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To Text or Not to Text is No Longer a Question

Medicare and The Joint Commission Clarify Position on Texting Patient Orders and Patient Information in Hospital Settings

By Isabelle Bibet-Kalinyak, Esq., McDonald Hopkins LLC

The verdict on whether healthcare providers may use texting as a method to communicate patient orders and patient information in the hospital is in. The Centers for Medicare & Medicaid Services (CMS or "Medicare") and The Joint Commission have unanimously spoken: **No texting of patient orders, but texting patient information through a secure platform remains permissible, albeit not preferred. Importantly, these rules only apply to providers working in hospital settings, including critical access hospitals.**

Medicare

Although the use of text messaging is now ubiquitous in our society, healthcare providers practicing in hospitals and critical access hospitals are subject to higher standards and simply cannot use texting as a substitute for computerized provider order entry (CPOE). In its December 28, 2017, Survey and Certification Memorandum[1], subsequently revised on January 5, 2018[2] to clarify the scope of the new rules, Medicare recognized that the use

(Continued on page 2)

AMCNO Supports Prescription Drug Co-Pay Integrity Act

The AMCNO attended a press conference held by Representatives Scott Lipps (R-Franklin) and Thomas West (D-Canton) to show our support for the Prescription Drug Co-Pay Integrity Act (HB 479)—important new legislation that will address clawbacks taken by pharmacy benefit managers (PBMs).

Clawback is a tool PBMs use to overinflate the cost of prescription medications at the point-of-sale transaction. Essentially, a PBM clawback forces some pharmacies to charge customers more than the pharmacy's cash price. The PBM then "claws back" the money the patient was overcharged. PBMs also use contractual gag restrictions to prevent pharmacy employees from discussing all prescription costs with their customers. Clawbacks and gag restrictions have been witnessed in every state and have resulted in more than a dozen lawsuits across the country.

This new bill will improve Ohioans' access to prescription medications by prohibiting a health plan or PBM from directing a pharmacy to charge a patient an amount greater than the pharmacy's cash price or the net reimbursement to the pharmacy. This practice ensures that the patient will pay the lowest possible amount at the pharmacy counter, regardless of any co-pay gimmicks. This legislation will also prohibit a health plan or PBM from forcing a pharmacist to remain silent when it comes to the financial details and options concerning their patients' medications.

(Continued on page 3)

Rep. Scott Lipps (left) and Rep. Thomas West (right) discuss the Prescription Drug Co-Pay Integrity Act at a recent press conference.

INSIDE THIS ISSUE

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To Text or Not to Text is No Longer a Question *(Continued from page 1)*

of texting as a means of communication among members of the healthcare team is "an essential and valuable means of communication." However, it also clarified that the use of standard unsecured short message service text messaging (SMS) from a personal mobile device is inadequate and therefore prohibited. In the spirit of fostering strong protections for patients' health records and continuing to curb the potential for medical errors, Medicare has now established some clear rules for healthcare providers in hospital settings, effective December 28, 2017:

1. Texting patient information among members of the hospital healthcare team is permissible, but only from secure, encrypted systems and platforms to minimize the risks to patient privacy and confidentiality. Providers cannot merely use their personal unsecured cell phones.
2. Medicare expressly prohibits the use of texting to communicate patient orders, a practice that is not in compliance with the Medicare Conditions of Participation[3] (CoPs) or Conditions for Coverage (CfCs).
3. CPOE is the preferred method of order entry for all providers working as part of the hospital healthcare team. Medicare continues to permit handwritten orders (and verbal orders, subject to some additional requirements[4]) in the medical records but it plainly prefers CPOE entry (even if the provider accesses remotely) because CPOE orders are automatically dated, timed, authenticated, and promptly downloaded into the electronic health records (EHR) system.

In its memorandum, Medicare emphasized that failure to comply with the above standards is a clear violation of the Hospital CoPs or Critical Access Hospital CoPs[5], as applicable, and reiterated such CoPs as a reminder:

> **42 C.F.R. § 482.24(b) Standard: Form and retention of record.** The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. […] Medical records must be retained in their original or legally reproduced form for a period of at least 5 years. The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with Federal or State laws, court orders or subpoenas.
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> **42 C.F.R. § 482.24(c)(2)(i) Standard: Content of record.** All records must document […] all practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.

The Joint Commission

These Medicare rules echo The Joint Commission recommendations issued in December 2016[6]. After weighing the issue for several months and consulting with industry experts, The Joint Commission declared that the use of text messaging for patient orders is simply not acceptable, even when using a secure platform. It identified a variety of issues that swayed its decision, including the increased burden on nurses to manually transcribe text orders into the EHR and the potential for errors at that stage, compounded by the necessity to undertake additional steps to confirm or clarify the text order and possible ensuing delays due to the asynchronous nature of the interaction between the provider and the nursing staff when texting as opposed to verbal communications. The Joint Commission and CMS agree that CPOE should remain the preferred method for submitting orders, followed by written orders, and if neither CPOE nor written orders are possible or practical without delaying treatment, providers may resort to verbal orders. Verbal orders should, however, not be used frequently and, as specified in the CoPs, definitely not for the convenience of the ordering practitioner.

The Joint Commission standards[7] require accredited organizations to have written policies addressing the privacy of health information. Such policies must now include a blanket prohibition on texting patient orders (even through secured media), and a prohibition on using unsecured text messaging for communicating protected health information among members of the healthcare team. Further, such policies should be discussed routinely during the orientation period of all personnel working in the facility.

Hospitals and healthcare practitioners have now been forewarned: No texting patient orders under any circumstances, and no using personal unsecured cell phones to text patient information. Although providers can expect these items to surface during quality and accreditation audits, the application of these new rules to billing audits remains unclear. Will Medicare consider a transcribed texted order a valid order for payment purposes? That remains a question. In light of the exponentiation of data breaches, private practice groups and individual physicians operating outside the hospital should take notice as well and begin to implement similar policies to foster patient privacy and the safety of patient care. Self policing may be less costly (and painful) than having to implement potential new insurance requirements mandating the use of secured platforms only as a condition for cyber liability insurance coverage. ■

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1 Center for Clinical Standards and Quality/Survey & Certification Group, Memorandum Ref. S&C 18-10-ALL. "Texting of Patient Information among Healthcare Providers," available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-10.pdf.

