

Medical Records Case Could Reshape the Definition of "Medical Records"

AMCNO Files Amicus Brief

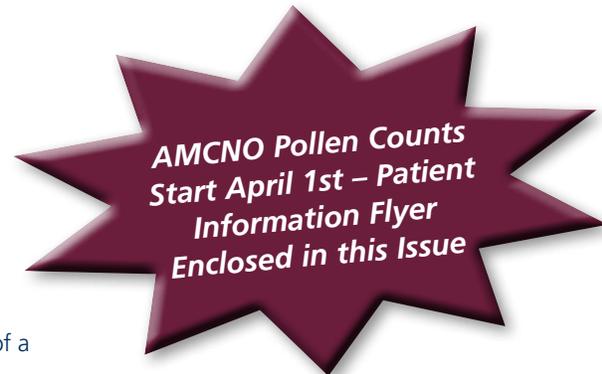
By Martin Galvin, Esq., and David Valent, Esq., Reminger Co., LPA

On October 8, 2014, the Supreme Court of Ohio accepted jurisdiction over and agreed to review *Griffith v. Aultman Hospital*. This case involves claims by the estate of a deceased patient against a hospital. The precise legal question raised by Griffith concerns the scope of medical records, and whether all patient data generated should be considered a component of a patient's "medical record." Specifically, the Supreme Court will determine whether a patient's medical records are only those records kept by a hospital's Medical Records Department or whether they include information received elsewhere, such as a Risk Management Department.

While this question is relatively narrow, the implications of the Court's ruling could reverberate in hospitals statewide. Should the Court expand the definition of medical records, hospitals and physicians will likely be subject to greater restrictions on how they record patient information, where that information is stored,

and what health information must be produced in response to a patient query.

In light of these issues, The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has decided to file an Amicus Brief arguing that the definition of the "medical



record" should continue to be defined by healthcare providers, and not by the courts.

AMCNO's specific interest in this litigation includes opposing attempts to compel impossibly overbroad data retention policies on medical providers, including physicians and hospitals. The statutory interpretation of

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AMCNO Board of Directors Meets with New SMBO Executive Director

The AMCNO Board of Directors was pleased to welcome Anthony J. Groeber, the new executive director for the State Medical Board of Ohio (SMBO) at their January Board meeting. Groeber was formerly the Executive Director for the Ohio Board of Tax Appeals and has a strong background in operations management and strategic planning. He informed the AMCNO board that, ultimately, the SMBO's role is to protect the public; however, the SMBO also has to interact with consumers, lobbying groups, physicians and other healthcare groups along with the administration.

Groeber stated that the SMBO is the state agency charged with regulating the practice of medicine and selected other health professions. The board consists of 12 members appointed by the governor to a 5-year term: 7 medical doctors, 1 doctor of osteopathy,

1 podiatrist and 3 consumer members. The SMBO's role is to protect Ohio patients and citizens and facilitate the good practice of medicine.

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Mr. Anthony J. Groeber, the new executive director for the State Medical Board of Ohio, provided comments to the AMCNO Board of Directors.

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AMCNO Board of Directors Report

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The SMBO issues more than 68,000 licenses, for medical doctors, osteopathic physicians, podiatric physicians, doctors in training, massage therapists, anesthesiologist assistants, physician assistants, radiology assistants, genetic counselors, massage therapists, cosmetic therapists, acupuncturists and oriental medicine practitioners.

Groeber outlined the SMBO complaint process, stating that as a complaint is being investigated, Ohio law requires that it be kept confidential. The board may, however, share investigative information with law enforcement agencies, other licensing boards, or other governmental agencies that are prosecuting, adjudicating or investigating alleged violations of statutes or rules. Final board actions are posted to the SMBO website and made public.

The board receives more than 4,500 complaints a year, with around 90% of these cases closed without disciplinary action by the board and about 10% resulting in a disciplinary board action. Groeber noted the top reasons for disciplinary action by the board: impairment of ability to practice, inappropriate prescribing, criminal acts or convictions, minimal standards of care and sexual misconduct and ethics violations. Currently the SMBO is monitoring 358 licensees for compliance with probationary terms of a Board Order or Consent Agreement. About 60% of those monitored are due to impairment issues. They are usually monitored by the SMBO for 5 years, and disciplinary action can be imposed for violation of the terms of probation. He noted that 70 new people go into the monitoring program every year.

Groeber outlined the latest SMBO legislative and rule changes impacting physicians and other healthcare providers. The first is the new Ohio Automated Rx Reporting System (OARRS) rule. OARRS is the statewide database showing prescription activity by patients. OARRS must be checked by physicians when prescribing opiates or benzodiazepines. He stated that OARRS is a tool meant to be used by physicians to provide increased insight into prescribing practices and history. OARRS can also put a spotlight on potentially negative behavior and give prescribers guidelines to point to when talking to their patients. The SMBO realizes that checking OARRS does require some time; however, it is a tool that the SMBO can rely on to not only protect patients that are on controlled substances but also to protect the physician practice. The message the SMBO wants to convey on

OARRS is that physicians should check it and indicate in the patient's chart that the OARRS report was reviewed. Groeber agreed that the OARRS still needs some refining, and it may be helpful to add some red flags in the system that will alert physicians when needed. Groeber noted that the goal is to spot negative behavior and then have a means to hit the pause button and evaluate if the prescribing is appropriate.

Groeber also mentioned that physicians may now put a copy of the OARRS report in a patient's chart. The AMCNO board questioned how physicians would know when this report could be released to the patient, and when it should be kept confidential. Board members recommended that additional information on this point be provided and informed Groeber that members of the AMCNO medical legal liaison committee were preparing some information on this topic for publication (see page 14).

Office-based opioid treatment (OBOT)

Suboxone rule – There has been an increase in the abuse of buprenorphine (Suboxone), and it has gone from a method of treatment to a potential problem. This rule sets a standard for appropriate prescribing, and expectations will be set with patients. This rule became effective January 31, 2015. (See page 7 for more information on this rule).

Chronic pain guidelines – The SMBO has prepared a single guidance document for treatment and prescribing for chronic pain. This guidance can be used as a tool to make good decisions and spotlight negative behavior. The SMBO has reviewed these guidelines with the Governor's Cabinet Opiate Action Team (GCOAT) and the Governor and these rules are now out for public comment. (The AMCNO is reviewing these guidelines and will publish the final document when it becomes available).

Telemedicine – Groeber stated that the rules for telemedicine are meant to set a standard of treatment for remote medical practice while ensuring that quality of care is not sacrificed at the expense of convenience or cost savings. It is meant to preserve the integrity of the patient/doctor relationship and allow for the responsible integration of new technology into medical practice. Groeber asked for input from the board on this issue.

The entire AMCNO board agreed that one of the biggest issues is that insurers are not

required to pay for telephone consultations or, in many cases, for telemedicine visits. There are also concerns about patients overusing this type of system, which could result in issues with appropriate diagnosis and continuity of care. Insurers should be held accountable for appropriate reimbursement, and they should assure that this does not impact quality of care.

Ohio Physicians Health Program (OPHP) –

One-bite Process – Groeber stated that the OPHP is designed to help licensees with drug and alcohol problems to seek treatment without SMBO action and it is meant to facilitate the health and wellness of practitioners. However, the SMBO believes that the current format of this program has some loopholes that may allow for lesser treatment, which they feel does a disservice to the licensee and casts the program quality into doubt. The SMBO is of the opinion that the OPHP is in need of some changes; however, any language that was sent out prior to this point was premature and the SMBO is working with interested parties, including the AMCNO, on how to best approach this issue. AMCNO board members cautioned that as this discussion continues it will be important to assure that any changes in the OPHP do not result in practitioners not getting the help they need for fear of repercussions.

