages up to a maximum of \$350,000 per plaintiff or \$500,000 per occurrence.
- (3) No limit on noneconomic damages where loss involves catastrophic injury, as follows:
 - (a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system; or
 - (b) Permanent physical functional injury that prevents the injured person from being able to independently care for self and perform life-sustaining activities.

By contrast, in medical malpractice actions S.B. 281 raises — but does not eliminate — the noneconomic cap for catastrophic injuries. In cases of alleged medical negligence, R.C. 2323.43(A)(2) caps damages as follows:

- (1) No limit on damages for economic loss;
- (2) Noneconomic damages for injury or loss to person or property shall not exceed the greater of \$250,000 or 3 times the

economic damages up to a maximum of \$350,000 per plaintiff or \$500,000 per occurrence.

- (3) Noneconomic damages shall not exceed \$500,000 per person or \$1,000,000 where loss involves catastrophic injury as follows:
 - (a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system; or
 - (b) Permanent physical functional injury that prevents the injured person from being able to independently care for self and perform life-sustaining activities.

The definition of catastrophic injury is the same in both provisions, but the ceilings for noneconomic damages differ in cases where the injuries are found to be more severe or permanent.

Prior Constitutional Challenges

In determining the constitutional challenges presented by Arbino, the Supreme Court of Ohio logically looked to its prior analysis and opinions in the cases of *Morris v. Savoy*¹ and *Sorrell v. Thevenir*.² In those cases, the Court held prior tort reform damage caps unconstitutionally violative of due process rights and the right of litigants to a trial by jury.

The case of *Savoy* dealt specifically with medical malpractice reforms enacted in the mid 1970's that limited noneconomic damage recoveries to \$200,000, regardless of the degree of injury. The Court tested the statute under a due process and equal protection analysis.

The due process analysis began with the Court's recognition that Ohio had a legitimate state interest in lowering malpractice insurance rates and improving the purported insurance crisis. Applying a "rational basis" test, the Court stated that the case involved neither a fundamental right nor a suspect class³. The Court next evaluated evidentiary materials that the General Assembly relied upon to enact the legislation and concluded that they did not provide adequate proof of a "rational connection between awards over \$200,000 and higher malpractice insurance rates." Therefore, without a sufficient nexus between

the damages cap and intended result, the Court held that the statute as enacted was unconstitutionally arbitrary and not rationally related to the stated interest. The Court further held the statute irrational and arbitrary for imposing the cost of the intended public benefit on the "class *most seriously injured* by medical malpractice."

Under an equal protection analysis, the Court recognized there was a legitimate governmental interest in treating medical malpractice cases differently than other torts, but tempered that with the need to treat all members of the class equally. The Court applied the "any conceivable state of facts" analysis, and struck down the statute on that ground.

In a separate opinion concurring in the decision, Justice Sweeney asserted that the right to a jury trial was fundamental and should be held "inviolable" pursuant to Section 5, Article I, of the Ohio Constitution. The concurrence defined "inviolable" as "free from substantial impairment".⁴ He then reasoned that the determination of damages was a jury function such that the imposition of the statutory cap substantially impaired the right to trial by jury.⁵

In *Sorrell*, former statute R.C. Sec. 2317.45 required the trial court to deduct from the jury verdict all collateral benefits that the plaintiff received, or would receive, as the result of the alleged injury. The statute did not require that damages be allocated between economic or noneconomic damages, or even past and future economic damages. The potential statutory set-off against the total award thereby violated a plaintiff's right to have all facts determined by the jury, including damages.⁶ The concern there was that the statute had the ability to deny the jury's determination of full compensation. As a result, the Court ultimately concluded the statute unconstitutionally interfered with a litigant's right to trial by jury.

Arbino v. Johnson & Johnson

On the above backdrop, the Supreme Court conducted its analysis of R.C. Sec. 2315.18 (B)(2) in *Arbino*. The Plaintiff challenged the constitutionality of noneconomic limitations, arguing violations of the (1) right to trial by jury; (2) right to a remedy/open courts; (3) due process; (4) equal protection; (5) separation of powers, and (6) the single subject rule. Each argument was struck down.

Acknowledging the right to trial as fundamental, the Court conceded that a jury verdict is not sacred. The opinion cited instances involving remittitur (judicial mechanism for reducing a jury's verdict) and statutory trebling of damages (judicial mechanism for increasing a jury's verdict) as support of this proposition.⁷

But unlike *Savoy* and *Sorrell*, this majority upheld the statute under Section 5, Article I:

{¶140} By limiting the noneconomic damages for all but the most serious injuries, the General Assembly made a policy choice that noneconomic damages exceeding set amounts are not in the best interest of the citizens of Ohio. The statute is distinguishable from those allowing courts to substitute their own findings of fact on collateral benefits or requiring repayment plans that "further reduce the jury's award of damages already once reduced to present value." *Sorrell*,⁸ *Galayda v. Lake Hospital System, Inc.*⁹ Courts must simply apply the limits as a matter of law to the facts found by the jury; they do not alter the findings of facts themselves, thus avoiding constitutional conflicts. (Internal cites omitted.)

The cap also did not violate the "right to a remedy" or "open courts." As the Court held, the statute prevents some plaintiffs from obtaining the same award they may have received prior to the effective date of the statute, but it neither forecloses their ability to pursue a claim nor obliterates the award completely.

The Court then entered into the due process and equal protection analyses, again recognizing its deference to the General Assembly's policy making decisions. In laying the groundwork for a rational basis analysis, the Court held there was a legitimate state interest at the heart of the enactment. Within S.B. 80, the General Assembly has compiled, sufficient evidence to justify the legislation. The Court therefore did not find S.B. 80 to be arbitrary or unreasonable for lack of nexus to the stated interest.