2. Center for Clinical Standards and Quality/Survey & Certification Group, Memorandum Ref. QSOG 18-10-Hospital, CAHs, "Texting of Patient Information among Healthcare Providers in Hospitals and Critical Access Hospitals (CAHs), available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-18-10-ALL.pdf.
3. See Medicare Conditions of Participation, 42 C.F.R. § 482.24(b), available at , and Medicare Conditions of Coverage available at https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part482.pdf.
4. 42 C.F.R. § 482.25(c)(i)-(iii). , available at https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part482.pdf
   (i) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section. (ii) For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under § 482.12(c) and authorized to write orders by hospital policy in accordance with State law. (iii) All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.
5. Critical Access Hospital Conditions of Participation, 42 C.F.R. § 485.638(a) and (b), available at https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part485-subpartF.pdf.
6. The Joint Commission, "Use of Secure Text Messaging for Patient Care Orders is Not Acceptable," December 2016, available at https://www.jointcommission.org/assets/1/6/Clarification_Use_of_Secure_Text_Messaging.pdf.
7. Joint Commission Information Management (IM) Standard IM.02.01.01, Element of Performance (EP) 1.

AMCNO Supports Prescription Drug Co-Pay Integrity Act *(Continued from page 1)*

Clawback fast facts:

- Most people believe that their co-pay is their portion of a shared payment with their insurance company for a particular medical or pharmacy service. However, a clawback is when the patient pays for the entire cost of the service and an extra hidden payment to the insurance company's PBM middleman.
- The legislation will ensure that patients are getting the best deal possible at the pharmacy counter and that they're not in the dark on PBM drug pricing. A recent analysis by a mid-sized pharmacy chain in Ohio found hundreds of clawbacks in the last three months.
- Most clawbacks are relatively small, ranging from a few cents to $5-$7 in most cases, but there are many transactions where patients are overcharged by more than $20. Some of the most egregious clawbacks occur in Medicare Part D, where overinflated co-pays not only pinch patients' wallets, they also place patients into different deductible phases, which has been found to cost taxpayers billions of dollars.

The AMCNO supports this legislation, and has become part of the Ohio Prescription Partnership, because it is an opportunity to do something on behalf of our patients to bring down the cost of prescription drugs. We will continue to follow this issue and report updates to our members.

Update on SMBO Confidential Monitoring Program

Throughout the past few months, the AMCNO and members of the Medical Association Coalition (MAC)—which is comprised of several state and regional medical associations—have been discussing the State Medical Board of Ohio's (SMBO) confidential monitoring program and corresponding rules. The MAC identified several concerns related to these draft rules, including how the program determines entry into the confidential monitoring program based on diagnosis of a condition and not conduct, it is not truly confidential, it could aggravate existing mental or physical health conditions, and it lacks adequate due process. Although the MAC continues to believe that any process—even if it is better than what we currently have—that is perceived as punitive will be a deterrent to physicians voluntarily seeking treatment at the earliest onset of symptoms, the MAC has decided to table our concerns if the SMBO is willing to introduce the program and agree that more data needs to be collected. To that end, once these rules are enacted the MAC has requested that the SMBO provide de-identified reports to the MAC on a six-month interval. We believe that having data to assess how many physicians are taking advantage of this new process will help both the SMBO and the MAC determine if it is an effective tool and reaching physicians with mental health issues. The MAC will continue to work with the SMBO on this issue and evaluate the effectiveness of the program.

AMCNO is Pleased that the One-Bite Legislation has Become Law

House Bill 145 ("One-Bite") cleared the House and Senate and has been signed into law by Gov. John Kasich. The AMCNO provided testimony for this legislation and has been working with the Medical Association Coalition to develop the provisions of this proposal, to make sure physicians' privacy and anonymity would be protected.

One-bite requires the State Medical Board of Ohio (SMBO) to establish a confidential program for the treatment of impaired physicians. It allows providers to avoid discipline by the SMBO if they seek and complete treatment (and other specific criteria are met) for a drug, alcohol or other substance abuse problem, as long as they have not previously participated in one-bite or been sanctioned by the SMBO for impairment.

The bill also requires the SMBO to contract with one organization to conduct the program and perform monitoring services related to the program – and it is likely that the Ohio Physicians Health Program (OPHP) will be selected. For more than 40 years, the OPHP has been confidentially helping impaired physicians regain their health and well-being to serve their patients.

The AMCNO is pleased with the passage of this legislation. It is the result of numerous discussions on how to best provide Ohio physicians with this valuable one-time opportunity to seek treatment for substance abuse-related impairment. It is important that providers are offered this chance to access treatment without fear of repercussion or negative career implications through reporting to the SMBO.

AMCNO and State Medical Associations Send Comments on Compounding Rules to BOP

The AMCNO, the Ohio State Medical Association (OSMA) and several other medical associations have been communicating long-term with the Ohio Board of Pharmacy (BOP) to express concerns about their rules pertaining to compounding practices. We have sent another letter recently, thanking the BOP for revisiting the compounding rules and making changes, but stating that we still have outstanding concerns.

Among the concerns is that the Food and Drug Administration (FDA) recently acknowledged a need to revise draft United States Pharmacopeia (USP) guidance documents related to compounding. The BOP largely relies on USP policies to dictate physician compounding in Ohio, but the FDA plans on better defining the circumstances under which drugs are being mixed and applied in a manner that creates negligible patient risk, and therefore wouldn't be subject to the same compliance policy under the agency's risk-based approach to implementing these requirements. The FDA has also recognized the need for a balanced approach to regulations. Any attempts by the BOP to set new policy prior to publication of these updated guidance documents may create an undue burden on physicians who routinely combine drugs and medicine in a manner that creates negligible patient risk. Therefore, we strongly suggested that the BOP rescind all compounding rules until the national regulatory authorities have determined the appropriate level of oversight needed.

