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AMCNO/CMBA Medical Legal Summit Provides Updates on Key Issues of Importance to the Practice of Medicine and the Law

Christopher Kennedy Lawford delivered the keynote address, "Overcoming the Stigma of Addiction" at the 2018 Medical Legal Summit—an annual event co-sponsored by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), the Academy of Medicine Education Foundation, and the Cleveland Metropolitan Bar Association (CMBA). It was held April 13-14 at the CMBA Conference Center.

Prior to Mr. Lawford's keynote presentation, opening remarks were provided by **Dr. Fred Jorgensen**, AMCNO President and Summit Co-Chair. The Health Care Law Update took place earlier in the afternoon, prior to the keynote presentation. Among the topics covered during that session were: "Behavioral Health Re-Design/Ohio Medicaid and Confidentiality," the "State of Medical Marijuana in Ohio," an "Immigration Update," and a session on the "Change and Challenges of Medical Records."

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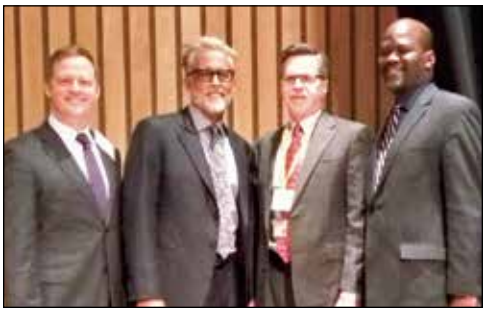

AMCNO President Dr. Fred Jorgensen (center right) stands with keynote speaker Christopher Kennedy Lawford (center left), Summit Co-Chair Justin Cernansky (far left), and CMBA President-Elect Marlon Primes (far right).

AMCNO Promotes the 2018 Cleveland Health IT Summit Series

The AMCNO was pleased to once again partner with *Healthcare Informatics* to promote and market to our members the Cleveland Health IT Summit Series, which was held March 27-28 at the Hilton Downtown Cleveland.

The goal of the Summit—an event that is held in various U.S. cities throughout the year—is to promote improvements in the quality, safety, and efficiency of health care through information technology (IT) and facilitate knowledge exchange. The event is open to C-level, physician, practice management and IT decision-makers from provider organizations and physician practices.

This year, the two-day program focused on telehealth, patient engagement, population health, cybersecurity, value-based care, and IT leadership. The co-chairs were **Dr. David Kaelber**, Chief Medical Information Officer and Vice President of Health Informatics with the MetroHealth System, and **Pamela Banchy**, Chief Information Officer with Western Reserve Hospital.

Edward Marx, Chief Information Officer at the Cleveland Clinic, provided the morning keynote presentation on the first day of the Summit. His presentation, "A Time to Lead: Identifying and Executing Business Strategies," focused on how to be a leader, regardless of a title, as the healthcare landscape continues to change.

"We all want a seat at the table, but we're rarely invited," Marx said. "So, take the lead. We're not called to sit back. And we owe it to our patients to take the lead." He discussed several examples of how to become an even better leader, such as celebrating quick wins, striving for excellence, continuously learning, becoming a trusted advisor and networking.

At the Health IT Summit, a panel featuring AMCNO member Dr. Joan Papp (far right) discusses the challenges of the opioid crisis.

Panel discussions and individual presentations were held throughout the remainder of the day.

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Keynote speaker Mr. Lawford stressed that as a community we need to make an effort to meet the needs of those who are looking to find their way out of active addiction into recovery. He noted that the topic of addiction is covered regularly by the media, but society continues to treat this disorder as if there is something wrong with a person's character. Addiction is a brain illness and needs to be handled as exactly that. We do not treat other diseases as moral failings and we should not treat addiction that way either, he said. Recovery is possible—it is about restoring and enhancing the lives of those affected and the lives of those around them.

He noted that attitudes will change when people are confronted with the science of the disease of addiction. He believes that it is treated differently because when the symptoms of addiction are in the active phase, people behave in ways that are all too visible and perhaps illegal. We need to demonstrate what recovery means and what it really is, and how it can be achieved.

Mr. Lawford quoted his uncle President John Kennedy, saying that "anybody who achieves something great in this world also overcomes something equally great." People in recovery are capable of achieving great things, but they are ostracized by society.

He provided insight into his own struggles with addiction, noting that for 17 years the only thing that mattered to him was getting a drug or a drink. He stated that he was born into a family where addiction is an issue. He spent time in jail and in hospitals but continued to abuse because his privilege allowed him to dodge accountability. He said that if had been held accountable and received treatment earlier, it might have changed his trajectory in life. For more than 10 years, he attempted to get clean and sober, but nothing worked until he had a moment of clarity 32 years ago, when he became willing to accept that it was time for a change. He sought treatment and has been in recovery since then.

Mr. Lawford noted that there are several things that must be confronted in order to effect real change on this issue in the United States. We have to address the structural and moral blocks—this is a primary brain disease, and not a moral failing of the person. Also, we know addiction treatment works and it can make a difference—addiction treatment services should be available and affordable. Changes also need to be made so that insurers treat this disease as a physical illness and cover these services. Continuum of care greatly improves outcomes. Addiction is a chronic condition and must be managed as such, with long-term continuum of care that includes monitoring to prevent relapse.

We need to look at this illness devoid of stigma, Mr. Lawford said, and we also have to realize that punishment and prison rarely work for someone with a dependence problem. He stated that of the 2.2 million people behind bars in the United States, half of them suffer from one form of mental illness and have concurrent addiction disorder. It is critical that the courts have the ability to combat this crisis. He noted that the Department of Justice estimates that 1.2 million people in the justice system may be eligible for treatment court but are unable to gain access.

The opioid epidemic is destroying the fabric of our society—present and future—and we cannot incarcerate our way out of this problem. We need to look at proven solutions that promote accountability and treatment. It is possible to recover, and providing individualized treatment plans and dignified support is the most effective way to lead people into recovery and deal with recidivism, he said.

Getting a person into recovery is one percent initiation of abstinence, one percent acute detoxification and 98 percent relapse prevention, Mr. Lawford said. Once a person decides to stop using, the detox is not hard. The hard part is keeping them clean and sober. The best overall signal of success is staying in treatment. If a patient breaks a leg, he or she is put in a cast and then sent off for physical therapy. If someone has an addiction, he or she is sent to detox—what is the next step to keep people on the road to recovery? If we are going to solve this problem, the answer is community and caring about one another, he said.

Mr. Lawford noted that he spent 10 years trying to solve his addiction and the best he could do was lock himself in the house or in jail. He said he believes that we all have intermittent windows of opportunity for profound change. He got to recovery because he climbed through that window, and the world must do this for others— treat addiction as a health issue and provide access to treatment for people who are suffering from it.