In closing, Groeber said that some people think the board is draconian and only wants to punish doctors — that is not the case. The SMBO truly cares about licensees' health and wellness and it is important to have a large number of practicing doctors. The SMBO understands that mistakes can happen and prefers not to have to investigate complaints and take action. Punitive action is a last resort and is generally borne from an obligation to protect the patient. The SMBO is working on new tools to better address administrative errors versus unlawful behavior. He also noted that the SMBO encourages collaborative relationships and feedback from advocacy groups such as the AMCNO.

AMCNO Partners with Local ADAMHS Board on QPR Training

The ADAMHS Board of Cuyahoga County has requested that The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) partner with them to sponsor and help promote the Board's Question, Persuade, and Refer (QPR) Training to physicians in the county. The AMCNO Board of Directors has agreed to sponsor this program.

QPR teaches three simple steps that anyone can

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AMCNO Board of Directors Report

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learn to help save a life from suicide. Just as people trained in CPR and the Heimlich maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

The ADAMHS Board's primary goal is to reach out to Cuyahoga County healthcare professionals who are most likely to encounter people at risk for suicide to train the professionals in the QPR method. They are targeting healthcare professionals and physicians because The American Association of Sociology reports that 45% of individuals who die by suicide visit their primary care physician within 1 month of their death and 20% visit within 24 hours. And this "last medical contact" before suicide is even higher among the elderly, with almost 50% of suicide victims having seen their doctor within the past week. This is an educational opportunity to teach healthcare professionals in Cuyahoga County their potential role in suicide intervention and prevention.

Healthcare professionals have been recognized as key gatekeepers, who are in need of training in the identification and management of suicide and depression. The ADAMHS Board will provide a certified QPR Instructor to conduct the 1- to 2-hour training session. This instructor will come prepared with all of the necessary resource materials. If it is convenient for the trainee group, the session may be held at the AMCNO's offices or individual doctor's offices. The ADAMHS Board also provides free conference space at their location. The ADAMHS Board is only providing this training in Cuyahoga County. The training is completely free for the AMCNO and those who attend the session. The QPR Institute has been listed as an evidence-based practice in the National Register of Evidence-based Practices and Policies (NREPP). The purpose of the registry is to assist the public and program-adopters to identify scientifically based approaches to preventing and treating mental and/or substance use disorders and prevent suicide. Only 12 suicide prevention programs or interventions have met the rigorous quality of research and readiness for dissemination requirements for listing.

The AMCNO board suggested that the ADAHMS Board try to obtain CME credits for these sessions. For more information on this program, see page 6.

AMCNO Approves Content-Specific CME Policy

The AMCNO Executive Committee and Board of Directors have extensively discussed the possibility that in the future either the legislature or licensure boards may require mandatory CME for opioid prescribing or pain management. The board discussed this issue at length and reviewed data from other states that showed in many cases other states require some type of mandatory content-specific CME — including for opioid prescribing.

In general, the AMCNO recognizes that to require mandatory CME requirements is not always necessary or helpful; however, we also recognize that certain societal problems could be impacted by appropriate training and education. In general, the board was in favor of mandatory CME for prescribing narcotics but not for pain management, since the latter is a much broader topic.

Upon motion duly seconded, the AMCNO Board of Directors adopted the following resolution:

WHEREAS, Ohio is facing a critical public health issue related to prescription drug abuse and physicians in Northern Ohio take their role in helping fight this problem very seriously; and

WHEREAS, It is a possibility that there may be requirements in the future for physicians in Ohio to obtain mandatory content-specific CME hours on topics related to appropriate opioid prescribing in order to retain their license in the State of Ohio; and

WHEREAS, the AMCNO believes that there is a reasonable expectation that CME courses on the topic of appropriate narcotic prescribing could be effective in improving patient care and increasing patient safety in the physicians' practice, therefore be it

RESOLVED, That the AMCNO agrees in principle to work with the State Medical Board of Ohio and other medical organizations and associations as necessary on the development of content-specific CME courses to address appropriate narcotic prescribing for physicians.

Practice Transformation Network (PTN) and Supply and Alignment (SAN) Grants: During a meeting with associations that included the AMCNO, the Office of Health Transformation Director Greg Moody informed the group that

the federal government was working on a transforming clinical practices initiative and that two grant opportunities were now available.

The first opportunity was a practice transformation network (PTN) grant. Applicants for this grant could include groups such as a health improvement collaborative. This project would entail peer-based learning networks designed to coach, mentor and assist clinicians in developing core competencies specific to practice transformation. The Centers for Medicare and Medicaid Services (CMS) will award funding to applicants who have pre-existing relationships with multiple clinical practices that include data-sharing capabilities. Director Moody thought it would be beneficial for Ohio to submit a combined application to provide the resources for this and work on it together. The Ohio Health Information Partnership (OHIP) has engaged other stakeholders in this initiative, including the AMCNO, and has submitted a grant application for the PTN in Ohio.

The second opportunity is for the support and alignment networks (SAN) grant. This grant is intended to provide a system for workforce development utilizing national and regional professional associations and public-private partnerships that are currently working in practice transformation. The Ohio State Medical Association has engaged other stakeholders in this initiative, including the AMCNO, and has submitted a grant application for the SAN in Ohio.

The AMCNO Board of Directors supports the AMCNO involvement in both the PTN and SAN initiatives.

AMCNO Board of Directors Continues Support of Medicaid Reauthorization in Ohio

The AMCNO Board of Directors discussed the need for associations (such as the AMCNO) to show their continued strong support for Medicaid reauthorization in Ohio. The AMCNO supported Medicaid expansion in the previous budget and our organization is involved with both regional and statewide coalitions gearing up to work on this issue in the 2015 budget. The AMCNO Board of Directors unanimously voted to continue to support Medicaid reauthorization in Ohio. For information on meetings that have already taken place as part of the Northeast Ohio Health Action Coalition (formerly the NEOMECE – Northeast Ohio Medicaid Expansion Coalition), of which the AMCNO is a member, see page 6. ■

Question, Persuade, Refer Suicide Prevention Training



The ADAMHS Board of Cuyahoga County is providing FREE Question, Persuade, Refer (QPR) Training to healthcare workers in Cuyahoga County who are in a position to recognize a crisis and warning signs that someone may be contemplating suicide.

TAKE A TRAINING. SAVE A LIFE.

Question, Persuade, Refer (QPR) teaches three simple steps that anyone can learn to help save a life from suicide.

QPR will teach healthcare workers that they are in a position to recognize the warning signs, clues and suicidal communications of people in trouble and to act vigorously to prevent a possible tragedy.

The goal of QPR Training is to help prevent deaths by suicide in Cuyahoga County and reduce the stigma associated with mental illness.

The ADAMHS Board, with the support of The Academy of Medicine of Cleveland & Northern Ohio and a grant from the Margaret Clark Morgan Foundation, is providing this training for FREE to healthcare workers in Cuyahoga County. Each training will last approximately one to two hours.

90% of people in a suicidal crisis will give some kind of warning of their intention to those around them.

45% of individuals who die by suicide visit their primary care physician within one month of their death.
20% visit within 24-hours.

This “last medical contact” before suicide is even higher among the elderly.

Almost 50% of elderly suicide victims visited their doctor within the week before their death.

FREE training. Snacks and beverages at each training.

Trainings may be held at AMCNO, the ADAMHS Board, hospitals, or a doctor's office.

Contact Katie Boland to schedule a training at 216-241-3400 x812 or boland@adamhsc.org. For more information, visit www.adamhsc.org



AMCNO Legislative Update

In February, Governor John Kasich unveiled his 2016-2017 state operating budget proposal. It includes a number of provisions that could impact physicians and other healthcare entities. Gov. Kasich's third biennial budget request includes a recommended \$38.1 billion General Revenue Fund Medicaid program appropriation that would cover Ohioans earning up to 138% of the federal poverty level in fiscal year 2016-2017.

For Medicaid expansion to continue it will require the approval of the General Assembly through the upcoming budget process. Although the Governor has the authority to set Medicaid eligibility parameters, ultimately legislative approval will be necessary to accept federal funds to cover the cost of expansion. The legislature will have to authorize additional funding for the program. The federal government pays 100% of costs incurred by the new Medicaid population through 2016; however, beginning in 2017 this payment will decrease to 95%, which will require additional state spending to cover the expansion.

