



# NORTHERN OHIO PHYSICIAN

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THE VOICE OF PHYSICIANS IN NORTHERN OHIO

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## AMCNO Pollen Line – 2016 Recap

By Tina Abraham, DO; Monica Sandhu, DO; and John Johnson, DO

Allergy/Immunology Associates has been dedicated to serving patients of the Greater Cleveland area through the use of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Pollen Line. As in years past, we have used a Rotorod Aeroallergen device provided by the AMCNO to obtain and then count the pollen levels daily throughout the 2016 pollen season.

These pollen counts not only provide insight to patients, they also allow allergists and physicians to have an extra tool to better direct therapy for their patients to achieve symptom relief. For those who suffer from allergic rhinitis, allergic conjunctivitis and asthma, the pollen season can be miserable. By following yearly trends, we can predict the timing of certain allergens and prepare our patients so that their quality of life can be maximized.

In the Greater Cleveland area, the pollen season begins with trees in April. Compared to last year, tree pollen levels peaked around the same time, just slightly earlier this year, and the raw numbers were quite similar. Confounders with last year's total counts can be attributed to issues related to the Rotorod Aeroallergen device. Although total counts differ, we were able to identify the peaks in each season, which correlate reasonably with years past.

Grass pollen is known to be the main offender over the summer months. It was on the rise in early-mid June this year, similar to last year. Compared with last year it peaked in the first week of June and then fell off quickly. The peak numerical grass count was the same as last year's.

As the temperature starts to cool, we move into fall, also known as ragweed season. Ragweed appeared around the same time as last year. However, the values did show some variation secondary to some issues related to the Rotorod Aeroallergen device during the end of August and September. We do tend to see ragweed every year around August 15 and

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## Cleveland Museum of Natural History Forum Addresses Lead Concerns

On Sept. 1, the AMCNO staff and president were pleased to attend the Cleveland Museum of Natural History's (CMNH) public forum titled, "Taking the Lead on Lead," which was held to inform the community about lead poisoning and its adverse effects, discuss ways to stop the public health problem, and identify what needs to be done to help ensure children live healthier lives.

This program was planned with the assistance of the CMNH Health Advisory Committee, which includes AMCNO Past President Dr. James Coviello and our President-elect Dr. Fred Jorgensen.

Prior to the presentations, a resource fair was held, where several local community and

healthcare groups provided materials to inform attendees of what resources are available to help prevent or assist with lead issues.

The speakers' forum was moderated by Dr. Dorr Dearborn, Chair Emeritus, Department of Environmental Health Sciences, Case Western Reserve University (CWRU) School of

Medicine. He is considered to be an expert in lead poisoning and prevention in Cleveland. Dr. Dearborn provided brief background information about lead before introducing the speakers for the evening.

Terry Allan, Health Commissioner for the Cuyahoga County Board of Health (CCBH), was the first speaker. His presentation focused

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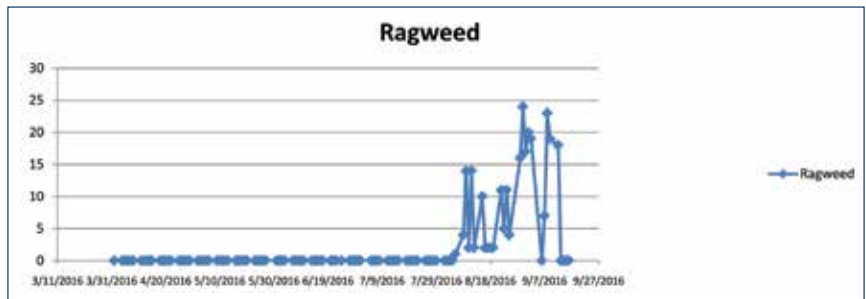
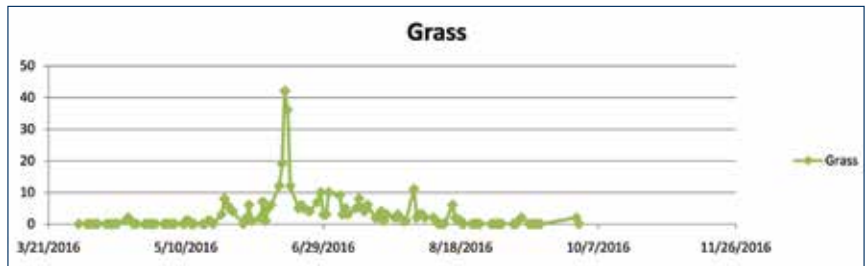
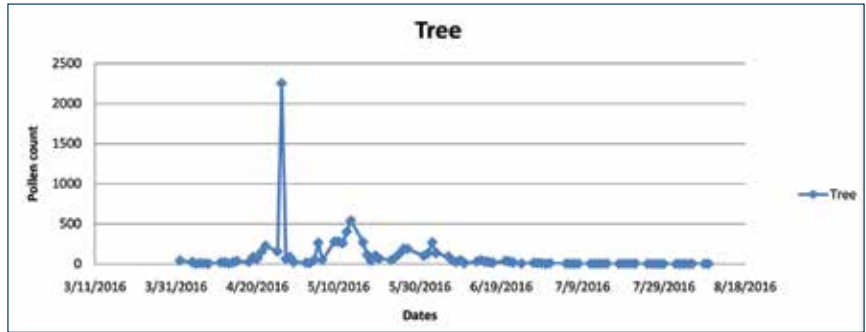
## AMCNO Pollen Line – 2016 Recap

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it continues to climb from there until it starts a downward slope over the first two weeks of September. The ragweed pollen had a second peak in the first week of September this year. But like years previously, levels trailed off by the end of September.

Each year, Allergy/Immunology Associates, in coordination with the AMCNO, is proud to provide the pollen count for the Greater Cleveland area from April 1 to September 30. The counts are made available to the Pollen Line at (216) 520-1050 as well as [www.amcno.org](http://www.amcno.org). Stay healthy and warm this winter, and we look forward to helping you prepare for next year's pollen season on April 1, 2017! ■

The AMCNO would like to thank Allergy/Immunology Associates for providing the pollen counts for the community.



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## Cleveland Museum of Natural History Forum Addresses Lead Concerns *(Continued from page 1)*

on “Data Matters: Childhood Lead Poisoning in our Community.”

Lead levels have decreased since 1978, particularly when the use of leaded products (such as gasoline and paint) was banned.

Lead, however, continues to be an issue because of the nature of the problem, and it can be challenging to educate families on the issue, Allan said. Peeling paint in and on older homes remains a major factor in transferring lead—interior paint becomes hazardous to small children when they touch the peeling paint and then transfer it to their mouths or breathe in the contaminated dust; exterior peeling paint contaminates the surrounding soil and ends up in children’s mouths or tracked through the home.

No level of lead is considered “safe.” The Centers for Disease Control and Prevention (CDC) defines Elevated Blood Lead Levels (BLLs) as higher than 10 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ). In 2007, the Greater Cleveland Lead Advisory Council adopted 5  $\mu\text{g}/\text{dL}$  as an “action” level.

