

## AMCNO and AMEF Co-Sponsor 2016 Medical/Legal Summit

At the 2016 Medical/Legal Summit—co-sponsored by the Cleveland Metropolitan Bar Association (CMBA), Academy of Medicine of Cleveland & Northern Ohio (AMCNO), and the Academy of Medicine Education Foundation—**Margaret E. O’Kane** delivered the keynote address. Her presentation followed opening remarks from **CMBA President Ann Owings Ford** and **AMCNO President Matthew E. Levy, MD**.

Ms. O’Kane has served as President of the National Committee on Quality Assurance (NCQA) since 1990. In 2011, she was named one of the Top 25 Women in Healthcare by *Modern Healthcare* for her contribution to improving quality. She was also awarded the 2009 Picker Institute Individual Award for Excellence in the Advancement of Patient-Centered Care. In 1999, Ms. O’Kane was elected as a member of the Institute of Medicine.

In her address, Ms. O’Kane spoke about “Healthcare in 21st Century America.”

During her speech, she provided background information on the NCQA, which she said focuses on working toward high-value healthcare. This is done by measuring quality and improving healthcare through the use of clinical quality measurement, patient experience measurement and resource use. NCQA also

*(Continued on page 2)*



*Ms. Margaret O’Kane discusses how the NCQA is working toward high-value healthcare.*

## AMCNO Participates in Advocacy Day to Support CPR in Schools

AMCNO representatives Dr. Robert Hobbs and Ms. Elayne Biddlestone were pleased to participate in an Advocacy Day to support HB 113 – CPR in Schools. The AMCNO supports this legislation which recommends all high school students in Ohio receive training in hands-only cardiopulmonary resuscitation (CPR), to include skills practice, as part of the school curriculum. During a “You’re the Cure” Advocacy Day sponsored by the Ohio Chapter of the American Heart Association, the AMCNO joined many other groups and associations in asking Ohio legislators to consider the number of lives that can be saved by passing HB 113.

The bill would:

- Put CPR training into school curriculum,

teaching Ohio’s students hands-only CPR, which will prepare more than 120,000 lifesavers each year.

- Allow for school districts to offer the training any time between grades 9-12 in the health curriculum.
- Ensure students practice “hands-on training” with a mannequin to learn the psycho-motor skills necessary to perform CPR.
- Allow Ohio to join at least 27 other states with similar laws.

At press time HB 113 had passed in the House and moves onto the Senate for more debate. The AMCNO will continue to work on this bill and advocate for its passage.



*Dr. Robert Hobbs (far left) spends a moment with Sen. John Eklund following a meeting with him to discuss HB 113. (also pictured, Trish Horvath from Healthspan and Laura Hoffman from the Heart Association.)*

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## AMCNO and AMEF Co-Sponsor 2016 Medical/Legal Summit *(Continued from page 1)*

accredits health plans, accountable care organizations, and patient-centered medical homes, along with recognition of physician practices. She noted that we are rapidly moving away from fee-for-service payments and moving toward assigning responsibility, and ensuring that patients receive high-quality care without fail. She outlined how population health has become a driver, with the intent to get and keep people healthy while working to identify at-risk people and doing something to minimize their risks.

Healthcare should be practiced according to professional standards in an effort to maintain healthy behaviors—but it should cost less and provide for a good patient experience. Ms. O’Kane addressed the ways hospital-patient experience surveys are utilized to measure quality. She also outlined how the quality ratings system (QRS), which will roll out this fall, will provide quality result displays and enable comparisons to create oversight and deliver actionable information to improve performance.

She provided an overview of the fastest-growing delivery system—the patient-centered medical home—which is organized to address population health and coordinated care. She touched on the widespread use of HEDIS data—the measurement system that encompasses 172 million people—and how gratifying it can be to see improvements in quality measurement.

She outlined how the Affordable Care Act (ACA) has resulted in providers having to change their model and the need for an insurance design to support reform, but even supporters believe that some portions of the ACA need to be fixed. Ms. O’Kane stated that the quality measures implemented through the ACA have a broad emphasis and resulted in the need for more accountability. A hospital star-rating system is coming in the near future, and this could also change the conversation. Medicare star ratings for healthcare plans have driven the market, and exchange plans will also have a star rating at some point, she said.

She touched on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), noting that this law will result in the Centers for Medicare & Medicare Services (CMS) rolling out a number of payment changes in the coming years. Payments will be pushed into some type of bundled payment model to help physicians practice medicine more efficiently—and there will be payment rewards for doing so.

Ms. O’Kane stated that we need to build organized systems with team-based care—and we need real-time data and care coordination.

She realizes, though, it takes time to redesign work flow. Providers will have to change their model, however, and outcomes need to be the true north in medical practice.

On Saturday, following a welcome and introductions, the first plenary session on Telemedicine began. The topic of the session was “Telemedicine: Achieving High-Quality Innovative Healthcare Delivery” and the panel members were **Natasa Sokolovich, JD**, Executive Director of Telehealth at the University of Pittsburgh Medical Center (UPMC); **John Jesser**, Anthem Insurance—President of LiveHealth Online, and VP of Provider Engagement Strategy; and **Kimberly Anderson, Esq.**, Chief Legal Counsel, State Medical Board of Ohio. The panelists were introduced by **Dr. James Coviello**, AMCNO Immediate Past President.

Ms. Sokolovich stated that the UPMC is the largest non-governmental employer in Pennsylvania, with 60,000 employees (3,600 are physicians), and it is comprised of 20-plus academic, community and specialty hospitals. Their telehealth program began in 2006-2007 with neurology services. Utilization has led to increased services.

Ms. Sokolovich defined telehealth/telemedicine as “the use of telecommunication and information technologies in order to provide clinical healthcare at a distance,” using internet, wireless, satellite and telephone media. UPMC leverages numerous devices to deliver patient care.

She discussed the current state of telemedicine law and legal/regulatory issues of telemedicine, specifically covering physician licensure and credentialing, standard of care, corporate practice of medicine, fraud and abuse, and reimbursement.

Mr. Jesser presented on Anthem’s LiveHealth Online program, which was designed to make healthcare safer and more affordable. It offers two private and secure telehealth solutions: LiveHealth Online for consumers, and a Practice Edition for physicians.

The program is available in almost all 50 states, on any device with an internet connection, providing access to in-network, board-certified doctors and licensed behavioral health professionals. As of January, almost 16 million plan members had access to it.

Ms. Anderson gave the final presentation on the practice of telemedicine in Ohio, as defined by the State Medical Board. She also discussed the timeline for telemedicine in the

state. It began in 1999, with Rule 4731-11-09 “Prescribing to Persons Not Seen by Physician,” and it has changed gradually over time. On December 15, 2015, House Bill 188 passed, addressing initial visits online—that they must meet the same standards as initial in-office visits. An updated telemedicine Rule will likely be reviewed in the legislature in September.



*Dr. James Coviello introduces the Telemedicine panel at the Medical/Legal Summit.*

The second plenary session covered End-of-Life Issues. **Dr. Robert Hobbs**, AMCNO President-Elect, introduced the panel, which consisted of **Lance Tibbles, JD**, Professor of Law, Director, Ethics Institute, Capital University Law School; **Elizabeth Malloy, JD**, The Andrew Katsanis Professor of Law, University of Cincinnati College of Law; and **Kristin Englund, MD**, staff physician at the Cleveland Clinic.