Arbino also tendered a separation of powers theory (the General Assembly had exceeded its powers in enacting the statute), but this was wholly rejected by the Court. And under the single subject rule of Section 15(D), Article II (no bill shall contain more than one subject), Arbino argued that S.B. 80 violated this provision by combining a variety of vastly different subjects under one title. However, since the Court was not asked to review the bill as a whole, but only specific statutes within the bill, it did not reach this issue.

Finally, Justice O'Donnell and Justice Pfeifer authored separate dissenting opinions from the *Arbino* majority. Justice O'Donnell argued S.B. 80 was unconstitutionally violative of the right to trial by jury on all issues, including damages. Justice Pfeifer's mainly commented on the majority's "shallow reasoning and shoddy logic." It can be assumed that both

Justices would opine similarly if called upon to do so again in evaluating the noneconomic damage caps of S.B. 281.

Guarded Prognosis

The Supreme Court was deliberate in revisiting the "arbitrary and unreasonable" due process analysis of earlier decisions. The Court reiterated that the damage caps in prior cases were arbitrary and unreasonable because they "imposed the cost of the intended benefit to the public solely upon those most severely injured." The tort/products liability caps at issue in *Arbino* survived the due process concerns by allowing *limitless noneconomic damages for those suffering catastrophic injuries*.

The relevant statute applicable to medical liability cases merely increases the limits for catastrophic injuries, it does not eliminate them. In practical application then, S.B. 80 and 281 would treat victims of catastrophic injury differently. Notwithstanding the nexus between damage awards, malpractice insurance costs and the overall effect on healthcare, a court would likely struggle to reconcile this disparate treatment. Therefore, even in the wake of *Arbino*, the door remains open to invite a due process challenge to S.B. 281. ■

- 1 (1991) 61 Ohio St.3d 684.
- 2 (1994) 69 Ohio St.3d 415.
- 3 This assertion was based on *Schwan v. Riverside Methodist Hospital*, (1983) 6 Ohio St.3d 300, which had invalidated a statute of repose that denied minors the right to sue. That decision, by Justice Locher, is conclusory and there is no discussion of the fundamental right to access to the courts granted by the Ohio Constitution.
- 4 Black's Law Dictionary (6 Ed.1990), 826.
- 5 Justice Sweeney goes on to cite Kansas as another state which holds the right to trial by jury inviolate. This accounts for the citation of *Estate of Sisk v. Manzanares*, (2003) 270 F.Supp.2d 1265 (USDC Kansas), which upheld a \$250,000.00, cap on wrongful death awards.
- 6 See *Miller v. Wikel Mfg. Co.*, (1989) 46 Ohio St.3d 76, (Douglas, J., concurring in part and dissenting in part).
- 7 After citing several statutes which treble damage awards, the Court emphatically announced, "We have never held that the legislative choice to increase a jury award as a matter of law infringes upon the right to trial by jury; the corresponding decrease as a matter of law cannot violate that right." However, the Court overlooked the fact that remittitur must be agreed to by the prevailing party.
- 8 Supra at 422.
- 9 (1994) 71 Ohio St.3d 421, at 425.

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By Michael Wise, JD, AMCNO Lobbyist
McDonald Hopkins, LLC

Alternative Dispute Resolution (ADR), SB 59 and Medical Malpractice Rates

As previously reported, the AMCNO has been integrally involved in legislation in Ohio that would provide for an alternative dispute resolution (ADR) for medical malpractice cases (SB 59). Although there have been reports of declining medical malpractice cases in Ohio, it is of note that there were fewer practicing obstetricians in Ohio in 2007 five years after a law was enacted to reduce medical malpractice rates in the state, (as reported recently by the Associated Press ("AP")). The AP went on that under the law, jury awards for noneconomic damages in medical malpractice cases with multiple victims, such as a mother and baby during a delivery, are capped at \$1 million. Most other cases are capped at \$350,000. According to the analysis, the number of obstetrics and gynecology physicians decreased by 5% since 2002 to 1,327 in 2007.

In other states, the *Philadelphia Inquirer* reports that the use of binding arbitration, rather than the court system, to resolve medical malpractice claims has become more common. According to the *Inquirer*, supporters maintain that binding arbitration is "faster, cheaper and fairer than trials," but opponents say "the secretive system can be weighted against consumers" and it can be "harder to track complaints or build legal precedents" through arbitration.

Many physicians on the West Coast have begun to ask patients to sign binding arbitration agreements, and the trend has begun to spread nationwide, according to legal experts. In addition, many nursing homes ask patients to sign such agreements, experts said.

In Kentucky, the two leaders of the Kentucky House of Representatives recently introduced legislation that would mandate mediation for all medical malpractice litigation against licensed health care providers. The bill would require the parties to a lawsuit alleging medical negligence to "fully explore" the possibilities of reaching a fair voluntary settlement in mediation.

In New York, there is a movement towards Health Courts. In March, doctors protested skyrocketing malpractice insurance premiums, which can reach as high as \$177,880 per year for a Long Island obstetrician.

As previously reported, SB 59, the AMCNO sponsored legislation that would provide for a pilot mandatory arbitration program that would focus on Northeast Ohio has stalled in the Ohio legislature. As reported in the last issue of this publication, the mandatory arbitration legislation more than likely will not pass in this General Assembly because of the fact that attorneys have come out in full force against the Bill, and because of the current political environment. The AMCNO plans to review other options, perhaps similar to those noted above, over the coming months to determine what next steps, if any, should be considered by the organization.

Executive Branch Issues

The big news here is the effort to raid the Ohio Tobacco Prevention Foundation ("OTPF"). The original plan for the OTPF called for an endowment to be set up using revenue from the Master Settlement Agreement between the tobacco industry and the state. The endowment was sufficient for perpetual tobacco prevention and cessation programs.