Panelists discuss the opioid epidemic in Ohio. (Left to right: Justin Herdman, W. Bradford Longbrake, Allisyn Leppla, and moderator Isabelle Bibet-Kalinyak)

The Saturday sessions began with a plenary session on Opioid Issues. The speakers were **Allisyn Leppla**, former Executive Director for the Northeast Ohio Hospital Opioid Consortium; **W. Bradford Longbrake, Esq.**, from Hanna, Campbell & Powell, LLP; and **Justin E. Herdman, Esq.**, U.S. Attorney, Northern District of Ohio. The session was moderated by **Isabelle Bibet-Kalinyak, Esq.**, from McDonald Hopkins, LLC, and AMCNO board member **Dr. Kristin Englund**.

Ms. Leppla provided an overview of the newly formed Northeast Ohio Hospital Opioid Consortium. She explained that the consortium is a partnership between The Center for Health Affairs, Cleveland Clinic, MetroHealth, Northeast Ohio VA Healthcare System, St. Vincent's Charity Medical Center and University Hospitals, and includes the AMCNO as a partner. The consortium is the result of years of work by community leaders and hospitals to reduce the widespread effect of the heroin and opioid crisis in Northeast Ohio.

The mission of the consortium is to serve as a model hospital system-based and physician-led consortium that significantly reduces the impact of the opioid epidemic in Northeast Ohio by sharing and implementing evidence-based practices, promoting policy changes, and increasing prevention efforts. The ultimate goal of the consortium and its members is to reduce the number of overdoses and deaths as a result of heroin and opioid use and misuse.

Mr. Herdman began by describing the breadth of his jurisdiction, which includes 40 northern Ohio counties, with four large city offices located in Akron, Toledo, Youngstown and Cleveland. This district is unique in that it includes urban and rural—small farm communities and big cities—so their perspective on the opioid crisis is diverse. He described how the U.S. Attorney's office convened a group of 700 people in 2013, which included treatment providers, hospitals,

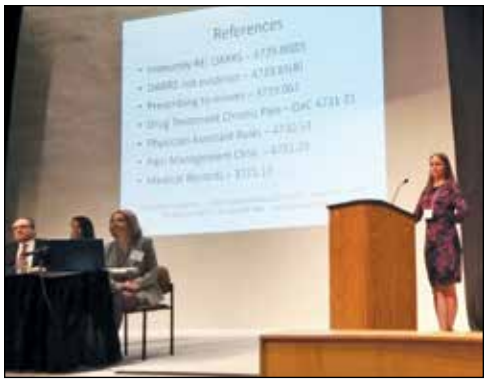
law enforcement and members of the community, to develop a plan to deal with the opioid crisis in our community. The strategy behind that plan was to address prevention and outreach, treatment and recovery, and enforcement.

He outlined how his office deals with enforcement issues and diversion of prescription drugs, noting that a lot of their enforcement activities surround the shipment of illicit drugs from outside of the country. He described in detail two recent cases where his office, along with law enforcement and others, had successfully stopped the flow of mass quantities of illicit drugs into our community.

He also stressed the importance of obtaining reliable data. Right now, we do not have a clear picture of what is going on in the community, he said, because we lack a common data set. The best data we have comes from the medical examiner's office after someone has died of an overdose. We need to work with first responders, hospitals, treatment facilities, law enforcement and others to figure out a way that we can all look at this problem in real time, based on a common data set.

Mr. Longbrake rounded out the session with a presentation on civil litigation involving opioids. He said "anyone who prescribes an opioid could be drawn into this issue." He outlined where these claims are emanating from and some of the scenarios he has seen. He acknowledged that opioid care is a challenge for physicians because pain is a real symptom and physicians want to help the patient. The relationship between the physician and patient has changed—physicians are no longer just asking how they can help patients, they are also charged with asking patients if they really need pain medication. Physicians are now concerned about diversion—and this adds an administrative and documentation burden. He encouraged institutions to give physicians guidance about prescribing opioids and he stressed the importance for physicians to learn the regulations regarding opioid prescribing practices in Ohio.

The next session, "Interaction between Hospitals, Law Enforcement and Mental Health Facilities," was moderated by **Shannon Jerse, Esq.** Speakers on this panel included **John A. Tafuri, MD,** Center Director for Regional Emergency Medicine, CCHS; **David Easthon**, Chief of Police, Cleveland Clinic; and the **Honorable Donna Congeni Fitzsimmons**, Rocky River Municipal Court.



AMCNO board member Dr. Kristin Englund addresses the audience.

This session was designed as a panel discussion and began with a video showing the arrest of a nurse at a Salt Lake City Hospital—a situation that arose when the police requested a patient blood draw on an unconscious victim.

The panel then spent time addressing the issues related to the Ohio statutes regarding blood draws on patients in the hospital setting. Hospital policies allow for the following: for a conscious patient, consent would be required; if the police had a search warrant, consent would still be required; for an unconscious patient, a hospital may agree to draw blood; and for a dead patient, the hospital may draw blood. Panelists described several scenarios in which they have had to address these issues from the physician and law enforcement setting as well.

The panel also addressed Ohio law vs. the HIPAA regulations, outlining what protected health information may be disclosed without patient consent to law enforcement as well as what physicians were authorized to do under the Emergency Medical Treatment and Active Labor Act (EMTALA).

The panel also briefly discussed violence against healthcare workers and how these issues are addressed in the medical

Panelists talk about Ohio law concerning patient privacy issues in the hospital setting. (Left to right: Honorable Donna Congeni Fitzsimmons, David Easthon, Dr. John Tafuri, Shannon Jerse, and Dr. Jorgensen)

community. They also discussed what should occur if a healthcare worker is assaulted. Hospitals are not safe havens for crimes and there should be zero tolerance for violence.

The next plenary session addressed "Cyber Security and Liability." Panelists were **Special Agent Bryan K. Smith**, Cleveland Office of the FBI; **Christine N. Czuprynski**, McDonald Hopkins, LLC; and **Iliana L. Peters**, Shareholder, Polsinelli, and former Acting Deputy Director HHS Office of Civil Rights. The panel was moderated by Ms. Bibet-Kalinyak.

Mr. Smith began the discussion by stating that over the past few years the FBI workforce has changed. In the past the FBI was focused on cyber-enabled crime, but now they mainly focus on intrusions and unauthorized access into computer networks. Two years ago, former FBI Director James Comey said that there are "two types of companies in the United States—those that have been hacked by the Chinese, and those that know they have been hacked by the Chinese." It is a very real problem, and no business is too small to be hacked.

He described how computers are hacked from the outside through spear phishing and purchases made off of the dark web. Hackers will go after a low-level employee and start sending phishing emails to them to gain access into the company's system. He also stated that once they get in successfully they will do it again. Mr. Smith cautioned that even if a system has been cleaned, do not let your guard down. He stated that, on average, once a hacker is in a system, he or she is in for about seven months and is looking at your notes, emails and prospective business acquisitions.