We also expressed specific comments on the draft rules, related to Ohio Administrative Code (OAC) 4729:7-1-01, such as removing "reconstituting" from the definition of compounding, differentiating between "immediate-use" and "immediate administration," and amending the definition of "non-sterile compounded drug" to better define what activities constitute non-sterile compounding. Comments were also addressed for additional sections of the OAC related to compounding.

AMCNO Joins Ohio Physician Wellness Coalition (OPWC)

The AMCNO recently became a partner in the Ohio Physician Wellness Coalition (OPWC). The OPWC is a coalition dedicated to addressing physician burnout and providing physician wellness initiatives. Members of the OPWC include: the Academy of Medicine of Cleveland & Northern Ohio, Ohio State Medical Association, Ohio Osteopathic Association, Ohio Psychiatric Physicians Association, Ohio Academy of Family Physicians, Ohio Hospital Association, Columbus Medical Association, Ohio Physicians Health Program, Ohio Chapter, American Academy of Pediatrics, and Ohio Chapter, American College of Emergency Physicians. The coalition is currently working on developing CME programs that will focus on various topics such as mindfulness and meditation, stress, burnout and resiliency, mental health, the benefits of counseling and

(Continued on page 4)

(Continued from page 3)

support, time management, isolation/socialization, gratitude and addiction. The coalition is also considering conducting meetings around the state to provide a forum for physicians to discuss the issues related to the causes of burnout. A physician advisory committee has been formed to work with the staff members from these associations to develop the program content. Dr. Fred Jorgensen, AMCNO president, will be our representative on this committee.

AMCNO Continues to Monitor the Pending Maintenance of Certification Legislation

As we reported the November/December issue of the *Northern Ohio Physician* magazine, the AMCNO is monitoring House Bill 273, which would prohibit physicians from being required to secure maintenance of certification (MOC) to obtain licensure, reimbursement, employment or admitting privileges.

The need for MOC is being questioned by physicians across the country, even resulting in the passage of legislation similar to HB 273 in eight states. Physicians supporting HB 273 recently provided testimony questioning the value of the current MOC process and whether it actually measures continuing competency in their specialty. Opponents of the legislation noted that this was not an issue for the legislature to decide, whereas others stated that MOC was an important educational process. The AMCNO has taken this legislation under advisement.

Following a December meeting among its board and representatives of state and specialty societies, coordinated by the American Association of Medical Society Executives, the American Board of Medical Specialties (ABMS) has issued a statement about the MOC issue. In part, ABMS said that they understand that MOC programs should deliver more value to participating physicians than they currently do. They have received concerns about complexity, convenience, relevance to practice, and the indirect cost of participating in the programs. They have also been encouraged to identify and implement best practices across the specialties, which will send a consistent signal about what it means to be certified by an ABMS Member Board. The ABMS stated that it is committed to working closely with medical associations and physicians to improve the experience of participating in continuing certification and to ensuring that every participating physician will find value in the process and satisfaction in the profession. They commit to doing so in a way that strengthens the trust that patients, physicians, hospitals, and other healthcare organizations place in certification.

All Boards are implementing changes to make their programs more convenient, supportive and cost-effective. Each Board has taken its own approach, based on its study of the validity and psychometric rigor of the assessment options, the ABMS said, as well as the preferences expressed by their diplomates. For example, Boards have modularized the exam in specific practice areas and given their diplomates more flexibility over the scope and frequency of assessment, modernized the assessment through convenient online testing or remote proctoring to eliminate the need for traveling to exam centers, and some Boards now permit the use of reference materials during the exam to simulate real-life application of knowledge and decision-making.

The Boards are also working on changes, such as initiating a major redesign of ABMS governance to increase Board accountability and provide ongoing opportunity for participating physicians to directly impact ABMS programs and policy; initiating the development of organizational standards to increase operational consistency, transparency and effectiveness across the Boards; and launching the *Continuing Board Certification – Vision for the Future* initiative to gather broad input about continuing certification from a wide range of stakeholders, consider alternatives and make recommendations for the future.

Additional changes are also under review, such as adopting a new governance structure that creates mechanisms to increase physician input, developing a mechanism to report initial certification along with continuing certification on the ABMS public website, and providing opportunities for physicians and all other stakeholders to provide direct input to ABMS about the MOC experience and advice for the future of continuing certification.

The full ABMS statement can be found on their website, www.abms.org.

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

State Medical Board of Ohio Answers Questions Regarding Medical Marijuana

May a licensee of the Medical Board administer, dispense, utilize, or topically apply products containing medical marijuana in the course of treatment of a patient?
No. Ohio law does not authorize any Medical Board licensee to possess medical marijuana in the course of his or her practice. This includes the application of massage oils and creams containing cannabinoids, including THC or CBD.

What are the requirements for doctors wanting a certificate to recommend medical marijuana?
Applicants must hold an active, unrestricted MD or DO license from the State Medical Board of Ohio. Additionally, applicants will need to complete at least two hours of continuing medical education that will assist in diagnosing qualifying conditions, treating those conditions with medical marijuana and possible drug interactions. Full requirements for a certificate to recommend are outlined in Ohio Administrative Code 4731-32-02.

Where can a physician find the qualifying CME training?
Only medical marijuana CMEs approved by the Ohio State Medical Association (OSMA) and the Ohio Osteopathic Association (OOA) meet the requirements for a certificate to recommend. OSMA has posted information on its website, www.osma.org; OOA will be sharing additional information soon.

Applications for certificates to recommend medical marijuana will be available in late spring. Log on to www.medicalmarijuana.ohio.gov for more information about Ohio's medical marijuana control program.