The health and human services portion of the budget proposal, however, also calls for an integration of services and person-centered case management as well as rigorous outcome expectations. The budget proposal itself calls for increasing personal responsibility by requiring premiums above 100% of poverty. Healthcare coverage purchased through the federal exchange requires adults at or above 100% of the federal poverty level (FPL) to pay monthly premiums. Ohio Medicaid plans to seek authority from the federal government to charge premiums similar to those on the exchange for Ohioans at or above 100% of the FPL. Currently, Medicaid enrollees whose incomes increase above eligibility levels are allowed to continue to receive Medicaid benefits for one year. Under the budget proposal, the time frame would be cut to 6 months and anyone on Medicaid with a higher income would be referred to seek coverage on the exchange. The plan is to shift more populations from fee-for-service and behavioral health services into managed care.

The budget proposal also calls for reforming hospital payments. When Medicaid was extended in 2014, Ohio's hospitals were able to receive payment for nearly all of the services they provided instead of having to absorb the costs of care for patients who lacked coverage or could not afford to pay. The administration believes that this change provided an

improvement in hospital financial stability, and, as a result, the 2016/17 budget calls for the temporary 5% hospital rate increase previously provided by Ohio Medicaid to expire. Medicaid would also launch new efforts to improve health outcomes and assist hospitals in controlling costs through strategies that would increase quality and prevent errors that could cause preventable readmissions.

There are also plans to encourage healthier families and communities across Ohio, as the Kasich administration would like to help all Ohioans lead healthier lives. One example: The budget provides enhanced maternal services through Medicaid health plans for every woman living in neighborhoods found to be at-risk for poor infant health outcomes. Work will be done to engage community leaders and health plans to connect women at high risk to healthcare services. The proposed case management approach will also be tied to the state's charge to reduce the infant mortality rate by encouraging community agencies to better connect women with a range of services that promote healthy pregnancies and births. The budget would require the Department of Health to determine areas in the community where infant mortality rates are at their highest, while managed healthcare organizations would be tasked with automatically connecting pregnant women and babies in those areas with high-risk care management benefits.

Ohio ranks 8th in the nation in the percentage of adults who smoke, with a substantial percentage of high school and middle school students who smoke. Gov. Kasich has included in the budget a series of initiatives that will lead to significant reductions in tobacco use in Ohio. The budget includes a proposed increase in the cigarette tax by \$1.00 per pack; an increase in the tax rate on other tobacco products like chew, snuff and cigars to match the rate on cigarettes; and a tax on e-cigarettes. The proposed increase on cigarette tax will reduce youth smoking rates by 12% and will help more than 73,000 Ohioans overcome their addiction to cigarettes. Raising the other tobacco products tax will help ensure that kids don't turn to or start using these products because they are cheaper. Additional policy proposals to make Ohio's schools and college campuses tobacco-free will encourage healthy living and lifestyle choices. The AMCNO has long advocated for these tax increases, and we applaud Gov. Kasich's bold proposals.

Other parts of the budget plan are intended to streamline how Ohioans are connected to services. The state would move to managed behavioral health care and allocations would be made over the biennium for the Department of Development Disabilities to increase home- and community-based services, and bring the state into compliance with a Centers for Medicare and Medicaid Services rule designed to shift people from institutions into community homes and the workforce.

The proposal also requires the state to move to a home health agency-only model, with the intent to improve oversight of those who are caring for older and disabled Ohioans who prefer to receive health care in their homes. The state would also implement electronic verification tools to improve honesty and accuracy in Medicaid provider billing.

Under expansion, as part of the Affordable Care Act, the federal government provided \$600 million to Ohio in order to temporarily increase physician payments under Medicaid to match the rate of payment under Medicare. Without it, the same medical care under Medicaid is paid at .59-cents on the dollar to Medicare payments. That temporary pay increase expired at the end of 2014. The Governor's budget proposal provides \$151 million for this provision, which the AMCNO believes is much less than what is needed. Physicians across the state began to see more Medicaid patients as a result of this temporary pay increase, however, without assurances that this pay increase will continue many physicians may no longer treat Medicaid patients.

The Office of Health Transformation (OHT) has created a document outlining the proposed health care reforms contained in the budget. The plan is to invest in preventive health care services by increasing Medicaid reimbursement rates for primary care and dental services to ensure that Ohioans have access to necessary services when they need them. In order to accomplish this, the budget plan calls for converting a portion of the graduate medical education subsidies into a primary care rate increase. In addition, the budget proposes to end cross-over claims for practices that serve dual eligible patients. This means instead of being paid 100% Medicare rates for seeing these patients, physicians would be paid the maximum Medicare allowable charge. Without a co-payment from Medicaid, this is generally 80% of Medicare.

LEGISLATIVE UPDATE

Many of these budget proposals, in particular the physician reimbursement issue, could have an impact on the AMCNO physician membership. There are still questions as to how much of a payment increase physicians will actually receive for specific services and the AMCNO will continue to monitor the budget activities as the debate at the Statehouse continues. The budget must be finalized and completed by the end of June.

AMCNO Works with Statewide and Regional Groups in Support of Continuing Medicaid Expansion

The AMCNO is a member of the Northeast Ohio Health Action Council (NEOHAC), which was formerly known as NEOMEC (Northeast Ohio Medicaid Expansion Coalition). This group continues to be active in our region and also works with the statewide coalition to support the continuation of Medicaid coverage for the thousands of individuals who became covered under the Medicaid program following the Medicaid expansion.

Recently, NEOHAC arranged a Lobby Day in Columbus and during the event members of the coalition met with legislators from the Northern Ohio area to discuss the importance of continuing the Medicaid coverage. AMCNO President Dr. James Coviello and the AMCNO EVP/CEO participated in this event and provided insight into how the changes to the Medicaid program have impacted the health and well-being of patients in the community. The AMCNO will continue to have discussions with legislators on this important issue and provide information back to our membership as the budget process continues.



AMCNO President Dr. James Coviello met with Rep. Nickie Antonio during the NEOHAC Lobby Day.

Legislation Under Review

Several healthcare-related bills have already been introduced and the debates have begun. Of interest to the AMCNO is House Bill 4 – Overdose Drugs. It was introduced by Representatives Robert Sprague (R-Findley) and Jeff Rezabek (R-Clayton). This bill would allow a physician to authorize an individual to furnish naloxone pursuant to the physician's protocol to a person at risk of an opioid-related overdose or to another person in a position to assist that person. It also authorizes a pharmacist or pharmacy intern to dispense naloxone without a prescription to a person at risk of an opioid-related overdose or to another person in a position to assist that person if the drug is dispersed in accordance with a physician's protocol. The bill also requires that a physician's naloxone protocol be in writing and include certain information. The bill also grants a physician acting in good faith who authorizes an individual to furnish naloxone and an individual authorized acting in good faith immunity from civil and criminal liability. The bill also grants immunity to other persons if he or she obtains and administers the naloxone in accordance with the bill.

Six other states currently allow pharmacists to distribute naloxone without a prescription and 12 that allow the general public to dispense naloxone without a prescription or any type of training. The AMCNO believes that this measure could save lives and help curb drug overdoses in Ohio.



In February, Dr. Joan Papp (pictured here with Rep. Robert Sprague) gave proponent testimony before the Ohio House for House Bill 4 – Overdose Drugs. Dr. Papp, an AMCNO member and emergency room physician at MetroHealth, is the medical director for

Project DAWN (Deaths Avoided With Naloxone), an overdose education and naloxone distribution program that aims to reduce overdose mortality within Cuyahoga County. Dr. James Coviello, AMCNO President also submitted proponent testimony on behalf of the AMCNO in support of the bill.