In 2014, in Cuyahoga County, 4,596 children who were tested (aged 0-71 months) had  $\geq 5$   $\mu\text{g}/\text{dL}$ . Ten years ago, most children averaged 10  $\mu\text{g}/\text{dL}$ . Allan said he attributes the decrease in lead levels to targeted education in areas that had the highest levels of exposure, but knows more needs to be done.

The biggest risk, Allan said, is complacency. There are still communities in Cuyahoga County that are above the national rates of elevated levels. Testing needs to be increased and the data tracked, he said.

More information about lead can be found on CCBH’s website: <http://www.ccbh.net/lead-poisoning/>.

The next speaker was Merle Gordon, Director of the Cleveland Department of Public Health.

For more than 20 years, Cleveland has been providing services to help ensure homes are lead-free. There are costs involved, however, with these services and money offered through grants only goes so far. More funds allocated for lead detection and the safe removal of it are needed, she said.

Legislation to be introduced in the near future will call for all rental units in Cleveland

to be inspected. The results would be entered into a registry, which would then be available to all citizens.

In the meantime, the department is looking into training more inspectors to clear up the large backlog of cases that were identified as unsafe properties. The department is also looking to hire public health investigators and additional environmental compliance officers to help identify and monitor the situation. In addition, they will be contracting with the CCBH and other local groups to increase education and outreach. And, they will be working with Cleveland State University and CWRU for case management, education, testing, and other resources to help prevent negative health effects before they can take hold.

Following Gordon was a presentation by Dr. Mary Jean Brown, Director of the Office of Healthy Homes and Lead Poisoning Prevention, National Center of Environmental Health, CDC. She has worked on lead issues for 30 years and has found that housing has a significant impact on BLLs. Even at low levels, adverse effects from lead exposure can be observed, such as lower IQ scores, speech problems, and behavioral issues.

Several things can be done to help decrease a child’s exposure to lead in the home. Examples include: keeping the house clean, placing a barrier between kids and lead paint (such as tape on chipping window sills), learning what foods can help absorb lead (such as iron- and calcium-rich foods), and most importantly, having your child tested for lead. If your child has higher levels, take the appropriate action and follow up with your physician to have your child re-tested as recommended.

In 1970, 17  $\mu\text{g}/\text{dL}$  was the average amount of BLLs for all tested children in the United States. Now, of the percentage of children tested, only 0.8% has a BLL of  $\geq 10$   $\mu\text{g}/\text{dL}$ . However, BLLs are 16 times greater in Greater Cleveland than they are throughout the rest of Ohio. Lead poisoning is preventable, Dr. Brown stressed, and added that the next 10 years will show the progress we’ve been making in curbing the occurrence.

At the conclusion of Dr. Brown’s presentation, Dr. Dearborn invited the speakers on stage to field audience questions. One pressing concern involved the water crisis that

occurred in Flint, MI, and whether Cleveland could, or does, face a similar issue. Dr. Brown stated that lead can be found in water, but most communities treat their water and the levels are small compared to the amount of water that flows through the pipes. When BLLs are elevated, it’s because the water source has changed, as what happened in Flint, and that water was not treated properly. She also added that we can’t point to one source (such as water or paint) as the leading problem—all lead sources are bad and all need to be addressed.

The challenge, however, all speakers agreed, is connecting with parents for testing and keeping track of tested kids. An effort is currently underway to educate physicians and educators in the community to refer children into the Child Find system for evaluation and follow-up. The Help Me Grow program through the Ohio Department of Health is working on this initiative.

The AMCNO will continue to provide additional information on this issue to our members. ■

## NORTHERN OHIO PHYSICIAN

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## Legislation Spotlight – AMCNO Supports Step Therapy Bill Under Review in Ohio

There's a common complaint from physicians in many specialties and from practices of all kinds. It's that the use of step therapy protocols by health insurers interferes with the care of patients and creates an administrative nightmare. Members of Ohio's legislature are hearing these complaints as well. The Ohio Senate subcommittee on Medicaid is currently considering Ohio Senate Bill 243, which would put some brakes on step therapy, though not completely eliminate it. Members of the AMCNO are urged to contact their state senator as well as Senator Dave Burke, chair of the subcommittee, to urge swift action on this bill.

Step therapy comes into play when you write a prescription and the insurer refuses to cover it, insisting instead on a different medication. Because the alternate medication is cheaper for them, they are substituting the judgment of a clerk in an insurance office for your professional opinion formulated in the exam room. Here are some examples about the fallout from this approach.

Rheumatologists say biologic drugs are routinely denied despite this testimonial from the FDA: *Biological products often represent the cutting-edge of biomedical research and, in time, may offer the most effective means to treat a variety of medical illnesses and conditions* (<http://bit.ly/VO51xc>). Instead, insurers are insisting patients take an older NSAID, available in generic form, which comes with a Black Box Warning enumerating several serious and some potentially fatal side effects. Similar reports have come in from dermatologists, including one who strongly objected to prescribing—as the insurer demanded—an immunosuppressant drug to a cancer patient with an already weakened immune system. There was also an instance where a young man, suffering from ulcerative colitis, was steered by the insurer to an anti-anxiety medication for which diarrhea is a common side effect.

The insurance industry refers to step therapy as “fail first.” Your patient is expected to fail on the drug the insurer demands, and often on a second cheaper alternative, before they will consider covering the prescription you wrote. In the case of patients with an aggressive rheumatoid arthritis, that can mean suffering additional joint damage and facing additional surgeries, but this is far from the only example of the how patients are harmed by a “fail first” approach.

Mental healthcare physicians are particularly challenged by step therapy protocols because the effectiveness of psychotropic drugs can

vary considerably with age, race, gender, and medical history. The physician must make a carefully nuanced treatment plan and monitor it closely. Step therapy interferes with effective treatment of mental health patients at the very time communities here in northern Ohio and nationwide are struggling to improve their treatment capacities. Here, the side effects of the wrong drug can include domestic violence, incarceration, and suicide, to name a few.

Of course, physicians can and do fight step therapy protocols, however. It seems every insurance company has a different appeals process and changes it regularly, making it hard to know whom to call or what form to fax in. A family physician spent (personally and with her nurse practitioner) over two hours on the phone trying to renew a medication her elderly patient had been successfully taking for nine years. Even the insurance company employees often don't understand their own process. Multiple practices have said they have staff devoted entirely to trying to get prescriptions approved. Clearly, this increases the cost of running a medical practice and every moment a provider spends navigating the maze of step therapy appeals is time taken away from patient care.

Insurers cite cost savings to justify increasingly widespread use of step therapy. That argument relies on a silo approach in which medication costs are somehow isolated from the rest of health care. Is money saved when a patient who's “failing first” (or second) on the insurer's drug of choice must make multiple office visits? Is money saved when the patient's conditions worsens and requires more extensive treatment, hospitalization, or surgery?

**Here's what Ohio Senate Bill 243 would do to rein in the practice of step therapy.** Guidelines would have to be based on clinical considerations, developed by medical professionals, and not based on cost alone.