SMBO Provides Input on ICD-10 Requirements

ICD-10 Required on Opioid Analgesic Prescriptions
Prescribers are required to indicate the first four alphanumeric characters of the ICD-10-CM medical diagnosis code (eg, M16.5) on all opioid analgesic prescriptions. The diagnosis/procedure code requirements became effective for all opioid prescriptions on Dec. 29, 2017. If your EHR system cannot generate the ICD-10 code automatically, simply write or type in the code on the prescription.

Days' Supply Required for Controlled Substance and Gabapentin Prescriptions
Changes in Pharmacy Board Rule 4729-5-30, OAC, require prescribers to include the days' supply (ie, minimum number of days) that the prescription for a controlled substance or gabapentin should last the patient. This requirement went into effect on Dec. 29, 2017.

Written, Faxed and Electronic Prescriptions
The Pharmacy Board rule also makes changes to the requirements for written, faxed and electronic prescriptions. Except in limited circumstances, prescribers can no longer transmit prescriptions using a transmission system that converts the prescription into a computer-generated fax or scanned image. For more information on the exceptions, visit the pharmacy board website, pharmacy.ohio.gov. ■

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Ohio Department of Medicaid Outlines Work Requirement and Community Engagement Waiver Proposal

The Office of Health Transformation (OHT) Director Greg Moody and the Ohio Department of Medicaid (ODM) Director Barbara Sears outlined a work requirement waiver proposal during a February telephone conference with the Ohio Medicaid Coalition (the AMCNO is part of this coalition). This information was also disseminated statewide and posted on the ODM website.

The goal of the work requirement is to promote financial independence, community engagement and better health outcomes among Medicaid expansion enrollees.

During the call Director Moody noted that the fiscal year 2018-2019 operating budget (HB 49) required ODM to seek federal approval to require Medicaid enrollees in the expansion group to work unless they are over the age of 55, enrolled in school or occupational training, participating in a drug or alcohol addiction treatment program, or have intensive physical healthcare needs or serious mental illness.

In January 2018, the Centers for Medicare and Medicaid Services (CMS) announced guidelines for states to test incentives that would make participation in work or other community engagement a requirement for continued Medicaid eligibility. These guidelines are only applicable to non-elderly, non-pregnant adults who are eligible for Medicaid on a basis other than disability. In February 2018, ODM proposed to implement a work requirement for Medicaid enrollees effective July 1, 2018, based on the budget requirement that aligns with Ohio's existing requirements for work and community engagement under the Supplemental Nutrition Assistance Program (SNAP) and the Able-Bodied Adults without Dependents (ABAWD) program. The department has now released its request for a waiver from the federal government to implement work requirements.

Director Moody noted that based on their review, most of the 700,000 Ohioans enrolled in the Medicaid expansion already work—58% earned an income in the previous year and 44% currently meet the work requirement. It is estimated that 95% of current enrollees will meet the requirement or will be exempt: 73% of current enrollees are known to be exempt from the work requirement (eg, they are aged 55 or older), 9% not otherwise exempt have income that indicates they meet the requirement, and 13% not otherwise exempt are likely to meet the requirement based on the SNAP guidelines. He noted that the remaining 5%, or about 36,000 current Medicaid expansion enrollees, will need to comply with the work requirement or face disenrollment from the program.

To comply with the work requirement, Medicaid expansion enrollees will need to demonstrate they work at least 20 hours a week or are engaged in other allowable activities, such as job search, education and training, or unpaid work in certain cases. New enrollees must meet the requirement when they enroll, and current enrollees must meet the requirement during their annual eligibility renewal. If they fail to meet the requirement, their Medicaid benefits will be terminated.

Recipients exempted from the Medicaid work requirements include those who are:

- 55 or older,
- Physically or mentally unfit for employment,
- Caring for a disabled or incapacitated household member,
- Pregnant women,
- Parents or caretakers of minor children,
- Receiving or who have applied for unemployment compensation,
- In school at least half time,
- In drug or alcohol treatment,
- In an assistance group under Ohio Works First and
- applicants for or recipients of Supplemental Security Income.

As noted, the waiver is posted on the Medicaid website and will be available for public comment through March 18, 2018. Public hearings took place in late February and early March. To learn more about how to comment go to the Ohio Medicaid website at http://medicaid.ohio.gov.

Following the public comment period the ODM will consider the comments and then finalize the application and send it to the federal government. The government has a 30-day mandatory requirement, where the application is open to public comment and then they wait an additional 15 days prior to making a final decision. ODM has timed this process in an effort to have this in effect in Ohio by July 2018–dependent of course upon the application process. Director Moody noted that they have tried to be careful in their approach to meet the letter of the law and the federal guidance. The AMCNO will continue to monitor this process and the hearings on this matter and provide information to our members as it becomes available. ■

March 30 is National Doctors' Day – AMCNO Salutes Our Members

March 30, 2018, marks the annual observation of National Doctors' Day, which was established to recognize physicians, their work and their contributions to society and the community.

On this special day, the AMCNO would like to say "thank you" to our members and to all of the physicians in Northern Ohio for everything they do for their patients in our community.

AMCNO Becomes Partner in Northeast Ohio Hospital Opioid Consortium

The AMCNO is pleased to note that we have become a partner in the Northeast Ohio Hospital Opioid Consortium. Dr. Tom Collins, an AMCNO officer and board member, is now attending the meetings of this group to provide input on behalf of the physician members of the AMCNO. Dr. Collins attended his first meeting of the consortium in February, where the group discussed how to move the action plan forward. It was decided that the action plan would be re-evaluated and brought back to the group in late March. While the action plan is under review, the physician members of the consortium plan to meet to consider educational materials that may be utilized across hospital systems.

