

AMCNO Participates in Conference on Improving the Patient Experience

By: Lawrence T. Kent, M.D.

In November, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to sponsor a roundtable discussion at the Quality Institute of the Ohio Hospital Association's conference on *Improving the Patient Experience in Ohio Hospitals*, addressing the *Role of Medical Societies in Education and Engagement of Physicians* to improve HCAHPS scores in the region. The conference was co-sponsored by the Cleveland Clinic, University Hospitals Case Medical Center, and The MetroHealth System. Breakout sessions covered additional topics ranging from improving physician engagement to improving the HCAHPS instrument.



Dr. Lawrence Kent, AMCNO Immediate Past President (left), facilitated the AMCNO roundtable discussion at the patient experience event.

The Origin of HCAHPS

The Hospital Consumer Assessment of Hospital Providers and Systems (HCAHPS) is a survey instrument designed to assess patient experiences during their hospital stays. Originally developed and validated by the Agency for Healthcare Research and Quality (AHRQ) for The Center for Medicare and Medicaid Service (CMS) in the early 2000s, HCAHPS was the first tool of its kind to create a set of common measures and national

standards for assessment of patient satisfaction. The HCAHPS survey consists of 27 questions covering eight "domains" of patient satisfaction. Each domain consists of two or three questions covering six core areas of a patient's experience with nurse communication, physician communication, staff responsiveness, pain management, medication reconciliation, and discharge

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AMCNO Co-Sponsors Medical Malpractice Seminar

Over 85 physicians attended a session on December 6, 2012, when Roetzel & Andress, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), and the Northeast Ohio Medical University co-sponsored, *Medical Malpractice Claims — The Impact of Being Sued*. This half-day seminar addressed risk management and medical-legal issues, including the lawsuit and trial process, the nuts and bolts of medical malpractice trial presentation, the False Claims Act (FCA), and the emotional and psychological impact of being sued on a healthcare provider.



AMCNO President, Dr. James Sechler, provided the opening remarks at the Medical Malpractice Claims seminar.

Dr. James Sechler, M.D., AMCNO President kicked off the meeting with some opening comments and was followed by Anna Carulus of Roetzel & Andress, who outlined "The Anatomy of a Lawsuit," in which she provided the most important clues that a lawsuit could be filed. These include a litigious patient, adverse event,

a records request, and the 180-day letter with the records request. The 180-day letter is followed by a Summons & Complaint document, the official notification that a lawsuit is in the works. At this point, the first reaction might be to

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Patient Protection And Affordable Care Act ("ACA")

Post-Election ACA in the U.S. and Ohio

Introduction:

As many readers may be aware, on June 28, 2012, the U.S. Supreme Court upheld a significant portion of President Obama's Act Healthcare Law — The Patient Protection and Affordable Care Act ("ACA"). Following that decision, this Journal published an article addressing the ACA's anticipated impact on physicians. Although the previous article analyzed the potential pros and cons of the ACA, there remained a significant degree of uncertainty as to how the ACA would be implemented, whether it would be supported by state governments, and whether the November election cycle would result in a change of leadership, which could have potentially caused the ACA to be rescinded.

Since the re-election of President Obama, and since the Democrats have remained in control of the Senate, it is increasingly clear that the ACA is here to stay. Accordingly, this article, as part of a series of articles, will further address the changes most imminently expected as a result of the ACA, as well as the State of Ohio's handling of its decisions related to the implementation of the ACA.

National Implementation of ACA; Changes expected in 2013:

Healthcare providers and patients alike are continually watching the federal government for more detailed information concerning the implementation of the ACA. To date, many questions remain unanswered. In a recent interview, economist, Gail Wilensky, Ph.D., the former chairwoman of the Medicare Payment Advisory Commission, stated, "watch out for anyone who tells you, this is what your future will look like, because they can't possibly know." Dr. Wilensky provided this commentary at an annual meeting for the Advocacy for Healthy Partnerships conference wherein she further expressed frustration over the ACA, and the lack of detail as to how the law will be carried out and/or impact physicians. Dr. Wilensky stated, "two thousand pages of legislation wasn't enough to say anything about reforming how we pay physicians." These frustrations are no doubt likely shared by many readers of this article. For that reason, over the next several months, this Journal will attempt to provide updates concerning the implementation of the new law and its impact on the health care industry. In the meantime, the remainder of this article will focus on the most transparent changes we are likely to see in 2013.

On November 1, 2012, in compliance with the mandates set forth in the ACA, the Centers for Medicare and Medicaid Services issued a final rule regarding Medicaid reimbursements for primary care practitioners. Pursuant to the rule, effective January 1, 2013, Medicaid reimbursements will be brought on par with those of Medicare for primary care providers in 2013 and 2014. The federal government will pay 100% of the difference between Medicaid state plan payments and the applicable Medicare rate. The

increase will most directly impact family medicine physicians, general internists and pediatricians. The Secretary of Health and Human Services Kathleen Sebelius says, "by improving payments for primary care services, we are helping Medicaid patients get the care they need to stay healthy and treat small health problems before they become big ones." This change in law has also come with great support by entities such as the American Academy of Family Physicians.