Insurers will argue they already use medical physicians to vet their drug substitutions. Physicians in specialty fields, however, often find that person (when there is one) lacks the in-depth knowledge necessary to make an informed judgment.

There are some circumstances defined in the bill under which step therapy protocol would be prohibited. This includes cases in which the physician is simply renewing a prescription for a medication on which the patient is currently doing well. That change alone will save medical practices precious time and countless frustration.

Finally, the insurer will be required to have a transparent appeals process and to explain it clearly for physicians and patients alike.

You can be certain the insurance companies will pull out all the stops to derail this bill, so here are two things you can do.

First, please send the AMCNO staff your own stories of patients who have been negatively impacted by step therapy. Legislators respond to specific examples, which can be provided without violating patient privacy. Please email these stories to Elayne Biddlestone at [ebiddlestone@amcnoma.org](mailto:ebiddlestone@amcnoma.org).

Second, please take a moment to contact your state senator and Senator Dave Burke to express your support for Ohio Senate Bill 243. State senators can be contacted directly from [www.ohiosenate.gov](http://www.ohiosenate.gov), where you can also find the name of your own state senator. Legislators need to hear from physicians whose patients are directly harmed by step therapy, and they pay more attention when those physicians live and vote in their districts.

Thank you in advance for helping our Cleveland and northern Ohio medical community reverse some of the abuses of step therapy. ■

## Senate Passes Bill Addressing Infant Mortality

Legislation aimed at reducing Ohio's high infant mortality rate by improving data collection and focusing on evidence-based practices has passed in the Senate. SB 332 is meant to address the state's abysmal rate of children who don't reach their first birthday. The proposal is intended to focus on healthcare efforts and practices designed to get better results.

The bill also addresses the social determinants of health—housing, economic situations, the environment, and other issues beyond clinical care that can drive health outcomes.

The substitute version of the bill included an amendment expanding the list of drugs that can be administered by pharmacists. The amendment added antipsychotics, opioid antagonist drugs and vitamin B12 to the drugs listed in the bill that could be administered by pharmacists, which adds in a House bill (HB 421) that was sent over to the Senate earlier this year. The new bill implements some of the recommendations made by the Commission on Infant Mortality but does not include the recommendation that physicians obtain mandatory CME training on cultural competency—an aspect of the bill opposed by the AMCNO and other medical associations.

However, an amendment was added to the substitute version of the bill which would require each state board to consider problems of race and gender-based disparities in healthcare treatment decisions. When doing so, the boards shall consult with the commission on minority health and one or more professionally relevant and nationally recognized organizations or similar entities that review the curricula and experiential learning opportunities offered by the applicable healthcare professional schools, colleges, and other educational institutions. In addition, each state board shall annually provide its licensees or certificate holders with a list of continuing education courses and experiential learning opportunities addressing cultural competency in healthcare treatment. If a state board determines that a sufficient number of courses or learning opportunities does not exist, the board shall collaborate with the organizations or similar entities to create such courses and opportunities.

## SMBO Medical Marijuana Update: What is required of a physician to recommend medical marijuana now that House Bill 523 is effective?

A physician is not permitted to issue a State of Ohio-approved written recommendation to use medical marijuana until the physician has obtained a certificate to recommend from the State Medical Board of Ohio. Per House bill 523, the rules outlining the standards and process needed to obtain such a certificate to recommend will be developed no later than September 8, 2017.

As a way to protect patients and parents or guardians of minor patients who seek to use marijuana prior to the creation and implementation of all the administrative rules necessary to run the Ohio Medical Marijuana Control Program, HB 523 created an affirmative defense for certain marijuana-related crimes. According to the law, a patient, parent, or guardian can only raise an affirmative defense if they have, among other requirements, received a written recommendation from his or her doctor that certifies a certain number of criteria are met. The Board recommends that physicians consult with their private legal counsel and/or employer for interpretation of the legislation.

Read more at [medicalmarijuana.ohio.gov](http://medicalmarijuana.ohio.gov).

## SMBO Clarifies Letters Sent to Prescribers Concerning OARRS Violations

Ohio law requires all prescribers of opioids or benzodiazepines to register for and consistently use Ohio's Automated Rx Reporting System (OARRS). And, Guidelines for the Management of Acute Pain Outside of Emergency Departments were established in January. Now that the law and guidance are in place, the State Medical Board of Ohio (SMBO) has begun to use OARRS data to identify and contact prescribers who have failed to register for OARRS or who demonstrate a pattern of failure to check patients in OARRS.

In September, the SMBO contacted approximately 12,000 physicians who appeared in a report from the Ohio State Board of Pharmacy that they may be in violation of the OARRS law. The SMBO has since clarified that the vast majority of those 12,000 physicians have non-egregious issues

and minimal non-compliance matters that need to be addressed. In fact, they stated that the median number of non-checks for each prescriber was in the single digits.

The SMBO added that the intent of the letter was to encourage physicians to check their individual OARRS report, identify if/how a check was missed, and make any necessary adjustments to office procedures to prevent missed checks in the future. Often a quick review of OARRS practices can correct most issues, they said. Resources are available on the SMBO website: [www.med.ohio.gov](http://www.med.ohio.gov).

In fewer than 1% of all instances, licensees had prescribed opioids or benzodiazepines without checking OARRS at rates that warrant additional, personalized discussion.

Medical organizations across the state, including the AMCNO, were concerned about the tone and content of the original letter and shared our concerns with the SMBO, which subsequently led to the clarified letter.

The SMBO's updated letter can be viewed on their website at [www.med.ohio.gov](http://www.med.ohio.gov).

## Changes Made to SMBO Application for Licensure

The State Medical Board of Ohio (SMBO) has finally voted to eliminate a question from its application for medical licensure that requires answers regarding a physician's mental health history without regard to whether a condition currently impairs or limits a physician's ability to practice medicine with reasonable skill and safety.

This issue has been under review for several years and the AMCNO and other state medical associations have been asking the SMBO to remove one of the questions on the application (Q22) that could stigmatize mental health treatment. In addition, this same question could create a barrier to physicians seeking appropriate and effective treatment at the onset of symptoms, for fear of retaliation by the medical board when having to answer these questions on the application for licensure later in their career.

At issue was Title II of the Americans with Disability Act (ADA) which prohibits states from discriminating against people with disabilities in the administration, requirements and eligibility

criteria of licensing programs, such as the application for medical licensure. Under Title II, medical board applicants with mental illness should not be treated differently compared to other applicants simply because they have a mental health diagnosis or have been diagnosed with a mental illness in the past.

The SMBO has voted to eliminate question 22 and to make significant revisions to question 23 regarding medical conditions. The AMCNO and several other medical associations were appreciative of the SMBO's decision to remove Q22 from the application. There is still a question on the application that needs some clarification and we will continue to work with the SMBO in an effort to get additional changes to the application if possible.

## Ohio State Board of Pharmacy Amends Draft Compounding Rules Again

In response to concerns brought forward by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and other local and national physician associations, the Ohio State Board of Pharmacy (OSBOP) has once again amended the draft compounding rules.