However, this March, state officials moved to transfer 90% of the assets to a new state fund intended to help stimulate Ohio's economy. OTPF was poised to lose the ability to fund tobacco prevention and cessation programs through the earnings from the OTPF. To stop this action, OTPF filed suit to block the transfer and has initially been able to obtain a temporary injunction. This is shaping up as a very high profile fight between legislative leaders and Ohio anti-tobacco groups that will be resolved in the court system.

AMCNO has been supporting the recent legislative effort to increase the taxes on non cigarette tobacco products and then earmark those taxes for the OTPF (see related story on page 1). We also fully supported the statewide smoking ban that was passed in Ohio. This most recent dispute is no longer a matter of policy. It is a constitutional/statutory issue that will be resolved in the courts.

Ohio Attorney General Issues

The nonprofit status of hospitals continues to be a pressing issue. Ohio AG Marc Dann and the Ohio General Assembly (through HB 456 – see next page) are reviewing this issue and it will likely blossom this fall and continue into next year.

Judicial Branch Issues

The AMCNO Medical Legal Liaison Committee met recently to discuss the development of the 2008 AMCNO Voting Guide. The AMCNO Board of Directors would like the guide to include the same items as 2006 (legislators, Ohio Supreme court candidates, Common Pleas judges in Cuyahoga County) and also this year include the 8th District Court of Appeals as well as judicial races in some of the contiguous counties (Lake and Geauga). The Committee endorsed that approach and work has now commenced on the guide. A letter will be sent to all candidates to obtain information for inclusion in the Guide.

Key Legislation

House Bill 125 — the Healthcare Simplification Act

Ohio recently enacted legislation that requires health plans to be much clearer and open about contract terms with physicians, including disclosing what insurers will pay for services and regulating the use of so-called silent preferred provider organizations (PPOs). The Healthcare Simplification Act, signed in late March by Ohio Gov. Ted Strickland, was the culmination of a 1½-year legislative fight between physician organizations that demanded health plans to be more transparent about contract terms, and insurers and corporate interests who viewed the law as cumbersome and not cost-effective.


The AMCNO supported HB 125 and the AMCNO lobbyists attended the interested party hearings on this legislation. House Bill 125, sponsored by Representative Matt Huffman establishes uniform contract provisions between health care providers and contracting entities, establishes rules for standardized credentialing, requires the Ohio Department of Jobs and Family Services to allow managed care plans to use providers to render care, modifies the fees for electronic copies of certain medical records and allows an authorized person to obtain one copy of a person's medical record without charge (certain medical records pertain to Medicaid, Workers' Compensation and government entities — the legislation does not change medical record fees already in place for physician offices) and creates an Advisory Committee on Eligibility and Real Time Claim Adjudication.

A key issue concerned insurance company usage of a most favored nation clauses in insurance contracts. The Bill forms a joint legislative committee to review this topic. The 15-member Joint Legislative Study Commission on Most Favored Nation (MFN) clauses in health care contracts is to be chaired by the Superintendent of Insurance and is charged with studying specified areas pertaining to most favored nation clauses in health care contracts, and requires the Commission to submit a final report of its findings and recommendations to the General Assembly. There is also a Moratorium on MFN clauses of two years during the deliberations of the Committee. There is also an outright ban on the MFN clauses that begins in three years. The MFN ban and moratorium does not apply to hospitals.

House Bill 456 – Ohio C.A.R.E.

This Bill introduced by Representative Jim Raussen would require the state to subsidize health insurance claims for people with chronic medical conditions and offer tax credits for poor adults that don't qualify for Medicaid. The AMCNO continues to closely follow this Bill. The inclusion of wellness discount programs along with the provision to adopt nutrition rules in schools and eliminate trans fat are important public health issues, however, other key issues in the bill that will warrant the attention of the AMCNO include the changes in contracting language between Medicaid Managed Care companies, the request that nonprofit hospitals define charitable care/ community benefits; the requirement of certain hospitals to post their tax liability as compared to their charitable care on their Web site; the requirement that ambulatory surgical facilities annually report certain data to the Director of Health; as well as a need to review how the discounts on premiums will be implemented for BWC employers who offer health and wellness programs. As the testimony on this legislation continues, the AMCNO will keep our members apprised of its' progress in the legislature.

We are now almost three quarters through this two-year legislative cycle. AMCNO has a comprehensive tracking system of all health care-related legislation in the General Assembly. If you are interested in receiving a copy of this document, please contact Elayne Biddlestone at (216) 520-1000. ■



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Revised Form 990 – New Requirements Could Mean More Disclosure About Hospital-Physician Transactions

By Bernard J. Smith

Overview

In late December, 2007, the Internal Revenue Service (IRS) issued a revised Form 990. Most exempt organizations, including tax-exempt hospitals, must file this form annually. The modified form will be used for tax years 2008 and thereafter. The information on these tax returns is readily available to the general public. This is because an exempt organization must provide copies of its tax filings upon request and the information is also accessible through sites such as GuideStar. Certain schedules on the revised Form 990 require disclosure of information about any number of transactions with private parties, including physicians. Thus, information about what participants believed to be relatively confidential business arrangements may now be reported in publicly available tax filings.

Revised Form 990 – In General

For years, the Form 990 has consisted of a "core" form of nine or so pages and two schedules. The revised form includes a core form of 11 pages and up to 16 schedules. The multitude of schedules included in the revised 990 are largely the result of the IRS using separate schedules to obtain further and more detailed information about a number of areas addressed in briefer form on the current 990. However, some schedules explore areas not scrutinized under the existing form. These include foreign activities, hospitals, tax-exempt bond issues and non-cash contributions.

