In this Issue:

Nevada’s Physician Shortage

CCMS President Dr. Daniel Burkhead takes a look at some of the factors affecting the shortage of physicians in the state of Nevada, and what can be done to encourage more doctors to practice in Clark County.

November is American Diabetes Month

The Southern Nevada Health District encourages residents to take proactive steps to avoid developing diabetes.

AMA announces policies adopted during Interim Meeting

Teaching hospital closures and public health surveillance data are among the topics discussed at the American Medical Association’s Interim Meeting.
I don't believe that anyone who lives in Southern Nevada will be surprised to know that there is a shortage of physicians in Las Vegas and in all of Nevada, especially some of the rural areas. However, what may be surprising is the enormous extent of the shortage. As it now stands, there are just over 180 full-time doctors in Southern Nevada per 100,000 residents, compared with 303 per 100,000 on average in the United States. Nevada is ranked 47th nationwide in this regard and in order to just meet the national average of physicians per 100,000 people, our state would need an influx of over 2,500 physicians assuming that there will be no additional population growth in the state. This is an incredible number! This physician shortage has a dramatic impact on patients’ access to care, and therefore this is one of the important issues and greatest challenges that we face at Clark County Medical Society.

While we have seen an increase in the number of physicians licensed in Nevada over the past decade, our general population has also continued to grow at a similar rate, so there has been no significant improvement in the number of physicians per 100,000. It is one of the primary goals of Clark County Medical Society to try to determine the causes of these issues so that we can work toward solutions.

I discussed this with Dr. Jerry Reeves, CCMS trustee and Medical Director of Comagine Health, a not-for-profit organization that works to improve healthcare through quality improvement, care management, and advances in health information technologies. Dr. Reeves believes that one important step towards finding a solution to the physician shortage revolves around improvement in our state Medicaid reimbursement. “It remains very difficult to recruit doctors to Nevada because the compensation rates are not competitive with other states,” Reeves said. “Las Vegas is a very attractive place to live once you’re here, but attracting someone to come here who doesn’t know that yet is tough if the pay isn’t competitive, and there are severe shortages.”

It is well known that physicians that are entering the workforce tend to remain in the areas where they complete their post-graduate medical training. State Senator and CCMS member Dr. Joe Hardy says, “The reality is, it’s not the medical schools where doctors stay, it’s where they do their residency.” This notion is supported by the Association of American Medical Colleges’ 2017 State Physician Workforce Data Book, which indicates that 54% of doctors who completed their residency in Nevada, stayed in Nevada. In addition, Nevada retained over 76% of physicians who completed both undergraduate medical education, and graduate medical education in state (ranked 9th among U.S. states) State and Federal Legislators have gained an appreciation of these facts, and Clark County Medical Society has been working alongside NSMA to promote legislation providing additional funding and allocation of more residency training programs of multiple specialties in our state.

There are many other peripheral issues involved with physician recruitment to a particular area, including cost-of-living, the public school system, housing availability and affordability, the cost of practicing medicine, and reimbursement rates, along with a general gestalt of “sense of community.” I personally believe that Las Vegas is one of the most attractive places in the country to live and practice, but as Dr. Reeves mentioned, it is difficult to convince a young physician to move here if the numbers don’t add up. CCMS and NSMA continue to work with state legislators to improve the Medicaid system and to prevent changes in legislation that would adversely affect the practice of medicine. We need to continue to expand our residency programs to assure that the physicians
that are training here in our medical schools will stay in Nevada to practice. And, if we don’t continue to aggressively recruit physicians into the state, then the patient’s access to care will be unlikely to improve. However, in order to accomplish these goals, we need the participation of all practicing physicians in Southern Nevada so that we can continue to have “clout” when discussing these issues with legislators and other stakeholders. Please consider joining CCMS if you’re not already a member, and if you are a member, consider attending some meetings so that you can join the discussion and actively help us in improving health care in Southern Nevada!

Sincerely,

Daniel Burkhead, M.D.
President 2019-20
Clark County Medical Society

UPCOMING EVENTS:

CCMS & NSMA

November 28 - 29
Thanksgiving & Family Day
CCMS Office Closed

December 4
Resident/Fellow and Medical Student Committee Meeting
5:30 p.m. | Conference Call

December 9
Membership Committee Meeting
6:00 p.m. | CCMS Office

December 11
Community Health & Public Relations Committee Meeting
6:00 p.m. | CCMS Office

December 17
CCMS Board of Trustees Meeting
6:00 p.m. | CCMS Office

December 24-25
Christmas
CCMS Office Closed

December 31
New Year’s Eve
CCMS Office Closed

January 1
Resident/Fellow and Medical Student Committee Meeting
5:30 p.m. | Conference Call

January 8
Community Health & Public Relations Committee Meeting
6:00 p.m. | CCMS Office

January 13
Membership Committee Meeting
6:00 p.m. | CCMS Office

January 21
CCMS Board of Trustees Meeting
6:00 p.m. | CCMS Office

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NOVEMBER 2019 • COUNTY LINE MAGAZINE | 1
Victory means leaving it all out there. Everything you have. Every time.
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Healers. Game Changers. Comprehensive.
Call to Order - The meeting was called to order by Dr. Burkhead at 6:04 p.m.

Guest Reports:

Clark County Medical Society Alliance: by Michele Volker (verbal report)
CCMSA's Holiday Scholarship Project 2019-2020 to raise money for Medical and Nursing School Student Scholarships Launched on the first week of Sept.

Action Items:

Minutes: by Dr. Burkhead
The minutes from the September 19, 2019 meeting were reviewed.
Motion to approve the September 19, 2019 minutes (M/S Bassewitz/Brimhall - Approved)

Financial Report: by Dr. McHale (verbal report)
- CCMS staff and Rosemary are working to finalize the 2017-18 reconciliation.
- Rosemary will be receiving an accountant's copy of the CCMS Quickbooks.
- The 2017-18 tax return will be refiled.
- Lisa will be taking on more accounting responsibility moving forward.
- FY2018-19 financials are looking good.
- Actuals for Accounts Payable and Accounts Receivable will be presenting soon.
- MedPAC funds are being transferred, as it is being dissolved and rolled into Nevada MedPAC—the joint action committee for both the north and south.
- We are coming up on the 75-day mark for our request from the IRS regarding 2017-18 payroll issues.
- Current cash assets are close to last year.
- Rising payroll expenses are being looked at.
- Salary, and health insurance costs will go up with the addition of a new Executive Director.
- Approx. $16,500 outstanding funds from the 2019 Installation Dinner have been deposited.

Motion to approve the September Financial Report (M/S Lehrner/Bassewitz - Approved)

Applicants to go before the BOT:
None this month.

