

AMEF Sponsors Crain's 2018 "Wellness in the Workplace" Health Care Forum

This year, Crain's Health Care Forum, held at the NEW Center at Northeast Ohio Medical University (NEOMED), focused on "Wellness in the Workplace." The Academy of Medicine Education Foundation (AMEF) was pleased to once again sponsor this event.

Elizabeth McIntyre, *Crain's Cleveland Business* editor and publisher, and Dr. Elizabeth Young, vice dean of NEOMED's College of Medicine, provided opening remarks before Ms. McIntyre introduced the keynote healthcare executive panel, which she moderated.

The panel consisted of: **Dr. Bernard Boulanger**, executive vice president and chief clinical officer, MetroHealth; **William Considine**, CEO, Akron Children's Hospital; **Tom Strauss**, president and CEO, Sisters of Charity Health
(Continued on page 2)



A panel of healthcare executives discusses healthcare-related obstacles at the Forum.

HB 7—Medical Provider Immunity—Passes Ohio House, Moves to the Senate

The AMCNO is pleased to announce that a bill we strongly support, House Bill 7—Medical Provider Immunity, has cleared the Ohio House floor by vote. This bill includes numerous medical liability reforms that represent an effort to achieve a goal of eliminating unnecessary litigation and to provide further clarity, stability and predictability to our medical and legal communities. The bill now resides in the Senate.

Some of the provisions include:

- **"I'm Sorry" Law:** HB 7 includes a clarification of Ohio's apology statute to make it clear that when there is an adverse medical outcome, physicians can open the lines of communication with the patient without those communications being considered an admission of liability. These apology laws have proven to help reduce overall lawsuits.
- **Insurer Reimbursements Can't Define Standard of Care:** Prohibits the use of insurer payment policies and guidelines from being used to establish the standard

of care. Recently adopted payment guidelines and performance incentives by insurers and the federal government were never intended to be used in legal proceedings to establish the standard of care. Rather, they were simply created as cost-management tools for the federal government and other third-party payers.

- **"Shotgun" Lawsuits:** Significantly reduces the practice of "shot gunning" defendants in medical claims, resulting in unnecessary expenses to plaintiffs and additional costs to physicians and their insurers. Plaintiffs would have a finite

period to name additional defendants after the initial filing of a medical claim and the legislation also imposes upon plaintiffs the obligation to exercise due diligence to discover the basis for asserting claims against any such additional defendants within that period.

Another provision of the bill deals with the on-site access to peer review committee records by the Ohio Department of Health during an inspection of records from a health care entity. The AMCNO Medical Legal Liaison Committee has reviewed this provision of the legislation and has expressed some concerns with the language. The AMCNO Board of Directors agreed with these concerns and believes that this provision of the bill may have
(Continued on page 4)

INSIDE THIS ISSUE

AMCNO Public Health Activities	Pages 9-11
2018 Election Guide	Page 13
AMCNO Health Information Technology Activities	Page 14

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AMEF/AMCNO COMMUNITY ACTIVITIES

AMEF Sponsors Crain's 2018 "Wellness in the Workplace" Health Care Forum *(Continued from page 1)*

System; **Dr. Theodoros N. Teknos**, president and scientific officer, University Hospitals Seidman Cancer Center; and **Dr. James B. Young**, chief academic officer, Cleveland Clinic; professor of medicine, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University.

Ms. McIntyre asked the panelists to discuss how the opioid crisis is affecting their organizations. Dr. Boulanger said the crisis has disrupted communities, and healthcare systems bear the burden. Opioid prescriptions have significantly declined, however, as other modalities of treatment have been provided. He briefly discussed the MetroHealth Office of Opioid Safety, of which AMCNO member Dr. Joan Papp serves as medical director, that helps patients manage their pain and educates physicians on prescribing practices.



Panelists discuss a new healthcare model.

Mr. Strauss said Rosary Hall at St. Vincent Charity Medical Center sees 16% of all opioid patients in the state. He acknowledged that the crisis has an impact on caregivers as well, so they train caregivers, including physicians and nurses. Dr. Teknos said patients shouldn't be vilified for taking prescription opioids, because they still are an important part of treatment, particularly for cancer patients. Mr. Considine said that one-third of babies born at Akron Children's Hospital are addicted to opioids—these children will have challenges throughout their lives, and everyone will pay into their future healthcare costs. All panelists agreed that more needs to be done to combat the opioid problem.