Also in 2013, the ACA requires implementation of authority to allow "bundle payments." The ACA established a nationwide pilot program designed to encourage providers to work with other providers to coordinate and improve the quality of patient care. Bundle payments allow the delivery of a flat rate for an "episode of care" to providers, rather than the current system of individually billing Medicare for each service provided. As an example, in the instance of a surgical procedure, instead of submitting multiple claims for payment, from multiple providers, the entire care team could be compensated with a bundled payment. The goal is that this program incentivize health services to be provided more efficiently, while still maintaining quality of care.

There is also a "Sunshine Act" component to the ACA that is expected to have impact beginning in 2013. A final rule regarding this provision has been drafted, but not yet approved by the Office of Management and Budget. Without all details yet available, the purpose of the rule is to create new transparency requirements. This law will likely take effect starting in March 2013, and will require pharmaceutical companies to report any single payment/transfer of \$10 or more made to a physician. This is just one example of the requirements expected to be set forth in the final rule that seeks to create more transparency in financial relationships between health care providers and suppliers.

Another change coming in 2013 as a result of the ACA is the new Internal Revenue Service ("IRS") provision related to medical devices. According to a final rule issued in December 2012, the IRS will impose a "Device Tax" on the sale of any taxable medical device at a rate of 2.3%. The tax is effective as of January 1, 2013. The government's justification for this tax is that the durable medical equipment industry is one set to gain business as a result of the expansion of health care coverage under the ACA — and since demand is increasing, the costs associated with the tax will be offset by increases in product sales.

In addition to the several provisions/changes highlighted above, the other most notable changes coming in 2013 relate to the way in which state governments respond to the ACA.

Ohio's Response to the ACA:

There are two primary issues of focus relative to the Ohio government's implementation of the ACA. The issues include the handling of: 1) the

"insurance exchange" program, and 2) the optional expansion of Medicaid.

On the first issue, the federal government has extended its deadline until December 16, 2012, for states to decide if they will allow the insurance exchange program to be run by federal agencies, instead of state agencies. Ahead of this deadline, Ohio has already made its decision. Lieutenant Governor Mary Taylor announced in November, 2012, that Ohio plans to let the federal government run the new health insurance exchange program.

Healthcare markets, called exchanges, are designed to help people and small businesses find affordable care coverage. The exchanges will help low income Ohioans enroll in Medicaid, as well as to set rules for premiums and provide consumer protection guidelines. The markets are a key element of the health care law, where millions of individuals are expected to shop for coverage and find out if they are eligible for government subsidies or Medicaid. The law requires the federal government to build and operate the markets, if states do not.

For the federal administration, one of the most difficult decisions will be to decide how insurance policies must be designed, priced, and sold, starting next October, 2013, when open enrollment begins for the new online marketplaces, called exchanges. For example, the ACA allows insurers to alter their prices for people based on their age, family size, where they live, and tobacco use. The Department of Health and Human Services has to determine how insurers can go about setting prices relative to these demographics.

The second primary consideration for states, such as Ohio, is whether the state government will decide to "expand" its Medicaid program. Pursuant to the U.S. Supreme Court's ruling this summer, states that do not want to expand Medicaid eligibility up to 133% of the federal poverty guidelines, or about \$30,000 for a family of four, could opt out in 2014, without losing current Medicaid dollars. The federal government has not set a date in which the states must decide if they will expand their Medicaid program. Ohio has not yet made this decision. Ohio officials have indicated that a decision on whether to expand Medicaid eligibility is likely to coincide with the drafting of the state's biennium budget next spring.

A report released in November, 2012, by Kaiser Family Foundation estimates that if Ohio participates with implementation of the Medicaid expansion, it will reduce the number of uninsured in Ohio by 991,000, by 2022. Importantly, the federal government, pursuant to the ACA, would pick up 100% of the tab for the expansion until 2017. After that, however, federal funding decreases annually down to 90% in 2020 and beyond. State leaders have estimated that Ohio's

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share in 2017 and 2018 would be \$457 million to pay for the newly enrolled.

The expansion of Medicaid was designed to be a major part of President Obama's health care law, originally expected to account for half of the 32 million people who were to gain coverage under the ACA. Whether states, including Ohio, choose to expand the program, will have a significant outcome on the overall impact of the ACA.

In a statement made in June 2012, Governor Kasich said his administration is "very concerned that a sudden, dramatic increase in Medicaid spending could threaten Ohio's ability to pursue needed reforms in other areas." Although Ohio has not decided whether it will expand its program, many believe this statement is a clue that it will not.

Conclusion:

In closing, although there still remains much uncertainty over the anticipated impact of the ACA, the federal government has issued several rules in recent months, which are starting to give

us a better picture of what to expect in the immediate future.