Take Charge Ohio Website Launched

Several state agencies—including the Ohio Department of Health (ODH), the Governor's Cabinet Opiate Action Team (GCOAT), the Prescription Drug Abuse Action Group (PDAAG), and state licensing boards including the State Medical Board of Ohio—have developed the Take Charge Ohio initiative. The AMCNO was initially involved in the GCOAT and continues to participate as a member of PDAAG. Each partner offered expertise and experience related to its field to provide a full picture of the current state of pain medication use in Ohio. These partners also shared resources, which have been consolidated to allow Ohio patients and prescribers to access valuable tools and information on one website, http://takechargeohio.ohio.gov.

Take Charge Ohio is an initiative to empower all Ohioans to work together to use pain medication safely. Its mission is to empower safe pain management and medication use by educating patients and providing resources for healthcare providers. The intent is to manage pain safely and prevent pain medication abuse.

In recent years, Ohio healthcare providers have made significant progress in transforming the healthcare system in our state to emphasize safe and effective pain management. The resources found on the website will continue to build a culture of responsible prescribing and use of medications. Educational materials empower patients to be involved in their pain management care, and tools such as prescribing guidelines and the Ohio Automated Rx Reporting System (OARRS) ensure that opioid medications are used conservatively and minimize the risk of abuse, misuse and diversion.

Toolkits are available on the website for healthcare professionals, the general public, patients and public awareness.

The AMCNO is assisting with the implementation of the campaign by posting the Take Charge Ohio information and web badge on our website and providing links to their toolkits at http://amcno.org/index.php?id=52. The AMCNO is also following the campaign on Twitter @TakeChargeOhio.

Health Policy Institute of Ohio (HPIO) Launches the Addiction Evidence Project

The Health Policy Institute of Ohio (HPIO) has launched the Addiction Evidence Project to provide policymakers and other stakeholders with information needed to evaluate Ohio's policy response to the opiate crisis, and accelerate and continually improve strategies to address substance use disorders in a comprehensive, effective and efficient way.

The HPIO Addiction Evidence Project will provide state policymakers and other stakeholders with tools to:

- Quickly find existing information about what works
- Review addiction policy changes enacted in Ohio in recent years
- Assess the extent to which new policies align with existing standards and evidence
- Identify areas where Ohio policy can be better aligned with standards and evidence, including potential gaps in Ohio's response to the opiate crisis

To learn more about the Addiction Evidence Project, log on to www.healthpolicyohio.org/tools/addiction-evidence-project. ■

In January, Dr. Joan Papp attended the AMCNO Board of Directors meeting to provide the committee members with an overview of her new role as director of the Office of Opioid Safety at MetroHealth.

A few highlights from her report:

- She and her team are currently focusing on educating providers on the opioid policies at their facility and at the state and federal levels.
- They are developing alternative pain management strategies and educating providers on how to identify patients at risk for opioid use disorder.
- They are working on getting providers educated and licensed to provide buprenorphine treatment for opioid use disorders; to date, about 100 providers have become licensed.

The AMCNO Board would like to thank Dr. Papp for her presentation. You can read more about the Office of Opioid Safety in the 2017 November/December issue of *Northern Ohio Physician*.

Up for Review: Five Keys to Managing Online Criticism

By Kevin Pho, MD, Founder and Editor, KevinMD.com

Patients have more avenues than ever to express themselves online, whether on social media or through physician rating sites like RateMDs, Vitals, and Healthgrades. No matter how professional and caring a doctor you may be, eventually you will face criticism on the web. No doctor will receive universally positive reviews. So when a patient posts critical comments about you, it's important to know how to respond. Here are five keys to managing that criticism.

1. Listen to the criticism. Patients may leave online reviews because they feel this is the only way they can have a voice. After patients leave your exam room, often you don't know what they thought about you or your practice. The criticism might not even be about you. You don't know what patients thought about the nurses or medical assistants, or if they were concerned about the parking or whether the waiting room magazines were up to date. These are issues you may not be aware of—but they matter to patients. By listening to online criticism, you can identify and fix easily correctable situations and improve patients' satisfaction scores.

2. Take critical conversations offline. Whenever you see criticism on the web, there's a strong temptation to respond to it immediately. You want to set the record straight and clear the air. Instead, take the conversation offline. An online argument is unlikely to result in anything productive. Post a standard reply thanking the patient for the comment and asking him or her to call the clinic. Be careful not to reveal any private patient information. If you can resolve the dispute over the phone or in person, the patient may take down the comment or even add an addendum stating, "You know what? This office is actually listening to what I have to say." That can turn a negative situation into a more constructive one. Take the same approach whether the patient's comment is on a ratings site or on social media. If you're employed by a hospital or healthcare system, coordinate your efforts with your marketing or public relations team, who are likely to see an offline conversation as the most beneficial solution for both you and the organization.

3. Read the fine print. If you believe any online comments are suspicious, contact the rating site to see if the comments violate the terms of service agreement. For example, a patient left my practice a little disgruntled. Shortly after that encounter, dozens of negative ratings appeared on a rating site that could have conceivably come from this one patient. I reported the comments because the rating site has a terms of service agreement that prohibits anyone from posting multiple ratings on a single doctor. The company investigated and found that all of the ratings came from a single computer. The site then removed the comments. Always read the terms of service agreement and report any possible violations.

4. Ask more patients to rate you online. Most patients generally like their doctors, and dozens of studies show that a majority of online ratings are positive. By asking more patients to rate you online, you can make negative ratings look more like outliers. In the surgical world, there's a saying about irrigating an abscess: "The solution to pollution is dilution." The same principle applies to physician rating sites. If you ask more patients to rate you online, the positive comments can dilute the negative ratings by placing them lower in search results and making them less visible. Your patients just need to be encouraged to write reviews. Ask your patients to post a review if there's something they like about you or what your practice is doing, or if they have any suggestions for your practice. Don't cherry-pick patients or pressure them to say something positive about your practice, but ask for a rating from every single patient in a low-key and low-pressure way. Many practices even hand out cards with specific instructions on how to rate their doctors online. On the whole, the reviews will be positive.