Ms. McIntyre asked the group to discuss other healthcare-related obstacles. Dr. Teknos discussed healthcare disparities throughout the region, including cancer (32% are active smokers), HPV vaccination (compliance levels are low), and access to health care (it's not

where it should be). Citing 80% of health is outside of a hospital, he said zip code largely determines health, not genetic code. But, he also said the area institutions are reaching out in significant ways to get people the care they need.



AMCNO Past President Dr. John Bastulli poses a question to the health system panel.

Dr. Boulanger said this region has excellent physicians and hospitals, but we aren't seeing great outcomes to reflect that. Not one hospital can handle all disparities—community partners need to be engaged. Dr. Young said physicians need to move toward an interdisciplinary team approach, and even ride-sharing services should be included in the equation as well, to physically get patients to a healthcare provider.

Ms. McIntyre asked the panelists to discuss how we can plan for the future in the healthcare field despite all of the disruptions that are occurring now. Dr. Teknos talked about the constant pressure on physicians to decrease costs, and he said two things have to change: how physicians care for patients, and how money spent needs to be monitored. He also said there is a need to embrace value-based care, and prevention should be emphasized. Accountable care organizations are crucially important, he added, and so is consumerism, because consumers will ultimately make the decisions. Mr. Considine said connections need to be made with communities, with a focus on being flexible and gaining credibility by being more than "just a hospital," he said.

When the panelists were asked about what can be done to mitigate the challenges of recruitment and retention, Dr. Young said more primary care physicians are needed, and NEOMED and Cleveland Clinic are working on it. Mr. Considine briefly discussed physician burnout, saying physicians aren't trained on the psychology of patients. They also need to

feel safe in their environment—literally and figuratively. Mr. Strauss added that the opioid epidemic has put additional stress on physicians, and emphasized that more addiction specialists are needed.

The panelists also shared their thoughts on why health care is so expensive and what can be done to decrease costs, touching on how current health care is based on "sick" care, instead of prevention; how home visits for Medicare patients can significantly decrease ED visits; and suggesting that children should be covered under a separate reimbursement system that's contracted with local governments, instead of being grouped into funding that can be cut by elected officials.

The panelists then fielded questions from the audience, which covered universal health care, social determinants of health, and Medicare solvency.

Dr. Brent Pawlecki, chief health officer at The Goodyear Tire & Rubber Co., discussed "Building a Culture of Health." He said about 25% of employers' direct costs are related to health care in the workplace, so he encouraged employers to start making better health a priority to prevent presenteeism (ie, employees are present but not engaged, because they are dealing with a health issue). Dr. Pawlecki said many people struggle with a chronic condition and are experiencing it at earlier ages. Goodyear includes wellness and health care as part of their overall strategy—they want to keep people healthy. To do so, the company focuses on four components: health benefits, wellness programs, environment (health and safety), and emergency preparedness. They empower employees to make the right decisions for themselves.

Goodyear's CEO is also engaged in making health a priority for employees. He wanted a large fitness center for the company's new headquarters, so one was built and employees can use it free-of-charge. They are encouraged to take breaks and get healthy overall. The company also changed workplace behaviors by charging more for unhealthier drink and food choices, instead of excluding them altogether. Employees have responded favorably, because they have options.

Goodyear measures "wellness" by looking at how healthy people are (using claims data), how healthy worksites are (using a specific scorecard), and how healthy the culture of health is (using an outside tool, based on 1,000 patients). Dr. Pawlecki said more people are getting healthier because of these initiatives.

AMEF/AMCNO COMMUNITY ACTIVITIES

Audience members asked questions following the presentation, inquiring about how the company handles emotional and substance abuse issues in the workplace, and what Goodyear is doing to work toward value-based care.

Amy Ann Stoessel, managing editor for *Crain's*, introduced the panelists for a "Case Study: A New Model of Health Care." **Tim Magaw**, *Crain's* sections editor, served as moderator. Panelists were **Dr. Eric Miller** from Paladina Health; **Ryan Pendleton** from Akron Public Schools; and **Monica Trusley** with Oswald Companies.