Mr. Tibbles began the discussion with “Medical Orders for Life-Sustaining Therapy” (MOLST). There is a clinical process behind these forms, requiring a conversation between a patient and his or her healthcare profession; it’s a shared decision-making situation, he said.

The MOLST form is neutral, covering treatment measures or comfort care. Senate Bill 165, before committee now, requires a MOLST form to be reviewed at least once a year so that it is current. These forms are not advanced directives—they are intended to be complementary, and they are voluntary. He noted several advantages to completing this type of form: it is signed by a healthcare provider, it is a single page, it addresses CPR and other life-sustaining treatment, and it protects autonomy.

The objectives of Ms. Malloy’s presentation on “Right-to-Die Legislation” were: correct terminology (e.g., death with dignity [DWD], not euthanasia), the legal definition, the states that allow DWD, DWD statutes, physician roles, the prescription process, and drug administration.

# AMCNO MEDICAL LEGAL ACTIVITIES

Ms. Malloy cited an interesting statistic from 2014: In Oregon, one of the few states that allows DWD, only 0.3% of deaths were attributable to it. Support for DWD is growing, she said. Fifteen states currently have pending legislation.

During Dr. Englund's presentation on "Futile Medical Therapy," she discussed the Hippocratic Oath and how taking care of patients has changed throughout history. She defined medical futility, emphasizing that "futility" applies to intervention, not the patient, and suggesting that the term should be changed to "medically inappropriate." Long before a crisis occurs, she said a patient, his or her family, and the patient's physician should discuss compassionate care.

Dr. Englund referenced an American Medical Association (AMA) report on medical futility in end-of-life care from the AMA's Council on Ethical and Judicial Affairs that cites a 7-step due process approach.

In January, a *JAMA* article discussed a movement toward better ICU use at the end of life. Researchers found that 1 in 5 U.S. residents receive this type of care, and more than 25% of Medicare dollars is spent on it. Dr. Englund then discussed ways to improve this statistic, such as increased access to and utilization of hospice care.



Dr. Robert Hobbs introduces the panelists for the second plenary session on End-of-Life Issues.

Following the plenary sessions, attendees were given the choice of four breakout sessions:

- HIPAA Update and Implications of the Use of Electronic Medical Records
- Medical Malpractice: The Effects of Tort Reform, Damage Caps and the Affordable Care Act
- Practicing in an "Opioid Epidemic" – Best Practices, New Regulations, and Other Developments
- Ohio State Medical Board Round Up: One-Bite, Mandatory Reporting and Other Issues

**Bill Berglund, Esq.**, from Tucker Ellis LLP, moderated the "HIPAA Update and the

Implications of the Use of Electronic Health Records" session. The panel consisted of **Joseph Dickinson, Esq.**, CHPC, Privacy & Information Security Officer, Office of General Counsel, from the MetroHealth System; and **Tejal Vakharia, Esq.**, Senior Vice President & Chief Compliance Counsel, Allscripts.

This session was held in a question-and-answer format—the presenters provided slides containing questions and asked for additional audience participation. An important issue deals with electronic medical record liability—namely, since physicians now have access to a lot of information in the EHR, are they liable if they do not check a specific item? In response, Ms. Vakharia stated that there is an overabundance of information today—it's questionable whether physicians need to look at all of it. She noted that this issue is still under review and undecided yet in the law. Regardless, from a practical standpoint, it's important for physicians to work with their EHR vendor on the usability piece to ensure the data they are receiving is more digestible so they can do their job more efficiently, she said.

It's vital that a patient receives a continuum of care, where alerts are showing up at the right time. One of the biggest problems is that these programs were built for one client—there was no crossover of information. Now there are these great analytic platforms that allow physicians to collaborate on a patient. Analytics are important and they have the power to assist with care. A physician can be proactively engaging with a patient if there is a change in his or her history and track information through a care coordinator. If a physician can get patients to a good outcome it will matter less if the physician looked at all the pages of the record.

Originally EHRs were started to get records off of paper—and these records were transferred into an electronic system, but it was not for interchange between systems. Now we are at the point of building a platform to change that—the health information exchange. It needs to be structured in a way that physicians can get the records they want when they need them and build a community to make that happen seamlessly. Although it is expensive to create this data exchange, it has a lot of potential and will benefit patients and physicians.

The "Medical Malpractice: Effects of Tort Reform, Damage Caps and the Affordable Care Act (ACA)" breakout session was moderated by **Dr. Matthew Levy**, AMCNO President, and featured several presenters: **Devin O'Brien** from The Doctors Company; **Paul Grieco, Esq.**, from Landskroner, Grieco and Merriman, LLC; and **Leslie Jenny, Esq.**, Marshall Dennehy, Warner, Coleman & Goggin, PC.



Dr. Matthew Levy moderates a breakout session on Medical Malpractice after introducing the panel.

Dr. Levy led the group through several questions, asking the audience to text their responses. The audience agreed that the greatest effect of tort reform in Ohio was that it has discouraged the filing of non-meritorious claims. However, the audience also responded that tort reform in Ohio does not go far enough and they would like to see additional measures adopted in the state.

This led into the presentation by Mr. O'Brien outlining the impact the Medical Injury Compensation Reform Act (MICRA)—the tort reform law in California implemented in 1975—has had on medical malpractice cases in that state. MICRA has a \$250,000 cap on non-economic, pain and suffering, and recoveries, and no cap on special damages. There is a slide-scale limit on attorney fees, collateral source evidence is admissible, and arbitration can occur. Cases are resolved faster there because the jury verdict lottery potential is diminished, but cases still get filed at a high frequency rate. The insurance market is stable in California at this time. This differs from Ohio, which has a \$350,000 cap on pain and suffering, affidavit of merit, and a host of other changes—but not the same as MICRA. In Ohio, claims costs are still climbing. And, Mr. O'Brien noted that future medical costs may be impacted by the ACA.

Mr. Greico commented that there has been a decline in the medical negligence claims filed in Ohio, but from the plaintiff perspective that does not mean that negligence is not occurring. He said that he has a conversation with each plaintiff that presents in his office to determine whether it would be economical to pursue the case, which has led to a diminished number of cases. He did note, too, that since tort reform has been passed, there has been a better working relationship with the defense bar when dealing with some cases, and that can result in an early resolution.

Ms. Jenny wrapped up the panel discussion by providing insight into the ACA's potential impact on future damages. She noted how the

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collateral source rule that prevents the defense bar from introducing evidence of payment of medical expenses or write-offs has impacted tort reform cases and the status of how this rule is applied in the various states.

She noted that we are beginning to see some positive ACA rulings in various states, with the courts considering a series of cases relating to arguments that the ACA could limit recovery on future damages. Basically, this could mean that now healthcare is officially not a collateral source, we should be able to give evidence to support this because all Americans are required to have it—it is not a benefit. Attorneys and physicians should continue to keep a close eye on how this could impact future cases.



*Ms. Kelley Long and Ms. Elizabeth Collis, Esq. discuss issues related to the State Medical Board of Ohio during a breakout session.*

In the “Practicing in an ‘Opioid Epidemic’” session, **Ryan Williams, Esq.**, from Brouse McDowell, introduced panelists **Steven Schierholt, Esq.**, Executive Director of the State Board of Pharmacy (BOP); **Cameron McNamee**, Director of Policy and Communications, BOP; and **Kimberly Anderson, Esq.**, Chief Legal Counsel, State Medical Board of Ohio.