Medical School Reports:

Touro University: by Dr. Gilliar (written report submitted)
- Dr. Joe Hardy, Associate Dean of Clinical Education, was recognized as one of Nevada Business Magazine's "Healthcare Heroes." Congratulations Dr. Hardy!
- The College of Osteopathic Medicine (COM) would like to congratulate Dr. Weldon Havins, Associate Dean, for being awarded with the Nevada State Medical Association's (NSMA) "Distinguished Physician" Award.
- During the NSMA Conference in Reno, 16 COM students presented research posters. Students Lauren Price and Sarah Fagan took first place for their research; and Savannah Spataro and Matt Shoemaker placed third. Congratulations to everyone on their hard work.
- Dr. Darin Thomas (DO2015) will be back in town for the 10th annual PHAST 5K race at the Henderson Aquatic Complex on Nov. 2. Dr. Thomas began the race while as a student at Touro. Between stages, participants must complete a service project which involves a core tenet of the university's mission. Dr. Thomas is offering Touro students and alumni a 20% discount using the promo code TOUROPHAST.
- Dr. Wolfgang Gilliar, Dean of the College of Osteopathic Medicine, was featured on KLAS Channel 8 as part of a story called “National OB-GYN shortage affects Nevada; Las Vegas is at highest risk” Story link: https://www.8newsnow.com/news/local-news/national-ob-gyn-shortage-affects-nevada-las-vegas-is-at-highest-risk/
- Dr. Don Havins, Associate Dean in the College of Osteopathic Medicine, was included in a Las Vegas Review Journal story called "Las Vegas tops list of cities facing worst shortage of OB-GYNs” Story link: https://www.reviewjournal.com/life/health/las-vegas-tops-list-of-cities-facing-worst-shortage-of-ob-gyns-1850778/

UNLV School of Medicine: no report submitted

Roseman University: by Dr. Morgenstern (written report submitted)
- Roseman University of Health Sciences, its College of Medicine and Tripp Umbach, the national consulting firm retained by Roseman to assist with moving the COM forward towards accreditation, are sponsoring a symposium entitled “The Future of Medicine” on October 24th, 2019 from 8:30 AM to noon, in the Roseman Summerlin campus auditorium. The symposium is hosted by Dr. Renee Coffman, president of Roseman and Paul Umbach, founder and senior principal of Tripp Umbach. Featured speakers include:
  - Dr. Roberto Vargas, Assistant Dean for Health Policy and Inter-Professional Education, Charles R. Drew University of Medicine and Science – Dr. Vargas is a leading physician champion of quality health care and reducing health disparities. He is a Principal Investigator on an NIH National Institute on Minority Health and Health Disparities-funded partnership in South Los Angeles and chairs the CDU/UCLA Cancer Center Partnership to Eliminate Cancer Health Disparities. He is a national leader in strategies for increasing access to care for minority populations.
• Dr. Doug Miller, Senior Associate Dean for Medical Education, Medical College of Georgia – Dr. Miller is a physician educator with leadership experience in the US and Canada. He was a Robert G. Petersdorf Scholar-in-Residence at the AAMC, and a member of the LCME. He also oversaw the creation and 2010 opening of the Augusta University/University of Georgia Medical Partnership, a 4-year medical school in Athens, GA. Dr. Miller is a leading authority at the intersection of medicine and technology.

• Dr. Pedro Greer (Keynote Speaker), Chair, Department of Humanities, Health and Society, Associate Dean of College of Medicine Community Engagement, and Professor University Hebert Wertheim College of Medicine, Florida International University (FIU) – “Joe” Greer Jr., MD, established the Department of Humanities, Health, and Society, at the FIU College of Medicine. He spearheaded and interprofessional medical education program, Green Family Foundation Neighborhood Health Education Learning Program (Neighborhood HELP), which prepares future physicians to assess and address the social determinants of health. He established health care centers for underserved populations in Miami, FL. He wrote “Waking Up in America,” about his experiences, from providing care to homeless persons under bridges to advising U.S. Presidents George H.W. Bush and Bill Clinton. Dr. Greer, amongst his services to many organizations, he is a Trustee at the RAND Corporation and current Chair of the Pardee RAND Graduate School Board of Governors.

Registration is online at: https://www.roseman.edu/future-medicine-registration/

SNHD: no report submitted

AMA: no report submitted

NSBME: by Dr. Nagy (verbal report)
• There are some arguments from ER docs regarding IV centers on the strip that are providing fluids to partygoers, and concerns over safe guidelines and ensuring that they do not become influenced by organized crime.
• The board discussed the creation of an investigative review board within the Clark County Medical Society.

NSBOM: no report submitted

Committee Reports:
Bylaws Committee: by Dr. McHale (verbal report)
• The Standard Operating Procedures draft has been distributed to members of the board for review.
• The committee is currently looking to revise job descriptions for CCMS staff with Jim.

CHPR & Subcommittees: by Dr. Fiore (verbal report)
• The CHPR Committee is still looking for physician volunteers for the Youth Wear the White Coat Internship October 16-23.
• The Resident Job Fair is scheduled for 11/20/19 in the Presidents Auditorium in the Optum building on Tenaya.

Resident/Fellows and Medical Student Committee: (verbal report)
• Chris Cornell of Touro has accepted the position of liaison for the RFMS committee.
• There is an AMA Med Student conference in Las Vegas January 17-18 that is looking for potential speakers on the UNLVSoM campus.

Membership Committee: no report submitted

NSMA: by Catherine O’Mara (verbal report)
• Thank you to all members who attended the NSMA House of Delegates.
• Dr. Brill is now the highest ranking CCMS member of the NSMA board.
• The next NSMA Annual Meeting will be August 28-30, 2020 in Las Vegas.
• The new meeting calendar is now available.
• NSMAs current office manager has given notice, and will be departing this week.
• Leslie Masterpool has joined the NSMA staff in the interim.
• MedPAC is dissolving, with the funds being combined with the northern action committee to form a single Nevada MedPAC.
• The Rare Disease council is looking for physician representatives.
• NSMA Government Affairs Commission will be meeting the last Monday of the month.

Building Committee: no report submitted

MedPAC/Government Affairs Committee: no report submitted

Past President’s Council: no report submitted

Delegate Committee: by Dr. Burkhead (verbal report)
Great job Dr. Lehrner for organizing the 2019 delegation, looking forward to 2020!

Scholarship Committee: by Dr. Burkhead (written report submitted)
The scholarship committee did not meet this month. They are in the process of getting PR opportunities regarding CCMS funding of $25k to scholarship fund. All IRS filings and Sec. Of State filings are current, fund investments are doing well.
The next meeting will be Tuesday, January 21 at 5PM.
Installation Planning Committee: by Dr. Burkhead (written report submitted)

- Committee met on Monday, October 7, 2019.
- Mark your calendars for MAY 16, 2020
- Members = Dr. Reeves, Dr. Kuhls, Dr. McHale, Dr. Hunt, Dr. Littman… Chair – Dr. Burkhead
- Discussion about venue… currently obtaining quotes for other options besides Bellagio (Mandalay Bay, Red Rock, Aria, Venetian/Palazzo, Cosmopolitan, Wynn), but so far, it appears that Bellagio is quite competitive and has the most support from committee members.
- Sponsorship levels were reviewed and modified.
- Next Meeting: Monday, October 28, 2019 at 6PM – (will review final quotes for venues, confirm sponsorship categories/prices, and start working on sponsorship list and outreach to sponsors)
- New members welcome!

Executive Director’s Report: by Jim Daggett (verbal report)

- Members of the CCMS Board of Trustees are encouraged to attend the Youth Wear the White Coat Internship Dinner on Wednesday, Oct 23 at Southwest Career and Technical Academy.
- Jim will be taking over planning of the 2019 Resident Job Fair on 11/20/19.
- Jim has scheduled a meeting with contacts at Optum for Thursday.
- Plans are underway for a President’s Roundtable Dinner in December.
- 40 days in!