Paladina Health is a Denver-based primary care outfit that has brought its care concept to Ohio. This model focuses on physicians having a smaller caseload so that they can take better care of patients, which, in turn, can ultimately lower an employer's healthcare spend by focusing on prevention rather than utilization. The Akron Public Schools is one of the local companies that uses this healthcare plan and has had success with it.

Dr. Miller stated that this model makes sense because it addresses the challenges and costs of traditional health care. It particularly addresses prevention before an illness or disease reaches a crisis stage. Patients are not charged for visits or incur additional fees or costs. Patients are also able to spend 30 minutes with their physician instead of 10.

Paladina expected four hundred people to enroll initially in the program for the Akron schools—1,200 actually signed up. Primary care is the most cost-effective sector—it can produce the best overall economic value, Dr. Miller said. The company pays physicians a competitive salary, and the physicians like having more time in front of patients (and vice versa). He admits some physicians are skeptical

of this model at first, but once they understand it, they love it and said they can't go back to the old system. It's a rare instance where it's a win for all parties.

Mr. Magaw asked the panel how we got to the point where basic health care is an innovation, and Dr. Miller said that because medical care has become more like a business. It's not health care, it's "disease care," he said, where we have valued taking care of people at the end of life instead of throughout their lives. That needs to change. We have to align incentives to get what we want, and work toward the same goal.

Ms. Stoessel moderated the next panel: "Advancing Wellness: How and Why Employers should Take the Lead," which featured **Dr. Francoise Adan**, medical director of UH Connor Integrative Health Network, and assistant professor at CWRU University Hospitals; **Jim Ellis**, executive VP and managing director of Integrated Wellness Partners; and **Dr. Donald Ford**, chief medical officer of Better Health Partnership, and family physician with Cleveland Clinic.

Ms. Stoessel asked the panelists to discuss the importance of a culture of wellness. Dr. Adan said it's crucial that it starts with engagement from the C-suite (eg, CEO, CMO, etc.). They need to serve as a model that it's ok to take a break and have a healthy work/life balance. Mr. Ellis said wellness and well-being should become company policy, and should be what employees want and what they will engage in.

Dr. Adan discussed the best practices of wellness, saying it's important for people to take a holistic approach—they need to care for their bodies (ie, don't smoke, maintain a healthy weight, keep blood pressure in a healthy range), as well as their minds (ie, manage stress).

Ms. Stoessel asked how wellness can be measured; how an employer would know if a stress management program is working, for example. Dr. Adan said 80% of office visits are caused or exacerbated by stress. By using practical tools, patients can deal with stress. It can be difficult to monitor wellness, but it's still important to address it.

Mr. Ellis suggested that employers offer flexible work schedules to alleviate stress, encourage activities that elevate social connectivity (such as work groups or clubs) and grow social networks. Some companies offer a wellness program to check a box; they don't see well-being as a successful business practice, he said.

Dr. Ford mentioned that within his workplace, employees receive certain benefits if they achieve specific goals, so there is an incentive to accomplish health goals. As for patients, it can be difficult to discuss wellness information in such a short amount of time during an office visit, but the cost is the wellness of the patient.

Dr. Adan said it's important to create incentives, but you likely are not going to reach everyone. Most successful programs are run by employees, or at least have input from employees about what interests them. Dr. Ford said it's important to offer safe environments for employees to exercise, and to simply enable them to take care of their health.

Several AMCNO members and staff attended this event, and provided positive feedback about it afterward. The AMEF looks forward to supporting this forum again next year, to provide the medical community with pertinent health information. ■

AMCNO Members Needed for Annual PALS Event

Would you like to talk to medical students about your field of medicine? The AMCNO is asking our physician members to consider participating in the fourth annual Physicians Are Linked with Students (PALS) networking event on October 7, from 6 – 8 pm, at the Case Western Reserve University School of Medicine.

During the program, you'll have the opportunity to speak with second- and third-year medical students in a group setting about the details of practicing medicine and what they can expect if they enter a specific specialty. We would like to have physicians from various fields involved in the event, so that the students get a better overview of different specialties and subspecialties.