The healthcare sector has reported the most breaches over any other sector. It is a major target because they are after Social Security numbers, personal information, billing codes, intellectual property and research. He also outlined the many ransomware schemes that are being addressed by the FBI, and what you should do if you are a victim of ransomware–stressing that if you are a victim, you should notify the FBI. Reporting the breach to them allows them to trace it back to its source.

Ms. Czuprynski discussed policies and procedures to follow to minimize data exposure, such as having a written information security program in place and an incident response plan. She also provided the audience with tips on what to do if they discover an incident, such as gathering and preserving evidence of the potential breach, engaging a

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forensic specialist to determine the scope of the incident, containing the breach, and quantifying the records compromised. She also advised contacting law enforcement agencies about the incident.

She stressed the importance of phishing training for employees. It used to be fairly easy to spot a phishing email, but now they are not that different from a regular email, so employees need to know what to look for. If there is a breach through a phishing email, it is important to view how that employee responded and how to keep it from happening in the future.

Ms. Peters wrapped up the session with lessons learned from the government on this issue. She cautioned about "credentials stuffing" and how to be prepared to protect against it. This happens when someone steals your password and goes through websites you frequent and "stuffs" your password into those websites to see what he or she can obtain.

She also provided various resources that physicians could use, including how to sign up for HHS alerts on how to protect your office or healthcare entity from security breaches. Ms. Peters also provided information from the Federal Trade Commission that could help address this issue.

Cyber security and liability are discussed during a plenary session. (Left to right: Iliana Peters, Christine Czuprynski, Bryan Smith, and moderator Bibet-Kalinyak)

The final panel was moderated by **R. Bruce Cameron, MD**, AMCNO president-elect, and featured three presenters: **Lori K. Posk, MD**, Cleveland Clinic; **Joan M. Zoltanski, MD**, Patient Experience Officer, University Hospitals; and **Edward E. Taber, Esq.**, Tucker Ellis LLP.

Dr. Zoltanski provided information on what is being done at University Hospitals to improve patient and provider communications. She noted that UH is now using Open Notes, which is an international movement that is making health care more transparent by having doctors, nurses, therapists, and others invite patients to read the notes they write to describe a visit. UH is one of seven organizations in Ohio participating in the program. To date, more than 295,000 notes have been sent to UH patient personal health record accounts. The idea is to get patients more engaged in their care.

The final plenary session of the Summit covers patient-provider communications. (Left to right: Edward Taber, Dr. Lori Posk, Joan Zoltanski and moderator AMCNO President-Elect Dr. R. Bruce Cameron)

Dr. Posk provided an overview of MyChart, noting that they have more than one million active MyChart patients at the Cleveland Clinic, and there are approximately 275,000 unique logins a month. She stated that one of the benefits of the patient portal is improved provider-patient communication. Patients who are engaged also have better outcomes and recover faster. They also tend to adhere better to treatment recommendations and are more likely to carry out health-related behavioral changes.

Dr. Posk provided information on the benefits and risks of patient/person-generated data, and she addressed the benefits and risks of patient messaging. She noted that it is important to educate patients and providers on the appropriate use of messaging and patient-generated data as well as stressed the importance of having a policy to turn messaging off if needed.

Mr. Taber rounded out the panel, discussing how technology and new laws have changed how physicians communicate, and the legal pitfalls that can accompany these communications.

He cautioned the physicians in the audience about engaging with a patient on social media, saying that this is a "minefield" and should not be done. If you are engaging with a patient on a personal level, that may be fine, but it should not be used on a professional level, and all institutions should have a policy on the usage of social media, he said.

He also cautioned about patients who want to record a medical visit or procedure. Most institutions have a set policy on the usage of cell phones on the premises and they should be followed. These policies state that the usage of cell phones is not permitted because it is a threat to patient privacy.

In addition, patient portals have started to come up in litigation—one of the first questions asked now in a deposition is whether or not the patient opened up one of these portals. Remember that whatever you are writing in those portals when you are responding to a patient's text or any links included in the portals can and will be evidence used in a lawsuit if that occurs, he said, so remember to exercise the same caution you would in normal charting/documentation.

Mr. Taber also cited an example of a malpractice case where the family of a patient who had died secretly recorded the physician during a conversation. He noted that it is important to remember that Ohio is a one-party consent state, which means that a patient can record you secretly without consent and it is legal in Ohio. Members of the public can do it and it can be used in evidence in a lawsuit. His advice is to be careful—assume you are being recorded, and be careful what you say and always stick to the facts, he said.

Mr. Taber discussed police body cameras, stating that physicians should remember that these cameras are a live feed and police recordings are considered public record, so if you are talking to a police officer in an emergency room or other medical setting, be cognizant of that fact.

He also briefly discussed sending texts to patients, that physicians should avoid doing it because it is not a secure message. It is better to refer patients to the patient portals where it can be incorporated into the medical record—and the same rules apply for emails. He also noted that cell phone records last forever and can be subpoenaed, and pager records are discoverable as well.

Mr. Taber wrapped up his session talking about the recent Ohio Supreme Court ruling which resulted in Ohio now having one of the strongest apology statutes in the country. He

thanked the AMCNO for filing an amicus brief in support of this case as well.

More than 175 Northern Ohio physicians and attorneys registered for this annual event, and both organizations appreciate their attendance. The AMCNO and CMBA especially thank the event sponsors for their generous support, as well as the planning committee and presenters for their hard work and sharing their expertise.

The planning committee will be meeting in the near future to discuss next year's agenda. AMCNO members are encouraged to participate, submit topics and suggest presenters for the Summit. Contact Elayne Biddlestone at ebiddlestone@amcnoma.org, or (216) 520-1000, ext. 100, for more information. ■

CMS Releases 2018 MIPS Eligibility Tool

You can now use the updated CMS MIPS Participation Lookup Tool to check on your 2018 eligibility for the Merit-based Incentive Payment System (MIPS).

Just enter your National Provider Identifier, or NPI, to find out whether you need to participate during the 2018 performance year.

Changes to Low-Volume Threshold

To reduce the burden on small practices, CMS has changed the eligibility threshold for 2018. Clinicians and groups are now excluded from MIPS if they:

- Billed $90,000 or less in Medicare Part B allowed charges for covered professional services under the Physician Fee Schedule (PFS)

OR

- Furnished covered professional services under the PFS to 200 or fewer Medicare Part B enrolled beneficiaries

This means that to be included in MIPS for the 2018 performance period you need to have billed more than $90,000 in Medicare Part B allowed charges for covered professional services under the PFS **AND** furnished covered professional services under the PFS to more than 200 Medicare Part B enrolled beneficiaries.