The AMCNO, Ohio State Medical Association (OSMA), and other physician associations have been communicating with the pharmacy board to express their concerns since the rules were released in May 2016. In response to these concerns the pharmacy board delayed the implementation of the rules that governed the practice of compounding dangerous drugs in physician offices.

Initially, the board created a new set of draft rules adding the "immediate use" rule that exempts physicians from having to invest in costly environmental control equipment, as long as compounded drugs are used within a 6-hour time period. While this amendment was appreciated by the physician community, there were still sections of the compounding rules that would restrict physicians from compounding in the manner that is consistent with the current standard of care.

The following additional changes were made to the draft rules.

### Reconstitution will NOT be considered compounding.

- The reconstitution or dilution of a conventionally manufactured nonsterile dangerous drug product with no intervening steps in accordance with the manufacturer's labeling for administration and beyond use dating. Any other reconstitution or dilution of a conventionally manufactured nonsterile product is considered compounding and shall be performed in accordance with United States Pharmacopeia Chapter <795>, USP 39-NF 34, or any official supplement thereto (6/30/2016).
- The reconstitution or dilution of a conventionally manufactured sterile dangerous drug product with no intervening steps in accordance with the manufacturer's labeling for administration and beyond use dating. These drug products shall be prepared using aseptic technique and procedures shall be in place to minimize the potential for contact with nonsterile surfaces and introduction of particulate matter or biological fluids. Any other reconstitution or dilution of a conventionally manufactured sterile product is considered compounding and shall be performed in accordance with this rule.

### Preparation of Cosmetic Fillers will not be considered compounding

- The Board exempted the reconstitution or preparation of a drug device from its definition of compounding. The FDA classifies fillers as drug devices.

### Closed System Transfer Devices will not be required when compounding

- The Board removed this requirement from the rules.
- The rule drafting process is not yet complete and many still have concerns about the most current draft of the compounding rules. The rules have entered the formal review process and will undergo more regulatory scrutiny and possible additional changes before being made final.

The AMCNO will continue to keep our members informed about this important issue.

## CMS Denies Healthy Ohio Program Waiver

Previously, we informed you of the 1115 Demonstration Waiver request the Ohio Department of Medicaid (ODM) submitted to the Centers for Medicare & Medicaid Services (CMS) to implement the Healthy Ohio program, as required in law by the FY16/17 Operating Budget. Now, CMS has announced that they have denied the waiver for several reasons. Visit the Ohio Medicaid website for more information at [www.medicaid.ohio.gov](http://www.medicaid.ohio.gov).

In 2015, Gov. John Kasich proposed Medicaid enrollees who are not disabled and have income above 100% of poverty pay a portion of their insurance premiums, which is the norm for private health insurance. The final version of the budget replaced the Administration's premium program with a legislative requirement to enroll most Medicaid recipients into health savings accounts regardless of income. The Kasich Administration has stated that they will restart talks with the General Assembly about other options to ensure greater personal responsibility as they had outlined in their request.

For more information about the Healthy Ohio program, go to <http://www.medicaid.ohio.gov/RESOURCES/PublicNotices/HealthyOhioHSA.aspx>.

## Ohio Department of Medicaid Releases 2016 Managed Care Plans Report Card

In a continuation of the state's efforts to inform consumers and provide incentive for health plans to improve their services, the Ohio Department of Medicaid (ODM) has released its second annual report card for Ohio Medicaid managed care plans. To compile the report, ODM used data provided by the plans and patient surveys to evaluate each plan on the following five categories: access to care, doctors' communication and service, keeping kids healthy, managing illness, and women's health.

To view the complete report card, <http://medicaid.ohio.gov/Portals/0/Resources/Reports/2016-mcp-reportcard.pdf>. ■

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e. Total Free or Nominal Rate Distribution (Sum of 15d (1), (2), (3) and (4))		380	400
f. Total Distribution (Sum of 15c and 15e)		3386	2650
g. Copies not Distributed (See Instructions to Publishers #4 (page #3))		25	20
h. Total (Sum of 15f and g)		3411	2670
i. Percent Paid (15c divided by 15f times 100)		77.4%	84.3%

17. Publication of Statement of Ownership  
 If the publication is a general publication, publication of this statement is required. Will be printed in the Nov/Dec 2016 issue of this publication.  
 Publication not required

18. Signature and Title of Editor, Publisher, Business Manager, or Owner  
 Elayne R. Biddlestone  
 Date: 9/20/16

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

PS Form 3526, August 2012 (Page 2 of 3)



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

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### Transitioning from PQRS and MU to MIPS

The Patient Protection and Affordable Care Act (ACA) of 2010 was landmark legislation that created the National Quality Strategy (NQS) and which included the redesign of Medicare's fee-for-service (FFS) payment structure. Medicare adapted the NQS with the express purpose of becoming an active purchaser of quality healthcare instead of a passive payer for medical services. As the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands, Health Services Advisory Group (HSAG) provides technical assistance to healthcare providers to help in making this transition to payment for quality clear and seamless.

HSAG's current work supports physician incentive programs including the Physician Quality Reporting System (PQRS) and Meaningful Use (MU). PQRS serves as the foundation for assessing the quality of care individual or group practices provide through electronic health record (EHR) submission of evidence-based quality measures. However, 2016 is the last year that quality measures and EHR MU attestation are required for providers who bill Medicare FFS. As set out in the new Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation signed into law

in April 2015, providers will now submit quality measures through the Merit-based Incentive Program System (MIPS). MACRA replaces the Medicare Sustainable Growth Rate (SGR) and puts into place two types of quality payment programs: Alternative Payment Models (APMs) and MIPS. MACRA streamlines PQRS, MU, and the value-based modifier into one quality program, MIPS. Its requirements mirror the PQRS quality measures and MU requirements (with only six instead of nine quality measures reported), with additional requisites for health information

exchange, patient care coordination, and interoperability. Data submission methods remain the same: EHR, qualified registry, web interface, clinical data registry, and claims.

Regardless of which data submission method the provider chooses, HSAG is here to provide technical assistance to make the transition to MACRA logical and efficient. For more information, contact Howard Pitluk, MD, MPH, FACS, HSAG, Vice President for Medical Affairs & Chief Medical Officer, at [hpitluk@hsag.com](mailto:hpitluk@hsag.com). ■

This material was created by Health Services Advisory Group, the Quality Improvement Organization for Arizona, California, Ohio, Florida, and the U.S. Virgin Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Publication No. QN-11SOW-D.1-07142016-01

*The AMCNO Board of Directors and Staff  
wish you and your family  
Happy Holidays and a Healthy New Year!*

# SAVE THE DATE!

# 2017 Medical/Legal Summit

## MARCH 24-25, 2017

Cleveland's Medical/Legal Summit will be co-sponsored by the Cleveland Metropolitan Bar Association, Academy of Medicine Education Foundation, and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO).