President’s Report: by Dr. Burkhead (written report submitted)

- For those absent last month, welcome to Jim Daggett!! Our new Executive Director!
- Jim has “hit the ground running” bringing over 30 years of experience to CCMS….He has completed his first month on the job, and has been working hard to get the “lay of the land.” Jim is now taking on many tasks related to programming, including the Resident Job Fair, and he will be the lead on the Installation Gala. He presented his 100 day plan at the last BOT meeting.
- Josh and Lisa continue to perform at an amazing level on their respective positions, and they are grateful to have Jim here to help ease the workflow burden!
- On October 3rd, I appeared with Dr. Woodard from DHHS for an “Opioid Round Table” on the Addicted Nevada segment of Channel 3 News, and have forged a great relationship with News 3, so hopefully this will translate into better exposure for CCMS.
- Jim and I met with State Senator Patricia Spearman on September 25, 2019 to discuss state healthcare issues.
- We will be meeting with U.S. Representative Steven Horsford on October 16, 2019 to discuss federal healthcare issues.
- Attended my first meeting for HEALs Board of Directors on

September 25, 2019.
- I also attended HEALs Happy Hour on Sept. 25, 2019. I think these events can go far in promoting the necessity of CCMS and I encourage attendance by our members!
- Several CCMS members attended the Volunteers in Medicine Gala at the Venetian on Sept. 28. THANKS DR. JAMESON for providing a few extra tickets to the event!
- I attended the WestPac Block Party on Sept. 27, as they were the presenting sponsors for our Installation Dinner.
- Dr. Reeves and I met with 10 other physician leaders at a Round Table Discussion about improving physician engagement entitled “Caring for the Care Team: A Healthcare Imperative” on October 8th.

Old Business:

NPA Signage on CCMS Building
The board discussed whether or not the County and or neighborhood association would permit the addition of more signage on the building, Jim Daggett to look into options.

New Business
Dr. Burkhead suggested that the Board of Trustees look to reschedule meetings that take place on the same night as Golden Knights home games to increase attendance.

Future Board of Trustees Meeting – November 19, 2019 at the CCMS Office.

Adjournment: 7:45 p.m.
Henderson Hospital Nationally Recognized with an ‘A’ For the Fall 2019 Leapfrog Hospital Safety Grade

Henderson Hospital was awarded an ‘A’ in fall 2019 Leapfrog Hospital Safety Grade, a national distinction recognizing the acute care hospital’s achievements protecting patients from harm and providing safer health care.

The designation is Henderson Hospital’s third consecutive ‘A’ grade from The Leapfrog Group, an independent national watchdog organization driven by employers and other purchasers of health care committed to improving health care quality and safety for consumers and purchasers. The Safety Grade assigns an A, B, C, D or F grade to all general hospitals across the country based on their performance in preventing medical errors, injuries, accidents, infections and other harms to patients in their care.

The third ‘A’ grade follows The Leapfrog Group’s earlier recognition of Henderson Hospital as one of only 35 Top General Hospitals in the United States in December 2018. The Top Hospital award is widely acknowledged as one of the most competitive honors American hospitals can receive.

“After recently celebrating our third anniversary of providing care to our community, earning this third ‘A’ grade is a nice way to kick off a new year,” said Sam Kaufman, CEO/Managing Director of Henderson Hospital. “Every shift, every day begins with a commitment by our hospital staff and medical staff to provide safe, high-quality healthcare. Together, we’ve built this foundation of patient safety within three years of opening, and that’s a direct reflection of our team’s duty, dedication and devotion to our patients, their families and one another.”

“A hospitals show us their leadership is protecting patients from preventable medical harm and error,” said Leah Binder, president and CEO of The Leapfrog Group. “It takes genuine commitment at every level – from clinicians to administrators to the board of directors – and we congratulate the teams who have worked so hard to earn this A.”

Developed under the guidance of a national Expert Panel, the Leapfrog Hospital Safety Grade uses 28 measures of publicly available hospital safety data to assign grades to more than 2,600 U.S. acute-care hospitals twice per year. The Hospital Safety Grade’s methodology is peer-reviewed and fully transparent, and the results are free to the public.

Henderson Hospital was awarded an ‘A’ grade today, when Leapfrog announced grades for the fall 2019 update. To see Henderson Hospital’s full grade details, learn how employers can help, and access patient tips for staying safe in the hospital, visit hospitalsafetygrade.org and follow The Leapfrog Group on Twitter and Facebook.
HEALTH DISTRICT UPDATE

2019-2020 Influenza Season Update
Fermin Leguen, M.D., MPH | Acting Chief Health Officer, SNHD
Member since 2018

Each year, the Centers for Disease Control and Prevention (CDC) issues its recommendations for influenza vaccinations, and the Southern Nevada Health District encourages the community to get immunized at its clinics or at one of the many convenient locations where the vaccine is offered throughout the Las Vegas Valley.

These recommendations include vaccinating all health care workers annually against influenza, and this means physicians and their staff, including those not directly involved in patient care but who interact with patients and may come in contact with infectious agents.

Physicians play an important role in encouraging both their patients and their staff to get vaccinated. The CDC reports that the 2017-2018 flu vaccination coverage among health care personnel was 78.4 percent. However, flu vaccination coverage among physicians was highest at 96.1 percent. Pharmacists were close behind at 92.2 percent, nurses at 90.5 percent, and nurse practitioners and physician assistants at 87.8 percent. According to the CDC, coverage was lowest among other clinical health care personnel at 80.9 percent, assistants and aides at 71.1 percent, and nonclinical health care personnel at 72.8 percent.

Health care providers can also promote vaccination in their practices by asking all patients who can get vaccinated if they have had the flu shot this season. Doing so not only promotes the individual’s health but can keep practitioners and office staff protected from patients who are sick with the flu.

This season, routine annual influenza vaccination is recommended for all people aged 6 months and older who do not have contraindications. Age-appropriate vaccines are available for patients, and packaging information should be reviewed to ensure the most effective immunizations are provided based on age group as well as health status. Additionally, flu vaccine should be emphasized for high-risk groups and their contacts and caregivers.

This includes but is not limited to:
• Children aged 6 through 59 months
• Adults ≥ 50 years old
• People with chronic diseases including cardiovascular, pulmonary, renal, hepatic, or metabolic disorders
• People who are immunocompromised due to any cause
• Women who are or will be pregnant during the influenza season

Full recommendations are available on the Health District website.

The CDC recently released updated information about the importance of vaccinating pregnant women to protect both mothers and babies. According to a CDC survey of women who were pregnant between August 2018 and April 2019, only 54 percent reported getting a flu vaccine before or during pregnancy. The women whose health care providers offered or referred them for vaccination had the highest vaccination rates.

These are significant findings because pregnant women who develop influenza are more than twice as likely to be hospitalized. However, a flu shot can reduce pregnant women’s risk of hospitalization due to the flu by an average of 40 percent. When pregnant women get vaccinated, it also provides protection to infants too young to receive the flu shot, reducing the risk of hospitalization in their infants younger than 6 months by an average of 72 percent.


Ten percent of adults over the age of 20 in Clark County live with the realities of diabetes every day. For others, November is a time to bring awareness to one of the most prevalent diseases in the United States. During American Diabetes Month, the Southern Nevada Health District reminds people with diabetes, people at-risk for developing diabetes, and their families that self-management and prevention are keys to good health. The Health District’s Office of Chronic Disease Prevention and Health Promotion offers diabetes self-management classes and a variety of resources. For more information, visit the Get Healthy Clark County Diabetes webpage or call (702) 759-1270.

Diabetes’ many complications include blindness, neuropathy, kidney disease, and hearing loss, as well as increased risks for heart disease or stroke. It remains the seventh leading cause of death in the United States. Self-management helps people understand and manage their disease, learn the skills to check blood sugar, eat healthy, reduce additional health care risk factors, learn how to increase physical activity, and how to work with a health care team for additional support.

“People with diabetes can live healthy lives, but they must learn to manage their disease. Diabetes can impact so many different aspects of health and people can become overwhelmed by that,” said Rayleen Earney, a diabetes health educator in the Health District’s Office of Chronic Disease Prevention and Health Promotion. “Self-management classes are excellent tools to learn the skills it takes to live healthy with diabetes. The Health District as well as our community partners offer classes and other activities.”