Tax-exempt hospitals will have to file several of the schedules included in the revised Form 990. Principal among these are "Schedule H – Hospitals," "Schedule J – Compensation Information," "Schedule L – Transactions with Interested Persons" and "Schedule R – Related Organizations and Unrelated Partnerships." The comprehensive reporting requirements of these schedules flow from one of the principal objectives of the IRS in revising the Form 990 – promoting transparency as to the operations and finances of exempt organizations. It is clear from a review of the revised Form 990 that the IRS believes greater transparency is achieved primarily through more detailed and extensive disclosure required under the existing version of the 990. This viewpoint reflects the influence of Sarbanes-Oxley, nonprofit reform proposals of various trade groups, IRS initiatives and

Congressional oversight of the nonprofit sector. For example, in March, 2005, the Independent Sector issued its recommendations for nonprofit reforms. High on its list of suggestions was increased transparency and better reporting by exempt organizations.

Schedules Impacting Physicians

Schedules J and L of the revised Form 990 may be of particular interest to physicians. These schedules require disclosure about employment arrangements and other business relationships of exempt organizations, including hospitals. This means hospitals will have to report more information about the compensation of members of its leadership team and about dealings with any number of private parties, including physicians.

Schedule J

Schedule J requires disclosure as to high dollar or complex compensation arrangements of exempt organizations. It will be of interest to any physician who has a significant compensation arrangement with a tax-exempt hospital. This schedule, much like the current version of the Form 990, calls for detailed reporting about individuals whose compensation exceeds certain thresholds, including any recipient of W-2 compensation of more than \$150,000 or total compensation (that is wages and all benefits) of more than \$250,000. What is new is that the schedule also mandates reporting about fringe benefits such as first class travel, travel for companions, tax indemnifications and gross-ups, club dues and personal services. It also includes new questions about whether the organization has a compensation committee, relies on independent compensation consultants or compensation surveys to set compensation levels, maintains written employment contracts in place or provides severance, contingency or other non-fixed payments.

If a physician is party to an employment arrangement that involves any of the types of fringe benefits noted above or that provides for compensation determined in a manner that does not involve reliance on objective comparability data and approval by an authorized group of disinterested individuals, the physician may find that not only is there more disclosure about his or her compensation in a hospital's Form 990 but also that the IRS will want to examine the arrangement in light of the rules

concerning reasonable compensation, private inurement and excess benefit transactions.

Schedule L

Schedule L will likely be of the greatest interest to physicians employed by, serving on the board of or participating in various business transactions with tax-exempt hospitals. It requires reporting as to any number of transactions between an exempt organization and certain individuals. These include excess benefit transactions, loans, grants and other business transactions.

Schedule L must be completed by any exempt organization engages in any excess benefit transaction or that:

- has outstanding loans to any current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person;
- has made a grant or provided other assistance to an officer, director, trustee, key employee, or substantial contributor, or to a person related to such an individual; or
- answers "yes" on the "core" Form 990 to any part of the following question:

During the tax year, did any person who is a current or former officer, director, trustee, or key employee:

- a) Have a direct business relationship with the organization (other than as an officer, director, trustee, or employee), or an indirect business relationship through ownership of more than 35% in another entity?
- b) Have a family member who had a direct or indirect business relationship with the organization?
- c) Serve as an officer, director, trustee, key employee, partner, or member of an entity (or a shareholder of a professional corporation) doing business with the organization?

The level of disclosure required varies by the type of transaction being disclosed. For example, for loan transactions, the lending exempt organization must disclose the name of the borrower, the original principal amount of the loan, the balance due and whether the loan is

REGULATORY ISSUES

in default, was approved by the organization's board or an appropriate committee and memorialized in a written agreement. For business transactions, the reporting exempt organization must identify the interested person involved in the transaction, how the person is related to the organization, the amount of the transaction, a description of the transaction and whether the transaction involves any sharing of the exempt organization's revenues.

It should be noted that transactions involving a physician are reportable under Schedule L only if the physician stands in one or more specified relationships with the reporting organization. First, any excess benefit transaction of the organization involving a physician must be reported. A transaction with a physician will constitute an excess benefit transaction only if the physician is in a position to exert substantial influence over the operations or affairs of an organization and the transaction provides for unreasonable compensation, other than fair market value transfers or certain impermissible percentage compensation

arrangements. Second, a wide variety of transactions are reportable if the physician is a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person as to the reporting organization. For these purposes, a "disqualified person" is any person who was in a position to exercise substantial influence over the affairs of the reporting tax-exempt organization at any time during the five-year period ending on the date of the transaction. Therefore, physicians in leadership or governance positions or who through any other means exercise significant influence as to the management or operation of an exempt organization will satisfy the relationship requirement necessary to trigger reporting under new Schedule L.

Bottom line, physicians who are key employees or trustees or directors of, or otherwise exercise significant authority or influence over the affairs of a tax-exempt hospital, may find their business dealings with that hospital subject to a higher level of public disclosure than ever before and such increased disclosure could lead to closer IRS scrutiny of the reported transactions. ■

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Streamlining Medical Licensure

Diann K. Thompson, J.D.
Assistant Executive Director, Licensure & Public Services
State Medical Board of Ohio

As a state regulatory agency, the Medical Board's mission is simply stated — to protect and enhance the health and safety of the public through effective medical regulation. The first goal in achieving that mission is ensuring that a license is issued if the applicant meets the standards of education and training, and there is evidence that the applicant is competent and of good moral character.

In order to appreciate our processes of today, I think it is important to take a brief look at the past. The State Medical Board of Ohio was created in 1896. From 1896 to 1996, the Board to a large extent conducted all aspects of the licensure process on its own. While important advances were made in the realm of medical education standards and standardized licensing exams, the licensing process itself was paper-based and done wholly by the individual state. We prime-source verified core credentials as well as evaluated the applicant's competency and moral character; if a physician wanted a license in another state, that state would do it all over again. It was an annoyingly redundant system.