Mr. Schierholt gave an overview of the Ohio Automated Rx Reporting System (OARRS), reviewed trends in opioid and other controlled substances prescribing, cited Ohio’s efforts to integrate OARRS into electronic medical records, reviewed new laws and regulations for the use of OARRS and recent enhancements, and provided information about naloxone distribution.

In October, Governor John Kasich announced an investment of up to \$1.5 million a year to integrate OARRS directly into electronic medical records and pharmacy dispensing systems across the state, allowing instant access for prescribers and pharmacists, he said. The BOP is currently processing integration requests from hospitals, physician offices, pharmacies and health systems.

Mr. McNamee talked about the required use of OARRS. House Bill 341, which took effect April 1, 2015, requires a medical professional to review OARRS data when initially prescribing or personally furnishing an opioid or benzodiazepine to an Ohio patient, except in certain care situations. Pharmacists are also required to check OARRS prior to dispensing; new regulations for these providers went into effect on Feb. 1, 2016.

As the final topic of discussion, Ms. Anderson talked about the “Guidelines for the Management of Acute Pain Outside of Emergency Departments.” The guidelines, developed by the Governor’s Cabinet Opiate Action Team (GCOAT), were released January 19. She stressed that these guidelines are a supplement—not a replacement of—clinical judgment.

Ms. Anderson defined “acute pain” as pain that is expected to resolve in days or weeks. The detailed guidelines stress trying non-opioid options as the first line of defense in pain treatment, such as physical therapy or over-the-counter products. If opioids need to be prescribed, the smallest dose possible is recommended. A link to the new guidelines can be found on the AMCNO website: [www.amcno.org](http://www.amcno.org).

In the “Ohio Medical Board Round Up” session, **Adam Davis, Esq.**, from Reminger, introduced the panel comprised of **Elizabeth Collis, Esq.**, Collis Law Group in Columbus; and **Kelley Long**, Executive Director, Ohio Physicians Health Program.

Ms. Long said that the Ohio Physicians Health Program is a non-profit organization focused on motivating physicians to look for mental health treatment.

Ms. Collis explained that the One-Bite Rule “allows impaired physicians and medical professionals who suffer from addiction or similar impairments, who seek treatment and complete a care program at a State Medical Board-approved treatment provider to remain in the private sector for care and monitoring without having to report it to the State Medical Board.” It is a one-time instance and covers fully licensed physicians and resident physicians who are Ohio residents, as long as their actions are not criminal and are not putting patients or others at risk. The rule was formally adopted in 1987 by the Ohio General Assembly.

In 2015, the State Medical Board of Ohio began working on drafting changes that would eliminate One-Bite and replace it with

the “First Occurrence Recovery Program.” The difference between the two is that the current One-Bite Rule allows a physician to voluntarily enter confidential treatment, and the new rule would require reporting through the Medical Board.

The change has received some backlash from physicians, who believe there will be a “chilling effect” on those who seek treatment. Ms. Collis stated that Kentucky and Missouri have imposed reporting requirements for license renewal, and both states have seen a significant to near total decrease in voluntary reporting of addictions and mental health issues. Another concern is that the new program creates unnecessary bureaucratic barriers for physicians seeking treatment. The panelists said that the success rate for physician’s completing this program and maintaining sobriety is very high.

Ms. Collis also discussed frequently-asked-questions from physicians, such as: “Am I allowed to prescribe medication to myself and/or my family members?” She said she advises against it, but if physicians choose to do this, she asks them to treat their family as they would any other patient—establishing a medical record for each family member and keeping it current. Another question is: “If the Board is investigating me, what parts of the investigation are confidential?” She said the Board is there to protect the public, not represent the physician. If the State Medical Board shows up at a physician’s door, the physician should be polite and courteous, but she discouraged physicians from inviting the representatives in to look around. Physicians have 20-30 days to provide information to the Board, so they do not need to meet with the representatives at that moment, and they do not need to sign anything. In the meantime, she highly encourages physicians to hire counsel to help them through the process.

The AMCNO and CMBA would like to thank the Northern Ohio physicians and attorneys who signed up to attend this informative event—we thank them for their attendance and for supporting our organizations. We would especially like to extend our sincere thanks to the planning committee, presenters and all of the event sponsors. The AMCNO and CMBA are already starting to plan for the 2017 Medical/Legal Summit. The planning committee will be meeting in the near future, and AMCNO members are encouraged to submit topics and suggest presenters for the Summit. Contact Elayne Biddlestone at [ebiddlestone@amcnoma.org](mailto:ebiddlestone@amcnoma.org) or (216) 520-1000, ext. 100. ■

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## AMCNO President-Elect Provides Testimony before the House on Medical Marijuana



A House task force listens to Dr. Robert Hobbs' testimony about the issue of legalizing medical marijuana.

AMCNO President-Elect Dr. Robert Hobbs recently testified before a House task force on the issue of legalizing medical marijuana.

Dozens of witnesses were scheduled for the House Medicinal Marijuana Task Force's final meeting examining the issue. Lawmakers and many who testified before the panel have expressed an interest in having the General Assembly act on medical marijuana before voters approve a constitutional amendment. Legislative action would allow lawmakers more control over the policy and its implementation. Dr. Hobbs had also testified before a Senate task force on this issue (see the *March/April issue of the Northern Ohio Physician*).

At press time, the House had just provided details on their medical marijuana proposal – which will be introduced in the House and move through a special select committee, with the goal of having it on the governor's desk by June. Under the proposal, physicians who are licensed by the State Medical Board of Ohio would have the ability to recommend medical marijuana to patients. They would also have to report to the state every 90 days on the type of patients they recommended it to and for what conditions. The proposed bill will outline a framework for allowing physicians to recommend and patients to obtain marijuana for medicinal purposes, and rules governing the system will be created by a Medical Marijuana Control Commission formed under the Department of Health. The AMCNO testified that we would prefer medication be researched and approved by the Food and Drug Administration, however the proposal would provide an avenue for physicians to make these judgments. The AMCNO also testified that we would like to see the federal government move marijuana from a Schedule I to a Schedule II drug, which we believe would allow for additional research. The legislature does plan to petition the federal government to allow for this change – which could then allow the legislature to develop incentive programs for educational and medical institutions to conduct research on the drug. The AMCNO will continue to monitor how this issue progresses through the legislature.

## Northern Ohio Political Action Committee (NOMPAC) Endorses Ohio Supreme Court Candidates

The AMCNO, through our PAC—the Northern Ohio Political Action Committee (NOMPAC)—has endorsed **Judge Pat Fischer, Judge Pat DeWine and Chief Justice Maureen O'Connor** for the Ohio Supreme Court.

As we have done in previous elections, the NOMPAC seeks to endorse candidates for the Ohio Supreme Court who understand judicial restraint, will interpret Ohio law (not rewrite it), and will maintain stability and balance in the Ohio Supreme Court. Judges Fischer and DeWine and Chief Justice O'Connor follow this judicial philosophy. To learn more about these and other judicial races, go to [www.judicialvotescount.org](http://www.judicialvotescount.org) and click on the "Who's Running for Judge" link.

## Dr. Robert Hobbs, AMCNO President-Elect, Debates HB 216 at CWRU Law Class

AMCNO President-Elect Dr. Robert Hobbs was invited to speak at a Case Western Reserve University School of Law class about HB 216—legislation aimed at revising the current law governing Advanced Practice Registered Nurses (APRNs). Essentially, if the legislation is revised, APRNs will no longer be required to collaborate with a physician to provide patient care. The AMCNO opposes the legislation.