SMBO Issues New Requirements for Providing Office-Based Opioid Treatment Effective January 31

Ohio physicians who provide office-based opioid treatment (OBOT) using Schedule III, IV or V controlled substances such as Suboxone or Subutex must comply with Rule 4731-11-12, Ohio Administrative Code, effective January 31, 2015. The rule requires the following:

- Prior to providing OBOT, the physician must conduct an assessment of the patient that meets the requirements of the rule.
- The physician's practice must be in accordance with one of the protocols listed in the rule, and the diagnosis of an opioid disorder must be made utilizing the criteria in the SMA, 4th or 5th edition.
- The physician must develop an individualized treatment plan for the patient, require the patient to actively participate in appropriate behavioral counseling or treatment for addiction, and provide ongoing toxicological testing.
- The physician's prescribing of the medication must comply with requirements that include, but are not limited to, prescribing only drugs specifically approved by the FDA for use in maintenance and detoxification treatment, prescribing no more than 16 milligrams of medication for a patient unless specified requirements are met, and accessing OARRS for each patient no less frequently than every 90 days.
- The physician must complete Category I CME related to substance abuse and addiction every two years, which will be accepted as part of the CME requirement for license renewal.

The rule also authorizes the physician to continue providing OBOT to a non-compliant pregnant patient during the pregnancy and for two months thereafter. Violation of the rule subjects the physician to disciplinary action by the SMBO. Link to the rule <http://med.ohio.gov/pdf/rules/NewRules/4731-11-12-eff-1-31-15.pdf> ■

AMCNO MEMBER BENEFITS

Reduce your Workers' Compensation Premium Today!

Is your organization paying more than it needs to for workers' compensation coverage in Ohio? Are you unsure? The Academy of Medicine of Cleveland & Northern Ohio is pleased to offer a member benefit to help reduce your annual premium by participating in group rating, group retrospective rating or other alternative discount programs available.

Join other members already experiencing a lower rate on their annual premium. CompManagement, the AMCNO's workers' compensation third party administrator, will provide your organization with a free, no obligation savings analysis today.

How Much Can You Save?

Now more than ever it is very important to keep rates as low as possible and find your

best options for savings for the 2016 policy year. In contrast to the 2014/2015 policy years, the Bureau of Workers' Compensation (BWC) will not be issuing transition credits for the 2016 policy year that went to assist employers with the prospective billing implementation. As a reminder, enrollment deadlines are again earlier than in years past, so it is important to act today. Contact CompManagement for your free savings

analysis and stop paying more than you need to pay.

How do I request a free analysis from CompManagement?

To get your free saving analysis, complete the Temporary Authorization to Review Information (AC-3) form at www.compmgt.com. Or speak to a Customer Service Representative at (800) 825-6755, option 3. AMCNO members can also access CompManagement forms and obtain more information about this program by contacting the AMCNO offices at 216.520.1000, ext. 101, or on our website at www.amcno.org under the Member Benefits tab. ■

AMCNO Participates in Discussion on Sustainable Growth Rate (SGR) and Payment Reform

In February, the AMCNO participated in an event hosted by University Hospitals that provided an opportunity for physician leaders to have a discussion with Congressional representatives on Medicare's Sustainable Growth Rate (SGR) and payment reform. Presenting at the event were House Ways and Means Subcommittee on Health

Chairman Kevin Brady (TX-8) and U.S. Representative Jim Renacci (OH-16). The discussion centered around the bipartisan, bicameral legislative framework that the House Ways and Means Committee produced and how it intends to move SGR reform legislation forward in the new Congress.

Rep. Brady commented that they are working hard to come up with a viable solution to the SGR issue and encouraged the physician participants to reach out to their Congressional representatives to enlist their help in finally getting a permanent fix to the SGR formula. ■



U.S. Representative Kevin Brady provides his comments on the SGR formula during the event.



AMCNO president Dr. James Coviello spends a moment with Congressman Renacci.



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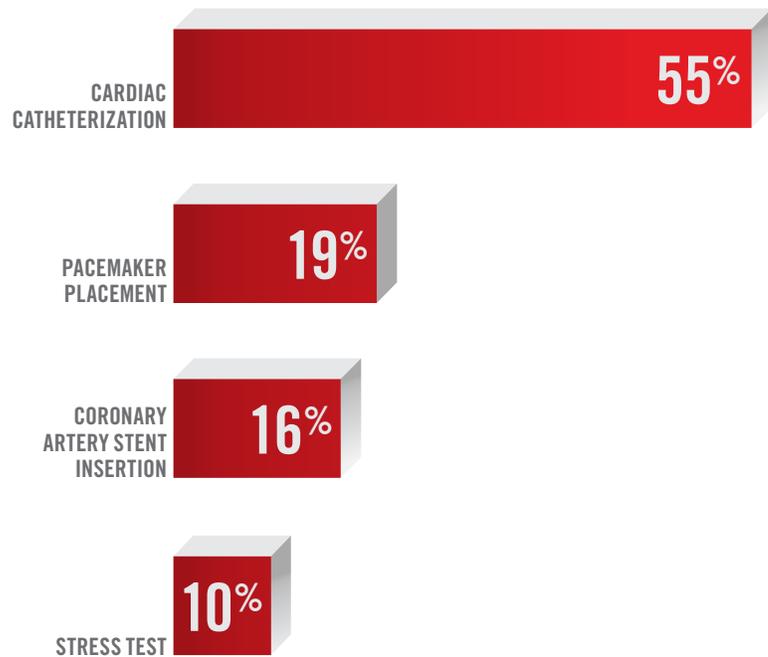
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THE DOCTORS COMPANY DOES.

As the nation's largest physician-owned medical malpractice insurer, we have an unparalleled understanding of liability claims against cardiologists. This gives us a significant advantage in the courtroom. It also accounts for our ability to anticipate emerging trends and provide innovative patient safety tools to help physicians reduce risk. When your reputation and livelihood are on the line, only one medical malpractice insurer can give you the assurance that today's challenging practice environment demands—The Doctors Company. To learn more, call our Columbus office at 800.666.6442 or visit WWW.THEDOCTORS.COM.



THE FOUR MOST COMMON PROCEDURES LINKED TO CARDIOLOGY CLAIMS
Source: The Doctors Company



Ohio's Quality Improvement Organization Helps Physicians Achieve Meaningful Use While Improving Chronic Disease Outcomes

By Howard Pitluk, MD, MPH, FACS, Vice President, Medical Affairs & Chief Medical Officer at Health Services Advisory Group

Focusing on quality in healthcare delivery and measuring quality outcomes leads to better care, healthier communities, and lower costs for both patients and providers. This focus is especially important as Medicare transitions from a volume-based, passive payer to an active purchaser of quality-based healthcare by linking performance to payment as a means of improving efficiency and value. Because Medicare payment will be based on physician performance, it is important that physicians in Ohio understand and implement quality measurement now.

Medicare's Approach to Quality Measurement

The Affordable Care Act of 2010 expands physician feedback reporting and requires Medicare to give providers information about the resources used and quality of care provided to their Medicare beneficiaries. This feedback is intended to incentivize physicians with greater reimbursement for high-quality care while reducing payments for low performers. By 2017, this "value modifier" will apply to all eligible physicians who bill Medicare for services provided under the physician fee schedule.

For the last few years, Medicare has employed a voluntary program of quality measurement reporting for individual providers using the evolving technology of electronic health records (EHRs). This Physician Quality Reporting System (PQRS) has evolved into a comprehensive means for reporting quality measures in every specialty and subspecialty through the use of EHRs or their registry functions. All of these quality indicators have been vetted by the National Quality Forum and allow for the establishment of national norms and standards that can be applied across diverse geographic areas and practice settings in order to improve care. For example, The Million Hearts Campaign® to prevent 1 million heart attacks and strokes advocates for appropriate aspirin therapy, blood pressure control, lipid lowering, and tobacco cessation, all of which are important heart-health quality indicators captured using EHRs. Physicians can use EHR feedback reports to document good care or shortcomings in their own practice, as well as identify how they compare to their peers. Over time, collection of these data will identify large-scale trends in chronic-disease management that could result in new approaches to primary and preventive care, reduce costly emergency care, and improve patients' quality of life.