Note: The 2018 Participation Lookup Tool Update for Alternative Payment Model (APM) participants will be updated at a later time.

Find Out Today

Find out whether you're eligible for MIPS today. Prepare now to earn a positive payment adjustment in 2020 for your 2018 performance. To find out if you are eligible go to https://qpp.cms.gov/participation-lookup/

AMCNO Promotes the 2018 Cleveland Health IT Summit Series

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One panel discussion focused on the topic, "Digitizing Patient Engagement: Telehealth, Patient Portals, and Mobile Healthcare." It was moderated by **Mark Hagland**, Editor-in-Chief of *Healthcare Informatics*, and speakers included **Dr. Lori Posk**, the Medical Director of MyChart for the Cleveland Clinic, and **Dr. Julia Bruner**, the Physician Executive of Ambulatory Operations at MetroHealth.

The panel was asked to discuss where telehealth is headed. Dr. Posk said that at the Cleveland Clinic, they are looking to break down barriers on how they deliver care, concentrating on how they reach out to patients, and the relationships they need to create.

Dr. Bruner said that it will take change to increase continuity with patients and address what their needs are—what they really need to improve their health, besides actual medications.

Posk also said they need to regroup and think about the way they do things, such as delivering technology and digital tools, forming community health groups for population health initiatives, and fitting in with customers' needs.

Other panelists stated that technology is the easiest part, but people often fail in the deployment of it, because not everyone is involved and/or engaged. All panelists agreed that the culture around telehealth also needs to change.

During a Provider Spotlight session, **Nathaniel Brown**, Program Director of the Delivery System Reform Incentive Payment (DSRIP) Program at Northwell Health in New York, addressed population health and discussed the opportunity the DSRIP represents and its initial impact.

The goal of the DSRIP is to transform the healthcare system for Medicaid beneficiaries—in particular, to reduce avoidable hospitalization and preventable emergency department use by 25% in 5 years. The New York State Department of Health (DOH) partners with 25 Performing Provider Systems (PPS), and provides funds for all 25 in the state.

New York also has a statewide health information network, and eight health information exchanges (HIEs). The New York State DOH establishes common services, privacy and security policies, and technical standards for interoperability. One particular network has 450 participants and 1,500 facilities—46 million clinical messages and 485,000 real-time alerts have been sent. These covered patients have shown improved health outcomes compared with those who are out of the network. One next step for the program includes examining how social determinants of health can be measured.

Another presenter, **May Wang**, Chief Technology Officer for ZingBox, addressed cybersecurity in her talk, "The Role of Artificial Intelligence in Securing Connected Medical Devices." Wang said that like patients, medical devices are vulnerable and noted that a cybersecurity attack actually builds up over time. It has been estimated that it takes almost 326 days for a healthcare system to detect malware. Steps can be taken, however, to prevent attacks from occurring.

Challenges exist for medical devices, especially because some devices are always on and used, but not all of them have software, so they can't download antivirus software. Artificial intelligence (AI), however, is machine learning that leads to deep learning, and that can be extremely helpful, Wang said. A device typically has a fixed set of purposes, so the advantage of AI is that it could "learn" normal behaviors and then "know" when the device deviates from it, so that IT teams can catch it.

Wang stated that the top three devices used within a hospital are IV pump, imaging system and patient monitor, respectively. The devices with the most security issues, however, are imaging system, patient monitor and medical device gateway. These three devices represent 86% of all security issues. The biggest vulnerabilities are user practice issues at 41% (ie, 22% rogue applications and 19% browser usage) and outdated operating system/software at 33%.

On day two of the Summit, the morning keynote presentation addressed value-based care and featured Dr. Kaelber and **Dr. Nabil Chehade**, who is the Senior Vice President of Population Health at MetroHealth. They discussed how MetroHealth's use of IT has led them to become one of 30 successful national Medicare Shared Savings Program (MSSP) participants.

Dr. Chehade noted that MetroHealth's success under alternative payments is attributable to three pillars: their patients and providers, state-of-the-art EMR and analytics, and leadership being fully committed to embracing population health as its brand. Dr. Kaelber cited examples of how his team uses ACO-related electronic health record tools to collect data, while making it as easy as possible for physicians to enter and obtain important information.

Dr. Chehade ended the presentation by saying, "We cannot afford the way things are going in the U.S.," and that "we are in a disruptive healthcare revolution today," but the goal remains the same—to keep everyone healthier.

The panel discussion, "At a Crossroads: Population Health and Managing Risk during the Opioid Crisis," included AMCNO member **Dr. Joan Papp**, who is the Medical Director of the Office of Opioid Safety at MetroHealth. Hagland moderated this session as well, and he asked the panelists to define the challenges associated with the opioid crisis as well as the biggest opportunities.

Dr. Papp said that physicians need to improve their practices, get a handle on at-risk patients with registries, and manage complex patients. Some physicians also don't know they're contributing to the problem, so how physicians prescribe to patients needs to be addressed. In addition, targeted education is important to identify knowledge gaps, so that broad-based education can then be provided. Additional resources should also be made available.

The panelists agreed that the challenges are different, based on each community. And, they agreed that the stigma surrounding addiction needs to change—it is seen as a personal failure instead of a biological issue. The panelists also discussed the use of HIEs to help curb the problem of doctor shopping, using this information (along with alerts in EHRs) to help stop relapse in patients, and trying to meet patients where they are instead of trying to get them into the health systems.

The Summit concluded with a keynote presentation by **Navneet Kathuria**, Senior Vice President of Population Health at Hackensack Meridian Health in New Jersey. He discussed how this health system has completely revisited and restructured the foundation of their population health strategy. ■

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Medical Records Fact Sheet – New Fees Effective January 2018

Retention of Medical Records

Medical considerations remain the key basis for deciding how long to retain medical records, whether in paper or electronic format, but providers must also comply with certain requirements. The Code of Medical Ethics of The American Medical Association establishes rules relating to the maintenance of patient records[1]. Under Ohio law[2], violating the ethical rules of the American Medical Association, the American Osteopathic Association, or the American Podiatric Medical Association can result in disciplinary action by the Ohio State Medical Board. Most states, including Ohio, do not have specific laws mandating the minimum record retention period for patient medical records. However, Ohio Medicaid rules mandates the retention of records associated with Medicaid claims for a period of at least six (6) years after payment of the claim to the provider[3]. For consistency purposes, it is also recommended that records relating to Medicare beneficiaries be kept for at least six (6) years as well although Medicare Conditions of Participation only requires a five (5) year retention period[4]. Managed care contracts should also be reviewed to ensure compliance with any contractual retention period. In all cases, medical records should be kept for the length of time of the statute of limitations for medical malpractice claims. Under Ohio law, an action for medical malpractice must be brought within one (1) year after the cause of action "accrues."[5] However, there are various exceptions or special rules. For example, the statute of limitations in wrongful death cases is two (2) years after the date of death. In the case of a minor, the statute of limitations does not begin to run until the minor has reached his or her 18th birthday. The statute can also be "tolled" or otherwise extended under various circumstances. As a practical matter, relying merely on the statute of limitation is difficult. If you are discarding or destroying medical records, patients should be given the opportunity to claim the records or have them sent to another physician. The AMCNO recommends that physicians keep medical records indefinitely, if feasible.