The term "APRN" covers four areas of nursing: Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA), and Certified Nurse-Midwife (CNM).



Dr. Robert Hobbs covers several points in opposition of HB 216, a revision of the law governing APRNs.

Dr. Hobbs covered several points about the proposed legislation. Although the bill is being touted as a solution to the shortage of providers in rural/underserved areas, he said current law does not prohibit APRNs from working in these areas. Most APRNs work in hospital settings, and nothing in HB 216 guarantees that they will move to rural areas to work. He also covered all of the expenses that an APRN would incur if he or she opened a solo practice in an underserved area.

Another point Dr. Hobbs covered is that there is no data to support that APRNs are leaving the state because care requirements are too restrictive. Among the 13,000 APRNs surveyed in 2015 by the Ohio Board of Nursing, only 21 were unemployed, and it was due to difficulty finding a job.

Under the proposed legislation, APRNs would also be allowed to prescribe Schedule II drugs without consulting a physician. Legislators and physicians see the need to restrict the practice of prescribing opioids, not expand it to include 13,000 APRNs.

Dr. Hobbs stressed that physicians and APRNs do not have equal education and training, so they are not interchangeable. Physicians who are trained in primary care log 11,520 resident clinical hours in 11 years of training (or 35,000 hours and an additional 5 years of training for specialty care); APRNs log 450+ hours of clinical time in their 7 years of training.

Physicians are concerned that patient care would be endangered under the proposed legislation. "On the healthcare team, each member has his or her role, and they work together for the patient," Dr. Hobbs said. For numerous reasons, he said he finds the proposed legislation unnecessary.

A proponent of the legislation, Mary Jane Maloney, NP, Director of Government Affairs for the Ohio Association of Advanced Practice Nurses (OAAPN), was also invited to share her views on HB 216.

She said that no one refutes team-based care, but APRNs see the standard of practice regulations as overly restrictive. Currently, Ohio law states that NPs, CNSs, and CNMs must be in a collaborative relationship with a physician. NPs also must have a standard care agreement to practice in Ohio, which includes when a patient must be referred to a collaborating physician. She also noted that Ohio is one of four states that requires a formulary.

Ms. Malloy stressed that *interprofessional* collaboration is essential but *regulatory* collaboration is not.

**Editor's note:** There have been numerous interested party meetings on this legislation and several meetings have taken place with legislators regarding the medical community's position on this bill. Several changes to the legislation have been proposed and it remains to be seen whether or not these changes will be made to the bill. This bill is in hearings in the House Health & Aging Committee. A companion bill has also been introduced in the Senate.

To learn more about HB 216, visit the AMCNO website: [www.amcno.org](http://www.amcno.org).

# AMCNO LEGISLATIVE ACTIVITIES

## Other Legislation Under Review

Here are the key pieces of legislation the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) expects to see movement on within the next few months.

## HB 248 – Insurance Coverage of Abuse-Deterrent Formulations of Opiate Medications

This bill would require insurers to cover abuse-deterrent formulations of opiate medications. Rep. Sprague is proposing an amendment that would require that when an opiate is prescribed for chronic pain, insurers must implement a prior authorization that requests that the prescriber demonstrate that:

- The prescriber is complying with existing law on the treatment of chronic pain.
- The prescriber is complying with the GCOAT 80-MED guideline.
- In instances when the prescriber is treating a patient with both an opiate and benzodiazepine, the prescriber has tried other drugs or therapies and those have failed.
- A granted prior authorization would be valid for 12 months.

The bill is in hearings in the House Health & Aging Committee. The AMCNO supports HB 248.

## HB 249 – Good Samaritan/Immunity in Reporting Drug Overdoses

This bill would provide qualified criminal liability protection for anyone seeking EMS for an individual experiencing an overdose.

Rep. Sprague & Sen. Bill Seitz (R-Cincinnati) are proposing the following amendments:

- Within 7 days after seeking or receiving medical attention, the OD victim is assessed by and receives a referral for treatment.
- The qualified immunity would not be available to any person who previously has been granted one or more immunities a cumulative total of 2 times.
- Upon the request of a law enforcement agency, EMS personnel shall disclose the name and address of an individual administered naloxone for the purposes of investigation or treatment/referral.

There have been discussions to amend this bill into HB 110—which has been re-referred to the Senate Criminal Justice Committee. The AMCNO supports HB 249 and the proposed amendments as suggested—with the caveat that if the bill were to pass and does not prove as effective as we hope, that the legislature would come back and revisit the issue.



(l-r) Dr. Robert Hobbs, Sen. John Eklund, Dr. Joan Papp and Aaron Marks met to discuss HB 249, Good Samaritan legislation.

## SB 129 – Prior Authorization

This bill outlines numbers changes for how health insurers conduct prior authorization (PA), to make the process more fair and transparent. These include modifications that ensure new or future PA requirements are disclosed prior to the new requirement being implemented, guarantee that once a PA has been approved, the insurer will not retroactively deny the service based upon previously approved medical necessity or coverage criteria, and allow providers and patients to obtain PAs through a web-based system.

At the end of last year, the legislation was passed unanimously out of the Ohio Senate. SB 129 is now in hearings in the House Insurance Committee. The AMCNO supports SB 129. ■



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MEDICAL MUTUAL®

## ICD-10: Protecting Your Cash Flow

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

For the most part, the transition to ICD-10 went off without a hitch, and most practices feel like claims are processing normally. Practices have put in a lot of up-front work preparing for ICD-10, which has definitely played a big role in the smoothness of the transition. With that being said, there have been some providers who have reported that they are seeing claim denials for screenings such as colonoscopies. Providers have also reported that they have seen a reduction in their productivity due to the extra time being spent on documentation and coding.

Medicare Administrative Contractors (MACs) have been reactive to fixing identified problems and have been very responsive to practice inquiries. The denials that providers are seeing have stemmed from Local Coverage Determination Edits (LCDs) not being properly loaded. In some cases, once the LCD has been properly loaded, claims have been automatically reprocessed by the MACs; this is a big help to the providers because the claims do not have to be resubmitted by the billing staff.

Before the transition to ICD-10, providers were aware that they were going to have to include more information in their documentation, but not to the extent that their productivity would be affected. Providers are not the only ones being impacted; coding professionals are also seeing a decrease in productivity as well, due to the amount of time it is taking to review provider notes to make sure documentation is correct and that the proper ICD-10 codes have been added to the claims before submission.

In July of 2015, CMS announced that non-specific ICD-10 codes would be permitted for one year from the ICD-10 transition date (October 1, 2015). Even though CMS has given providers this much-needed grace period, practices should be taking the following steps to ensure cash flow is not delayed in any way.

**Make sure that the Practice Management System/Electronic Health Record have the necessary updates needed to transmit claims with ICD-10 codes.** Although most software vendors have been taking the necessary steps to be ICD-10 compliant, that doesn't mean that claims will not be denied. If denials are happening, it is important to

determine what has caused the denial. The following questions will need to be answered:

- Are the ICD-10 codes on the claim accurate and valid?
- Is all of the patient demographic information on the claim correct?
- Did all of the claim information provided transmit correctly from the Practice Management System to the clearinghouse to the insurance company?