In 1996, the licensing process changed dramatically with the advent of the Federation Credentials Verification Service — the FCVS. In establishing the FCVS, the Federation of State Medical Boards identified and adopted the "best practices" of the member boards. Using these best practices, the FCVS prime-source verifies the core credentials — credentials that are static and routinely verified as part of the medical licensing process. The Ohio Medical Board has required the FCVS for all medical and osteopathic applicants since 1996. The FCVS maintains a lifetime portfolio of verified credentials for the physician that is available any time the physician applies for licensure in a state that accepts the FCVS. As of January 2008, only Arkansas and Nebraska do not accept the FCVS.

The FCVS has its own history of streamlining their processes. In May 2005, Ohio began accepting the FCVS reports in electronic format. Receiving the electronic version avoids mail sorting and delivery, possible loss of the documents, and having to file and retrieve the paper when needed.

The next step in streamlining the licensure system was the development of the Common Licensure Application Form — the CLAF. Every state had its own, unique licensure application form, but much of the information sought by the medical boards was in fact common to all. The Federation of State Medical Boards established a workgroup to identify those common elements and bring them together into a common form. Each state would then also have a state-specific addendum through which the information unique to that state would be collected.

The CLAF includes the following information: name of applicant; home and practice address; identification (date of birth, social security number, gender, US citizenship); medical education; 5th pathway; post-graduate medical education; licensure exam history; ECFMG certification/status; licensure in other states; chronology of activities; and malpractice history.

The Ohio Addendum seeks information concerning preliminary education, Board certification and the need for a demonstration of proficiency in spoken English; it contains personal recommendation forms that must be completed and submitted to the Board; and requires completion of the "Additional Information" section, which contains twenty-five questions designed to elicit information that may lead us to a basis for denial of a license or granting a license with restrictions.

Ohio implemented the use of the CLAF for medical and osteopathic applicants in the fall of 2005. At that time, it was still a paper-based system, but the advantage to the physician was that, once completed, if the physician kept a copy, it could be used again for other states using the CLAF. Of course, some updating would be needed, but the majority of the information would

be there in the same form and order. The advantage to Ohio was that it positioned us to move to the next stage, the online application process.

In December 2006, Ohio became the first state to pilot the online CLAF. Through the CLAF, the information previously provided on the FCVS application is automatically incorporated into the Common License Application Form used by the Ohio Board, making completion of the Ohio application faster and easier, since much of the application is already finished. The applicant provides the chronology of activities and malpractice report history information; prints out the forms needed (including the Ohio addendum) and submits the application electronically. The Medical Board receives the self-reported application almost immediately.

The online CLAF provides all the benefits that any online licensure system should provide: convenience for the applicants by being available almost 24/7, from any computer with internet access; reduction in incomplete applications by the use of mandatory fields; reduction in paper, which also eliminates losing pieces of the application; and improved access to the application for review by the licensure staff.

Through the online CLAF link to the FCVS, applicants are saved a great deal of time and frustration — filling out redundant portions of the applications is eliminated. Kentucky also uses the CLAF, so applicants can begin to reap the other benefit — the major part of the applications for both states will already be completed; with a few clicks of the mouse and completing the state addenda, they can apply to two states at the same time. We expect to see a significant number of physicians in the northern Kentucky/Cincinnati area take advantage of this. As additional states implement the CLAF and join the online system, the benefits to the applicants continue to increase.

The Medical Board's role as gatekeeper is a serious responsibility; yet, part of that role is to improve the process so that, for most applicants, applying for and receiving a license is relatively pain-free while not compromising the Board's ability to identify those who should be denied. The online CLAF system is an important step in that direction. ■

Contracting for Electronic Health Records: What You Need to Know

By Steven M. Harris, Esq., McDonald, Hopkins LLC

You may be considering entering into a licensing agreement with a vendor for an electronic health record (EHR) system. If you are at the stage in the process where a vendor has presented your practice with a contract for signature, you have already invested a significant amount of time sorting through the process. The EHR system will have a significant impact on your practice and a rushed or ill-informed decision could bind you to undesirable terms and conditions for years to come. So before you sign that agreement, there is some information that you and others in your practice need to know. In addition, it is highly advisable that a lawyer experienced in software contracts reviews the EHR licensing agreement.

Since the early 1990s, EHRs have been used in hospitals and medical offices throughout the world. With increased governmental scrutiny and advances in computer technology, physicians continue to inquire about EHRs and are interested in learning how their practices can benefit from this type of system. These systems are believed to increase efficiency within a medical office, reduce medical errors, provide the ability to rapidly communicate physician orders outside the office, and potentially increase profits.

In order to purchase an EHR system, the vendor will require your practice to enter into a licensing agreement. The agreement will likely be the vendor's standard licensing agreement, slightly modified to fit your practice's needs. Please keep in mind that the vendor has drafted the agreement to protect itself, not your practice. While some contracts are indeed nonnegotiable (stay away from these companies), many licensing agreements are negotiable. Remember, the EHR vendor wants your business and should accommodate your practice by tailoring the agreement to your reasonable specifications.

When analyzing an EHR licensing agreement, there are four main considerations you should keep in mind:

1. What is the practice purchasing?
2. What are the respective duties of the vendor and the practice?
3. What liabilities is the vendor disclaiming?
4. How can the practice get out of the contract?

While the answers to these questions may appear throughout the agreement, there are four common provisions that address these questions: (1) Scope of the License, (2) Support Duties, (3) Warranty & Liability Disclaimers, and (4) Termination.

Scope of the License

The scope of the license provision describes what the practice is purchasing from the vendor.

This provision typically addresses issues like the number of units on which the software can be installed, the number of people who can use the software, and the number of physical locations you can install the software. Frequently, the broader the scope of the license, the higher the cost of the software. Therefore, it is imperative to determine your practice's individual needs and relay that information to the vendor so that they may personalize the system and the supporting licensing agreement. An EHR system installed and used on only a few computers will cost less than a system installed on numerous computers.