Update on Providing Charging for Copies of Medical Records

There are very limited circumstances under which a provider may refuse to make patient records promptly available to the patient, the patient's "personal representative"[6] or "authorized person"[7] (not an insurer), or another provider treating the patient upon written request signed by the patient or by the patient's personal representative or authorized person. For example, medical records cannot be withheld because of unpaid medical bills. However, if a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, then the physician can provide the record to a physician chosen by the patient instead of the patient directly. Ohio law establishes maximum fees that may be charged by health care providers or medical records companies that receives a valid request for a copy of patient's medical records. These fees are adjusted annually. Ohio law provides for certain limited situations in which copies of records must be provided without charge, notably where the records are necessary to support a claim for Social Security disability benefits.

Effective January 2018, the following maximum fees apply when the request comes from a patient or patient's personal representative:

- No records search fee is allowed
- For data recorded on paper or electronically: $3.18 per page for the first ten pages; $0.66 per page for pages 11 through 50; $0.27 per page for pages 51 and higher
- For data resulting from an X-ray, MRI, or CAT scan recorded on paper or film: $2.18 per page
- The actual cost of postage may also be charged

The following maximum fees apply when the request comes from a person or entity other than a patient or a personal representative:

- A $19.58 records search fee
- For data recorded on paper or electronically: $1.29 per page for the first ten pages; $0.66 per page for pages 11 through 50; $0.27 per page for pages 51 and higher
- For data resulting from an X-ray, MRI, or CAT scan: $2.18 per page
- The actual cost of postage may also be charged

For additional information regarding medical records, please contact the AMCNO offices at (216) 520-1000.

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1 Code of Medical Ethics Opinion 3.3.1, available at https://www.ama-assn.org/delivering-care/management-medical-records
2 Ohio Revised Code § 4731.22 (B)(18), available at http://codes.ohio.gov/orc/4731.22
3 Ohio Revised Code § 2913.40(D), available at http://codes.ohio.gov/orc/2913.40
4 Medicare Conditions of Participation, Medical Record Service, available at https://www.gpo.gov/fdsys/pkg/CFR-2004-title42-vol3/xml/CFR-2004-title42-vol3-sec482-24.xml
5 Ohio Revised Code § 2305.113, available at http://codes.ohio.gov/orc/2305.113v2
6 Ohio Revised Code § 3701.74(11), available at http://codes.ohio.gov/orc/3701.74
7 Ohio Revised Code § 3701.74(14), available at http://codes.ohio.gov/orc/3701.74

HITRUST and the American Medical Association Conduct a Cybersecurity Workshop in Cleveland

With ransomware and other cyberattacks increasingly targeting the healthcare industry, many clinics, physician offices, and other small providers are looking for local, community-based resources to help guide them through the journey of establishing governance and risk management programs to avoid a cyber-related breach or event that would disrupt their organization and expose the confidential information of their patients or members.

The American Medical Association (AMA) and the Health Information Trust Alliance (HITRUST) have partnered to provide education on cyber risk management and to ensure that key organizations in the healthcare system have access to trusted information and strategies to effectively address these important issues.

The workshop, hosted by the Cleveland Clinic and held at the Cleveland Clinic Foundation House, covered topics and programs including performing cyber and Health Information Portability and Accountability Act (HIPAA) risk assessments, the fundamentals of good cyber hygiene, implementing cost-effective and manageable cyber security solutions within a practice, and lessons learned from physician practices.

AMCNO staff and physician leadership attended the session, which began with welcoming remarks by CCF Chief Information Security Officer **Dr. Vugar Zeynalov**, who also outlined when and why the CCF began working with HITRUST.

Ms. Laura Hoffman, Assistant Director of Federal Affairs for the AMA, provided a presentation outlining how cybersecurity is a patient safety issue, noting that healthcare records are so valuable that attacks on health information technology (health IT) systems have increased 125% in the last five years. She also noted that stolen patient data can result in identity theft and numerous types of fraud because of the information contained in a medical record. She noted that cybersecurity can impact patient safety if systems are in lock down and physicians cannot get to records–with limited access to critical care information.

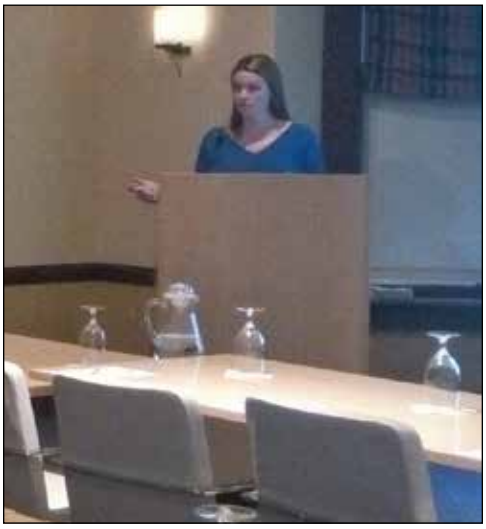
She noted that the AMA has partnered with HITRUST because they know that health care is not immune to cyberattacks regardless of whether you are working in a large system or in a medium- to small-sized practice. Physicians need to figure out where the risks are and how to control those risks, she said. It is "first do no harm" in the digital age. Nearly one million pieces of malware are created each day; however, about 85% of targeted attacks on computers are preventable, and there are ways to prevent these attacks.

While the HIPAA security rule and the Electronic Health Record (EHR) Meaningful Use/Advancing Care Information program both require physicians to conduct a security risk analysis, good health IT system hygiene goes beyond compliance with government regulation. Also using certified EHR technology is not a guarantee of legal compliance or protection.

The AMA believes there is a need to change the national conversation—the historical approach has been that cybersecurity is a technical issue focused on compliance—but it is important to remember that cybersecurity is a not just a technical issue, it is a patient safety issue as well.

Ms. Hoffman then outlined how physicians could work to protect their practice from cybersecurity threats and how to improve cybersecurity practices. She reviewed the importance of conducting a risk analysis and the elements to review in the analysis. Then there is a need to develop a work plan—a list of projects or actions that will be conducted in response to a risk area.

The work plan should contain specific actions to be taken and the resources required to take the action, the date work is scheduled, conducted, and completed goals to measure effectiveness as well as the party responsible for the action, she said. The workplace design will be different for a brand new security program vs. an organization that has already implemented a security program—or for organizations that already have a well-developed and well-functioning security program. She emphasized that it is also important to do a periodic review and updates to the risk analysis because cyber threats are always evolving.