Implementing Measurement at the Local Level

Health Services Advisory Group (HSAG), the Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization for Ohio, is a resource for physicians and hospitals, offering eligible physician practices no-cost:

- Technical assistance with their EHRs.
- Tools and education to improve the level of care for individuals and communities.
- Assistance with meeting the requirements of Meaningful Use (MU), PQRS, and value-based purchasing.
- Access to participate in HSAG-sponsored webinars, teleconferences, community collaboratives, learning and action networks, and other virtual and face-to-face gatherings that drive improvement and bring evidence-based practices, knowledge, and tools to their practices.
- Support for integrating EHR technology that advances quality care into their practices, while earning CMS payment incentives.

This work is grounded in foundational principles that align with the four goals of the CMS Quality Strategy platform: eliminate disparities, strengthen infrastructure and data systems, enable local innovation, and foster learning organizations.

In keeping with these principles, HSAG also offers eligible physician practices evidence-based best practice training on cardiac and diabetes care with the goal of enhancing the quality of care Medicare beneficiaries receive from their healthcare providers to prevent heart attacks and strokes, increasing opportunities for patients to attend diabetes self-management education (DSME) classes, and expanding the ranks of DSME educators in the community. HSAG offers no-cost EHR technical assistance to providers who identify and refer patients with diabetes or pre-diabetes to a DSME program—a proactive means to prevent avoidable hospitalizations and adverse drug events.

Measuring and reporting on quality is central to improvement. To ensure future success, providers must work to promote better and more efficient care at a more affordable cost. The work being done in each and every physician office and hospital is grounded in evidence-based quality performance that is measurable and reportable. Working in partnership with HSAG, physician practices will have an advocate and a resource for

Physician Benefits of Working With HSAG on Chronic Disease Management

Diabetes-Related Assistance

- Receive no-cost assistance to identify Medicare patients who are pre-diabetic and refer them to a local diabetes prevention program.
- Learn best practices to improve diabetes care.
- Become a DSME trainer in your local area through no-cost DSME trainings from HSAG.
- Increase the number of community residents trained in DSME, broadening public knowledge.

Hypertension-Related Assistance

- Receive technical assistance to identify at-risk patients for cardiovascular disease to proactively manage your hypertensive patient panel.
- Access cardiovascular educational sessions designed for providers to highlight evidence-based best practices that improve cardiac care.
- Apply your quality improvement knowledge towards the Million Hearts® goal of preventing one million heart attacks and strokes by 2017.

PQRS and MU Assistance

- Learn how to harness EHR technology for chronic disease management and preventive services.
- Earn CMS incentive payments by receiving provider-directed training to produce quality measure reports from your EHR.
- Obtain assistance to help enroll patients into your EHR portal.
- Gain technical assistance to boost patient and family engagement.

obtaining information and assistance for quality improvement to help the patients they serve.

For more information about how HSAG can assist your practice, please email Bonnie Hollopeter, LPN, CPHQ, CPEHR, HSAG Physician Office Lead, at bhollopeter@hsag.com or call 614.307.2036. ■

This material was prepared by Health Services Advisory Group, the Quality Improvement Organization for Ohio under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. OH-11SOW-XC-02132015-01



2015

Medical/Legal Summit

April 17 & 18, 2015

Summit Details

Location: CMBA Conference Center
1375 East 9th Street, Floor 2, Cleveland, Ohio 44114

Health Care Law Update CLE – 12–4:15 p.m.
April 17 (3.00 CLE, CME not available)

11:30 a.m. Boxed Lunches available

12:00 p.m. Federal & State Update

12:45 p.m. Medical Malpractice Trends

1:45 p.m. Break

2:00 p.m. Current Legal Review of Behavioral Health Issues

3:00 p.m. Criminal Investigations in Health Care

4:00 p.m. Health Care Law Section Annual Meeting (not eligible for CLE credit)

4:15 p.m. Adjourn to Networking Reception

Medical/Legal Summit – Friday Session – April 17
(1.50 CLE, 1.50 CME, 1 UH CRME)

4:15 p.m. Registration & Networking Reception

5:10 p.m. Welcome & Introductions

Bruce G. Hearey, Esq., *CMBA President*; James M. Coviello, MD, *AMCNO President*; Raymond Krncevic, Esq., *University Hospitals, Seminar Chair*

5:15 p.m. Keynote Presentation: Health Care Reform 2.0:
Navigating Uncertainty and Anticipating What's Next

Michael O. Leavitt is the founder and Chairman of Leavitt Partners, a health care intelligence firm dedicated to helping clients navigate the future of health care. He previously served as Secretary of Health and Human Services and Administrator of the Environmental Protection Agency in the Cabinet of President George W. Bush, and as a three-time elected Governor of Utah.

6:45 p.m. Adjourn

Saturday Session – April 18
(4.00 CLE, 4.00 CME, 4 UH CRME)

7:00 a.m. Registration & Breakfast

8:00 a.m. Welcome & Introductions

8:15 a.m. Telemedicine – Plenary Session

David Chmielewski, *VISN 10 Cleveland Facility Telehealth Coordinator, Dept. of Veterans Affairs*; Brook Watts, MD, *CMIO, Louis Stokes Veterans'*

Affairs Medical Center; Kimberly C. Anderson, Esq., *Assistant Executive Director, State Medical Board of Ohio*; James Gartner, *Vice President, Pharmacy Services, Medical Mgmt. and Retail Strategy, CareSource*

9:15 a.m. Physician Extenders – Plenary Session

Thomas A. Dilling, J.D., *Adjudication Coordinator/Legislative Liaison, Ohio Board of Nursing*; Sallie J. Debolt, Esq., *General Counsel, State Medical Board of Ohio*; Edward E. Taber, Esq., *Tucker Ellis LLP*; *Physician TBA (tentative)*

10:15 a.m. Break

10:30 a.m. Breakout Sessions

(1) End of Life Issues

Monica L. Gerrek, Ph.D., *Director of Ethics Education, MetroHealth*; May H. Al-Abousi, MD, *University Hospitals, Parma Medical Center*; Kim F. Bixenstine, Esq., *Vice President & Deputy General Counsel, University Hospitals*; Sandra M. DiFranco, Esq., *The Cleveland Clinic Foundation*; Emily E. Williams, Esq., *The Cleveland Clinic Foundation*

(2) Medical Marijuana

Jason M. Jerry, MD, *FAPA, The Cleveland Clinic Foundation*; Barry Maram, Esq., *Partner, Taft, Stettinius & Hollister LLP, Chicago*; Michael D. Froelich, Esq., *Senior Counsel, Taft, Stettinius & Hollister LLP, Chicago*; Timothy J. Cosgrove, Esq., *Squire Patton & Boggs (US) LLP*

11:30 a.m. Break

11:45 a.m. Breakout Sessions

(1) Affordable Care Act

Thomas S. Campanella, Esq., *BakerHostetler LLP*; Michael M. Hughes, MD, *FACC, Summa Health System*; Patricia Decensi, *Vice President General Counsel, Medical Mutual of Ohio*; Donald Ford, MD, *American Academy of Family Physicians*.

(2) Opiates and Pain Medicine

William J. Schmidt, Esq., *Senior Counsel, Enforcement Compliance & Investigations, State Medical Board of Ohio*; Chris L. Adelman, MD, *Medical Director, Rosary Hall, St. Vincent Charity Medical Center*; Bina Mehta, MD, *FAAPMR, The Spine & Pain Institute*

12:45 p.m. Adjourn

Location: **CMBA Conference Center**
1375 East 9th Street, Floor 2, Cleveland, Ohio 44114

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



Keynote Speaker:
Governor Michael O. Leavitt
Former Secretary, Department of Health & Human Services

Co-sponsored by the Cleveland Metropolitan Bar Association, Academy of Medicine Education Foundation, and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO).