In licensing agreements, there are three commonly used price-based approaches for valuing the EHR software. First, licenses may be priced on a per-computer basis. This approach is best used for a medical practice that expects to have a few computers with EHR accessibility, but permits access by multiple users. Second, if the practice plans on having only a few users but a large number of computers installed with the software, then the per-user price approach is more economical. Lastly, a license covering an entire physical location will benefit larger practices with numerous users and multiple computers since the site license covers an entire building or office location and is not evaluated based on the number of users or computers with EHR accessibility. A site license may be more expensive than the other options.

Vendor and Practice Responsibilities

The vendor's responsibilities after the installation of the software are typically limited to software technical support. The support provision is one of the most important aspects of the licensing agreement. This provision addresses the role the vendor will play and the amount of time the vendor will commit to implementing the EHR system in your practice. Vendors often provide "support" by training the practice's personnel, offering telephone and in-person technical support, and supplying software

patches and updates. Payment for such support services varies by vendor, but is frequently offered for a monthly fee or it may be included in the overall contract price.

While the licensing agreement describes the support provided by the vendor, the agreement may also impose operational and maintenance requirements on the practice. Such requirements include requiring the software to be installed on a computer stored in a climate-controlled room, that the computer be used solely for EHR, and/or that all software patches and updates provided by the vendor are installed by the practice. While these requirements may not seem onerous, satisfying them may require some changes in your practice's existing infrastructure.

Cost-saving tip: Negotiate a number of "free" training hours or days with the vendor as part of the purchase of the system.

Limitations of Vendor Liability

The provisions relating to disclaimers of warranties and liabilities are typically difficult to negotiate and are of critical importance to understand. Warranty and liability disclaimers limit the vendor's liability and the damages available to the practice in the event that the vendor fails to fulfill a contract requirement or the software malfunctions. If the software malfunctions and practice profits are lost or worse, a patient is injured because of such malfunction, the practice will be interested in seeking redress from the vendor. The scope of the limitation of liability will have a material effect on the pursuit and ultimate success of obtaining compensatory payments from the vendor.

Termination

The termination provision is of critical importance in the licensing agreement because it details ways the vendor and the practice can get out of the contract. A termination clause may permit either or both parties to terminate without cause. This means that either party may terminate the agreement for any reason by providing notice (typically in writing) to the other party within a stated period of time. Other termination clauses will only permit termination with cause (e.g. breach of the agreement). If the contract does not provide grounds for which the practice may terminate the agreement, it is essential that specific language is added.

Typically, EHR licensing agreements have lengthy terms, spanning from 10 years to lifetime. If the contract is to terminate in 10 years, be

(Continued on page 16)

Contracting for Electronic Health Records: What You Need to Know (Continued from page 15)

sure you know what happens thereafter. Some EHR agreements may require that you return the software after the contract period terminates. If, after the contract ends, the software must be returned, be sure that the agreement provides for a way to retrieve the information stored in the system. In addition, it is highly advisable that the agreement contain a clause stating that any and all data created through the EHR system is exclusively owned by the practice. This clause will help avoid a potential information ownership problem in the future.

In addition, be sure to consider the possibility that the vendor could go out of business before your practice does and how that could affect your patients' records. A possible solution to this concern is to require that the vendor put its source code in escrow. The agreement should explain the circumstances under which you can obtain access to that source code.

Make sure you review and understand the terms and conditions of the licensing agreement prior to signing to ensure that the contract suits your practice's particular needs. At a recent convention, an EHR vendor representative disclosed to me that in his experience, once a practice decided to purchase an EHR system, the practice rarely questioned or negotiated the licensing agreement. The licensing agreement you sign will impact your practice for years to come. It is therefore essential that the agreement be tailored to your current needs and that it can also grow with your practice.

Harris, a partner at McDonald Hopkins, formerly Harris Kessler & Goldstein, in Chicago, concentrates on healthcare law and has counseled physicians, physician networks and healthcare groups nationally. The author and publisher are not rendering professional advice and assume no liability in connection with its use. He can be reached at (312) 280-0111, or by e-mail (sharris@mcdonaldhopkins.com). This article first appeared in AMNews in January 2008 and was reprinted with the permission of the author. ■

Electronic Communications with Patients

Physicians have many ways to communicate with patients, including e-mail and through the Internet. The American Medical Association (AMA) Council on Ethical and Judicial Affairs recommends that physicians consider these guidelines prior to communicating with patients electronically:

1. E-mail correspondence should not be used to establish a patient-physician relationship. E-mail should supplement other, more personal, encounters.
2. When using e-mail communication, physicians hold the same ethical responsibilities to their patients as they do during other encounters. Whenever communicating medical information, physicians must present the information in a manner that meets professional standards. To this end, specialty societies should provide specific guidance on the appropriateness of offering specialty care or advice through e-mail communication.
3. Physicians should engage in e-mail communication with proper notification of e-mail's inherent limitations. Such notice should include information regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. Disclaimers alone cannot absolve physicians of the ethical responsibility to protect patients' interests.
4. Proper notification of e-mail's inherent limitations can be communicated during a prior patient encounter or in the initial e-mail communication with a patient. This is similar to checking with a patient about the privacy or security of a particular fax machine prior to faxing sensitive medical information. If a patient initiates e-mail communication, the physician's initial response should include information regarding the limitations of e-mail and ask for the patient's consent to continue the e-mail conversation. Medical advice or information specific to the patient's condition should not be transmitted prior to obtaining the patient's written authorization. ■

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Are We Ready?