### Co-Chairs:

- Marlene Franklin, Esq., Associate General Counsel, MetroHealth Medical Center
- Robert E. Hobbs, MD, AMCNO President

The Summit is intended to bring together doctors, lawyers, healthcare professionals and others who work in allied professions for education, lively discussion and opportunities to socialize.

## SUMMIT DETAILS

March 24 – CME, CLE TBD

March 25 – CME, CLE TBD

### FRIDAY, MARCH 24, 2017

3:30 p.m. Registration

4:15 p.m. Welcome & Introductions

Richard D. Manoloff, *CMBA President*; Robert E. Hobbs, MD, *AMCNO President*; Marlene Franklin, Esq., *Associate General Counsel, MetroHealth Medical Center*

4:30 p.m. Keynote Speaker and Q&A

### Gail Wilensky, PhD, Project HOPE

“Update on the Affordable Care Act and the Impact of Medicare Payment Reforms”

Followed by a networking reception

### SATURDAY, MARCH 25, 2017

7:00 a.m. Registration & Breakfast

8:00 a.m. Welcome & Introductions

### Plenary Sessions

8:15 a.m. MACRA Update

9:15 a.m. Addressing the Opioid Crisis in Northeast Ohio

10:30 a.m. How to Survive, How to Avoid Lawsuits

### 11:45 a.m. Breakout Sessions

Medical and Legal Aspects of Medical Marijuana

or

How to Manage Patients/Clients with Behavioral Issues

Location:

**ONE CLEVELAND CENTER  
1375 EAST NINTH STREET  
SECOND FLOOR  
CLEVELAND, OHIO 44114**

### REGISTRATION RATES

\$75 CMBA members, AMCNO members and other healthcare providers

\$125 Non-Members

\$15 Students and Residents



**GAIL WILENSKY, PhD**, is an economist and senior fellow at Project HOPE, an international health foundation. She directed the Medicare and Medicaid programs from 1990 to 1992 and served in the White House as a senior health and welfare adviser to President GHW Bush. From 1997 to 2001, she chaired the Medicare Payment Advisory Commission, which advises Congress on payment and other issues relating to Medicare and previously chaired one of its predecessor commissions, the Physician Payment Review Commission.

Dr. Wilensky is an elected member of the Institute of Medicine and has served two terms on its governing council.

She received a bachelor's degree in psychology and a PhD in economics at the University of Michigan and has received several honorary degrees.

## Registration

\$75 CMBA members, AMCNO members and other healthcare providers

\$125 Non-Members

\$15 Students and Residents

Please select a breakout session:

- Medical and Legal Aspects of Medical Marijuana or  How to Manage Patients/Clients with Behavioral Issues

TOTAL \$ \_\_\_\_\_

Name \_\_\_\_\_ Atty. Registration No. \_\_\_\_\_

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I have submitted a membership application within the last 30 days.

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Add \$15 to registration fee the day of the program. Registration must be pre-paid by cash, check or credit card to qualify for the advance registration price.

**Attorney Registrations:** Please make checks payable to Cleveland Metropolitan Bar Association. Mail to P.O. Box 931891, Cleveland, Ohio 44193, or fax your reservation form to (216) 696-2129 (all fax reservations must include a credit card number, expiration date, and signature). CANCELLATIONS must be received in writing three business days prior to the program.

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

**Physician and Health Care Provider Registrations:** Phone/fax or mail to: AMCNO, 6100 Oak Tree Blvd., Ste. 440, Independence, OH 44131, Phone: (216) 520-1000 FAX: (216) 520-0999. Physicians and other healthcare providers may also pay the AMCNO online at [www.amcno.org](http://www.amcno.org). Make checks payable to the AMCNO.



## What Should I Know about MACRA Alternative Payment Models?

By *LaDonna Kessler, CMUP, and Tamiya Williams, CMPE*  
Senior Managers at *Medic Management Group, LLC*

The implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislative proposal includes significant changes to the way providers will attest to quality improvements and technology use, but also includes a heavy emphasis on value-based reimbursements, alternative frameworks for payments, and patient-centered care.

### What's the difference between MIPS and APMs?

There are two paths for participation in the quality improvement programs included in the MACRA legislation for Eligible Clinicians (EC): the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs).

Clinicians will need to begin attestation under one of these two models in 2017 and will receive their first payments under the new framework in 2019. Both MIPS and APMs are value-based payment models that incentivize providers on quality, outcomes and cost containment.

MIPS is a program that streamlines parts of the Physician Quality Reporting System, the Value-based Payment Modifier and the Medicare Electronic Health Record (EHR) Incentive Program into one single program called the Quality Payment Program. Under MIPS, ECs will be measured on quality, cost, clinical practice improvement and use of certified EHR technology.

Under MACRA, 50% of the MIPS score would be based on quality, 25% of the score would be based on care information. The cost category would make up 10% of the score. This category would involve Medicare claims and would use 40 episode-specific measures to account for differences among specialties. Clinical Practice Improvement category makes up the remaining 15%.

Clinicians who are in their first year of Medicare participation and those who successfully participate in the APM track are exempt from attesting to the MIPS program – if they qualify for bonus payments.

The APM program, on the other hand, includes the Medicare Shared Savings Program (MSSP) ACOs, all CMS Innovation Center initiatives except Health Care Innovation awards, and certain demonstration programs. Only certain APMs will be categorized as an “eligible APM” under the MACRA proposal.

MACRA requires that payments under an APM be based on quality measures that are comparable to those used in the MIPS program. To qualify for payments, the APMs must also use certified EHR technology, report on certain quality measures, and bear more than nominal financial risk. Overall, APMs offer greater potential financial risks and rewards than MIPS.

It is important to note that not all providers who participate in an APM will qualify for an exemption to MIPS attestation, though they will receive

favorable scoring under MIPS for undertaking an APM agreement. Only those providers participating in Advanced APM structures will have the potential to escape MIPS attestation.

### What are Advanced APMs?

Advanced APMs are very similar to APMs. They just have a few additional requirements. According to MACRA, there are actually two types of advanced APMs: Advanced APMs and Other Payer Advanced APMs.

Advanced APMs must:

- Require participants to use Certified EHR Technology
- Provide payments based on quality measures comparable to those used in MIPS
- Require participants to adopt a Medical Home Model or accept more than a nominal amount of financial risk

To qualify as an Other Payer Advanced APM, a commercial or Medicaid APM must:

- Require participants to use Certified EHR Technology
- Provide payments based on quality measures comparable to those used in MIPS
- Require participants to adopt a Medicaid Medical Home Model or bear financial risk for more than a nominal amount

The Medical Home Model requirement is what sets the Advanced APM apart from regular APMs. Success under the Advanced APM umbrella may allow participants to become qualifying APM participants (QPs), which can produce additional financial incentives.

### What are the financial implications of MIPS, APMs and Advanced APMs?

Under MIPS, providers' base rate of Medicare Part B payment would be adjusted based on a composite performance score. Providers would receive positive, negative, or neutral adjustments. In 2019, the maximum negative payment adjustment is -4%, but a positive payment adjustment could be as much as +12% when the bonus potential is accounted for. The baseline then incrementally increases to +/-9% in 2022 and onward.