If you're interested in learning more, or you would like to participate in the program, please contact Tara Camera at the AMCNO offices at tcamera@amcno.org or (216) 520-1000, ext. 102.

It should be another fun evening—*join us!*

HB 7—Medical Provider Immunity—Passes Ohio House, Moves to the Senate *(Continued from page 1)*

the potential to negatively impact the peer review process in Ohio, and, therefore, the AMCNO would like to see this provision removed from the legislation. The AMCNO will continue to follow this legislation as it moves through the Senate and relay our concerns to legislators.

Prescription Benefit Managers (PBMs) Under Scrutiny

The AMCNO is pleased to announce that the Ohio House of Representatives voted unanimously in favor of HB 479—known as the “Prescription Drug Co-Pay Integrity Act.” The bill currently resides in the Ohio Senate for further debate. This bill would prohibit the practice of PBMs requiring pharmacists to charge patients an amount greater than the pharmacy’s cash price for a prescription drug, and second, it would prohibit gag clauses that some PBMs place in pharmacy contracts that penalize pharmacists for disclosing all of the information related to a patient’s prescription drug costs.

The passage of HB 479 in the House was preceded by an announcement by the Ohio Department of Insurance (ODI) that effectively prohibits PBMs and/or health insurers from engaging in the following practices:

1. 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.
2. 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 were purchased without coverage under a health benefit plan.

Ohio Attorney General Mike DeWine recently noted that he expects an ongoing investigation into the practices of PBMs that conduct business with state agencies to result in lawsuits against the PBMs. The investigation, which began in 2017, is looking into PBMs and their contracts with state agencies and state pension systems.

In addition, on the federal front, President Trump has announced drug pricing reform—which includes a sharp focus on PBMs and their gag rules. Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma has also issued a memo to all Medicare

Part D plans indicating that CMS is committed to empowering patients with the information they need to make informed decisions about their care. In Medicare Part D, CMS policy requires plan sponsors to ensure enrollees pay the lesser of the Part D negotiated price or copay or be subject to CMS compliance actions. CMS believes that any form of gag clauses are contrary to their efforts to promote drug price transparency and lower drug prices.

The AMCNO applauds all of these efforts and strongly supports HB 479.

Ohio Sets Precedent for Nation in Pharmacy Benefit Transparency Reporting

Ohio Medicaid recently released the first report of its kind in the nation that shows the price the state’s Medicaid managed care plans pay for prescription drugs, the amount pharmacy benefit managers (PBMs) retain to administer the program, and the amount paid to pharmacies. The report was prepared by HealthPlan Data Solutions (HDS), based on one year of actual pharmacy claims data.

The total amount paid per prescription is now known for pharmacies (\$59.90) and PBMs (\$5.77), so Ohio’s taxpayers, legislators, managed care plans and others are in a better position to assess whether the products and services provided for that price is fair. In addition, HDS identified the following:

- The spread between what was billed to plans and paid to pharmacies is 8.8%
- Independent pharmacies were paid more than CVS pharmacies for the same drugs
- Medicaid health plan PBM pricing saves Ohio taxpayers at least \$145 million annually compared with fee-for-service pricing (the savings increase to at least \$245 million annually when revenue generated from managed care pharmacy benefit fees is included)

Following the report, ODM directed its five managed care plans to terminate contracts with PBMs that use a “spread” pricing model by the end of 2018. The ODM said it is looking to adopt a “pass-through” funding model instead to increase transparency and stem rising costs by January 1. This type of model would allow all participants to see what is paid out for all pharmacy transactions. To review the PBM performance report, go to <http://www.healthtransformation.ohio.gov/Portals/0/Press%20Releases/PBM%20Review.pdf?ver=2018-06-26-162945-687>.

Northeast Ohio Hospital Opioid Consortium Sends Comments to SMBO about Proposed Subacute/Chronic Pain Rules

The AMCNO is a partner in the Northeast Ohio Hospital Opioid Consortium, a partnership that also includes The Center for Health Affairs, Cleveland Clinic, MetroHealth, Northeast Ohio VA Healthcare System, St. Vincent Charity Medical Center, and University Hospitals, that are all working together to address the region’s opioid epidemic. (For more information on the Consortium, see pages 9-10.)