5. Resist the urge to sue. Only rarely have doctors successfully sued rating sites, which may argue that removing negative ratings is an infringement of a patient's right to free speech. Also, suing patients for bad reviews may backfire. A doctor once sued a patient for a negative review and made front-page headlines in a newspaper. Now whenever you search online for that doctor's name, the newspaper story comes up as the first result. By suing patients over criticism, you will only bring more attention to it and highlight the negative reviews.

Final Thoughts

Doctors by nature take all patient interactions very seriously—and often take criticism personally. We are trained to take a one-on-one approach to patient care and to make sacrifices for our patients. That makes negativity especially hard to hear. It may be difficult to regard online criticism as an inevitable part of the job, but that's what it is. Patients don't expect us to be 100 percent perfect, and patients are more likely to see an 89 percent positive rating on a website as more authentic than a 100 percent rating. Try to manage your patients' expectations—and also try to manage your expectations for yourself. Recognize that you may not be the right fit for every patient, and that sometimes a patient simply has different expectations than you do.

We now live in a world where doctors are rated like professionals in many other industries, a trend that will continue to grow. Many doctors dislike being rated at all, but to succeed in the online world you shouldn't ignore reviews. Instead, approach online ratings proactively. You'll find yourself better able to influence the online conversation about you, fix any shortcomings in your practice, and engage critical patients in a positive, constructive way.

For more tips on social media and online issues, visit The Doctors Company social media resource center at www.thedoctors.com/socialmedia. ■

Contributed by The Doctors Company (www.thedoctors.com).

10 Things You Need to Know and Do prior to the Fast-Approaching MIPS Reporting Deadlines

If you plan to submit data for the 2017 Merit-based Incentive Payment System (MIPS) performance period, be aware that the deadlines are fast approaching. It is suggested that you submit your data early and often. Two key dates to keep in mind are March 16 and March 31. **March 16 at 8 pm ET** is the deadline for *group reporting* via the Centers for Medicare & Medicaid Services (CMS) Web Interface. **March 31** is the deadline for *all other MIPS reporting,* including via the Quality Payment Program (QPP) website, www.qpp.cms.gov.

If you are an eligible clinician, there are 10 things you need to know and do for MIPS data reporting via the qpp.cms.gov data submission feature. It's important to note that the following list focuses on reporting via the qpp.cms.gov data submission feature—not on group reporting via the CMS Web Interface or individual reporting on Quality Measures via claims submission data. (If you're not sure whether you are required to report for MIPS, enter your National Provider Identifier (NPI) in the MIPS Lookup Tool at qpp.cms.gov/participation-lookup to check.)

1. Log on to qpp.cms.gov and click on the "Sign In" tab to use the date submission feature.
2. Check that your data are ready to submit. You can submit data for the "Quality Measures," "Improvement Activities," and "Advancing Care Information" performance categories.
3. Have your CMS Enterprise Identity Management (EIDM) credentials ready, or establish an EIDM account if you don't have one. This type of account gives you a single ID to use across multiple CMS systems. Please note that if you've reported for legacy programs such as the Physician Quality Reporting System (PQRS), you already have an EIDM account.
4. Sign in to the QPP data submission feature using your EIDM account.
5. Begin submitting your data early, so that you have time to familiarize yourself with the data submission feature and prepare your data.
6. The data submission feature will recognize you and connect your NPI to associated Taxpayer Identification Numbers (TINs).
7. Group practices
   a. A practice can report as a group or individually for each eligible clinician in the practice. You can switch from group to individual reporting, or vice versa, at any time.
   b. The data submission feature will save all the data you enter for both individual eligible clinicians and a group, and CMS will use the data that results in a higher final score to calculate an individual MIPS-eligible clinician's payment adjustment.
8. You can update your data at any time until the March 31 deadline. The data submission feature doesn't have a "save" or "submit" button—it automatically updates as you enter data. You'll see your initial scores by performance category, indicating that CMS has received your data. If your file doesn't upload, you'll get a message noting the issue.
9. You can submit data as often as you'd like. The data submission feature will help you identify any underperforming measures and any issues with your data. Starting your data entry early gives you time to resolve performance and data issues before the March 31 deadline.
10. For step-by-step instructions on how to submit MIPS data, you can view a video on YouTube at www.youtube.com/watch?v=q0Cvke6fnrg, or read the fact sheet at www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-2017-Data-Submission-Factsheet.pdf.

If you are in an Accountable Care Organization (ACO) or another alternative payment model (APM), work with your ACO or APM to ensure they have the patient information they need to report. Remember that you need to report Advancing Care Information measures on your own.

Any questions related to your participation status or MIPS data submission can be directed to the QPP Service Center by email at qpp@cms.hhs.gov or by phone at (866) 288-8292. ■

NORTHERN OHIO PHYSICIAN

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AMCNO Members and Guests Gather for a Craft Beer Tasting Event

This year, the AMCNO held a craft beer tasting event on February 11 at the Tremont Taphouse for our members, residents, medical students and their guests.

During the event, attendees were treated to four different samples—ranging from a stout to a saison (a fruity pale ale)—presented by the house craft beer expert. Delicious appetizers were also available for the guests. Attendees seemed to enjoy sampling the beers and spending time together in an inviting atmosphere as well as meeting new colleagues.

A big thank you to all who were able to attend and support this event—it was great to have you there, and we appreciate you taking the time to spend a fun evening with us. *Thank you!* ■

AMCNO is Partnering with *Healthcare Informatics* to Present the Health IT Summit in Cleveland: March 27-28, 2018

Fuel your passion. Transform health care.
The AMCNO is once again partnering with *Healthcare Informatics* for its Health Information Technology (IT) Summit Series in Cleveland. This year's event takes place March 27-28 at the Hilton Cleveland Downtown.

As an **Academy of Medicine of Cleveland & Northern Ohio Member,** use code **AMCNO** to reserve your complimentary seat.