In 2019, the Health District’s Diabetes Self-Management Education Program earned recognition from the American Diabetes Association as a program that meets the national standards for diabetes education. In addition to the Health District, Diabetes Self-Management Classes are offered by several community partners.

A Nevada Diabetes Resource Directory that provides information about classes, prevention, clinics, specialists, support groups, and more is available in English and Spanish on the Get Healthy Clark County Diabetes webpage.

The Health District offers education about how people can lower their risk of developing type 2 diabetes with a free, online diabetes prevention program called the Road to Diabetes Prevention. The program was developed specifically for people with prediabetes or who are at risk for diabetes. The six-session course is available in English and Spanish. It teaches participants about risk factors and how to make simple lifestyle changes. Participants can sign up for the Road to Diabetes Prevention program on the Get Healthy Clark County or the Viva Saludable’s Programa de Prevención de Diabetes en línea webpages.

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- Andrew J. Bronstein, M.D., Bronstein Hand Center, Las Vegas
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75% of adult Nevadans* don’t get a flu vaccine – you can change that.

Physician advice is the most influential factor in motivating vaccination decisions (Adult Vaccination Saves Lives, www.adultvaccination.org). So this flu season, help your patients stay healthy. Recommend the annual flu vaccine – directly and strongly. Research shows they’ll listen.

For free vaccination support resources, contact our office at 775-624-7117 or info@immunizenevada.org.

*Nevadans aged 18-64
Support for this content is through grant number 1 NH23IP922609-01-00 from the Nevada State Division of Public and Behavioral Health through the CDC, and is solely the responsibility of Immunize Nevada.

You’ve got the power. (Thanks for using it wisely.)
The American Medical Association (AMA) today adopted new policy expanding its efforts aimed at ensuring all medical students and residents receive training in health care economics. Building on the AMA’s ongoing work to transform the way future physicians are trained to deliver care within modern health systems, the new policy encourages medical schools and residency programs to include basic content related to the structure and financing of the current health care system in their curricula.

Specifically, the AMA calls on medical schools and residency programs to incorporate content on the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and quality assurance. The policy also calls on these programs to ensure that medical students and residents are presented with content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems at an educationally appropriate time during their training.

“While many medical schools and residency programs currently provide students and residents with training in health care financing, it has become clear that future physicians require further instruction to ensure they are well-prepared to deliver care to patients in modern health systems,” said AMA Immediate Past President Barbara L. McAneny, M.D. “Medical students and residents with a deeper understanding of cost, financing, and medical economics, will be better equipped to provide more cost-effective care that will have a positive impact for patients and the health care system as a whole. We will continue working to ensure future physicians are ready on day one to meet the needs of patients in the modern health care environment.”

The new policy expands on the AMA’s work over the last several years to incorporate Health Systems Science curriculum, which provides training on medical economics, throughout medical schools and residency programs. Health Systems Science emerged in 2016 as one of the major innovations developed through the AMA’s Accelerating Change in Medical Education Consortium, and is now considered the third pillar of medical education that should be integrated with the two existing pillars—basic and clinical sciences.

The AMA has developed numerous resources, including the AMA’s Health Systems Science textbook, to help ensure physicians-in-training enter practice with a better understanding of how health care is delivered, how health care professionals work together to deliver care, and how they can improve patient care and health care. To date, the textbook has sold more than 4,000 copies worldwide and is being used in more than 30 medical and health professions schools and residency programs. The second edition of the textbook is currently in development and is expected to be published in 2020.

Most recently, the AMA published its new Health Systems Science Review book—the first study tool of its kind—to help physicians-in-training and other health professionals, as well as their instructors, evaluate competencies in Health Systems Science and learners’ readiness for navigating modern health systems. This includes competencies in value-based care and health care policy and economics. Both the textbook and review book are available for purchase at the AMA Bookstore.

The AMA also recently announced a series of free, online education modules for students to help them develop competencies in Health Systems Science. The first six modules in the new Health Systems Science Learning Series are available for free through the AMA Ed HubTM. Additionally, through its Graduate Medical Education Competency Education Program (GCEP), the AMA also offers a series of online educational modules designed to complement teachings in residency and fellowship programs—including a module on how payment models affect patient care and costs.

To help ensure medical and other health professions students are proficient in Health Systems Science, the AMA is also currently working with the National Board of Medical Examiners to develop a standardized exam, which is expected to be available later this year.

The AMA will continue its efforts to drive the future of medicine by reimagining medical education, training and lifelong learning—ensuring physicians are better equipped to provide care in the rapidly-evolving health care environment.
Join a Committee
More Involvement, More Impact

The Clark County Medical Society (CCMS) invites all members in good standing to participate in one or more of the standing committees. This offers members an opportunity to work with other physicians and influence CCMS policies on issues of interest.

You may choose to participate in more than one committee. We solicit active participation from committee members to achieve the most success in shaping the CCMS. Committee assignments begin in September and end in June 30th of the following year. Please provide a first and second choice of the committee that you are most interested in and email to membership@clarkcountymedical.org.

Name: ___________________________ Phone: ___________________________

Email: ___________________________ Fax: ___________________________

CCMS Standing Committees:

☐ Board of Trustees (Elected Position Only) – CCMS at 702.739.9989
☐ Building Committee
☐ Bylaws, Policies & Procedures Committee
☐ Community Health & Public Relations Committee (CHPR)
   - Sub-Committees under CHPR:
     ☐ Mini-Internship
     ☐ Speakers Bureau
     ☐ Winged Heart Awards
     ☐ Resident/Student Outreach
     ☐ Continuing Medical Education
☐ Credentials Committee
☐ Ethics & Grievances Committee
☐ Government Affairs Committee
☐ Internal Affairs Committee
☐ Membership/Credentials Committee
☐ CCMS Delegate: Participate in the Nevada State Medical Association Annual Meeting

If you have any questions about the purpose and obligations of any committee please contact the Clark County Medical Society at 702-739-9969 | membership@clarkcountymedical.org
Universal Health Services (UHS) announced the 2018 results of its seven UHS Accountable Care Organizations (ACOs), including the Silver State ACO, showing a continued trend of increased cost savings and improved quality.

In northern and southern Nevada, the Silver State ACO represents 44 practices, and has earned Shared Savings for four consecutive years (2015 – 2018). It is ranked first in Nevada for program savings with $33.9 million, and is ranked in the top two percent nationally. Silver State ACO is partnered with Northern Nevada Health System and The Valley Health System in Southern Nevada.

What Are ACOs?
ACOs are groups of physicians who agree to reduce costs and increase quality within a value-based contract, which results in a shared savings agreement. Physicians are incentivized to bend the healthcare cost curve, manage utilization and maintain high quality care by shifting from volume-based payments to value-based payments. Within the shared savings program, providers can earn back part of the savings they generate for Medicare by hitting pre-determined spending goals.

UHS ACOs are physician-led and hospital-sponsored, centered on primary care with community partnership in post-acute and specialty care. Hospital sponsorship is a differentiator in UHS ACOs as the hospitals provide capital funding, partnership in downside risk, and integrated ACO-friendly hospital initiatives focused on avoiding unnecessary utilization and increasing communication with ACO providers. The support from UHS facilities allows for ACO leadership and governance to be driven by participating providers in the community – a vital component to success in value-based care.

“Physicians with the Silver State ACO have worked tirelessly to focus on high-value activities for our patients to better manage their health,” said Karla Perez, Vice President overseeing the Nevada market, which includes The Valley Health System and Northern Nevada Health System.