Chair: **Raymond Krncevic**, Associate General Counsel, University Hospitals, Law Department

Co-Vice Chairs: **Lisa M. Barrett**, Senior Counsel, Cleveland Clinic and **James M. Coviello, MD** University Hospitals, and AMCNO President

Formoreinformation,calltheCMBAat(216)696-2404 or AMCNO at (216) 520-1000.

Registration

Summit Only

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- \$125 Non-Members
- \$15 Law and Medical Students (limited seats available)

Health Law Updated & Summit

- \$125 CMBA Members, AMCNO Members and other Health Care Providers
- \$175 Non-Members
- \$15 Law and Medical Students (limited seats available)

Please select breakout sessions:

First Track: End of Life Issues **OR** Medical Marijuana

Second Track: Affordable Care Act **OR** Opiates and Pain Medicine

TOTAL \$ _____

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Refunds will be charged a \$15 administrative fee. Substitutions or transfers to other programs are permitted with 24 hours written notice. **(Transfer is to a single program and the funds may be transferred only once!)** Persons needing special arrangements to attend this program are asked to contact the CMBA at (216) 696-2404, (fax 696-2129) at least one week prior to the program.

PHYSICIAN AND HEALTH CARE PROVIDER REGISTRATIONS: Phone/fax or mail to: AMCNO, 6100 Oak Tree Blvd., Ste. 440, Independence, OH 44131, Phone: (216) 520-1000 FAX: (216) 520-0999. Physicians and other healthcare providers may also pay the AMCNO online at www.amcno.org. Make checks payable to the AMCNO.

This activity was planned and implemented in accordance with the Essential Areas and Policies of the Ohio State Medical Association (OSMA) through the joint providership of The St. Vincent Charity Medical Center and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO). The St. Vincent Charity Medical Center is accredited by the Ohio State Medical Association (OSMA) to provide continuing medical education for physicians. The St. Vincent Charity Medical Center designates this live activity for a maximum of 5.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

*The AMCNO has obtained approval from University Hospitals (UH) for five hours of Clinical Risk Management Education (CRME) credit for those physicians participating in the UH Sponsored Physician Program. Please note: 1 CRME Credit is available for 4/17/15 (Friday) and 4 CRME credits for 4/18/15 (Saturday).

Professional Practice Gap: The Patient Protection and Affordable Care Act (PPACA), has significantly transformed the U.S. healthcare delivery system and the culture of medicine. In addition to the Act, other forces are already reshaping medical practice. They include the management of patients on chronic opioid therapy, the use of telemedicine, the use of physician extenders, medical marijuana, and end of life issues.

This program will give participants a medical-legal overview of changes in the health care delivery systems, their impact on the practice of medicine, and various strategies to meet these challenges.

Global Desired Learning Outcomes: At the completion of the session, participants should be able to:

- Identify the benefits, risks and legal ramifications of the use of telemedicine,
- Identify the benefits, risks and legal ramifications of the use of physician extenders,
- Describe effective avenues for communication between government and the medical community in the Affordable Care Act,
- Cite legislative and regulatory initiatives that affect the practice of medicine and understand how these initiatives impact the treatment and the prescribing of opiates to patients,
- Recognize the issues related to medical marijuana

Medical Records Case Could Reshape the Definition of “Medical Records”

(Continued from page 1)

“medical record,” being advanced by a plaintiff would result in an unworkable and interpretation of the terminology “medical record,” as defined in R.C. 3701.74. If this interpretation is adopted, the likely result will be endless discovery disputes, as well as unwarranted claims/allegations of obstruction, spoliation, etc., against medical providers.

The Underlying Case:

Howard Griffith was a patient at Aultman Hospital. Following a successful surgery to remove a portion of his lung, Mr. Griffith was transferred to a recovery room. He was subsequently found in an unresponsive state with his central line, chest tube and cardiac monitor disconnected.

Following Mr. Griffith’s death, his daughter filed a lawsuit against Aultman Hospital and sought to obtain copies of his medical records. The hospital released the “complete” medical record, which did not contain certain EKG strips generated by the patient’s cardiac monitor. The hospital had removed these rhythm strips from the patient’s room and stored them with the Risk Management Department.

These strips form the basis for the present dispute. The plaintiff argued that the rhythm strips were part of Mr. Griffith’s medical record because they were generated incident to his care and treatment. The hospital, however, claimed that the strips were not part of the record because they were not collected and stored in the records department. It is important to note that the strips were ultimately provided to the plaintiff, after they were requested during litigation discovery. The hospital has argued that the purpose of the medical record was to record the information needed to process the patient’s care and not to include all information generated during an inpatient stay.

The lower courts agreed with the hospital. They based their decision on R.C. 3701.74(A)(8), which defines a “medical record” as “data in any form that pertains to a patient’s medical history, diagnosis, prognosis, or medical condition and that is generated and maintained by a health care provider in the process of the patient’s health care and treatment.” The trial and appellate courts focused on whether the EKG strips were maintained in the course of the patient’s treatment. Ultimately, the courts found that, because the EKG strips were *maintained* separately from the medical record, they were excluded from the statutory definition.

Implications: What Constitutes a Patient’s Medical Record?

If Ms. Griffith prevails, the ability of patients to request and timely receive complete and accessible copies of their medical records may be compromised. Medical providers may be required to provide boxes and boxes of redundant and irrelevant data – in a format that is far less accessible. Patients may actually become less educated, not more educated, on their own medical histories. Further, patients may be discouraged from making requests for records

under R.C. 3701.74(B), knowing that the end result of such requests will be a seemingly limitless production of records in non-user friendly format and with expensive copying fees.

If medical providers are required to provide far more documents in response to a request made under R.C. 3701.74, then the fees charged to patients per R.C. 3701.74(B) (“fees for copies of medical records”) will likewise increase.

While the question of whether this particular patient’s EKG strips are part of the medical record may seem esoteric, the answer could have broad implications for hospitals and practitioners statewide. Should the Ohio Supreme Court determine that these EKG strips were part of the patient’s medical record, all data pertaining to a patient, presumably even information stored offsite, could be defined as part of the medical record to be required to produce every time any patient makes a medical records request.

Given the volume of electronic and print data generated by the healthcare industry, requiring this information to be included in a medical record could place unreasonable record-keeping and disclosure requirements upon practitioners. Certainly, the process of cataloging, storing and maintaining this information would require additional financial and administrative commitments. It is likewise unclear to what extent practices and hospitals would be required to store extraneous information, including metadata, generated ancillary to a patient’s treatment.

On the other side of the argument, commentators have cautioned that the *Griffith*

decision could lead to the unintended concealment (i.e., “sanitization”) of medical records. Specifically, there are concerns that if a hospital can self-define “medical records” to include only those stored within the records department, it could conceal information from patients by storing files elsewhere.

The appellate court did not resolve this issue. Instead, it noted that there is nothing in the statute indicating that it was intended to be used as a broad discovery device. Instead, the statute is a “miscellaneous provision” intended to ensure that patients can access their records in order to obtain a second opinion or transfer to a new provider. The lower courts agreed with the hospital that a medical record is not that which the plaintiff thought should be maintained, but rather that which a hospital actually determines is necessary to be maintained.

Conclusion:

In closing, the questions raised by the *Griffith* case implicate not only patient access to medical information, but also hospital administration and record-keeping. The question is whether hospitals and physicians get to decide what information is included in a medical record, or whether this decision will be made by the courts. ■

Martin Galvin is a partner with Reminger Co., LPA in Cleveland and serves a co-chair of the Appellate Practice Group. Marty can be reached at mgalvin@reminger.com or (216) 430-2237. David Valent is a partner with Reminger Co., LPA in Cleveland, and serves as the co-chair of the firm’s Health Care Group. Contact him at dvalent@reminger.com or (216) 430-2196.