How the Cuyahoga County Public Health Collaborative Would Respond to a Major Public Health Emergency

By Terry Allan, R.S., MPH, Health Commissioner
Cuyahoga County Board of Health

Historically, the four health departments in Cuyahoga County have worked diligently but independently to respond to public health events in the Greater Cleveland community. Recognizing the need for more effective and efficient coordination, a historic commitment was made in the spring of 2002, among the four departments (Cuyahoga County Board of Health, Cleveland City Health Department, Lakewood City Health Department, and Shaker Heights Health Department) to substantially improve the infrastructure necessary to coordinate a response to a multijurisdictional public health event. The **Cuyahoga County Public Health Collaborative** was born and continues to build consolidated plans for response to a major disease event and other public health emergencies that may affect the citizens of Cuyahoga County.

An infectious disease emergency (IDE) could impact Cuyahoga County in numerous ways. The most likely scenario is a naturally occurring event such as a major outbreak of food borne illness, pandemic influenza, SARS, or a particularly virulent strain of *N. meningitidis*. A less likely but equally devastating scenario could occur through the planned release of a bacteria, virus, or toxin causing diseases such as *Anthrax*, *Tularemia*, *Brucellosis*, *Plague*, *Smallpox*, *Botulism* or *Ricin poisoning*.

Regardless of the scenario, an IDE would have an enormous impact on both the health of Cuyahoga County residents and our social infrastructure. Depending on the specifics, there would likely be an increased demand on our health care facilities by both the ill and the worried well, some disruption of essential services, and counterproductive behaviors driven by rumors and misinformation. On a daily basis, we respond to small outbreaks using current staffing and infrastructure. However, responding to a large-scale outbreak will require additional staff, equipment, support, and an enhanced infrastructure. To plan for such a large-scale event, we have developed our combined Emergency Response Plan in conjunction with our emergency managers. This plan guides the "scaling-up" of epidemiology and surveillance, containment measures (mass prophylaxis, isolation and quarantine, and infection control), and communication with clinicians, hospitals, safety forces, elected officials and the public.

Epidemiology and Surveillance

An infectious disease emergency may not be as readily detected as other types of

disasters, such as earthquakes, fires, or chemical releases. In the early stages of an outbreak, cases may be dispersed among several health care providers and facilities throughout the community. Or, for emerging diseases such as avian influenza H5N1, diagnostic tests may not be commercially available, so recognition, identification and control of the threat could be delayed.

The most effective outbreak detection system is lead on the front lines by the clinicians in our community making early reports of unusual disease clusters and individual reportable diseases to the local health department. According to Ohio Revised Code, clinicians are legally required to report more than ninety diseases to Public Health. For more information on infectious disease reporting, visit our Web site (www.ccbh.net) and click on Epidemiology and Surveillance. Diseases should be reported to the local public health jurisdiction in which the patient resides. All disease reports for Cuyahoga County can be faxed to the Cuyahoga County Board of Health (CCBH) at (216) 676-1316 or called to (216) 201-2080. This is centralized, county-wide number is a 24/7/365 disease reporting line for the Collaborative.

Recent health emergencies were detected by astute clinicians who promptly reported an unusual pattern of disease to public health authorities. Reports of several encephalitis cases in combination with wild bird die-offs in New York City led to the detection of the West Nile Virus in North America in 1999. Reports of possible anthrax meningitis in Florida uncovered the anthrax outbreaks of 2001. Closer to home, a clinician reported

a cluster of *Legionella* cases associated with and automotive plant back in 2002, which proved critical to a prompt public health response. Please call us as soon as you suspect a case or potential outbreak of an urgent and severe communicable disease. HIPAA does not require you to obtain patient consent to disclose information to health authorities conducting a public health investigation.

Other surveillance tools used by the Collaborative and the Ohio Department of Health (ODH) are the Real-time Outbreak and Disease Surveillance (RODS) and the National Retail Data Monitor (NRDM) systems. RODS is an open-source public health surveillance software program that collects and analyzes disease surveillance data in real time. The Ohio Department of Health and the Collaborative use RODS to examine de-identified emergency department visits from local hospitals and monitors increases in patients with symptoms of flu, respiratory illnesses, diarrhea, and skin rashes. Sales of over-the-counter medications are monitored through the NRDM. This information helps public health officials to identify potential outbreaks of infectious diseases, enhancing the traditional disease reporting system.

When health departments receive a report of an outbreak or case of communicable disease, public health epidemiologists may call the health care provider to confirm the diagnosis and gather specific data on symptoms, signs, diagnostic tests, treatment, and known contacts to the patient. Patients (or their proxies) are interviewed to determine exposures and risk factors associated with acquiring the infection, their occupation, and their contacts. For emerging and bioterrorism threat diseases, we may request specimens for confirmatory testing by the public health laboratory network as an epidemiologic tool for outbreak identification and management. In an infectious disease emergency, multiple teams will be activated to find and interview cases and contacts by phone, in the community, and in health care facilities. Assistance may be requested from clinicians and health care facilities to identify all persons needing follow-up by public health for investigation and interventions according to criteria that will be disseminated at the time of the emergency.

Mass Dispensing of Antibiotics and Vaccines

In the extremely unlikely event of an infectious
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Are We Ready?

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disease emergency that requires dispensing of antibiotics on a massive scale, Cuyahoga County has plans in place. In partnership with first responders, the Collaborative has identified dispensing sites throughout the county that can be rapidly activated as Point of Dispensing or "POD" sites. Over the past several years, we have exercised our ability to dispense antibiotics to individuals picking up for both themselves and others.

Plans are also underway to reach vulnerable populations (e.g., the homebound or culturally or linguistically isolated) via the organizations that serve them. Mass prophylaxis plans also include models and protocols for administering immunizations. Supplies of antibiotics or immunizations would come from the federally managed Strategic National Stockpile. The overall mass prophylaxis planning effort is also regional via monthly Northeast Ohio Public Health Partnership planning meetings, so that screening standards and dispensing methodologies remain consistent across county lines.