Laura Hoffman, Assistant Director of Federal Affairs for the AMA, provides information to the audience.

Final takeaways for the participants:

- Update and patch your software—operating systems, software to manage your practice, web browser and word processing programs.
- Check your virus scan schedule to ensure it updates and runs regularly.
- Train staff on data governance and opening attachments—how to avoid email phishing attempts—and small practices should have a brief training with employees.
- Conduct and thoroughly document a risk analysis to identify potential threats to patient safety and comply with regulations.
- Create and implement security policies and procedures.
- Risk analysis reminders—document everything and remember it is only one piece of the cybersecurity life cycle.

Ms. Hoffman provided information on the various AMA activities underway right now to assist physicians with addressing cybersecurity, and she also noted that many tools and other resources are available, including ones from the AMA and from HITRUST. ■

Adventures at Better Health Partnership

By Diane Solov, Director of Communications and Foundation Relations

Better Health Partnership has led community-wide collaboration to improve health care, health outcomes and reduce costs since 2007. Learning and working together, we have documented measurable achievements on evidence-based quality measures selected by our partners to drive a healthier community.

By providing a safe space for competitors to collaborate, we bring together the region's major health systems and community health centers in Cuyahoga County and beyond. A growing suite of programs and activities leverage data, shared learning, and clinic- and population-level strategies to improve clinical care and outcomes and reduce the impact of social determinants on health. Better Health's model increasingly is tapped in regional statewide initiatives for data-driven improvements in population health.

Our journey to date is a lesson in the power of partnership and possibilities for healthy communities.

Better Health released its first report in 2008 on 26,075 adults with diabetes. Our latest reports describe care delivered by 1,570 providers in 189 practices of 13 healthcare systems who care for over 530,000 adults and children. Reports on adults include patient-level data elements on 44 core measures, and 34 specialized measures on diabetes, hypertension, and heart failure. Data analyses and collaboration reveal best practices that accelerate community-wide change, shrinking disparities in adult diabetes care and increasing rates of well-managed control in adults with high blood pressure.

In the Children's Health Initiative, improvements in rates of obesity, high blood pressure and well-managed asthma are targeted, with growing attention to social determinants of health that too often portend a lifetime of poor health. A new feature on www.betterhealthpartnership.org is an interactive tool that highlights opportunities for population health interventions. Moreover, a partnership with Health Data Matters enables depiction of patient- and neighborhood-level data on heat maps to guide interventions for targeted populations, and we are working to build an integrated system to connect clinic patients with services and resources in the community with United Way of Greater Cleveland 211.

The Triple Aim of better care for individuals, better health for populations, and lower *per capita* costs has been Better Health's North Star. For the last 10 years, our collaborative has documented better care and outcomes, and recently won national attention for averting costs.

A study published in *Health Affairs* in February 2018 links Better Health's collaboration to nearly $40 million in savings over six years by delivering better care to primary care patients with diabetes, high blood pressure and heart failure, avoiding nearly 6,000 costly hospitalizations for ambulatory-care sensitive conditions that would have occurred from 2009 through 2014 had trends in Cuyahoga County been similar to other large Ohio counties. The paper credits the impact of Better Health's role as an "integrator" of complementary activities and programs.

As do all things in health care, programs and activities evolve with changes in policy, payment and community priorities. Our current portfolio includes:

Rates of Overweight / Obesity in Children in Cleveland and Cuyahoga County

Oct 2016 - Sep 2017	
No. of Children	255,785
Ages	2 - 18
No. of Providers	895
No. of Primary Care Practices	135

A.	Most Healthy	< 20%
B.		21 – 30%
C.		31 – 40%
D.	Least Healthy	> 40%
E.	Insufficient Data	

Children's Health Initiative

- **Targeting improvements in obesity and asthma in children.** Childhood obesity is the most common chronic disease in children and reliably results in chronic disease in adulthood, and asthma increases school absenteeism and avoidable hospital utilization. Better Health collaborates to strengthen primary care and connect children and their families to resources in the community. Neighborhood-level maps of children with these conditions identify "hot spots" to address.
- **Partnering with United Way 211 Help Center to connect patients to community resources.** Efforts are underway to build a scalable model to bridge the divide between individuals' needs and community resources to abate them. The goal is to enable primary care practices to refer patients to 211 for help and establish two-way communications between clinics and 211 navigators, facilitating follow-up.
- **Reducing infant mortality rates.** Prematurity is the largest contributing factor to infant mortality in Cuyahoga County. Better Health joins First Year Cleveland's efforts to prevent infant deaths related to extreme prematurity, deploying its model and data capabilities to pinpoint contributing factors and identify and spread best practices for healthy, full-term babies.

Chronic Disease in Adults

- **Transforming primary care delivery for better outcomes.** Better Health plays a major role in a federally funded statewide effort to help primary care practices adopt functions of high-performing sites to improve care and outcomes. We assist 184 primary care practices across 27 northern Ohio counties (along with two regional health improvement collaboratives working downstate), as part of a Comprehensive Primary Care Plus federal grant awarded to the Health Collaborative in Cincinnati.
- **Improving rates of well-managed hypertension: a best practice.** Better Health's 2012 routine analyses of patient data from diverse practice sites found a dramatic rise in blood pressure control concentrated in one health system. Inquiries uncovered a new care process that we adapted to benefit all patient populations, then built an online toolkit to help practices and consultants adopt the best practice.
- **Cardiovascular Disease Best Practices Network.** Better Health is a founding member of an Ohio-based initiative to identify and disseminate best practices for primary care providers who care for

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Adventures at Better Health Partnership

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Ohio's Medicaid insured populations. Goals include expanded capacity of primary care teams to prevent, diagnose and effectively treat patients using technology to enable virtual training for remote practices. We partner with Case Western Reserve University School of Medicine, the awardee of Ohio Department of Medicaid grant that supports the initiative.

Programmatic fundamentals

- Nationally recognized strategies to reduce disparities across subpopulations that capitalize on healthcare information and partnerships. Adoption and spread of best practices for targeted conditions document better care in disadvantaged populations.
- Increased attention to population management and transforming health care across patient populations has led to more holistic, cross-sector collaboration that leverages both clinical interventions and non-medical community resources.
- Timely and trusted data inform practice-level and community-wide improvement; expert analyses reveal best practices to share for broad adoption.
- Learning Collaborative Summits assemble crosstown competitors who learn together and share effective improvement strategies.
- Annual events engage the community with reports on improvement, challenges and health policy implications.
- Experienced consultants go onsite to help practices adopt best practices and accelerate change. ■

The AMCNO has been a partner organization of BHP since its inception in 2007.