Each of the four MIPS performance categories are weighted to help determine performance. For 2019 to 2024, CMS will give an additional payment adjustment to the highest MIPS performers for exceptional performance.

QPs in one or more eligible APMs will be exempt from MIPS, receive a 5% bonus on Medicare Part B services, and receive higher annual increases in their payments.

According to the Healthcare Financial Management Association, MACRA identified specific eligible APMs that will qualify for bonus payments and exemption from MIPS reporting. These include:

- Next Generation ACO
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program (MSSP) Tracks 2 and 3
- Oncology Care Model with two-sided risk
- Comprehensive ESRD Care (for large dialysis organizations)
- An additional proposed ruling has been submitted to qualify Bundled Payment Models as an Advanced Payment Model

However, 95% of MSSP ACOs are participating in Track 1 of the program, which would not qualify them for an exemption from MIPS. These providers, who do not currently accept downside risk from Medicare, would have to attest to the MIPS program instead.

Additionally, under MACRA, a bonus payment would be made to providers who operate under the most advanced APMs. Advanced APMs would still be able to get APM specific rewards. However, clinicians would also be subject to a quality performance score that could lead to reductions or increases in their Medicare reimbursement.

### Who can receive financial incentives under the eligible APM framework?

An Advanced APM that expands the Medical Home Model or requires participants to accept a significant amount of downside financial risk is considered to be an “eligible APM,” according to MACRA law. Eligible APMs are able to gain even more financial benefits compared to MIPS and regular APMs. Eligible APM participants can get specific rewards as well as a 5% lump sum bonus.

### How do ECs become a Qualifying APM Participant (QP)?

Clinicians that participate in the most advanced APMs may be able to become QPs. QPs are exempt from MIPS. They will receive 5% lump sum bonus payments for years 2019-2024. They will also receive a higher level of reimbursement during fee schedule updates for 2026 and going forward.

QPs are providers who receive 25% of their payments through an eligible APM. Starting in 2021, this threshold percent may be reached through a combination of Medicare and other non-Medicare payer arrangements, such as Medicaid and private payers.

Websites referenced for this article: [MGMA.com](http://MGMA.com), [RevCycleIntelligence.com](http://RevCycleIntelligence.com), and [CMS.gov](http://CMS.gov) ■

## Employing Advanced Practice Providers: Balancing Benefits and Potential Malpractice Risks

By Kathleen Moon, ARNP, LHRM, Patient Safety Risk Manager, The Doctors Company

Advanced practice providers (APPs)—mainly nurse practitioners (NPs) and physician assistants (PAs)—can be found in a wide variety of specialty areas and clinical settings, including hospitals, outpatient clinics, and rural community centers. The APP is an important and integral member of the healthcare team, assisting physicians in providing a wide range of healthcare services.

Practices and hospitals that employ APPs can experience many benefits; however, employers of APPs should consider implementing effective risk management measures to help ensure that the benefits of using APPs are not at the expense of increased liability exposure.

The role of APPs has broadened substantially since the first training programs were created in response to a physician shortage approximately 40 years ago. The number of PAs in the United States has increased 36.4% over the last five years<sup>1</sup>, and the number of NPs has doubled in the past 10 years<sup>2</sup>. APPs now perform both routine and complicated medical services for hospitals and medical practices across the country.

An APP is often covered under the physician's or hospital's malpractice insurance policy under vicarious liability coverage. APPs can be held directly liable for their own acts or omissions, but, in addition, under the legal theory of vicarious liability, physicians and hospitals can also be held liable for the actions of their employees, including APPs. Therefore, the physician or hospital is often named in malpractice claims involving their APPs.

According to closed claims data compiled by The Doctors Company and the PIAA, most malpractice claims attributed to APPs can be traced to clinical and administrative factors that potentially could have been identified and remedied by the employing physician or hospital, including:

- Operating outside of the APP's scope of practice,
- Inadequate physician supervision of the APP,
- Absence of written protocols,
- Deviation from written protocols, and
- Failure and delay in seeking referral or physician collaboration.

The following is an example of a claim involving an APP:

*A 53-year-old female underwent a laparoscopic cholecystectomy, which was performed without incident by the insured general surgeon. The surgeon saw the patient three days post-op, noting that she was doing well and had no complaints other than the expected incisional pain. The patient was next seen at five days post-op by the surgeon's PA. The PA noted an obvious infection at the umbilical surgical wound. He obtained a culture (which was later proved to be Klebsiella) and started the patient on Levaquin, an antibiotic. The patient returned four days later and was reevaluated by the surgeon, who noted that the wound still looked infected, with the presence of drainage. The surgeon felt that the patient had cellulitis, continued the antibiotic, and advised her to return if needed. A week later the patient returned and was seen by the PA. She complained of recent onset of nausea, vomiting, and diarrhea and had a temperature of 103 degrees. Although the PA noted that the wound still appeared infected, because the patient's abdomen was not tender and no masses were felt, he diagnosed the patient as having a "superficial wound infection" and "gastroenteritis." The PA told the patient to continue the Levaquin and prescribed Phenergan for the nausea and vomiting. Three days later, the patient was admitted through the ER with an acute abdomen. She underwent exploratory surgery and was diagnosed with an intrahepatic abscess. The patient then developed disseminated intravascular coagulopathy, continued to deteriorate, and expired several days later. Suit was filed against the insured, the PA, and the insured's medical practice. The primary issue was the failure to diagnose and treat the intrahepatic abscess. Defense experts could not support the PA's failure to properly assess the patient when she presented with obvious clinical signs of infection. The PA was criticized for failing to consult with the surgeon. The surgeon, who signed off on the PA's medical*

*management of the patient, was held vicariously liable for the acts of the PA and directly negligent for his inadequate supervision of the PA.*

To help decrease liability risks, the employing physician or hospital should have a written policy outlining the APP's scope of practice. This policy should be signed by the APP and other staff members annually. In putting together this policy, it is important to know the laws in your state that govern the scope of practice of APPs. For example, supervision of an NP by a licensed physician is not required in certain practice settings in some states, which allows NPs to practice independently. Although supervision may not be required, most NPs practice under the guidance of a licensed physician. PAs, however, are only allowed to practice under a supervising physician.

Other suggestions to decrease liability risks include:

- Ensure that all newly hired APPs undergo orientation with the practice or hospital.
- When scheduling appointments, staff should inform patients when they are being scheduled with an APP. If that patient requests to see his or her physician, the staff should provide the patient with that option.
- Make certain APPs wear identification that indicates their name and their job title.
- Develop treatment guidelines and clinical triggers for physician consultation. Meet with the APPs regularly to discuss their roles and expectations within the practice, and document these meetings.
- Regularly review the charts, including prescription monitoring, of patients seen by the APPs.
- Make sure that all staff members, including APPs, have adequate professional liability coverage. For nonemployed APPs, liability coverage should be equal to what the physician or practice carries.