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OARRS Medical / Legal Update

By Martin Galvin, Esq., and David Valent, Esq., Reminger Co., LPA

As this readership is likely aware, the Ohio Automated Rx Reporting System (“OARRS”) is an electronic database maintained by the Ohio State Board of Pharmacy. This database stores information for certain prescription medications, including Schedule II through Schedule V controlled substances. The requirements governing the use of this platform changed with the introduction of Ohio House Bill 341, which Governor Kasich signed into law this past summer, and which became effective, in part, January 1, 2015.

The new law amends several Ohio Revised Code provisions and generally requires prescribers to obtain an OARRS registration and perform an OARRS query prior to prescribing or dispensing opioid analgesics or benzodiazepines. The registration requirements took effect on January 1, 2015, while the provisions pertaining to prescribing and dispensing medications will take effect April 1, 2015. The law also allows prescribers to include and consider an OARRS report as part of the patient’s medical record beginning March 20, 2015.

With these changes coming into effect, this article is intended to address some frequently asked questions.

Who Is Required To Register With OARRS?

The new law is directed primarily toward those prescribers who prescribe or dispense opioid analgesics and/or benzodiazepines. “Prescribers” include physicians, dentists, advanced practice registered nurses holding certificates to prescribe, optometrists holding therapeutic pharmaceutical agents certificates, and physician assistants holding certificates to prescribe.

Beginning in 2015, these prescribers will be required to register to use OARRS and to query the database. OARRS registration will also be required as a component of license initiation and renewal as of January 1, 2015.

How And When Must I Query The OARRS System?

HB 341’s OARRS query requirements take effect April 1, 2015. As of that date, prescribers will face three query requirements.

First, prescribers must request patient information covering the previous 12 months

prior to initially prescribing or personally furnishing an opioid analgesic or a benzodiazepine. The law defines “opioid analgesic” as a controlled substance that has analgesic pharmacologic activity at the opioid receptors of the central nervous system, and includes drugs such as buprenorphine, butorphanol, codeine, hydrocodone, methadone, morphine sulfate, oxycodone and tramadol, among others.

“Benzodiazepine” is defined as a controlled substance such as benzodiazepine, or a benzodiazepine derivative, including, but not limited to, alprazolam, chlordiazepoxide hydrochloride, clobazam, diazepam, lorazepam, midazolam and triazolam.

Second, prescribers must make periodic follow-up requests every 90 days, if the drug is prescribed for 90 days or more. These requests must be made at intervals not exceeding 90 days, according to the date of the initial request.

Finally, prescribers are required to review the OARRS report and document in the patient record that the report was requested, received and assessed.

How Far Does The Query Requirement Extend?

The OARRS inquiry requirements are not limited to Ohio. Depending on the location of a practice, prescribers may be required to search for records in other states. In particular, the law requires prescribers practicing primarily in an Ohio county that is adjacent to another state to search the adjoining state’s prescription information. For example, depending on the location of a practice, a physician may be required to search records from Kentucky, West Virginia, Indiana or Michigan.

This requirement does not apply to Pennsylvania, which does not have an active prescription monitoring program. However, should Pennsylvania begin such a program, then prescribers in counties adjoining Pennsylvania would be required to review that system.

Are There Exceptions To The Query Requirement?

The law does not require an OARRS query in all circumstances. Specifically, the law provides that the OARRS query is not needed when:

- (1) The drug is prescribed or personally furnished for less than a 7-day supply (applies to all prescribers except optometrists);
- (2) The drug is prescribed or personally furnished for cancer treatment or for another condition associated with cancer (applies to advanced practice registered nurses, physician assistants, and physicians);
- (3) The drug is prescribed or personally furnished to a hospice patient in a hospice care program or to any other terminally ill patient (applies to all prescribers except optometrists);
- (4) The drug is prescribed or personally furnished for administration in a hospital, nursing home or residential care facility (applies to advanced practice registered nurses, physician assistants, and physicians);
- (5) The drug is prescribed or personally furnished to treat acute pain resulting from a surgery, invasive procedure or delivery (applies to physicians only); or
- (6) An OARRS report is not available (applies to all prescribers). In this case, the provider should document in the patient record why the OARRS report was not available.

Are There Penalties For Failing To Query The OARRS System?

HB 341 authorizes regulatory boards, such as the State Medical Board of Ohio, to sanction prescribers who fail to comply with the bill’s informed consent requirement. The Board may also become involved if a prescriber does not query OARRS, and a patient abuses an opiate. Further, a prescriber may be disciplined for a false certification regarding

(Continued on page 19)

Foreseeability of Harm May be Necessary to Prove Medical Malpractice

By Christine Marshall, Esq., Partner, Sutter O'Connell, Co.

The Supreme Court of Ohio resolved a long-disputed issue in *Cromer v. Children's Hospital Medical Center of Akron* that foreseeability of harm may be relevant for a jury to consider in the context of a medical malpractice case.

The *Cromer* case involves the death of 5-year-old Seth Cromer while he was being treated in the PICU at Children's Hospital. Several days earlier, the child had been diagnosed with an ear infection by his pediatrician. Although he had been taking antibiotics and had shown signs of improvement, his condition worsened and his parents took him to the hospital's emergency room. At approximately 10:44 pm, triage assessed Seth as "urgent" then noting he had a stomachache and fever, was clammy, cold and listless. He was initially treated for dehydration but his condition worsened within a few short hours. By 1:14 am, Seth was transferred to the PICU where the critical care staff determined he was in shock. Despite the efforts of various medical professionals, the child went into cardiac arrest and by 4:05 am was pronounced dead.

At issue on appeal was a jury instruction the hospital had requested, and the trial court agreed to provide, on the foreseeability of harm. Specifically, the instruction given to the jury read:

In deciding whether ordinary care was used, you will consider whether the defendant should have foreseen under the attending circumstances that the natural and probable result of an act or failure to act would cause Seth Cromer's death.

The test for foreseeability is not whether the defendant should have foreseen the death of Seth Cromer precisely as it happened. The test is whether under all the circumstances a reasonably cautious, careful, prudent person would have anticipated that death was likely to result for someone from the act or failure to act.

If the defendant, by the use of ordinary care, should have foreseen the death and should not have acted, or if they did act, should have taken precautions to avoid the result, the performance of the act or the failure to act to take such precautions is negligence.

The jury returned its verdict in favor of the hospital, and the parents appealed. The Ninth District Court of Appeals vacated the jury's verdict and remanded for a new trial, finding that foreseeability of harm was irrelevant to a determination of a medical professional's standard of care. The Supreme Court of Ohio accepted jurisdiction as a matter of public or great general interest, and considered the appropriateness of including a foreseeability instruction in the context of medical negligence cases and the factual propriety of the above instruction in this instance.

The Supreme Court of Ohio held that while foreseeability may be irrelevant to a determination of a physician's duty, the scope of that duty owed includes the expectation that physicians will exercise the degree of care that is reasonable in light of the physician's superior training and knowledge. Specifically, the Supreme Court stated, "just as with the general negligence standard, it necessarily follows that we would not expect medical professionals to guard against a risk of harm that a medical professional of ordinary skill, care, and diligence would not foresee."

Therefore, foreseeability of harm is relevant to a physician's standard of care, and a general statement of the law regarding the standard of care or the breach of that standard includes the element of foreseeability. Under the particular facts

of *Cromer*, the Supreme Court of Ohio determined that the instruction on foreseeability was not necessary but found no material prejudice as a result of giving the unnecessary instruction.

The Supreme Court was divided in their opinion and has remanded the case back to the Ninth District Court of Appeals for further consideration of other potential errors that may have occurred during trial. However, the future landscape of medical malpractice cases in Ohio has changed. It is now clear that foreseeability of harm is not only relevant, but may be necessary, for a jury to consider when determining if medical negligence has occurred. ■

NORTHERN OHIO PHYSICIAN

THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

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Joan J. Papp, M.D., Special Honors

Anthony E. Bacevice, Jr., M.D., Outstanding Service

The Honorable George V. Voinovich, Honorary Membership

Toinette Y. Parrilla and **Terry M. Allan**, Special Recognition

Kimberly C. Anderson, Esq., Presidential Citation

Please join us in congratulating our medical scholarship recipients and awardees on April 24, 2015.