All of the above questions are important when taking a look at the systems in use and/or identifying why a claim was denied. When making sure that the technology in use is up to par, the third question is the most important. If a practice finds that claims aren't transmitting properly from the software currently being used, the vendor needs to be contacted immediately. The issue could be a simple or complicated fix for the vendor, but it will allow the practice to implement changes and/or workarounds to prevent future denials until the issues have been corrected by the vendor.

**Assess productivity and provide ongoing training for providers and coding staff.** It is important to know where the staff stands in regard to productivity. If staff is falling behind, it is important to know why, in what areas, and if there are identifiable reasons. Ultimately, a delay in workflow means a delay in cash flow. Productivity delays can easily be corrected by providing things such as: training in the area specific to the specialty, implementing the use of templates, implementing the use of electronic coding software, and utilizing outside coding vendors and staff on a temporary basis. It is also important to remember that training should be ongoing in every practice so everyone is

kept up to date on changes and new information.

**Conduct ongoing coding/documentation audits and closely monitor denials.** It is important for the practice to be aware of the types of claims being submitted to the insurance companies and the types of denials being received. Knowing what claims are being denied will allow a practice to focus on specific claim types and correct issues prior to claims submission. Knowing what claims are being denied will also provide a platform for training all staff. When a practice is aware of the certain types of claims being denied, the billing staff will know what claims to keep an eye on to make sure that there isn't a delay in the processing of the claim for payment.

As we quickly approach October 1, 2016, providers need to make sure that their documentation is in compliance with all of the ICD-10 requirements to prevent denials from insurance payers. A good training method is to take a provider's top 20 ICD-10 codes and claim types (e.g., office visit, procedure, screening, etc.) and make sure that the documentation is in line with the requirements set forth by CMS.

It is also important to remember that even though CMS has given providers a break on documentation and coding to the highest specificity, by not denying claims solely for that reason, the end of the transitional period will be here before we know it. Providers should keep the lines of communication open with all support staff (i.e., clinical, clerical, billing, and coding) to make sure everyone is on the same page about what is required for a claim to be considered "clean" prior to submission. A "clean" claim means that everything—including patient demographics, insurance information, CPT codes, ICD-10 codes, and documentation—is in order prior to submission to the insurance company. Using this transition period to educate providers and support staff will help prevent any future delays in cash flow. ■

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# UNRIVALED REWARDS

## Ohio Supreme Court Expands Definition Of “Medical Records” For Purposes Of Discovery – *Griffith v. Aultman Hospital*

By Martin Galvin, Esq., Reminger Co., LPA

In *Griffith v. Aultman Hospital*, the Ohio Supreme Court recently reversed the Fifth District Court of Appeals (located in Canton) on the question of what constitutes “medical records” in Ohio, that must be produced to a patient upon request.

The Court of Appeals had held that the medical records that must be produced upon request are those that are maintained by the hospital’s medical records department and for which medical providers made a decision to keep or preserve to further the treatment process.

The Supreme Court’s ruling preserved part of this standard, but did so in a way that expanded the concept of what is a medical record to include all “records” regardless of where in the hospital they are kept, or which department of the hospital keeps the records. This new standard will almost certainly prove cumbersome and may ultimately be unworkable. For example, records kept by risk management departments, multi-disciplinary committees, and by IT departments (including extremely large volumes of electronic records that are never reduced to print) may now be discoverable. The burdens that will be imposed in gathering and producing these types of records will likely be considerable. Many sophisticated testing procedures “create” thousands of images. This can result in the technical production of theoretical “records”, a small fraction of which are relied upon or preserved by medical records departments.

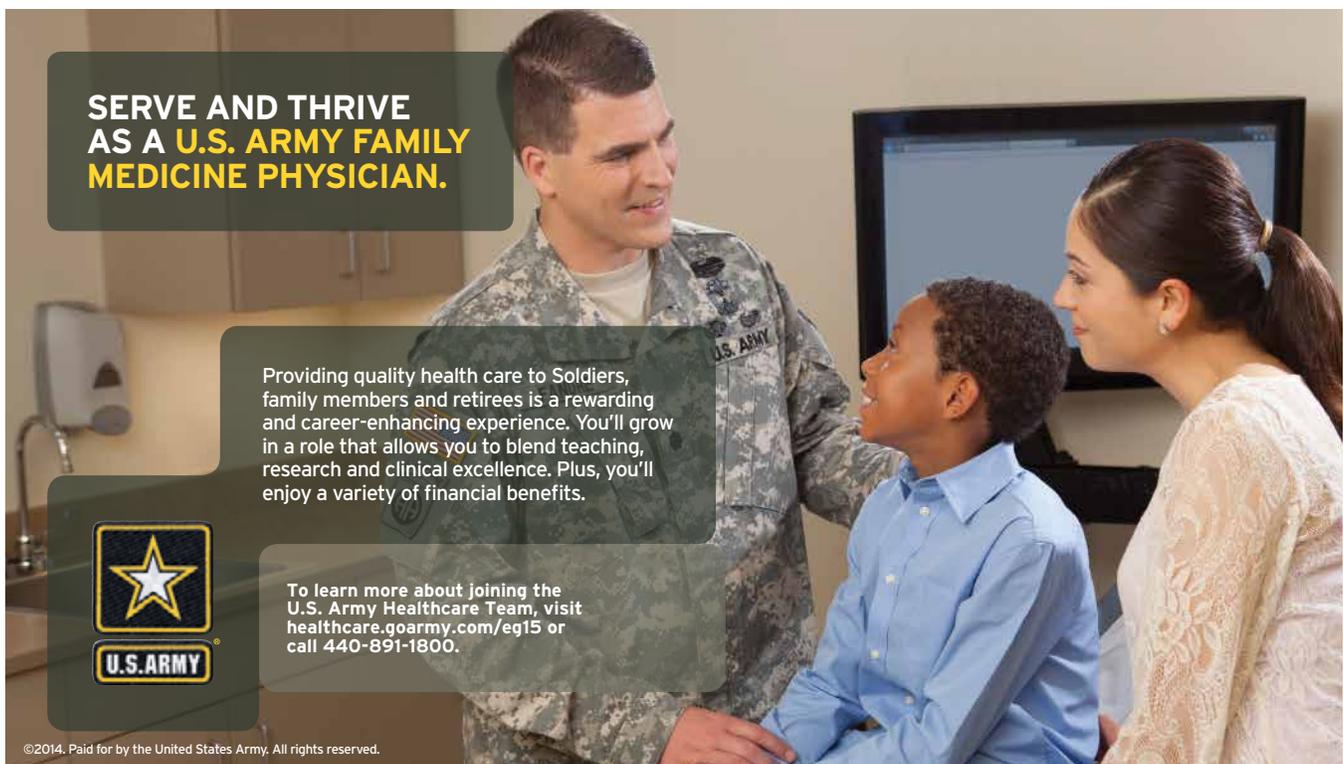
The Supreme Court remanded the *Aultman* decision to the trial court to reconsider what must be produced under the facts of that case. Justices Terrence O’Donnell and Judith Lanzinger dissented and would have defined medical records consistent with the Court of Appeals. Justice Lanzinger succinctly recognized the practical implications raised by AMCNO in its *Amicus Curiae* Brief to the Supreme Court as follows:

The judgment of treating healthcare providers must be relied upon to determine what is (or is not) part of a patient’s medical record, those providers being best able to determine what information is relevant to a patient’s treatment. Hospitals and other providers have teams of employees dedicated to collecting and maintaining this information, and, as the *amici curiae* have noted, many hospitals have multidisciplinary committees that determine what information should be included in a medical record. The information in the medical record presents the relevant and necessary information that is always subject to being supplemented in the clinical judgment of the treating providers.