AMCNO LEGISLATIVE ACTIVITIES

Update on One-Bite Legislation

In the March/April issue of *Northern Ohio Physician,* the AMCNO was pleased to report that House Bill 145 ("One-Bite") had cleared the House and Senate and was signed into law by Gov. John Kasich. The AMCNO provided testimony for this legislation and has been working with the Medical Association Coalition (MAC) 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 we were hopeful that the organization of choice for this work would be the Ohio Physicians Health Program (OPHP). For more than 40 years, the OPHP has been confidentially helping impaired physicians regain their health and well-being to serve their patients.

Once HB 145 became law the SMBO began to work on proposed changes to their one-bite program rules—these rules have now been sent out for comment. HB 145 was enacted by the Ohio Legislature due to the outstanding leadership of several legislators as well as through collaborative efforts of the Medical Board (members and staff), medical associations, and the OPHP, who worked together tirelessly to establish the framework of an effective one-bite program. In addition, discussions regarding the initial draft rules eventually served as the foundation of the one-bite program established by HB 145.

The MAC fully endorsed HB 145, with the understanding that the rules and processes previously agreed upon would be honored once the bill was enacted. Although we understood that the existing rules would need to be edited to align with the legislative language, we were surprised to see that significant changes were made to the most recent rules circulated for comment. The MAC has participated in good faith to assist in establishing a confidential program that provides clarity to those who can utilize the program, allows for flexibility of individualized treatment plans and monitoring terms, and includes safeguards to ensure public safety. We believe that the proposed changes made to the rules are too prescriptive, and are not clinically based, so they will ultimately deter physicians and other licensees from seeking treatment and the help they need, which can place the public at risk. In addition, the changes appear to model current language used in Consent Agreements for discipline related to impairment cases and does not support an intervention and recovery model. The MAC sent specific details of the variances in the rule as written. We have requested that the rules be amended to reflect the previously agreed upon criteria, and the MAC has suggested that a meeting should be held to discuss these issues. The AMCNO will continue to keep our members apprised of these discussions.

AMCNO Supports OPPA Comments on SMBO Office-Based Opioid Treatment (OBOT) Rules

The AMCNO has reviewed the rules and the response letter regarding these rules as submitted to the SMBO on March 6 by the members of the Ohio Psychiatric Physicians Association (OPPA), and we completely concur with their comments.

Specific comments sent to the SMBO by the OPPA included concerns about the Board's decision to mandate the required components of treatment, and, in particular, to require at least one of five behavioral interventions—noting that the appropriate behavioral interventions are best determined by the behavioral health provider or a collaborating team of providers. OPPA also questioned the choice of the five interventions selected, some of which are quite specialized and others which are very broad. The OPPA was also concerned that the rule would make it difficult for a physician to prescribe mono-buprenorphine without risking his or her medical license except in very limited circumstances. Questions were also raised about what amount of buprenorphine could be prescribed along with concerns about other issues that need to be addressed in the rule.

Of particular concern to the AMCNO is how these rules have the potential to actually prohibit the prescribing of an effective treatment for opioid use disorder when we are experiencing a massive opioid epidemic across the state. We completely agree with the OPPA that these rules could result in making it even harder for patients to receive appropriate treatment, and create a situation where physicians will be reluctant to prescribe the medications necessary to treat patients with opioid use disorders. Ohio needs more treatment providers to address this epidemic, not less.

The AMCNO is hopeful that the SMBO will carefully evaluate the response letter submitted by the OPPA and consider amending these rules to address their concerns and ours.

AMCNO Participates in Immunization Advocacy Day – Supports HB 559

Ohio House Bill 559, sponsored by State Representatives Anne Gonzales (R-Westerville) and Al Landis (R-Dover), calls for a streamlined process on how data concerning immunization opt-out is handled and reported for school-age children.

Provisions in the bill include:

- Establishing a universal immunization information form school districts can use, and requiring a physician, advanced practice nurse or health department nurse to sign the form for all required immunizations for kindergarten, school entry, and grades 7 and 12. This universal form also calls for parents or guardians who ask for a vaccine waiver to have a dialogue with a healthcare provider to ensure they have all the appropriate medical and scientific information prior to making healthcare decisions, such as immunizing their child.
- Streamlining how the statewide immunization rates are reported, so that public health officials, stakeholders and parents can know the opt-out percentage rate by school building.

Bill sponsors introduced HB 559 to help improve the reliability of Ohio's immunization data. With a consistent method of data collection, public health officials will have access to more reliable data in case of disease outbreak. It also prevents parents of children who cannot be vaccinated because of allergies or other compromised medical issues from knowing the potential for exposure.

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The bill would have no impact on a parent's or caregiver's ability to choose to vaccinate or not. In addition, the legislation does not call for disclosure of a student's vaccine status or personal identity.

Organizations supporting HB 559 include: the AMCNO, Parents for Advocating for Vaccines (PA4V), Every Child by Two, American College of Obstetricians and Gynecologists, The National Meningitis Association, National Organization for Rare Disorders, Voice for Children, Ohio State Medical Association, Ohio Children's Hospital Association, Association of Ohio Health Commissioners, Ohio Chapter of the National Association of Pediatric Nurse Practitioners, and Immunize Ohio.

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

Ohio Department of Insurance Takes Regulatory Strike against PBM Practices – AMCNO Provides Testimony on Legislative Solution

The Ohio Department of Insurance (ODI) recently issued a bulletin that effectively prohibits Pharmacy Benefit Manager (PBM) co-pay clawbacks and gag orders. The AMCNO has been reporting on this issue for several months.

According to the ODI announcement, PBMs and/or health insurers are prohibited from engaging in the following practices:

- Prohibiting any person, directly or indirectly, from informing, by any means, an individual about less expensive ways to purchase prescription drugs that may also be available under any insurance policy or benefit plan.
- Requiring cost-sharing in an amount, or directing a pharmacy to collect cost-sharing in an amount, greater than the amount an individual would pay for the prescription drug if the drug was purchased without coverage under a health benefit plan.

This edict signifies that there is a problem. The AMCNO will continue to support clawback legislation. HB 479 will build on the reforms of the ODI bulletin by ensuring all non-audit-based retroactive takebacks do not occur, which then ensures the consumer pays the least amount at the pharmacy. This bill will also permanently codify this consumer protection and ensure that consumers aren't at risk when changes in administration occur.

The AMCNO submitted written testimony in April outlining our concerns with the PBM activities and clawbacks. Our testimony, sent by AMCNO President Dr. Fred Jorgensen, noted that this legislation will ensure that patients are getting the best deal possible at the pharmacy counter and that they're not in the dark about PBM drug pricing.