UHS also provides administrative oversight and data analytics for ACO operations in addition to ACO-friendly hospital initiatives within each UHS facility. These initiatives include PCP notification of ACO beneficiary admit/discharge, ACO patient flags within the hospital EMR, partnerships with hospitalists and ED providers to ensure appropriate utilization, and integrated case management navigating PCP communication and post-acute care.

The Center for Medicare and Medicaid Services established the ACO program to improve the quality of care for Medicare beneficiaries and lower Medicare costs. If an ACO achieves high quality and saves money for Medicare, then the ACO shares in those savings. Since the beginning of the ACO program in 2013, ACOs have saved Medicare $2.66 billion.

Silver State Accountable Care Organization Saved Medicare $33.9 Million in 2018
Nevada’s Silver State ACO, a Medicare Shared Savings program, delivers high quality and demonstrates significant savings.

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The Centers for Medicare & Medicaid Services (CMS) announced today that the Medicare Fee-For-Service (FFS) improper payment rate has fallen yet again, and is at its lowest level since FY 2010. Today’s announcement reinforces the Trump Administration and CMS’ commitment to strengthening Medicare and ensuring that tax dollars are spent appropriately. CMS’ aggressive program integrity measures lowered the estimated amount of Medicare fee-for-service (FFS) improper payments $7 billion from FY 2017-2019 to a total of $28.9 billion.

Medicare Fee-for-Service Estimated Improper Payments (in Billions) 2017-2019

In October, President Trump announced an Executive Order instructing CMS to undertake all appropriate efforts to detect and prevent fraud, waste and abuse and more aggressively ensure the integrity of the federal health care programs. Improper payments represent payments that don’t meet program requirements – intentional or otherwise – and contribute to inaccurate spending of Americans’ tax dollars.

“At a time when Medicare’s ballooning costs are threatening the long-term sustainability of the program, President Trump is taking action to protect the program,” said Administrator Seema Verma. “Every dollar spent inappropriately is one that should have been used to benefit patients. Under President Trump’s leadership CMS is pulling every lever at its disposal to safeguard precious resources and direct them to those who truly need them – both today and in the future.”

Taxpayer Savings

The reduction in improper payments represent considerable savings for the American public. The Medicare FFS estimated improper payment rate decreased to 7.25 percent in FY 2019, from 8.12 percent in FY 2018, the third consecutive year the Medicare FFS improper payment rate has been below the 10 percent threshold for compliance established in the Improper Payments Elimination and Recovery Act of 2010. This year’s decrease was driven largely by progress in a number of important areas:

- Home health claims corrective actions, including policy clarification and Targeted Probe and Educate for home health agencies, resulted in a significant $5.32 billion decrease in estimated improper payments from FY 2016 to FY 2019.
- Other Medicare Part B services (e.g., physician office visits, ambulance services, lab tests, etc.) saw a $1.82 billion reduction in estimated improper payments in the last year due to clarification and simplification of documentation requirements for billing Medicare under our Patients Over Paperwork initiative.
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies improper payments decreased an estimated $1.29 billion from FY 2016 to FY 2019 due to various corrective actions implemented over the years.

Healthcare costs are skyrocketing; by 2026, one out of every five tax dollars will be spent on healthcare. To constrain costs, we have to ensure that payments are made according to the rules. Improper payments are not necessarily a measure of fraud. The term refers to government payments that do not meet statutory, regulatory, administrative, or other legally applicable requirements. Improper payments might be overpayments or underpayments, and may or may not represent expenses that should not have occurred.

CMS has developed a five-pillar program integrity strategy to modernize the Agency’s approach to reducing the improper payment rate while protecting its programs for future generations: Stop Bad Actors. We work with law enforcement agencies to crack down on “bad actors” who have defrauded federal health programs.

- Prevent Fraud. Rather than the expensive and inefficient “pay & chase” model, we are focused on preventing and eliminating fraud, waste and abuse on the front end and proactively strengthening vulnerabilities before they are exploited.
- Mitigate Emerging Programmatic Risks. We are exploring ways to identify and reduce program integrity risks related to value-based payment programs by looking to experts in the healthcare community for lessons learned and best practices.
- Reduce Provider Burden. We want to assist rather than punish providers who make good faith claim errors. To that end, we are we are reducing burden on providers by making coverage and payment rules more easily accessible to them, educating them in our programs, and reducing documentation requirements that are duplicative or unnecessary.
- Leverage New Technology. We are working to modernize our program integrity efforts by exploring innovative technologies like artificial intelligence and machine
learning, which could allow the Medicare program to review compliance on more claims with less burden on providers and less cost to taxpayers.

“Our progress on improper payments is historic, but there’s more work to be done,” Administrator Verma said. “CMS has taken a multifaceted approach that includes provider enrollment and screening standards to keep bad actors out of the program, enforcement against bad actors, provider education on our rules and requirements, and advanced data analytics to stop improper payments before they happen. These initiatives strike an important balance between preventing improper payments and reducing the administrative burden on legitimate providers and suppliers.”

Results of First Cycle of States to Undergo New PERM Eligibility Component
As states were implementing new rules under the Affordable Care Act for determining eligibility for many beneficiaries — including using the Modified Adjusted Gross Income — the previous administration paused Payment Error Rate Measurement (PERM) eligibility reviews from FY 2014 to FY 2018. In 2017, the Trump administration took steps to restart these reviews so that beginning in FY 2019, CMS reintegrated the measurement of the eligibility component of the Medicaid and Children’s Health Insurance Program (CHIP) improper payment rates in the PERM program. Even prior to the completion of this review, CMS began conducting eligibility audits of state beneficiary eligibility determinations in states identified as high risk by previous OIG and state audit findings (beginning in California, New York, Kentucky, and Louisiana). These efforts will allow consistent insight into the accuracy of Medicaid and CHIP eligibility determinations and will shed light on vulnerabilities and the effectiveness of the agency’s work with the states on this issue.

The national improper payment estimates reported in FY 2019 are 14.9 percent, or $57.36 billion for Medicaid and 15.8 percent, or $2.74 billion for CHIP. The FY 2019 Medicaid and CHIP improper payment measurement includes the first of three cycles of 17 states (Cycle 1) reporting for the updated eligibility component. CMS expects to see a steady increase in eligibility vulnerabilities identified over the next two years once all three PERM cycles are measured under the updated eligibility component.

The increase in the PERM rates are driven by high levels of observed eligibility errors. Some of the most consistent findings included states maintaining insufficient documentation to substantiate that income and other information was appropriately verified, failures to conduct timely and appropriate annual redeterminations, and claiming beneficiaries under incorrect eligibility categories that provide a higher federal matching rate than was appropriate. Eligibility errors of this nature are particularly concerning as it can indicate that individuals are allowed to remain enrolled in the program during times in which they do not qualify, potentially diverting limited resources that could otherwise be invested in better serving vulnerable populations.

The agency is not waiting to take action. CMS is taking steps to ensure that states are working with their eligibility systems vendors to guarantee that every person on the program meets eligibility requirements and states maintain appropriate documentation of their verification process. This will continue work that began over a year ago as CMS initiated efforts to implement an aggressive Medicaid program integrity strategy designed to safeguard taxpayer dollars and ensure the sustainability of this critical program. These actions have included a recently proposed rule to enhance transparency and oversight of Medicaid spending and supplemental payments.

In addition, CMS has already released guidance on expectations for state eligibility practices, particularly for populations covered at enhanced federal match rates.