In our view, this dissenting opinion did a much better job at capturing the essence of the issue. That is, what is the relevant and necessary information for making a determination on standard of care? Unfortunately, the majority seems to have bought into the suggestion that “records” kept outside the medical records department of a hospital are being kept away from patients, so that they cannot learn about all of their treatment and care.

The majority decision did recognize “that the term “medical record” in R.C. 3701.74(B) does not include all patient data but **includes only that data that a healthcare provider has decided to keep or preserve** in the process of treatment.” But the opinion is less clear where it states that “[t]he statute defines ‘medical record’ to mean any patient data ‘generated and maintained by a health care provider,’ **without any limitation as to the physical location or department where it is kept.**”

An initiative with the Ohio Legislature to clarify the meaning of R.C. 3701.74 could prove helpful on this issue. Nobody is looking to prevent patients from having full access to their medical records. But at the same time, hospitals and other medical providers should not be burdened with large scale additional documental retrieval responsibilities that will be extremely time consuming but add little of substance to questions of whether medical negligence occurred. ■



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## AMCNO President-Elect Participates in OU-HCOM Policy Day

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to participate and present at the Ohio University Heritage College of Osteopathic Medicine (OU-HCOM) Health Policy Day that took place in February. Dr. Robert Hobbs, AMCNO president-elect, and AMCNO staff participated in the day-long event.

The day began with a legislative breakfast with Reps. Nickie Antonio (D-Lakewood) and Sarah LaTourette (R-Bainbridge Township). The breakfast discussion included first-year medical students from the Cleveland branch of OU-HCOM, Dr. Isaac Kirstein (Dean of the Cleveland campus), Dr. Hobbs, Dr. Robert Juhasz, other OU physician representatives, and AMCNO and Cleveland Clinic executive and lobbying staff.

Dean Kirstein provided the legislators with background about the college and their affiliation with the Cleveland Clinic. He noted that Ohio is facing a critical shortage in primary care physicians. In fact, experts predict that the state will need an additional 5,000 primary care physicians to meet its healthcare needs by the year 2020. He pointed out that the OU-HCOM has a track record of having the majority of its graduates go on to practice medicine in Ohio. The Heritage College, Cleveland, is committed to preparing tomorrow's physicians to practice where they are needed the most—medically underserved urban and rural communities throughout the state, especially in Northeast Ohio. He stated that their partnership with the Cleveland Clinic gives students access to world-class medical facilities, physicians, scientists and clinical training opportunities.

The legislators in attendance commented that they hear a lot about physician shortages—in primary care, in particular—and there have been arguments on both sides of the aisle that the nurses could help fill that gap. This comment led to a lengthy discussion about HB 216—legislation under review at the Ohio legislature that would remove the collaboration agreement between physicians and nurses and change how nurses would practice in Ohio.

Physicians in attendance at the breakfast noted that the medical community is not opposed to all facets of the legislation—there is room for some compromise; however, it is important to remember that the nurses' training is not equivalent to what the students



*Reps. Nickie Antonio and Sarah LaTourette participate in a legislative breakfast session as part of Health Policy Day at OU-HCOM.*

are working their way through right now at OU-HCOM. Nurses are not equivalent to primary care doctors—they are great educators and very good at managing common medical problems, and they work well in medical teams; however, physicians have more training and are well-versed in the clinical management of patients. Physicians participating in the legislative breakfast also commented that most physicians and physician associations recognize there is a big difference in training and that is why, along with other reasons, physicians are in opposition of the bill.

Several students asked how they could become more involved in the debate on this bill. Legislators and staff provided information on how the students could testify or come and shadow someone at the legislature for a day.

Other topics brought up for discussion by the students included infant mortality, childhood immunizations and graduate medical education (GME) funding. The legislators outlined the discussions that have taken place recently at the Statehouse with regard to GME and the physicians in attendance stated that it will be important to try to find a way to address adequate GME funding in addition to increasing the residency slots available.

Legislative breakfasts took place at all of the OU-HCOM campuses, including Cleveland, Dublin and Athens. Following the breakfast, legislators were taken on a tour of the respective campus locations while students from all three campuses convened via teleconference to hear presentations on health policy basics, population health and payment reform, and the upcoming presidential election.

During the afternoon, students participated in several breakout sessions on a myriad of topics, including women's health, pain management and addiction, Medicaid, mental health, children at risk, Medicare, and long-term care. The session on Medicare held at the Cleveland campus was facilitated by Dr. Hobbs and was very well-received. The AMCNO was pleased to be a part of the OU-HCOM Health Policy Day and we would like to thank the Ohio Osteopathic Association for inviting us to participate in this event. ■

### NORTHERN OHIO PHYSICIAN

**THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO**

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# AMCNO COMMUNITY ACTIVITIES

## AMCNO Gathers to Celebrate Membership and Fine Wines

Academy of Medicine of Cleveland & Northern Ohio (AMCNO) members and their guests gathered for the annual wine tasting event, held at La Cave du Vin on a very cold Valentine's Day.

Almost 40 members attended the event, which featured six wines from Spain.

In addition to sampling excellent wine, members and their guests enjoyed great conversation and delicious hors d'oeuvres throughout the event.

We thank our members for spending their evening with us and making this event such a success each year. Look for "save the date" information for next year's outing in the upcoming months.

Photos from the Wine Tasting can be found on the AMCNO Facebook page and Twitter feed. ■



*A wine expert provides detailed descriptions of the wine samples as they're presented.*



*Members and their guests gather for the annual Wine Tasting event.*



*Six wines from various regions of Spain are featured for the evening.*



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## Improving Ohio's Health: Controlling Diabetes and Hypertension

### Ohio Hospital Inpatient Discharges for Diabetes and Hypertension<sup>1</sup>

By Cathy Costello, JD, Director of CliniSyncPLUS Services

This article is the first in a series devoted to diabetes and hypertension in Ohio and the prevalence of these chronic conditions. It explores efforts to quantify the impact of these two conditions on inpatient rates in Ohio counties.

Healthcare providers are inundated with statistics about the prevalence of diabetes and hypertension in the United States. Patients with chronic diseases drive the costs in the American healthcare system, both inpatient and ambulatory. About 86% of the United States annual healthcare spending is related to chronic diseases.<sup>2</sup> According to a 2012 report by the American Diabetes Association, the total economic cost of diabetes in the United States was \$245 billion, with Ohio accounting for \$9.3 billion of those costs.<sup>3</sup> In 2013, 921,012 people in Ohio were diagnosed with diabetes, ranking Ohio seventh among all states in number of people with diabetes.<sup>4</sup>

#### Centers for Disease Control and Prevention (CDC) Funding to Comprehensively Address Chronic Disease

To more effectively manage these chronic conditions and reduce their prevalence in the population, CDC has funded two grant programs through 2018 with state health departments across the country. These grants support population-wide approaches to prevent obesity, diabetes, heart disease and stroke and to reduce the disparities in priority populations. All states received initial funding in 2013 to support state-level activities.<sup>5</sup> In 2014, 17 states, including Ohio, were competitively awarded additional funds to support a broad-scale multi-year initiative at the state and local levels.<sup>6</sup> Both grants contain strategies to support the use of health information technology to improve performance and increase the implementation of quality improvement processes in health systems.