The Consortium recently sent comments to the State Medical Board of Ohio (SMBO) and the Common Sense Initiative (CSI) concerning the proposed subacute and chronic pain rules. In the letter, Dr. Randy Jernejcic, who is the Consortium chairman, wrote that, overall, the Consortium generally agrees with the majority of the recommendations included in the proposal, but after a thorough review, found a few areas of concern, specifically related to informed consent, consultation with experts, and thresholds for increased monitoring.

As for informed consent, the Consortium’s hospital members and providers expressed concerns with the burdensome nature of obtaining informed consent at 50 MED. Since additional regulations will be required once a prescription exceeds the 50 MED dosage, physicians will have already informed patients of the risks associated with opioid use. Adding an additional layer of paperwork to obtain informed consent will be proven a redundant step in delivering care. The Consortium asked the SMBO/CSI to consider the implications of this rule change.

As for consultation with experts, the Consortium asked for the consideration of engaging pain medicine specialists prior to reaching 120 MED, and recommended that an addictionologist is engaged prior to chronic opioid therapy in all patients with a prior or current substance use disorder, and they should be required to consult an addictionologist, at any dose level, if evidence of aberrant behavior emerges.

And, finally, as for thresholds for increased monitoring, the rule requires “periodic” follow-up assessments for patients receiving less than 50 MED per day. The Consortium recommended requiring follow-up assessments every 90 days, with exceptions for patients who experience serious impediments traveling to a provider; in which case, opportunities for telemedicine should be permitted to meet this requirement (when available).

AMCNO LEGISLATIVE ACTIVITIES

Ohio Medicaid Achieves State's Longstanding Goal of Behavioral Health Parity

The Ohio Departments of Medicaid and Mental Health and Addiction Services announced that the July 1, 2018, integration of Medicaid behavioral health redesign and physical healthcare benefits will achieve the state's goal for parity between those benefits.

The Mental Health Parity and Addiction Equity Act of 2008 specifically prevents health plans from imposing less favorable benefit limitations on mental health or substance use disorder benefits than on medical/surgical benefits. Ohio Medicaid assessed its benefits following guidance provided by the federal Centers for Medicare & Medicaid Services (CMS) and, effective July 1, assured compliance with parity requirements in federal law.

This announcement marks a critical step in Gov. John Kasich's strategy to rebuild community behavioral health system capacity and fully integrate physical and behavioral healthcare services to support recovery for those with a substance use disorder or mental illness. To read the final report, go to <http://medicaid.ohio.gov/Portals/0/Providers/OH-MHPAEA-Final-Report.pdf>.

Ohio Auditor's Report Confirms Medicaid Expansion is Necessary in Fighting Opioid Epidemic

A report from Ohio Auditor Dave Yost confirms the necessity of Ohio's 2014 Medicaid expansion in providing access to services that support recovery from addiction. For example, the report states that the number of Ohioans with access to medication-assisted treatment increased from 6,500 before the expansion (2010) to 48,000 (2016), showing that Medicaid effectively links individuals to the recovery services they need.

The report also verifies that Ohio's Medicaid providers are engaged in responsible prescribing practices. For example, opioid prescriptions for Medicaid recipients in the state are shorter in duration than the national trend in the commercially insured population, there are almost no long-duration opioid prescriptions for Ohio Medicaid recipients, and almost all opioid prescriptions written for Ohio Medicaid recipients are low dosages.

An increased cost is associated with providing necessary recovery services during a national opioid crisis; the report states that beginning July 1, these costs will be managed by Ohio Medicaid's five private sector managed care plans. For Medicaid overall, the managed care plans have assisted in holding per person Medicaid spending growth to below 2% in each of the past four state fiscal years. As a

result, more Ohioans can receive the critical recovery services they need within a well-managed and sustainable budget. The auditor's report is available at https://ohio.auditor.gov/publications/Special_Report_The_Opioid_Crisis.pdf.

AMCNO is Pleased with ODM Decision to Defer to Regulatory Boards to Determine Physician's Status

The Medical Association Coalition (MAC), a group that the AMCNO works with extensively, recently reviewed the Medicaid termination letter and issues related to the application of Medicaid Rule 5160-1-17.6(l) (1.), which required the Ohio Department of Medicaid (ODM) to terminate their provider agreement with any provider whose license is suspended, revoked or otherwise limited.