Furthermore, in remarks to the National Association of Medicaid Directors, Administrator Verma recently announced plans to overhaul eligibility rules to tighten the standards for eligibility verification and ensure that CMS and states have appropriate safeguards in place to ensure finite resources are going to those who need it most. CMS will propose new rules to tighten the standards for eligibility verification and ensure that CMS and states have appropriate safeguards in place.

For more information on the agency’s improper payments for Medicare, Medicaid and the Children’s Health Insurance Program (CHIP) can be found at https://www.cms.gov/newsroom/fact-sheets/2019-estimated-improper-payment-rates-center-medicaid-medicaid-services-cms-programs


For a copy of Administrator Verma’s recent comments on Medicaid program integrity efforts, please see https://www.cms.gov/blog/medicaid-program-integrity-shared-and-urgent-responsibility

In the wake of the recent lung illness outbreak linked to more than 2,000 illnesses and over 40 deaths across the country and a spike in youth e-cigarette use, the American Medical Association (AMA) today called for a total ban on all e-cigarette and vaping products that do not meet Food and Drug Administration (FDA) approval as cessation tools. At the Interim Meeting of the AMA House of Delegates, physicians, residents, and medical students from across the country voted to adopt policies on the AMA’s longtime efforts to prevent another generation from becoming dependent on nicotine.

The new policies include:

- Urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those approved by the FDA for tobacco cessation purposes and made available by prescription only;
- Advocate for research funding to study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes;
- Call for immediate and thorough study of the use of pharmacologic and non-pharmacologic treatment strategies for tobacco use disorder and nicotine dependence resulting from the use of non-combustible and combustible tobacco products in populations under the age of 18;
- Actively collaborate with health care professionals, particularly pharmacists and other health care team members, to persuade retail pharmacies to immediately cease sales of tobacco products;
- Advocate for diagnostic codes for e-cigarette and vaping associated illnesses, including pulmonary toxicity.

“The recent lung illness outbreak has alarmed physicians and the broader public health community and shined a light on the fact that we have very little evidence about the short- and long-term health consequences of e-cigarettes and vaping products,” said AMA President Patrice A. Harris, M.D., M.A. “It’s simple – we must keep nicotine products out of the hands of young people and that’s why we are calling for an immediate ban on all e-cigarette and vaping products from the market. With the number of young people using e-cigarettes spiking it is not only critical that there is research into nicotine addiction treatments for this population, but it is imperative that we continue efforts to prevent youth from ever using nicotine.”

For the past five decades, the AMA has championed seminal anti-tobacco efforts, including prohibiting smoking in public places and on public transportation and airplanes, and calling on tobacco companies to stop targeting children in their advertising campaigns. In addition to the new policies above, the AMA has called on media organizations to reject advertising that markets e-cigarette products to young people, supported laws setting the minimum age for purchasing tobacco products, including e-cigarettes, at 21, and urged e-commerce CEOs to vigorously enforce their existing policies to keep illicit vaping products off their platforms.

“We since declaring e-cigarette use and vaping an urgent public health epidemic in 2018, the AMA has pushed for more stringent policies to help protect our nation’s young people from the harmful effects of tobacco and nicotine use. For decades we have led the public health fight to combat the harmful effects of tobacco products, and we will continue to support policies and regulations aimed at preventing another generation from becoming dependent on nicotine,” said Dr. Harris.

We want to hear from you!
Do you have an idea for a story for the County Line Magazine, or an important update about your practice?

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Legal 2000: Civil Commitment in Nevada
Lesley Dickson, M.D.
Member since 2006

Patients arriving in hospital emergency rooms with psychiatric symptoms often are considered for a “Legal 2000” which is now the old name of the form used to initiate a civil commitment in Nevada. Civil Commitment is a legal process for admitting a mentally ill person to a psychiatric treatment program, usually involuntarily and involves a court or judicial procedure. The Nevada laws regarding civil commitment can be found in NRS 433A and from those laws the Legal 2000 form was designed. The 2019 Nevada Legislature made several changes to commitment statues via Assembly Bill 85 (AB85) and the form is now called the Mental Health Crisis Packet, available on the DPBH website.

In the first half of the 19th century patients could be committed solely on grounds of mental illness with such decisions made by physicians and families rather than the courts. After the Civil War, public protests about abuses led to procedural safeguards and jury trials. In the early 1900’s and after WWII, criminalization of the mentally ill declined and medicalization, the need for treatment, dominated such admissions. In the 1960’s and 70’s, state hospitals came under attack by civil rights actions, and the court system again dominated with dangerousness becoming the primary standard for commitment.

Case I: The following illustrates a typical case brought in on a Legal 2000, now called a Mental Health Crisis, to a hospital emergency room. Ms. A, a 74 year old African American woman, was brought to the ER by the police. She was unkempt, dirty and foul smelling. She does not look at the interviewer and is apparently confused and unresponsive to most questions. She knows her name and address but not the day or month. She is unable to describe the events that led to her coming to the ER. The police have completed the first page of the form and have written that they were called by neighbors because Ms. A was wandering around the neighborhood and not taking care of herself. The mobile crisis unit had gone twice but could not get in. Finally, the police broke in and were met by a snarling German shepherd whom they tranquilized. They found Ms. A hiding in the corner, wearing nothing but a bra. The apartment was filthy and the floor littered with dog feces. They found a gun which they confiscated and brought Ms. A in.

Medical Clearance: Medical clearance serves to establish that a patient does not have a medical problem that is causing or significantly contributing to the psychiatric symptoms. It also establishes that any other medical problem is stable enough for the patient to be admitted to a mental health facility where acute medical interventions are very limited. Legislation activated January 1, 2008 added physician assistant and advanced practice nurse to statute as able to perform a medical clearance which can be done where the examiner practices and does not always have to be done in a hospital emergency room. Medical clearance may include a pregnancy test in a female, a urine toxicology screen and blood alcohol or breathalyzer test if not done in the field. Optional testing would include a CBC and chemistry panel including blood glucose and other laboratory testing as indicated by the medical history. Once the patient stabilizes medically, they are evaluated for inpatient psychiatric treatment.
Mr. B is a middle-aged man who shuffles into the psychiatric resident's office in the ER and slumps into the chair, his deep sigh releasing a whiff of alcohol. He remarks, "Perhaps I shouldn't have come." He is graying, unshaven and his somewhat disheveled clothes fit him loosely. The police had brought him in after finding him wandering on the strip. Empathic questioning reveals that two months ago he lost his job because of alcohol related absenteeism. This proved to be the last straw for his wife who took the children and went to her parents' home. He is sleeping little and his appetite is gone. His drinking buddies say he's "no fun" and his parents do not want to hear from him. He has no friends or relatives in town. He has been thinking seriously of suicide and would use a gun.

Suicidal: Criteria 1 of the Mental Health Crisis form focuses on suicidal actions, threats or intent. High risk illnesses include schizophrenia, major depression, bipolar disorder, substance abuse/dependence and personality disorders. Static risk factors include male, single, increasing age, white and Native Americans, prior suicide attempts and family history of suicide but anyone can be at risk of attempting suicide. While males are much more likely to complete a suicide with a firearm or hanging, females are more likely to attempt a suicide, usually by poisoning. Psychosocial stresses are frequent and suicidal individuals are usually experiencing feelings of hopelessness. The younger patients are more likely having relationship or legal problems while older individuals frequently are coping with declining health, physical illness and loss of important relationships. Other issues relate to financial ruin or shame and failure and recent substance abuse is extremely common.