Because APPs can be full partners with physicians in malpractice litigation, it is

(Continued on page 13)

## AMCNO Past President Named to First Year Cleveland Board

AMCNO Past President, **Dr. Laura David**, was selected by the AMCNO Board of Directors to represent the AMCNO on the First Year Cleveland Board. First Year Cleveland is an initiative aimed at reducing infant mortality in Cleveland and Cuyahoga County and the board includes representatives from the City of Cleveland, Cuyahoga County, area health systems and organizations and the philanthropic community. Their purpose is to reduce infant mortality and its disparities in Cleveland and Cuyahoga County.

The overall infant mortality rate—babies who die before their first birthday—in Cuyahoga County is 8.1. In Cleveland it is around 13. Cuyahoga County is one of nine Ohio communities engaged through the Ohio Department of Medicaid to identify innovative projects that connect at-risk women and infants to quality health care and care management.

First Year Cleveland has been awarded more than \$2.9 million from the Ohio Department of Medicaid and the plan is to utilize this funding to support the following:

- Centering Pregnancy – a unique program that provides prenatal care and birth-related information and support to pregnant women in a group setting.
- Home Visiting Programs – through partnerships with MomsFirst, the Ohio Infant Mortality Reduction Initiative and other programs, first-time mothers receive valuable knowledge and support in the

areas of prenatal care, breastfeeding, safe sleep and family planning.

- Local Fatherhood Initiatives – support and funding to target and teach new fathers how to care for their new babies.

## Dr. Ronan Factora is Appointed to the SMBO

Governor John Kasich recently announced several state appointments, including AMCNO Cleveland Clinic Foundation group member **Ronan M. Factora, MD**, to the State Medical Board of Ohio.

Dr. Factora's term began August 12 and will end March 18, 2019. He is part of the staff at the Center for Geriatric Medicine at the Cleveland Clinic Medicine Institute, as well as Program Director for the Geriatric Medicine Fellowship and Co-Director of the Aging Brain Clinic. He is Associate Professor of Medicine at the Cleveland Clinic Lerner College of Medicine of Case Western Reserve University. Dr. Factora is also a diplomate of the American Board of Internal Medicine.

After receiving his medical degree from The Ohio State University, College of Medicine and Public Health, he completed his internal medicine residency at Montefiore Hospital, University of Pittsburgh Medical Center, and his geriatrics fellowship at the Cleveland Clinic.

### Additional Member News:

**Brian Harte, MD**, has been selected to serve as the new president of Cleveland Clinic Akron General and the Southern Region. He began his new position on Sept. 26. Dr. Harte has

been working with the Cleveland Clinic since 2004, where he has served in numerous leadership roles. For the last three years, he has been serving as president of Cleveland Clinic Hillcrest Hospital. Prior to that, he was the president of Cleveland Clinic South Pointe Hospital.

**James Hekman, MD**, has been appointed as Medical Director for the new Cleveland Clinic Lakewood Family Health Center, where he will focus on achieving world-class ambulatory and emergency department care. He will also work with the Lakewood community to encourage wellness through educational talks, health fairs, community volunteerism and partnering with local organizations. In 2014, Dr. Hekman was appointed as a Clinical Assistant Professor with the Cleveland Clinic Lerner College of Medicine.

**Joan Papp, MD**, received an Emergency Medicine Basic Research Skills Grant for her project, "Take-home naloxone rescue kits following heroin overdose in the emergency department to prevent opioid overdose related repeat ED visits, hospitalization and death."

**Michael Steinmetz, MD**, has been named Chairman of the Department of Neurosurgery at Cleveland Clinic. In this role, Dr. Steinmetz will lead a team of neurosurgeons devoted to the most advanced surgical treatments for patients with neurological disorders and injuries, according to Cleveland Clinic. He will also oversee the administrative and academic activities of the Department of Neurosurgery and continue to serve in a leadership role in The Center for Spine Health. ■

## Employing Advanced Practice Providers: Balancing Benefits and Potential Malpractice Risks *(Continued from page 12)*

imperative that medical practices and hospitals design purposeful measures to reduce risks. Employers of APPs should work with their APPs to initiate meaningful changes that will potentially protect the healthcare team from liability risks, reduce adverse events, and promote patient safety.

To read more case studies about employing APPs and for detailed risk management checklists, download The Doctors Company's guide to an APP preventive action and loss prevention plan at <http://ow.ly/OxqBm>.

### References

1. 2014 *Statistical Profile of Certified Physician Assistants*. National Commission on Certification of Physician Assistants. <https://www.nccpa.net/uploads/docs/2014StatisticalProfileofCertifiedPhysicianAssistants-AnAnnualReportoftheNCCPA.pdf>. Accessed May 18, 2015.
2. Auebach DI. Will the NP workforce grow in the future? New forecasts and implications for healthcare delivery. *Med Care*. 2012 Jul;50(7):606–10.

*Kathleen Moon, patient safety risk manager at The Doctors Company, can be contacted at [kmoon@thedoctors.com](mailto:kmoon@thedoctors.com).*

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The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered. ■

## CMS Region V Update

In September, staff from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) participated in a Centers for Medicare & Medicaid Services (CMS) Region V State Medical Society teleconference. Also attending this meeting were representatives from statewide medical associations representing Ohio, Michigan, Indiana, and Missouri. Some of the topics covered are outlined below.

**Revalidation** – CMS has established new screening requirements for new and existing providers/suppliers – which required all new and existing providers/suppliers to be revalidated under these new requirements. Due dates for revalidation were posted on the data revalidation website. Revalidation is required to avoid a possible hold on Medicare payments and deactivation of Medicare billing privileges. For more details visit the CMS website at <http://go.cms.gov/MedicareRevalidation>.

**QRUR** – Annual Quality and Resource Use Reports (QRUR) are now available for all group practices and solo practitioners nationwide. The QRUR is available on the CMS Enterprise Portal at <https://portal.cms.gov> and can be accessed by an authorized representative of the Tax Identification Number (TIN) using the Enterprise Identity Management (EIDM) account.

**MACRA** – In an effort to allay concerns raised by physicians and other stakeholders in health care, CMS announced four options that will allow physicians and other providers to “pick their pace of participation” in the new Medicare Quality Payment Program that gets underway January 1, 2017.

In a recent blog post CMS Acting Administrator Andrew Slavitt detailed how these options would allow physicians to avoid a negative payment adjustment in 2019. He described four options that would allow physicians to “pick their pace” of participation, including the first option, which is designed for smaller practices that may not be ready to provide a full year’s worth of reporting information. In that option, a physician practice need only submit “some data” to “test the Program” and avoid a negative payment adjustment. The second option would permit a practice to submit a

partial year’s worth of data, including data that might relate to a performance period beginning after January 1, 2017. In this scenario, a practice could still qualify for a positive payment adjustment. The third option is to participate for the full calendar year in order to qualify for the positive payment adjustment. The fourth and final option is to participate in an Advanced Alternative Payment Model, such as the Medicare Shared Savings Track 2 or 3 in 2017.