In addition to local directors meeting with ODM and other government officials, the MAC had sent a letter to the ODM regarding this issue. The AMCNO is pleased to report that the ODM has agreed to pull back on their termination policy for providers related to Board action. The ODM office and Governor's office stated that they have agreed to defer to regulatory boards as to whether a person is qualified or fit to practice.

Termination letters will no longer be sent due to an action, limitation, or restriction of a license; instead, the ODM will allow for physicians and other healthcare professionals to be eligible to be Medicaid providers once the licensing board has determined them fit to practice and they no longer have a suspended license. They will also be reviewing all of the individuals who received termination letters during this period and notifying them of the change in policy (eg, for physicians, this would mean they could not be an ODM provider while suspended on a Step I Consent Agreement but would be eligible to be an ODM provider once they enter into a Step II Consent Agreement with probationary terms).

ODM appreciated the MAC's involvement on this issue, which resulted in a quick resolution to the matter. The MAC will continue to work with the ODM office to clarify a few additional outstanding issues, and we will continue to provide updates to our AMCNO members on the matter.

AMCNO Joined Coalition that Opposed the Proposed Ohio Dialysis Amendment

Ohioans Against the Reckless Dialysis Amendment is a coalition of organizations, including the AMCNO, and advocates who opposed the proposed reckless dialysis constitutional amendment.



AMCNO Past President Dr. Laura David (right) spends a moment with Rep. Stephanie Howse.

The proposed amendment was written by the California-based SEIU-UHW, which is sponsoring a similar proposal that is scheduled to appear on the California ballot on November 6. The SEIU financed a paid petition drive, with hundreds of paid circulators from out of state, to gather signatures in Ohio in recent months.

This proposed amendment would have mandated arbitrary revenue limits for Ohio dialysis clinics and require rebates to private health insurance companies if revenues exceeded those arbitrary limits. The proposal had no requirement that any savings be passed on to patients, nor did the rebate provision apply to the nearly nine out of 10 Ohio dialysis patients who are covered by Medicare, Medicaid or other government programs, such as the Veterans Health Administration.

The AMCNO was pleased when the Ohio Supreme Court decided to throw out a 300,000-signature petition for a proposed constitutional amendment intended to control the cost of kidney dialysis. The court unanimously ruled that because the paid organizers of the petition campaign didn't make the required disclosures to the Ohio Secretary of State's office before gathering signatures, they must all be thrown out. The deadline to file ballot measures for the November 6 election passed July 4. As a result, the proposed amendment failed for the November 2018 general election.

This was welcomed news for the coalition that had joined together to oppose the amendment because of the harm it would bring to the 18,000 Ohioans who rely on the high-quality, life-saving dialysis care provided by the state's 326 outpatient dialysis clinics. The amendment sponsor has indicated that it intends to bring the issue back in 2019. The coalition will remain prepared to educate Ohio voters on the dangers of this reckless proposal. ■

Ohio Medicaid Releases Report – Expansion Four Years Later

The Ohio Department of Medicaid (ODM) recently released the second assessment of the Medicaid expansion. The first assessment, which was also required by the Ohio General Assembly, was released in 2016.

Some key highlights from the 2018 assessment indicate that Medicaid expansion has:

- Helped individuals find work and improve financial stability. A 2018 review of the state's Medicaid expansion population indicated that it was easier for them to keep or find work, and most reported better health and financial security because of obtaining coverage.
- Cut Ohio's uninsured rate by half. Due in large part to Medicaid expansion, Ohio's uninsured rate has been cut in half, and 700,000 previously uninsured residents now have health coverage.
- Provided services necessary to treat mental illness and addiction. Since Medicaid expansion became a reality in 2014, 1.26 million individuals have received Medicaid coverage, and more than 630,000 individuals with behavioral health needs have received services to assist in their recovery from mental illness and/or substance use disorders.