Case II: Since Mr. B meets Criteria 1 for commitment the doctor on call recommends hospitalization. Mr. B demurs at first, then argues, then threatens. The doctor is firm and the patient looks at the doctor for a long moment, then sighs quietly and says, "OK, Doc, you've convinced me. I'll go pack some things and meet you here in an hour." Rising, he turns toward the door. The resident manages to get Mr. B to wait and summons additional personnel. He explains to Mr. B he is taking over responsibility for now since his depression is clearly impairing his judgment. The patient threatens a lawsuit but grudgingly complies and sits down. To be safe, the doctor fills out the MH Crisis Form after checking with the ER doctor to be sure he had been medically cleared. When filling out the form, it is important to describe clearly the symptoms the patient is exhibiting so that the treatment team and others appreciate the necessity of the commitment and have something to compare to as the patient progresses through his treatment. Following changes in NRS in 2015, in addition to a psychiatrist, psychologist or other physician, APRN's, PAs and licensed social workers with special training can complete the Legal 2000 form to certify a patient or decertify a patient.

Case II: Mr. B sobers up and improves rapidly with the addition of an antidepressant and the psychiatry ward behavioral treatments. He begins to deny any further suicidal ideation and the psychiatrist discontinues the Legal 2000 before 72 hours have expired so the form is not filed with the commitment court. Three days after admission, Mr. B confesses he had bought a gun on the day he presented to the ER and if he had been allowed to go home to pack, he would have used it on his wife and then himself. Later, after he was doing much better, he expressed gratitude for having his momentary wish overridden. His wife agrees to come in for a couples session and she is advised to take the gun out of the house and Mr. B agrees.

Criteria 2 and 3: Patients who meet Criteria 2 or 3 are seen less often in the emergency room while at the same time may be more difficult to evaluate and treat. Criteria 3 refers to individuals who self-mutilate such as cutting and often will report the action converts psychic pain into physical pain which affords some relief and gives them a sense of control. It is most common in those with a borderline personality and frequently has a manipulative aspect. However they can miscalculate and do real damage, including killing themselves accidentally so a good mental status evaluation is important. Although often an admission may be necessary to help the patient calm down, sometimes a counseling session with a trained professional such as the ER social worker can lead to a safe discharge with an outpatient referral.

Criteria 2 describes individuals who are a danger to others and have made threats to harm someone or have done violence in the recent past and a mental illness is believed to be responsible for such actions. Since past history of violence is the best predictor of future violence it is important to obtain as much history as possible from multiple sources. The mentally ill have only a slightly higher risk of violence than the general population but psychotic states associated with arousal or agitation predispose to violence, particularly if they involve paranoid delusions or hallucinations. Mental illnesses most associated with violence are schizophrenia, bipolar mania, alcohol and other substance abuse and some personality disorders. Demented and delirious patients can behave unpredictably and strike out, thus the Nursing Home transfer to the ER, but those diagnoses are generally excluded from commitment to a psychiatric facility. Recent stressors which may precipitate violence are relationship issues such as divorce and economic problems such as job loss. History of abuse, victimization and family violence predispose to violence and affect states are most important to assess such as fear, anger, confusion and humiliation. Recent legislation (AB85) no longer requires this danger to be imminent and now in Nevada, the threats or previous actions no longer must be within the previous 30 days. Clinicians must judge the dangerousness of the threats or acts and whether the individual has the means to carry them out. Since the police are unlikely to arrest someone for verbal threats only, the mental health system is often left to attempt treatment of antisocial personalities. As substance use is often present, time to sober up and calm down may be accomplished in a quiet area in the ER and the violent thoughts and threats may dissipate.
The ER Problem: It is estimated that of the 20,000 or more patients presenting yearly to local (Clark County) ERs with the initial part of a Legal 2000 (now Mental Health Crisis Form) completed, only 4000 or fewer will ultimately receive inpatient care at a psychiatric hospital. The remainder will be found to have medical problems or dementia, need detoxification from alcohol or other substances, need rapid stabilization of an acute exacerbation of a chronic mental illness, i.e. get back on meds, or need help with an acute crisis situation such as homelessness, job loss or relationship problems. Of 23,000 petitions filed in 2017, only 212 required a civil commitment. Patients who are intoxicated will resolve much of their suicidal and homicidal ideation once they sober up or detoxify while many other patients who are experiencing acute crises due to environmental stressors and will calm down with time and some empathic listening and/or problem solving. Some patients with mental illnesses are off their medications and will benefit from a prescription and/or dose in the ER while others should be referred for detox or substance abuse treatment if they will go voluntarily. It is important to keep a list of resources to give to patients and families. If a patient has improved while in the ER and does not meet commitment criteria, the last page of the form is completed (decertification) and the patient can be discharged by the ER staff.

The Court Process: Once it is decided the patient must be admitted to a psychiatric facility and the MH Crisis form is completed, the patient is transferred to the facility and the paperwork is sent to Commitment Court within 72 hours. It is important to note that the new legislation (AB85) starts the 72 hours when the first page is signed, usually by a police officer, rather than when the second page (certification) is signed. The case is put on the calendar and scheduled to be heard within 6 days. Court appointed psychiatrists and psychologists evaluate the patient for the court and write a report. The patient is appointed a lawyer and the case is heard by the appointed court justice or hearing master. In the days leading up to the court date the patient may respond to treatment and no longer meet commitment criteria so the MH Crisis Form is discontinued by signing page 3 (decertification) with the patient either being discharged or signed in voluntarily. But if the court finds the patient meets commitment criteria, the patient will be held for treatment for up to six months which can be extended if necessary. If the patient is not committed, they can sign in voluntarily or must be discharged within 24 hours.

Mental Health Petition: Family members may petition the court for a mental health evaluation of a person who is in the community but has not been picked up by police. They must be related by marriage or blood and if imminently dangerous, should be advised to call 911 instead and let police know it is a mental health crisis to get a CIT team. To petition, family members go to Clark County Family Court at 601 N Pecos Rd and request a civil commitment packet. The judge reviews it and if approved, police are sent to pick-up the individual who is taken to UMC for medical clearance and psychiatric evaluation. Similar arrangements can be made in Washoe County, but in rural areas, local law enforcement will have to arrange for an evaluation which may involve some time in jail and/or transport to Las Vegas or Reno.

Summary: Civil Commitment is a process to get a person in a Mental Health Crisis into a safe environment and treatment. The process has recently undergone some minor changes to simplify the process and several are identified in this article. Members of the Nevada Psychiatric Association are very familiar with this process and are willing to meet with our medical colleagues for more extensive training if desired. Please call 702-623-4319 or email executivedirector@nvpsychiatry.org. The new adult form can be found at: http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Resources/Nevada-L2K-07-29-19.pdf.
CMS Issues First Annual Update to the Medicaid and CHIP Program Scorecard

The Trump Administration and the Centers for Medicare & Medicaid Services (CMS) are continuing to transform Medicaid with the publication of the first annual update to the Medicaid and Children’s Health Insurance Program (CHIP) Scorecard. The update promotes greater transparency and accountability by including additional data points, measures and enhanced functionality, and ensuring taxpayers’ dollars are being used efficiently on the $600 billion programs which serve nearly 73 million children and adults.

“Taxpayers have a vested interest in assuring we maintain a strong safety net in our nation’s commitment to care for our most vulnerable citizens,” said CMS Administrator Seema Verma. “Under the leadership of President Trump, CMS is taking the steps necessary to hold states accountable, in part, by giving the public access to more information on these programs that pushes us all to move toward better accountability for results – a necessary step for the largest coverage program in the nation.”