Featured panel discussion
It Takes a Village:
Clinical and IT Collaborating in Securing Patient Data

When it comes to securing patient data, it takes a village. Every team member must be acting in lockstep to adhere to HIPAA standards and advance upon the organizational cybersecurity framework.

In this panel discussion, we explore the physician-security team dynamic in detail, and how collaboration can ultimately lead to new workflows that are a win-win for security personnel and clinicians alike.

To review the full agenda for the Health IT Summit, go to https://vendome.swoogo.com/2018-cleveland-health-it-summit/Agenda

Register today and remember to use code AMCNO to reserve a complimentary seat: https://vendome.swoogo.com/2018-cleveland-health-it-summit/begin

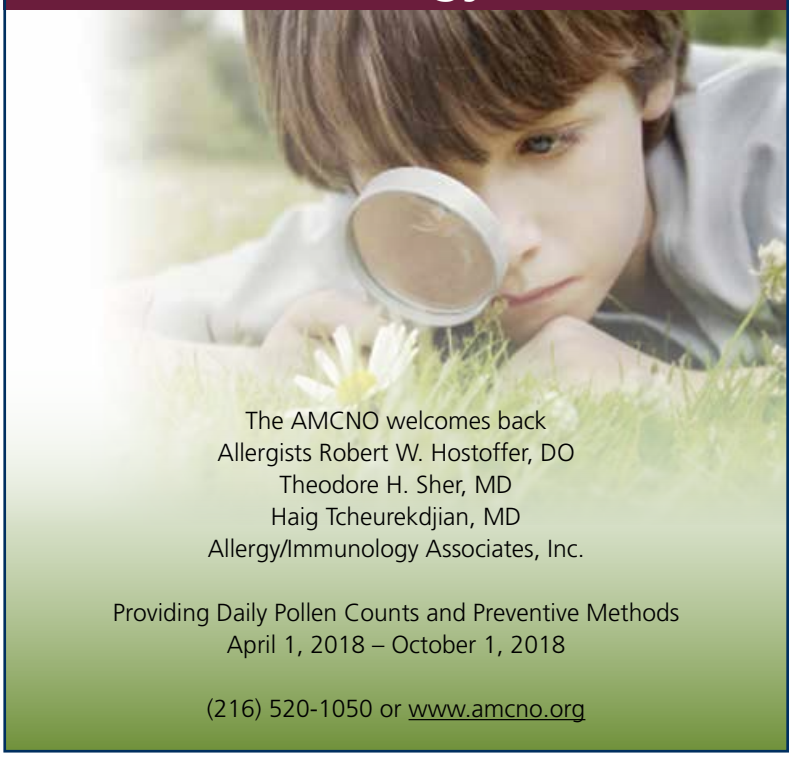
For more information about the event, contact Pam Durget at pdurget@vendomegrp.com or (347) 380-2028. ■

Did You Know? The AMCNO is on Twitter and Facebook!

Stay up to date on what's happening within the AMCNO by following us on Twitter @AMCNOTABLES and liking us on Facebook at The Academy of Medicine of Cleveland & Northern Ohio. On both accounts, we highlight AMCNO events and photos, post articles about what we're working on, and more.

Be in the Know—Join Us on Social Media Today!

AMCNO Pollen Counts Kick Off Allergy Season



The AMCNO welcomes back
Allergists Robert W. Hostoffer, DO
Theodore H. Sher, MD
Haig Tcheurekdjian, MD
Allergy/Immunology Associates, Inc.

Providing Daily Pollen Counts and Preventive Methods
April 1, 2018 – October 1, 2018

(216) 520-1050 or www.amcno.org

2018

Medical/Legal Summit

April 13-14, 2018

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

Friday, April 13, 2018

Health Care Law Update

11:15 a.m. Registration & Boxed Lunch
11:45 a.m. State & Federal Update
12:15 p.m. Behavioral Health Re-design/Ohio Medicaid and Confidentiality
1:00 p.m. The State of Medical Marijuana in Ohio
1:45 p.m. Break
2:00 p.m. Immigration Update: Nuts and Bolts for Healthcare Attorneys
3:15 p.m. The Change and Challenges of Medical Records
4:15 p.m. Adjourn to Medical/Legal Summit

Summit Details

Medical/Legal Summit – Friday Session – April 13, 2018

(CLE TBD, CME* and UH CRME** 1.0)

Friday, April 13, 2018 - Afternoon

4:15 p.m.
Welcome & Introductions
Darrell A. Clay, *CMBA President;* **Fred M. Jorgensen, MD**, *AMCNO President;* **Justin Cernansky, Esq.,** *Associate General Counsel, University Hospitals*

4:30 p.m.
Keynote Presentation: "Overcoming the Stigma of Addiction"
Christopher Kennedy Lawford - *At a young age, Christopher Kennedy Lawford became addicted to drugs and alcohol, the latter of which has been a genetic "curse" in his family for generations. Sober for almost 30 years now, he continues to campaign tirelessly in both the public and private sectors for the recovery community. He currently works with the United Nations, White House Office on Drug Control Policy, and World Health Organization.*

Lawford holds a BA from Tufts University, a JD from Boston College Law School, and Masters Certification in Clinical Psychology from Harvard Medical School, where he held an academic appointment as a lecturer in psychology. He is the author of three New York Times best-selling books related to his personal experience with addiction and recovery.

At the Summit, as he does when he travels around the world for speaking engagements, Lawford will discuss addiction and mental health issues as well as how to overcome the stigma associated with both.