The second CDC grant received by Ohio takes a more in-depth local look at prediabetes screening and various other strategies to improve obesity, diabetes, heart disease and stroke outcomes in selected communities. The counties that are part of this more targeted grant are Athens, Lorain, Montgomery, Richland, Summit and Washington. In these counties, ODH is providing support to county health departments to increase residents' opportunities for physical activity and access to healthy foods, as well as participation in lifestyle change programs (such as the National Diabetes Prevention Program). For providers, the grants are designed to improve the use of electronic health systems for quality data monitoring and reporting of diabetes- and hypertension-related conditions. The work on these two grants reflects in part the Centers for Medicare & Medicaid Services' (CMS) premise that there is a close relationship between what occurs in the community setting and the inpatient setting.

The work of these CDC grants can ultimately contribute to reducing the rate of inpatient admissions for patients with hypertension and/or diabetes.

#### Ohio Data on Hypertension and Diabetes in the Hospital Setting

Diabetes and hypertension data from all 88 Ohio counties were compiled from two areas: 1) hospital inpatient rates of admissions for patients with diabetes or hypertension; and, 2) ambulatory quality data that tracks HgA1c and blood pressure. These de-identified data were aggregated and reported by county.

The hospital data are displayed at the county level for inpatient discharges where either hypertension, diabetes or both conditions

(Continued on page 14)

**Table 1: 2014 HOSPITAL INPATIENT DATA ON DIABETES AND HYPERTENSION DISCHARGES IN OHIO, BY COUNTY**

COUNTIES	DIABETES AS % OF TOTAL INPATIENT DISCHARGES	HYPERTENSION AS % OF TOTAL INPATIENT DISCHARGES	COUNTIES	DIABETES AS % OF TOTAL INPATIENT DISCHARGES	HYPERTENSION AS % OF TOTAL INPATIENT DISCHARGES
<b>AVERAGE FOR ALL OHIO COUNTIES</b>	<b>43.1%</b>	<b>56.2%</b>			
Adams	48.0%	62.2%	Licking	41.6%	51.9%
Allen	46.2%	56.9%	Logan	40.5%	55.6%
Ashland	44.8%	62.7%	Lorain	43.8%	58.9%
Ashtabula	45.1%	57.9%	Lucas	45.0%	55.9%
Athens	47.6%	60.3%	Madison	45.1%	59.7%
Auglaize	40.3%	54.6%	Mahoning	46.3%	57.9%
Belmont	46.5%	59.5%	Marion	49.8%	61.3%
Brown	48.8%	60.4%	Medina	38.2%	55.0%
Butler	43.7%	57.0%	Meigs	49.4%	60.9%
Carroll	46.0%	61.2%	Mercer	40.3%	55.2%
Champaign	46.1%	61.0%	Miami	41.2%	52.0%
Clark	49.0%	62.4%	Monroe	43.5%	63.7%
Clermont	42.1%	56.1%	Montgomery	43.6%	55.5%
Clinton	42.4%	53.3%	Morgan	49.4%	64.0%
Columbiana	46.9%	58.3%	Morrow	43.7%	61.6%
Coshocton	45.7%	60.5%	Muskingum	45.2%	61.2%
Crawford	49.7%	60.5%	Noble	46.2%	62.9%
Cuyahoga	42.9%	55.6%	Ottawa	43.9%	60.2%
Darke	39.0%	51.8%	Paulding	46.5%	54.5%
Defiance	45.0%	53.9%	Perry	41.8%	57.0%
Delaware	34.2%	52.2%	Pickaway	45.4%	57.8%
Erie	44.9%	59.8%	Pike	50.5%	59.8%
Fairfield	42.8%	56.0%	Portage	40.2%	57.0%
Fayette	47.4%	59.2%	Preble	45.1%	57.9%
Franklin	39.8%	51.8%	Putnam	35.6%	51.9%
Fulton	42.7%	54.2%	Richland	45.1%	60.4%
Gallia	45.8%	57.4%	Ross	45.7%	55.2%
Geauga	34.0%	55.0%	Sandusky	45.3%	57.1%
Greene	43.3%	54.9%	Scioto	51.3%	64.4%
Guernsey	48.2%	63.9%	Seneca	42.1%	53.2%
Hamilton	41.4%	53.1%	Shelby	37.3%	52.0%
Hancock	37.4%	50.3%	Stark	43.9%	57.7%
Hardin	45.9%	61.9%	Summit	42.7%	58.0%
Harrison	45.8%	59.1%	Trumbull	45.4%	57.3%
Henry	42.8%	55.8%	Tuscarawas	46.0%	60.2%
Highland	44.1%	55.3%	Union	43.0%	55.4%
Hocking	43.9%	54.5%	Van Wert	42.6%	52.1%
Holmes	40.9%	54.7%	Vinton	52.7%	63.2%
Huron	43.6%	55.0%	Warren	36.7%	51.1%
Jackson	53.1%	64.6%	Washington	50.0%	66.5%
Jefferson	48.8%	60.0%	Wayne	42.7%	58.8%
Knox	42.6%	58.5%	Williams	39.5%	47.5%
Lake	43.0%	59.3%	Wood	41.9%	52.6%
Lawrence	47.4%	57.4%	Wyandot	38.7%	49.6%

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## Improving Ohio's Health: Controlling Diabetes and Hypertension *(Continued from page 13)*

appeared on the patient's problem list. The Ohio Health Information Partnership obtained data from the Ohio Hospital Association and individual hospitals around the state.

In Ohio, out of the 1.1 million inpatient hospital discharges in 2014, nearly 6 out of every 10 discharged patients had hypertension in their problem list. Four out of every 10 patients had diabetes listed. The county with the highest percent of discharges related to diabetes was Jackson County (53.1%). Washington County was the highest county for inpatient discharges linked to hypertension (66.5%). The percent of inpatient discharges for diabetes and hypertension are listed in Table 1 for all Ohio counties.

By aggregating the data by region, a clearer picture emerges of variations around the state. As shown in Table 2, the region with the lowest percent of inpatient discharges that are linked to patients with either diabetes or hypertension is the Southwest region. This region (which includes Cincinnati) has only 41.7% of its discharges linked to diabetes (compared to the statewide average of 43.1%) and 54.4% of its discharges are linked to hypertension (statewide average 56.2%). The Southeast region has the highest rates of diabetes and hypertension among inpatient discharges (47.3% and 60.4%, respectively).

A significant rate of diabetes and hypertension was also identified among people who use Emergency Department (ED) services. For the state of Ohio, the average number of patients with diabetes who utilized the ED was 13.8%. The average number of patients with hypertension who utilized the ED was 22.6%.

### Identifying Individuals with Two or More Chronic Conditions

One in four Americans have two or more chronic conditions.<sup>7</sup> It is important to note, too, that a significant number of hospital admissions and ED visits are linked to patients who have both diabetes and hypertension. In Ohio, 15.1% of all inpatient discharges involve patients who have both diabetes and hypertension. This is important information for providers in Ohio to know because CMS has focused its attention on providing increased care to patients who have two or more chronic conditions. Reflecting this fact, CMS has focused much of its new payment reform models on the management of these two conditions. Within the past two years, CMS has established a new billing code for chronic care management (99490) that permits practices to bill for time spent managing a patient's care between visits. Chronic care coding is in addition to the transitional care management codes that allow a practice to bill a higher level of visit within two weeks post-discharge (99495 and 99496). The second article to be published in this series, *New Approaches to Managing Chronic Conditions*, will discuss how these codes can be used to assist practices in managing patient care in the ambulatory setting.