CMS released its first-ever Medicaid and CHIP Scorecard in June 2018. The fall 2019 Scorecard updates are part of a broader three-pillared Medicaid strategy to achieve a better balance between appropriate federal oversight and state flexibility, ensuring fiscal integrity and promoting accountability for the quality of care provided to Medicaid beneficiaries. The Scorecard includes measures in three areas: State Health System Performance; State Administrative Accountability; and Federal Administrative Accountability.

The Scorecard is the public-facing federal dashboard of state health and administrative performance in the Medicaid and CHIP programs. The first Scorecard promoted significant steps to improve transparency and accountability for program outcomes giving insight into states’ Medicaid and CHIP program through public reporting. In July 2019, sections of the Medicaid and CHIP Scorecard were refreshed with updated data. The fall 2019 Medicaid and CHIP Scorecard update reflects an expanded set of measures and enhanced functionality.

CMS is responding to stakeholder feedback and continuing to enhance transparency and accountability in Medicaid and CHIP by strengthening the Scorecard with better usability and more information in the national context. New measures include breast cancer screening, diabetes care poor control, follow-up after hospitalization for mental illness (children), nursing facility long-stay hospitalization rate, and healthcare fraud prevention partnership participation. New national context data points include annual enrollment by payer, enrollment in any type of managed care plan by state, waivers for Home & Community Based Services by state, and substance use disorders Section 1115 Demonstrations by state. In addition, the Scorecard includes the first set of T-MSIS based per capita Medicaid expenditures across a subset of states.

The site will provide more functionality by allowing users to sort measures by performance rate or alphabetical order and toggle between screens to view measures that have multi-component rates.

CMS continues to engage internal and external stakeholders in identifying enhancements to the Scorecard, including receiving input from variety of Medicaid agencies through a collaboration with the National Association of Medicaid Directors.

For more information pertaining to the Scorecard please visit: https://www.cms.gov/newsroom/fact-sheets/2019-medicaid-and-chip-mac-scorecard
The American Medical Association (AMA) announced new policies adopted by physician and medical student leaders from all corners of medicine at its Interim Meeting held this week to shape guiding policies on emerging health care topics.

The AMA’s House of Delegates is the policy-making body at the center of American medicine, bringing together an inclusive group of physicians, medical students and residents representing every state and medical field. Delegates work in a democratic process to create a national physician consensus on emerging issues in public health, science, ethics, business and government to continually provide safer, higher quality and more efficient care for patients and communities.

The policies adopted by the House of Delegates this week include:

**Protecting residents and fellows displaced by unexpected teaching hospital closures**

In light of the recent closure of Hahnemann University Hospital, which displaced more than 570 residents and fellows, the AMA adopted policy aimed at ensuring residents and fellows impacted by unexpected teaching hospital closures are financially and professionally protected. Specifically, the new policy calls for the AMA to urgently partner with interested parties to identify viable options to secure malpractice insurance “tail coverage” for residents and fellows impacted by the Hahnemann closure, covering their time at Hahnemann, and also for residents and fellows impacted by any future teaching hospital closures, at no cost to those who are displaced. Under the new policy, the AMA will also work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that will help protect residents and fellows affected by training program closures.

Pennsylvania law requires that physicians, residents and fellows have malpractice tail coverage from their previous employers.

“We have an ethical obligation to do everything we can to provide assistance to physicians-in-training who are left in professional and financial limbo after their teaching institution closes unexpectedly. By no fault of their own, these residents and fellows are forced to find new training programs and many face deep financial hardships as a result,” said AMA Board Chair Jesse M. Ehrenfeld, M.D. “We are committed to working together with other organizations to help protect these students and help eliminate financial and regulatory barriers as they seek new residencies, relocate and transition to their new training programs.”

In July, after Hahnemann University Hospital closed its doors, the AMA issued a letter to CMS urging it to offer an increased level of support, technical guidance, and applicable waivers for any rules or regulations creating barriers for displaced residents and fellows. The AMA also simultaneously sent a letter to the U.S. Department of State, U.S. Citizenship and Immigration Services, calling on them to waive the grace-period requirement under the J-1 physician visa program for the impacted physicians-in-training.

Additionally, the AMA, in partnership with the Philadelphia County Medical Society and the Pennsylvania Medical Society, led an effort to support the moving expenses for the displaced Hahnemann residents and fellows—raising a total of $125,000 in contributions from the AMA, AMA Foundation, American Osteopathic Association, American Board of Medical Specialties, and Association of American Medical Colleges. The Education Commission for Foreign Medical Graduates also provided substantial administrative and financial assistance to International Medical Graduate residents and fellows who were affected by the closing.

**Modernizing public health surveillance to alleviate the burden on physicians and improve data**

The AMA adopted policy recognizing public health surveillance as a core public health function essential to informing decision making, identifying underlying causes, and responding to acute, chronic and emerging health threats. The AMA’s new policy calls for increased state and local funding to modernize the country’s public health data systems to improve the quality and timeliness of the data. To help alleviate the burden of reporting on physicians, the policy also supports efforts underway to implement electronic case reporting—a process by which reportable conditions are automatically generated from EHR systems directly to public health agencies for review and action.

Additionally, to ensure reporting requirements for new diseases are based on scientific evidence and will meet the needs of population health, the AMA encourages state legislatures to engage state and national medical specialty societies and public health agencies when proposing new mandatory disease reporting requirements.

“We know that disease surveillance is essential to monitoring, controlling, and preventing disease and clinicians play an important role in this process. However, submitting data to public health agencies can be burdensome and disruptive to workflows for physicians and other mandatory reporters. By modernizing the nation’s public health surveillance systems and implementing electronic case reporting, data will automatically be reported directly through EHR systems in accordance with applicable health care privacy and reporting laws—improving the quality and timeliness of the data while also removing the burden on physicians,” said AMA Board Member Willie Underwood III, M.D., MSc, MPH.
Why should I join the Clark County Medical Society?

our MISSION

The Clark County Medical Society (CCMS) is ultimately striving:

To serve the needs of physicians and their patients with responsibility and integrity.

But what is the Clark County Medical Society? How does it work with the Nevada State Medical Association, and why should you become a member?

what does CCMS/NSMA do?

Through joint membership and partnership with the Nevada State Medical Association (NSMA) we work to advocate on the behalf of physicians, engage them with their community, and work with medical schools to help develop the next generation of physicians right here in Nevada.

Other member benefits include:

• Your voice represented and amplified to lawmakers
• Discounts on CCMS and NSMA events
• Discounts on services from our corporate partners ranging from malpractice insurance to show tickets
• Public & Professional Referrals
• Free relevant CME courses
• Opportunities to become a leader in the local medical community
• Shape the future of medicine by mentoring medical students & residents
• Networking opportunities with fellow medical professionals
Section I: Personal Information

Last Name __________________________ First Name ______________________________ M.I. _________ Title ______

Birth Date __________________________ Gender ______________ NV Medical License #: _______________________

Cell Phone ________________________________ E-mail Address ___________________________________________

Home Address ____________________________________________ City _________________ State _______ Zip______

Spouse’s Full Name ______________________________ How Did you Hear About Us? ___________________________

Primary Specialty ___________________________________________________________________________________

Section II: Mailing Information

Office Address ____________________________________________ City __________ State _______ Zip ______

Please Designate Your Preferred Mailing Address: Office _____ Home _____

Office Phone _________________________________ Office Fax _____________________________

Section III: Education

Medical Education ____________________________ Date of Graduation ______________

Internship ____________________________ Date Started _________ Date Completed __________________

Residency ____________________________ Date Started _________ Date Completed___________________

Fellowship ___________________________ Date Started __________ Date Completed __________________

Please share any board certifications_____________________________________________________________
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