A networking reception follows

Saturday Session – April 14, 2018

(CLE TBD, CME* and UH CRME** 4.0)

7:30 a.m. **Registration & Breakfast**

8:00 a.m. **Welcome & Introductions**

8:15 a.m. **Opioid Issues**
(Co-Chairs: Isabelle Bibet-Kalinyak, Esq. & Kristen Englund, MD)

Overview
Ohio remains at the epicenter of the national opioid crisis. As it has become the state where all federal opioid litigation nationwide will be consolidated, Ohio will be in the legal spotlight. The comprehensive medical approaches we use across our community to treat addiction and avert death are being scrutinized as well. This ongoing battle requires the involvement of many different partners in our community to develop creative, compassionate and effective plans. To build on the statistical and physiological opioid issues discussed last year at the Summit, this panel will delve into the legislative, legal, medical, and community-based advances over the past year as Ohio seeks to turn the tide of the opioid epidemic.

Speakers
Allisyn Leppla, Executive Director for the Northeast Ohio Hospital Opioid Consortium, Center for Health Affairs; **W. Bradford Longbrake, Esq.,** Hanna, Campbell & Powell, LLP (invited); **Justin E. Herdman, Esq.**, United States Attorney, Northern District of Ohio

9:15 a.m. **Interaction between Hospitals, Law Enforcement and Mental Health Facilities**
(Co-Chairs: Drew R. Barnholtz, Esq. & Fred M. Jorgensen, MD)

Overview
Interactions between law-enforcement personnel and healthcare providers are occurring more frequently in various settings, and are sometimes problematic. Issues involving confidentiality and privacy, ongoing police investigations, warrants and subpoenas, requests for specimens, violence in healthcare settings, and "duty to report" are just some of the complex issues that can come into play during these interactions. A diverse panel of law enforcement, legal, and healthcare providers will utilize a case-based format to illustrate and discuss these issues.

Speakers
John A. Tafuri, MD, Center Director for Regional Emergency Medicine CCHS; **David Easthon,** Chief of Police, Cleveland Clinic; **Shannon F. Jerse, Esq.,** General Counsel, St. Vincent Charity Medical Center**; Hon. Donna Congeni Fitzsimmons,** Rocky River Municipal Court

10:15 a.m. **Break**

10:30 a.m. **Cyber Security and Liability**
(Co-Chairs: Isabelle Bibet-Kalinyak, Esq. & Robert E. Hobbs, MD)

Overview
This session will explore cyber threats to healthcare systems and the exposure to liability resulting from failure to comply with regulatory requirements.

Speakers
Special Agent Bryan P. Smith, Cleveland Office of the FBI (invited); **Christine N. Czuprynski, Esq.**, McDonald Hopkins; **Iliana L. Peters, Esq.,** Shareholder, Polsinelli (former Acting Deputy Director HHS Office of Civil Rights in charge of cybersecurity)

11:30 a.m. Break

11:45 a.m. **Patient-Provider Communications, Technology and Apologies**
(Co-Chairs: R. Bruce Cameron, MD & Kathryn E. Hickner, Esq.)

Overview
Communications between physicians and patients are being revolutionized by technology. Web-based patient portals, texting, emails, patients and families recording interactions, and the like have opened up vast new opportunities and challenges in health care. Whether the setting is communication prior to or during treatment, or transparency initiatives after treatment (including "apology" situations), you will hear from a panel of physicians and attorneys operating on the front lines of this revolution about best practices, rules, policies, pitfalls, laws and other aspects of this important new area.

Speakers
Edward E. Taber, Esq., Tucker Ellis LLP; **Lori K. Posk, MD,** Cleveland Clinic; **Joan M. Zoltanski, MD**, Patient Experience Officer, University Hospitals

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

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

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

Co-Chairs: **Fred Jorgensen, MD**, *AMCNO President;* **Justin Cernansky, JD**, *Associate General Counsel, University Hospitals*

For more information, call the CMBA at (216) 696-2404 or AMCNO at (216) 520-1000.

Registration

Medical/Legal Summit Only
(includes Friday keynote speaker and Saturday sessions)

- ❑ $85 CMBA Members, AMCNO Members & other Healthcare Providers
- ❑ $150 Non-Members
- ❑ $15 Law & Medical Students (limited seats available)

Health Care Law Update & Summit

- ❑ $150 CMBA Members, AMCNO Members & other Healthcare Providers
- ❑ $225 Non-Members
- ❑ $15 Law & Medical Students (limited seats available)

Health Care Law Update Only

- ❑ $75 CMBA Members, AMCNO Members & other Healthcare Providers
- ❑ $125 Non-Members

TOTAL $ _____

Name_____Atty. Registration No. _____

Company _____

Address _____City _____

State _____ Zip ___ Phone _____E-mail _____

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

Credit Card No. _____ Exp. Date _____

Signature _____

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, OH 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, at least one week prior to the program.

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

ST. VINCENT CHARITY MEDICAL CENTER

*This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Ohio State Medical Association (OSMA) through the joint providership of St. Vincent Charity Hospital and the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), and the Academy of Medicine Education Foundation. St. Vincent Charity Hospital is accredited by the Ohio State Medical Association (OSMA) to provide continuing medical education for physicians.

St. Vincent Charity Hospital designates this educational activity for a maximum of 5.5 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

University Hospitals

**The AMCNO has obtained approval from University Hospitals (UH) for five hours of Clinical Risk Management Education (CRME) credit for those physicians participating in the UH Sponsored Physician Program. Please note: 1.0 credits are available for 4/13/18 (Friday) and 4 CRME credits are available for 4/14/18 (Saturday).

Professional Practice Gap: The U.S. healthcare delivery system has significantly transformed over the last decade and changed the culture of medicine. Current changes in the country's administration and other forces are already reshaping medical practice. They include the management of patients on chronic opioid therapy; interaction between hospitals, law enforcement and mental health facilities; cyber security and liability; and patient and provider communications, such as the use of audio/video during medical appointments. Increase knowledge of current rules and regulations and how they impact the practice of medicine.

- Current medical approaches and legislation and how they impact the practice of medicine.
- The risks and legal ramifications of the interaction with law enforcement in hospitals and other healthcare facilities.
- The current legal and security initiatives and how they impact patients and physicians.
- Best practices, rules, and policies of social media, technology and apologies in patient-provider communications.