For further information regarding the ACA and/or issues that may be specific to your practice, please do not hesitate to contact David Valent, at Reminger Co., L.P.A., dvalent@reminger.com, with your questions or thoughts. Also, please feel free to contact the AMCNO editorial staff at ebiddlestone@amcno.org with your thoughts regarding specific issues of the ACA that you would like to see addressed in the series of articles this Journal intends to publish regarding the ACA. ■

AMCNO Co-Sponsors Medical Malpractice Seminar (Continued from page 1)

contact the plaintiff (patient), the plaintiff attorney, other named doctors, subsequent treating doctors, or even the judge. According to Ms. Carulus, none of these ideas are viable options. A defendant does not have attorney-client privilege in any of these conversations. Anything said can be repeated during the litigation process. She advised that physicians should notify and provide documents to the insurance carrier or hospital law department and make sure that the attorney-client privilege is maintained at all times.

Ms. Carulus also advised against amending medical records at any time noting that any changes to existing medical records can be construed as an intention to "cover up wrongdoing" and may result in a punitive damage claim as well.

The judge can also make a significant difference in how the case is dealt with in the court system by establishing a schedule, setting dates and deadlines for discoveries, expert reports, the final pre-trial, settlement conferences, and the trial date, if necessary. Ms. Carulus also noted that trial preparation is of key importance and it behooves the defendant(s) to know the facts of the case. Working closely with the attorney, and providing full disclosure of the facts, can help the defendant anticipate all areas of questioning before it begins. Expert witnesses will also be deposed to establish the common standard of care, causation, and damages.

R. Mark Jones, representing Roetzel & Andress, cautioned physicians to be flexible and patient, however difficult it may be during the pre-trial period. Trial preparation includes putting all of the pieces together, developing a strategy, and creating a persuasive argument that focuses on the facts, explain the practice of medicine, creates proper perception among jurors and overcomes sympathy. Before the trial, lawyers will try to limit the evidence, as well as facts and issues of fault. Jurors will be selected and a civil case requires eight jurors; and only six of the eight needs to agree with the case in order for

penalties to occur. The civil case is simply plaintiff vs. defendant, with the objective being not to remove the defendant's freedom but to provide financial "recovery" to the "victim." The burden of proof is the preponderance of evidence rather than the "beyond a reasonable doubt" required in a criminal case. Criminal cases move much faster but require a unanimous jury and the defendant is facing the state/prosecutors office rather than the "victim."

How to Deal with a Cross Examination

Roger Dodd, of Dodd Law shared his expertise on cross examination. Mr. Dodd pointed out that logic and intuitive thinking don't always work in the courtroom. He advises that defendants disassociate from what is familiar to them and to keep in mind that even lawyers are insecure in the courtroom. According to Mr. Dodd, the doctor factors into only 30 percent of the case but makes up the most important part. He noted that sixty-five percent of the case is comprised of the events occurring in the courtroom and five percent involves the defense attorney. Mr. Dodd noted that jurors tend to base their votes on moral belief, not mere facts. Facts that are bogged down with detail are not often remembered, and he noted that convincing, not facts, leads to certainty so putting testimony into the form of a story will help teach the case to reluctant listeners.

He also noted that cross examination is often one of the most stressful components of a trial. In all cases, the facts trump all so always work with just the facts (no conjecture) and assume no one understands what you are about to say and explain everything in as simple terms as possible. In addition, rely on the attorney to determine which facts are best to share, stay focused on the theory, don't volunteer information and finally, remember; the odds are most likely on the physician's side.

Ms. Stacy Ragon Delgros, from Roetzel discussed the apology statute noting that this statute protects any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that relates to the discomfort, pain, suffering, injury, or death of the alleged victim as the result

of the unanticipated outcome of medical care. She noted that under Ohio law a physician may speak with a patient and/or a patient's family members and express his/her heartfelt sympathy for their pain following a negative outcome without risk of that expression of sympathy being used against him in court, but remember that this statute does not include making a statement that something was your "fault."

The Emotional and Physiological Impact of Being Sued

Dr. Gregory Collins of the Cleveland Clinic Foundation; and Dr. Martha Hackett, participated on a panel discussion with Dr. Jason Kolb, Alliance Community Hospital; Stacy Ragon Delgros and Beverly Sanchacz, from Roetzel & Andress. The panel discussed the emotional and physiological impacts often suffered by physicians embroiled in long-term lawsuits. Dr. Collins noted that the most common emotional and physical impacts of a lawsuit on a person, include depression, anger, intense worry, and distraction. According to Dr. Collins, 16 percent of doctors experience some type of physical illness, seven percent abuse alcohol, and less than one percent abuse drugs as a result of the stress of a long-term lawsuit. In addition, fear and anxiety are frequently experienced along with longer workdays, avoidance, and an obsession over the incident, and/or the practice of defensive medicine. The panel did point out that it is unproductive to believe oneself to have failed or to accept too much blame for an unexpected outcome noting that it is advisable to manage emotions by working closely with one's defense counsel and to be actively involved in the defense process.

The AMCNO would like to thank Roetzel & Andress and the Northeast Ohio Medical University for co-sponsoring this important seminar. (Editor's Note: The session also included a presentation on "Strategies in False Claims Act (FCA) Cases and Compliance Techniques" — this topic was already covered in a previous issue of the Northern Ohio Physician in an article prepared by R. Mark Jones from Roetzel & Andress. To view the article go to our website at www.amcno.org and search on "False Claims.") ■