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AMCNO ACTIVITIES



The Honorable Evelyn Lundberg Stratton provided the opening remarks at the ceremony.

The AMCNO was on hand for the swearing-in ceremony of The Honorable Sharon L. Kennedy and The Honorable Judith L. French, Justices of the Supreme Court of Ohio. The emcee for the event was The Honorable Evelyn Lundberg Stratton, and the ceremony was followed by a reception. The AMCNO strongly supported both justices in their bid for re-election to the court.



AMCNO EVP/CEO Elayne Biddlestone spends a moment with Justice Judith French (right).



Dr. Geraci spends a moment with Dr. Laura David (left) and Dr. Karen Jaffe.



AMCNO President Dr. James Coviello delivers remarks at Dr. Geraci's retirement event.

The AMCNO President and staff were pleased to be part of the retirement party held in honor of Dr. Kevin Geraci, AMCNO Past President. Dr. Geraci served as AMCNO President from 2002-2003. He also served as an Academy of Medicine Education Foundation (AMEF) board member for several years and has been a big supporter of the annual AMEF fundraising event.

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AMCNO ACTIVITIES

Salute! AMCNO Toasts another Memorable Wine Tasting Event!

Braving bitter cold temperatures, attendees of the AMCNO Wine Tasting Event stepped into the warm La Cave du Vin on Feb. 15 to sample some of the popular cellar's finest red and white wines.

This year, physician members and their spouses or guests welcomed a slew of invited residents and medical students, who all happily chatted throughout the evening.

La Cave's wine expert showcased six wines, describing the samples before they were poured. She also shared an interesting background story for each wine.

Our thanks to those who were able to attend this fun night out. Be sure to watch for a "save the date" for next year's event! ■



AMCNO Past President Dr. James Sechler spends a moment with participants at the event.



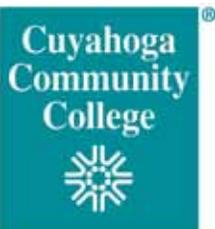
AMCNO Past President John Bastulli, MD discusses the AMCNO with an AMCNO resident member.



Fred Jorgensen, MD (left) poses with two residents at the event.



A large group of AMCNO resident members turned out for the event.



2015 Cuyahoga Community College Center for Health Industry Solutions



Date	Time	Title	Fee	Location
3/2/2015	9:00am- 12:00pm	Comprehensive Professional Medical Coding Bundle-Weds	4200	UTC
3/2/2015	6:00pm-9:00pm	The Professional Medical Coding Curriculum-Weds	1750	UTC
3/3/2015	6:00pm-9:00pm	Fundamentals of Billing Reimbursement – Tues, Thurs	425	UTC
4/1/2015	8:00am-8:00am	Comprehensive Professional Medical Coding Bundle -Online	4000	Online
4/6/2015	6:00pm-9:00pm	Medical Terminology – Mon, Weds	350	UTC
4/6/2015	9:00am-12:00pm	Patient Access Specialist Fundamentals – Mon, Weds	499	UTC
4/25/2015	9:00am-3:00pm	CPT Coding Fundamentals and More – Sat	249	CCE
4/28/2015	6:00pm-9:00pm	Essentials of Electronic Health Records – Tues, Thurs	325	UTC
5/18/2015	9:00am-12pm	Comprehensive Patient Access Specialist Program - MTWTH	2400	Westshore
5/18/2015	9:00am-12pm	Health Care Navigator - MTWTH	2100	Westshore
6/1/2015	9:00am-12:00pm	Comprehensive Professional Medical Coding Bundle- Thur	4200	Westshore

Take advantage of discounted classes for AMCNO Members and their staff. Contact AMCNO at 216-520-1000 for exclusive AMCNO member course numbers to register and obtain a discounted price.

Course Locations: Corporate College East 4400 Richmond Rd, Warrensville Hts, OH 44128

Unified Technologies Center Rd 2415 Woodland Ave, Cleveland, OH 44115

Westshore 31001 Clemens Road, Westlake, Ohio 44145

ONLINE

Governor's Cabinet Opiate Action Team (GCOAT) Meets to Address Acute Pain Treatment

The Opiates and Other Controlled Substances Reforming Practices Committee (OOCs) of the Governor's Cabinet Opiate Action Team (GCOAT) has been working to develop and disseminate responsible opioid prescribing practices for Ohio's clinicians. A critical area of focus for the group has been identifying where clinician support is needed to achieve appropriate pain management. To date, the stakeholder group has developed practice guidelines for clinicians practicing in emergency and urgent care settings and those caring for patients who are experiencing chronic, non-terminal pain. The group is now broadening their focus and has been charged with developing guidelines for the safe, appropriate and effective prescribing of

medications for acute pain. The guidelines are intended to assist clinicians in driving "best practices" as defined in the medical literature and by Ohio clinicians to improve patient care and minimize harm. Specifically, these guidelines may reduce the rate of new opiates prescriptions, reduce the number of patients receiving high-dose chronic opiates, and limit the available leftover narcotics.

As noted above, the GCOAT clinical subgroups have already established two prior guidelines for prescribing opiates for chronic pain and prescribing opiates in the emergency room setting. This third guideline is focused on the prescribing of self-administered medications for acute pain with the understanding that

guidelines do not replace clinician judgment. Instead, these guidelines may delineate standardized processes that include key checkpoints to pause and consider additional questions.

Physician volunteers have been recruited to serve on a subcommittee to come up with a definition of acute pain. There are also subcommittees working on patient educations and guidelines. Two AMCNO board members, Drs. James Coviello and Matthew Levy, are serving on this subcommittee. The AMCNO board will continue to review these guidelines and provide our input on this important issue. ■

OARRS Medical / Legal Update

(Continued from page 14)

OARRS. As a result, providers are encouraged to familiarize themselves with the new OARRS requirements before April 1, 2015. Should you receive notice of an investigation or potential disciplinary action, consult with your designated risk management contact or a licensed attorney specializing in healthcare matters to evaluate your options.

How Should A Provider Chart The Information In An OARRS Report?

Questions have arisen as to whether an OARRS report should be included in the patient chart. While Ohio law previously discouraged including the report within the patient's medical record and included stringent non-disclosure standards, these requirements are set to change.

Beginning March 20, 2015, Ohio law will permit a prescriber to include the OARRS report within the patient's medical record. Once this information is incorporated into the patient chart, the report is considered to be a part of the record and subject to disclosure. As a result, the report will essentially be subject to the same disclosure

requirements as the remainder of the medical record. In addition, the law permits a prescriber or pharmacist to review the information contained within the OARRS report with a patient.

Regardless of where the OARRS report is stored, Ohio law requires physicians to document the receipt and assessment of all OARRS reports in the patient record. This requirement extends to both initial OARRS reports and follow-up queries if the course of treatment exceeds 90 days. The State Medical Board's preferred method of fulfilling this requirement is to record the date the report was requested, along with any pertinent findings, in the patient's medical record.

Is An OARRS Report A Psychological Record?

There is also a question as to whether an OARRS report can be considered a mental health record. Some of the medications listed in the reports, including benzodiazepines, may be used to treat mental health disorders. As such, although the new law soon allows

for OARRS information to be included in the record, if the medications relate to psychological illness, a provider must be cautious of that when a records request is made. Sufficient release language may be needed to meet the HIPAA standards applicable to release protected mental health information. If there is any question on this issue, please seek advice prior to the production of information.

Conclusion

In closing, Ohio law now requires physicians and other prescribers to register with and query the OARRS platform when prescribing opioid analgesics or benzodiazepines. The law also allows the OARRS report to be included in a patient's medical record.

For further information regarding the new OARRS requirements and/or issues that may be specific to your practice, please do not hesitate to contact David Valent or Martin Galvin, at Reminger Co., L.P.A., dvalent@reminger.com or mgalvin@reminger.com, with your questions or thoughts. ■

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