AMCNO Takes a Position of Support on Telemedicine Legislation

House Bill 546 would prohibit health plans from treating telemedicine services differently from in-person healthcare services solely because they are provided by telemedicine services. This bill contains language similar to what was contained in last year's budget bill, but the intent of the bill is to provide for coverage parity not payment parity–namely, if this is a service that would be provided in a physician's office and covered if it was performed in his or her office, it should be covered through telemedicine. Thirty-one other states have passed some type of legislation concerning telemedicine—whether it is coverage parity or reimbursement parity—and it is time that Ohio had similar legislation. The AMCNO will be working with a statewide coalition of provider and patient groups to try to move this legislation forward.

AMCNO Supports Emergency Care Legislation – HB 536

House Bill 536 would prohibit health plan issuers, including those participating in the Medicaid care management system, from implementing any form of selective emergency services coverage. This bill was introduced because of the recent decision by Anthem to limit coverage of emergency room care for non-emergencies.

Anthem has stated that its new program is designed to encourage consumers to use the most appropriate healthcare provider for the treatment that they need. The company will always cover non-emergency emergency room visits when the consumer is directed to the ER by a provider, for patients under the age of 15, if the patient's home is farther than 15 miles from an urgent care center, on weekends and major holidays, and if patients are traveling out of state.

This legislation was introduced in response to a new policy implemented in January by Anthem Blue Cross Blue Shield. This new policy states that patients treated in emergency room departments may have coverage denied and be responsible for the entire cost of the visit if Anthem retrospectively decides that based on the diagnosis the visit was non-emergent and the patient should have sought care at an alternative facility. The AMCNO and statewide medical associations have raised concerns about this change and communications have been exchanged with Anthem and the Ohio Department of Insurance (ODI).

Current law in Ohio provides patients with the ability to externally appeal a health insurer's decision. This independent review is administered by the ODI. If physician practices learn of a claim that an ER claim has been denied due to this new Anthem policy, they should consider working with the patient to seek Anthem's internal review of the denied claim, and, if necessary, seek external review from the ODI. The ODI has resources available on their website to assist patients and physicians with the internal and external review process. The ODI website is www.insurance.ohio.gov. Organized medicine will continue to attempt to get Anthem to rescind this ER policy altogether, if possible.

AMCNO Reviews HB 464 –Stroke Patients - Takes Position of Support

House Bill 464 permits eligible hospitals to be recognized by the Ohio Department of Health (ODH) as comprehensive or primary stroke centers or acute stroke-ready hospitals. It also prohibits a hospital from representing itself as one of these types of centers or hospitals unless it is recognized as such by ODH. The bill requires the establishment of written protocols for use by emergency medical service personnel when assessing, treating, and transporting stroke patients. Testimony provided about the bill indicated that passing this stroke facility recognition legislation will not require any Ohio hospital or center to seek or change their accreditation for stroke care, and certification is completely voluntary. The bill will also not require the ODH to survey hospitals regarding stroke care, and there is no fiscal impact. The bill is meant to be more of an awareness and education bill because hospitals would educate local EMS on what is available for stroke care. ■

Meeting at Global Center Focuses on Opioid Crisis

The AMCNO was on-hand at an event held in March at the Global Center for Health Innovation that brought together physicians, hospitals, community organizations, government representatives and others to review data and try to find a solution to the opioid crisis. Entitled "The Role of Private Capital in Attacking the Opioid Crisis," this executive briefing convened lawmakers with innovators to focus on the impact of private capital in the healthcare industry and advance discussion of initiatives that move toward prevention and the curtailing of opioid abuse across the nation.

BioEnterprise partnered with several partners, including Accenture Consulting, G2 Consulting and the Healthcare Information and Management Systems Society (HIMSS) to develop the briefing. This was the second in a series of briefings presented by BioEnterprise, which manages the Global Center and works with healthcare companies and bioscience technologies. This platform provides an opportunity for discussion about opportunities and challenges in achieving the vision of healthcare transformation. This initiative is part of the Global Center's work to participate in addressing healthcare issues.

Physicians and representatives from local organizations and government offices gather to work on solutions to the opioid crisis.

Following opening remarks and comments from BioEnterprise and Accenture, participants heard from government representatives, treatment providers and other experts on how they are working to address the opioid crisis.

Based on the presentations and discussions, it was clear that there are already numerous local, statewide and national efforts underway to address the opioid crisis; however, the intent of BioEnterprise is to work with experts to try to develop new innovative solutions to the problem. The plan is to set up a working group that will meet on a regular basis at the Global Center throughout the next year to create a solution to a specific issue related to the opioid crisis. It is also possible that other working groups will be formed. ■

AMEF
Academy of Medicine Education Foundation

PLEASE JOIN US on August 13, 2018, at The Mayfield Sand Run Club in support of the **15TH ANNUAL MARISSA ROSE BIDDLESTONE MEMORIAL GOLF OUTING.**

The Northern Ohio community benefits greatly from this yearly summertime event. Proceeds help fund local educational programs (including medical school scholarships) and help physicians and the patients they serve achieve better health outcomes through the implementation of new initiatives, plus so much more.

So do your part! Tee up and help continue the tradition of excellent health care in our region!

The Academy of Medicine Education Foundation (AMEF) was established for charitable, educational and scientific purposes.

The purpose of the AMEF is to add a charitable component to the AMCNO and position the Academy as a viable resource dedicated to the improvement of health care through education. The AMEF enhances the philosophy of the AMCNO in its focus on healthcare-oriented education for physicians, their staff and patients by providing support for meaningful education and highlighting the value and quality of health care.

Please select your level of support:

- ❑ **Diamond Sponsor** — **$10,000** Includes fees for 2 foursomes, plus your company name featured prominently in the brochure, in a full page in the day's program, on signage at dinner and on a list of event sponsors displayed at several areas around the course.
- ❑ **Platinum Sponsor** — **$5,000** Includes fees for a foursome, plus your company name featured prominently in the brochure, in the day's program, on signage at dinner and on a list of event sponsors displayed at several areas around the course.
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- ❑ **Hole Sponsor** — **$1,000** Includes your company name in the brochure, in the program for the event, and displayed on a specific hole.
- ❑ **Individual golfer** — **$350** Your entry fee of $350 includes greens fees, cart and one caddy, lunch, dinner and prizes.
- ❑ Can't make it. But I'd like to make a tax-deductible contribution $_____

A portion of the sponsorship and golf fees are tax deductible.

Golfers: please indicate foursome names & handicaps

1. _____ 3. _____

2. _____ 4. _____

Make checks payable and mail to:

AMEF, 6100 Oak Tree Blvd., #440, Cleveland, OH 44131

For more information or to register by phone call Abby Bell or Tara Camera at: 216-520-1000

Fax registration to: 216-520-0999 OR Pay by credit card: ❑AMEX ❑MasterCard ❑Visa

Account # _____ Exp. Date _____