In addition, CMS is working on a portal system for physicians to use so that physicians can utilize the portal to review options and other background materials and start preparing for the coming year. The portal will offer scenarios on inputting the data, and it will not only show how to submit data but how to improve practices.

**At press time the Final Rule had just been released. Additional information will be provided in future publications as well as on the AMCNO website. To view an executive summary of the Final Rule go to [https://qpp.cms.gov/docs/QPP\\_Executive\\_Summary\\_of\\_Final\\_Rule.pdf](https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf) ■**

## Physicians Need to Consider Immediate Action to Comply with Section 1557 – New ACA Anti-discrimination and Effective Patient Communication Posting Requirements

Earlier this year, the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) adopted final federal regulations concerning the anti-discrimination mandate of Section 1557 of the Affordable Care Act, requiring many medical practices that receive federal funding to post an anti-discrimination notice and provide information for effective communications as of October 16, 2016.

Under Section 1557, individuals are protected from discrimination in health care on the basis of race, color, national origin, age, disability, and sex, including discrimination based on pregnancy, gender identity, and sex stereotyping.

The Final Rule applies to those who provide or administer health-related services or insurance coverage and receive “federal financial assistance,” which includes Medicare, Medicaid, Meaningful Use payments, Centers for Medicare & Medicaid Services gain-sharing demonstration projects, and other federal funds. Every healthcare provider must determine whether this rule applies to its operations.

Among the mandate, affected medical practices must conspicuously post notices containing the following information:

- The medical practice does not discriminate

on the basis of race, color, national origin, age, disability, or sex.

- The availability of auxiliary aids and interpreter services to people with disabilities or limited English proficiency for purposes of effective communications.
- The procedure for reporting a complaint.
- Where to file a discrimination claim with the OCR.
- Medical practices with 15 or more employees need to provide contact information for the employee responsible for coordinating Section 1557 compliance investigations within the medical group.

Additionally, medical practices must post “taglines,” or short statements indicating the availability of language-assistant services free of charge. Notices and taglines must also be posted on the medical practice’s website.

Affected medical practices, regardless of the number of employees, must **develop a written plan outlining the procedure** that will ensure the adequate and timely provision of language-assistant services. In addition, medical practices with 15 or more employees need to designate a coordinator to handle Section 1557 complaints. Private medical practices, ambulatory surgery centers, and other providers that receive any federal funds should assess whether they need to become compliant with the October 16 deadline notice requirements. Failure to act could expose healthcare providers to considerable penalties or legal sanctions. Complaints to OCR can result in investigations by HHS and the Department of Justice.

To assist with implementation, OCR has translated into 64 languages a sample notice and taglines for use by covered entities. In addition, OCR has published a summary of the rule, factsheets on key provisions and a list of frequently asked questions. To access these materials, visit [www.hhs.gov/civil-rights/for-individuals/section-1557](http://www.hhs.gov/civil-rights/for-individuals/section-1557). ■

## AMEF to Sponsor the Infant Mortality Summit 2016

The Academy of Medicine Education Foundation (AMEF) is pleased to be a sponsor of the Infant Mortality Summit 2016, hosted by the Ohio Department of Health (ODH) and the Ohio Collaborative to Prevent Infant Mortality. The event will take place Dec. 5 and 6 at the Huntington Convention Center of Cleveland.



Registration for this free event is now open. You can sign up online through the ODH website at [www.odh.ohio.gov](http://www.odh.ohio.gov). Through the site, you'll also be able to view an agenda for the two-day event, as well as receive parking and hotel accommodation information. Continuing Professional Development credit is being offered for the Dec. 6 event.

Ohio's infant mortality rate is higher than most states and the nation as a whole. The 2014 overall infant mortality rate was 6.8. In Cleveland, it was 5.3 among whites, 14.3 among African-Americans, and 6.2 among Hispanics. This conference will highlight the problem and focus on solutions.

The goal of the event is to have 1,500 Ohioans be committed to achieving the Healthy People 2020 objective of 6.0 infant deaths per 1,000 live births in every racial and ethnic group, be better informed about infant death and disparities in Ohio, and be inspired, energized and equipped with ideas and action steps to work for change in their communities.

### Register NOW

REGISTER @ <http://bit.ly/2016OhioIMSummit> Or go to [www.eventzilla.net](http://www.eventzilla.net) and search Infant Mortality Summit

Hotel, Parking, and venue information are located on the Eventzilla registration page. For more information, including an agenda go to <http://bit.ly/OCPIMSummit2016>

## 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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## Are you Interested in Running for the AMCNO Board of Directors in 2017?

Directors are elected to represent their district, which is determined by primary hospital affiliation or at large for a two-year term. Members of the Board are responsible for addressing issues of importance to physicians and the patients we serve, and setting policy for the AMCNO. If you are interested in running for the Board of Directors please return this form with your name and contact information to the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio, 44131. You may also FAX your information to Elayne Biddlestone at (216) 520-0999 OR call her at (216) 520-1000, ext. 100. Deadline: 12/31/16.

Yes, I am interested in running as a candidate for the AMCNO Board of Directors \_\_\_\_\_

Name and contact information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



The Academy of Medicine of Cleveland & Northern Ohio, The Academy of Education Foundation and the William E. Lower Fund Present:

## GEARING UP FOR RETIREMENT

**WHO:** Physicians and spouses

**WHAT:** Retirement Seminar

**SPEAKERS:** Representatives from Walthall CPAs and Sagemark Consulting

**WHERE:** AMCNO Offices Lower Level Meeting Room, 6100 Oak Tree Blvd., Independence, OH 44131

**WHEN:** January 25, 2017 (Registration/Dinner: 6:00 PM, Program: 6:30 - 8:30 PM)

As a physician, you have a lot to do throughout the day. Worrying about whether you're doing enough for your retirement shouldn't be on the list.

The AMCNO is hosting a seminar on the simple steps you can take now to help ensure you have a financially comfortable retirement.

During this event, you will learn valuable information that will benefit your future.

### Walthall CPAs Topics:

- Maximize Your Social Security Benefits
- Learn More about Medicare Coverage
- Find Out which Taxes Will be Relevant to You
- Review Estate Planning - wills, trusts, advanced directives

### Sagemark Consulting Topics:

- Assess Investment Risk in Retirement
- Investment Strategies During Retirement
- Develop and Maintain a Financial Plan
- Creative Estate Preservation Designs

**Registration is required.** Use the form below or call us 216-520-1000. For more information email Abby Bell at [abell@amcno.org](mailto:abell@amcno.org).

**REGISTRATION FEES:**  
 AMCNO Members - \$50  
 Non-Members - \$100

**Mail:** AMCNO, 6100 Oak Tree Blvd, Suite 440, Independence, OH 44131  
**FAX:** 216-520-0999  
**Call:** 216-520-1000  
**Email:** [abell@amcno.org](mailto:abell@amcno.org)  
**Register online:** <http://www.amcno.org/index.php?id=1187>

Name \_\_\_\_\_

Company/Hospital \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Check Enclosed  Visa  MasterCard  Discover  AmEx

Credit Card No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

Signature \_\_\_\_\_