Pandemic Influenza Planning

Planning for an influenza pandemic presents unique challenges in emergency planning. There are several characteristics of an influenza pandemic that differentiate it from other emergencies. Unlike other natural disasters, a pandemic has the potential to cause illness in a large number of people, overwhelm the health care system, and jeopardize services by causing high levels of absenteeism in the workforce. Basic services such as health care, law enforcement, fire, emergency response, communications, transportation, and utilities could be disrupted during a pandemic. Finally, the pandemic, unlike many other emergency events, will occur in waves, each wave lasting several months and will affect many areas throughout the world simultaneously.

Working as the Collaborative, representatives of the four local public health departments meet regularly to plan and coordinate pandemic flu preparedness activities. Initially we focused on educating the people of Cuyahoga County about pandemic influenza and how to prepare for a future pandemic, emphasizing the importance of hand washing and cough etiquette and social distancing. We have presented to a wide variety of groups and distributed information

at libraries, health fairs and through local businesses.

More recently we have shifted our focus more toward community preparedness activities. Representatives of the Collaborative and four surrounding counties developed protocols addressing issues of community containment. We have encouraged businesses, county agencies, organizations and local governments to develop business continuity plans for any type of public health emergency. We are starting to identify local organizations and agencies responsible for providing services to groups with special needs and have begun working with them to ensure the needs of their clients are considered in emergency planning. In July 2007, the health departments hosted a forum for representatives of school stakeholder groups to discuss pandemic related schools closure concerns. We envision providing similar opportunities for organizations serving those with special needs.

Despite the above mentioned efforts, there is still much to do. The Center for Health Affairs has been assisting hospitals in developing plans to provide care during a pandemic flu, but issues remain to be resolved about the interaction of public health and the health care community as we prepare to meet this challenge. We welcome the opportunity to work with health care providers to address the many concerns related to pandemic flu and public health emergency preparedness.

As a Clinician, How Can I Help?

The most important contribution you can make as a practicing physician is to report suspected or confirmed cases and outbreaks of diseases that are unusual, severe, or highly infectious to the local health department. Once the local health department receives a communicable disease report, they can investigate and act on it as necessary.

In addition, review your office emergency response plans. Consider how your office will respond if phone call volume and drop-in rates increase five- to tenfold. Consider implementing infection control practices for patients with a cough and fever. Guidelines for infection control during a pandemic are available at our Web site at www.ccbh.net. These simple recommendations (such as posting signs, providing masks to patients with a cough, and isolating patients you suspect may be infectious) should be implemented now to decrease the transmission

of seasonal influenza in the office setting. In addition, they provide training for both staff and patients in the event of a pandemic.

Finally, encourage your staff to implement family emergency plans. A link to suggested contents can be found at www.ohiopandemicflu.gov. Staff feeling confident that their families are safe will be more likely to come to work. ■

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included in this issue.

The AMCNO urges support of SB 2785 – The Save Medicare Act

A bill introduced by U.S. Sen. Debbie Stabenow, D-Mich., would replace 18 months of Medicare payment cuts to physicians with payment updates that better reflect medical practice cost increases. On July 1, 2008, Medicare will cut physician payments by 10.6 percent. The 18-month timeframe in the Save Medicare Act of 2008 (S. 2785) will provide stability into the payment system. It will also give Congress time to begin working on a long-term solution to the payment system without having to take action to stop the cuts twice in one year. The Medicare Payment Advisory Commission has made a recommendation to lawmakers to replace physician payment cuts with updates that reflect medical practice cost increases.

The AMCNO and other organizations support the bill sponsored by Sen. Debbie Stabenow (D-Mich.) that would increase physician fees by 1.8% for 18 months and would not include “balloon financing” language that would set up higher pay cuts in the future to compensate for a temporary delay. The AMCNO physician leadership has written letters to our Congressional representatives asking for their

support of S 2785. AMCNO members are encouraged to do the same.

To send a letter to Congress in support of S. 2785 AMCNO members may visit our Web site at www.amcnoma.org and click on the “Legislation link/Find you legislator” to send a prepared letter to your representative or senator directly through our Web site. ■

AMCNO Takes the *Healthlines* Radio Program “On the Road”

As a member of the AMCNO, you are welcome to participate in our award-winning radio program *Healthlines*, broadcast on WCLV, 104.9 FM every other week. Guest appearances offer physician members a prime radio spot where they can communicate important and up-to-date medical topics with the general public.

Three segments, approximately three minutes each, are taped in one 30-minute session. Up until now, interviews could be conducted through a face-to-face discussion at the WCLV studios located in Warrensville Heights or via teleconference.

AMCNO is pleased to now offer *Healthlines* tapings right in your office. Dr. Anthony Bacevice, a physician host of the *Healthlines* program, now has equipment available whereby he can come to you to conduct the interview.



Dr. Anthony Bacevice (right), host of the *Healthlines* radio program, conducts his first remote interview with Dr. Louis Keppler. Dr. Keppler's interview focused on the topic of “New Concepts in Orthopedic Surgical Treatment.” Dr. Keppler is Co-Director of the Spine and Orthopedic Institute at St. Vincent Charity Hospital.

The *Healthlines* segments use a question-and-answer format with a topic selected by the physician. Segments are broadcast on Monday, Wednesday and Friday of a scheduled week at 5:45 p.m. Tapings for the program occur on weekday mornings, typically in the 8:30 a.m. to 10 a.m. time frame and last approximately one half-hour. The program is also available as an audio stream on www.amcnoma.org.

Scheduling a *Healthlines* show is just a phone call away. Our members may contact the Academy of Medicine of Cleveland & Northern Ohio at (216) 520-1000 and ask for our communications department to let us know if you would like to be a guest on *Healthlines*. *Healthlines* is an excellent way for our members to

provide information to the general public on timely, medically related topics. It also provides you, our members, with the opportunity to get your name out in the community — truly a member benefit. For more information on the *Healthlines* program, please contact the AMCNO at (216) 520-1000. ■

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