For more information on the requirements for chronic care management billing, please see the CMS tip sheet on CCM: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

Two common quality metrics used by medical practices to monitor diabetes and hypertension control rates in the office setting are being used to measure improvement over the course of the grants. Practices are being asked to share their data on NQF #0018, CMS 165 or PQRS #236 (Patients with hypertension under control: < 140/90) and NQF #0059, CMS 122 or PQRS #001 (Patients with diabetes out of control or not monitored: HgA1c > 9.0%). These are measures usually reported as a part of the Meaningful Use or PQRS programs. The information on each county's performance metrics on the A1c and hypertension measures will be discussed

**Table 2: 2014 HOSPITAL INPATIENT DATA ON DIABETES AND HYPERTENSION DISCHARGES IN OHIO, BY GEOGRAPHIC REGION**

TOTALS FOR OHIO REGIONS	TOTAL INPATIENT DISCHARGES	TOTAL INPATIENT DISCHARGES WHERE DIABETES WAS LISTED	% INPATIENT DISCHARGES WHERE DIABETES WAS LISTED	TOTAL INPATIENT DISCHARGES WHERE HYPERTENSION WAS LISTED	% INPATIENT DISCHARGES WHERE HYPERTENSION WAS LISTED
<b>Ohio</b>	<b>1,122,047</b>	<b>484,013</b>	<b>43.1%</b>	<b>630,099</b>	<b>56.2%</b>
<b>Southeast Region:</b>					
(Adams, Athens, Belmont, Carroll, Coshocton, Gallia, Guernsey, Harrison, Highland, Hocking, Holmes, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Vinton, Washington)	96,217	45,545	47.3%	58,143	60.4%
<b>Southwest Region:</b>					
(Brown, Butler, Clermont, Hamilton, Warren)	153,982	64,268	41.7%	83,710	54.4%
<b>West Central Region:</b>					
(Auglaize, Champaign, Clark, Clinton, Darke, Fayette, Greene, Mercer, Miami, Montgomery, Preble, Shelby)	123,749	54,077	43.7%	69,315	56.0%
<b>Northwest Region:</b>					
(Allen, Crawford, Defiance, Fulton, Hancock, Hardin, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wood, Wyandot)	127,843	56,261	44.0%	70,747	55.3%
<b>Northeast Region:</b>					
(Ashland, Ashtabula, Columbiana, Cuyahoga, Erie, Geauga, Huron, Lake, Lorain, Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, Wayne)	441,298	191,070	43.3%	252,679	57.3%
<b>Central Region:</b>					
(Delaware, Fairfield, Franklin, Knox, Licking, Logan, Madison, Marion, Morrow, Pickaway, Union)	178,958	72,792	40.7%	95,505	53.4%

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in the third article in this series: *Ohio Ambulatory Data on Hypertension and Diabetes Management*.

**Note:** If you are interested in having your data aggregated with other providers in your county, you may contact Cathy Rich at (614) 664-2606 or email her at [crich@ohionline.org](mailto:crich@ohionline.org) with your numerator and denominator figure for these two quality metrics. If your organization is part of a system, she can let you know if the system is already reporting data. ■

1 This article was supported by Cooperative Agreement #5NU58DP005508 and #6NU58DP004826, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

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6 CDC-RFA-DP14-1422: State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke.

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# AMCNO EDUCATION UPDATE



## 2016 Cuyahoga Community College Center for Health Industry Solutions

Date	Time	Title	Fee	Location
5/16/16	6:00pm-9:00pm Tues, Wed, Thurs.	Comprehensive Professional Medical Coding	TBD	CCE
5/18/16	9:00am-12:00pm Tues, Wed, Thurs.	Fundamentals of Billing Reimbursement	\$404	UTC
6/15/16	9:00am-12:00pm Tues, Wed, Thurs.	Comprehensive Professional Medical Coding	TBD	UTC
7/1/16	6:00pm-9:00pm Tues, Wed, Thurs.	Patient Access Specialist Fundamentals	\$474	CCE

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

**Course Locations:** Corporate College East 4400 Richmond Rd, Warrensville Hts, OH 44128  
Unified Technologies Center Rd 2415 Woodland Ave, Cleveland, OH 44115  
**ONLINE**



We provide services in the home to help older adults remain safe and independent in the community.

- Home health services
- Needs assessments
- Counseling
- Case management
- Mental health case management
- Adult day services
- Partial hospitalization
- Senior Companions

For referrals,  
call 216.791.8000  
or email inquiries to  
[intake@benrose.org](mailto:intake@benrose.org)

216.791.8000  
[www.benrose.org/services](http://www.benrose.org/services)



## If you've got questions, we've got the answers

Do I need the services of a financial advisor? That depends on how you answer these important questions.

- Have you formulated a detailed strategy to help transition into retirement?
- Do you know what investment accounts you will draw funds from in retirement? How tax efficient is your strategy?
- At what age is it appropriate to begin taking social security?
- What is your legacy plan for the wealth you have created? You may have taken certain steps to prepare your wealth for your family, but have you fully prepared your family to receive your wealth?
- Is it important for you to leave a legacy so that you are remembered for what you stood for, believed in and truly valued?

As a financial advisor, I will work with you to develop a solid family wealth financial plan. This plan can help provide the answers to these questions. Call for an appointment, and let's get started.

**Philip G. Moshier, CFP®, CRPC®, AEP®**  
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Philip G. Moshier is a registered representative of Lincoln Financial Advisors Corp.

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# THE 13th ANNUAL MARISSA ROSE BIDDLESTONE MEMORIAL GOLF OUTING

Proceeds to Benefit The Academy of Medicine  
Education Foundation (AMEF)

Monday, August 8, 2016

Mayfield Sand Ridge Golf Club  
12150 Mayfield Rd.  
Chardon, OH 44024

Registration at 10:30 am  
Shotgun Start at 1:00 pm

**Registration** - Deadline for entry is July 26, 2016. Foursomes will be finalized on that date. Prepayment and Registration are Required. A portion of the sponsorship and golf fees are tax deductible. Your entry fee of \$350 includes greens fees, cart and one caddy, lunch, dinner and prizes. Plan to arrive early—late arrival will disqualify you from participating.

Contact Name \_\_\_\_\_  
Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_

Make checks payable to AMEF and mail to:  
6100 Oak Tree Blvd., #440 Cleveland, OH 44131  
Phone: 216-520-1000, FAX 216-520-0999  
or email [abell@amcno.org](mailto:abell@amcno.org)  
Credit Card:  
Account # \_\_\_\_\_  
Exp. Date \_\_\_\_\_ I.D. # \_\_\_\_\_

Please select your level of support:

- Diamond Sponsor \$10,000 (includes 8 golfers)
- Platinum Sponsor \$5,000 (includes 4 golfers + ½ pg. in program)
- Event Sponsor \$3,000 (includes 4 golfers)
- Hole Sponsor \$1,000
- Individual golfer \$ 350
- I can't attend, but I'd like to make a tax-deductible contribution \$ \_\_\_\_\_

Golfers: please indicate foursome & handicap

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

By participating in this special AMEF fundraiser, your contributions will assist in expanding educational programs, including medical school scholarships, as well as implementing new initiatives to assist both physicians and the patients they serve.

Thank you from the 2016 AMEF Golf Committee!