The 2018 review of Ohio's Medicaid population also found:

- High-cost emergency department use decreased by 17% among enrollees continuously enrolled in Medicaid;
- A continued decline in the uninsured rate to the lowest recorded level for low-income adults between ages 19-64;
- Most enrollees—290,000 (71%)—reported getting a job or increased income as a reason for disenrolling from Medicaid;
- It was easier for enrollees to continue working (83%) and it was easier to look for work;

- Enrollees were more than three times as likely to report that their physical and mental health had improved since enrolling in Medicaid compared with those reporting it had worsened;
- Nearly 26,000 enrollees have stopped smoking due to help from Medicaid expansion; and
- Of those diagnosed with opioid use disorder, 96% receive some form of treatment.

Medicaid expansion in Ohio was a huge policy choice spearheaded by Governor John Kasich, which resulted in increased review by the General Assembly—who, in turn, required these reports from the Ohio Medicaid. Beginning in 2019, a new governor and the legislature will begin the budget process, and there will be debate about how the state will handle the cost of expansion. This latest assessment clearly shows that Ohio's Medicaid expansion continues to be important for Ohio citizens—it has reduced financial stress for many individuals, supported individuals seeking jobs or remaining employed, expanded access to care and provided access to preventive care, and created improved access to diagnosing and treating chronic health conditions.

The AMCNO supports Medicaid expansion, and we are hopeful that the legislature will focus on the positive benefits of the program as the discussion continues on this important issue.

To review the entire ODM report, visit www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf. ■

SAVE THE DATE! March 22-23, 2019

The 2019 Medical Legal Summit will be held March 22 and 23 at the Cleveland Metropolitan Bar Association (CMBA) Conference Center. This annual event is co-sponsored by the AMCNO, Academy of Medicine Education Foundation, and CMBA.

The purpose of this Summit is to bring together physicians, attorneys, healthcare professionals and others who work in allied professions for education, lively discussion and opportunities to socialize and network.

More information will be available soon.

NORTHERN OHIO PHYSICIAN

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Providers Have Until October 1st to Request to Enter Targeted Review Process

By Joseph M. Bucaro, Brouse McDowell, LPA

Providers and clinicians who participated in the Merit-based Incentive Payment System (“MIPS”) in 2017 now have the opportunity to review their MIPS performance feedback. This will allow participants in the program to request a targeted review of their payment adjustment scheduled for 2019 if they feel an error has been made by CMS. Advanced alternative payment model (“APM”) entities and accountable care organizations can also access and review 2017 performance feedback to determine if they should request a targeted review. The targeted review process was created to allow providers an opportunity to review the CMS determinations made regarding their MIPS performance feedback.

In order to determine if a targeted review should be requested, participants should first log on to their respective Enterprise Identity Management (“EIM”) account to view their MIPS performance feedback. The performance feedback for each provider will include the provider’s 2017 final score, 2019 MIPS payment adjustment, and final performance category scores and weights. The 2019 MIPS payment adjustment will include a positive, negative, or neutral payment adjustment that will be applied to the Medicare paid amount for covered professional services furnished under the Medicare Physician Fee Schedule in 2019. Participants will also be able to view detailed scoring and performance information for each of the performance categories.

Participants should review all the information available on their EIM account carefully to determine if they should submit to the targeted review process. Below are several

potential issues participants may see that indicate they should seek out the targeted review process:

- Errors or data quality issues on the measures/activities which were submitted by the participant;
- Eligibility issues, such as participants falling below the low-volume threshold and should not have received a payment adjustment;
- Exclusion from the APM participation list and not being scored under APM scoring standard; and
- If a participant is not automatically reweighted, despite qualification due to the 2017 extreme and uncontrollable circumstances policy.

While this is certainly not a comprehensive list of circumstances, it’s these types of issues that participants should look for when reviewing their MIPS feedback.

If participants determine that there has been an error in their performance feedback and they wish to enter the targeted review process, there are several steps they can take to increase their chances of altering their 2019 payment adjustment. First and foremost, CMS has encouraged participants to provide supporting documentation that a targeted review is warranted. Any written evidence that there are errors in MIPS feedback will significantly increase participants’ chances of receiving a favorable adjustment. Second, participants should note that the deadline to request a targeted review is **October 1, 2018, at 8:00pm EST**. No targeted review requests will be accepted after that date.

If your targeted review request is approved, CMS has stated it will update participants’ final score and associated payment adjustment as soon as technically feasible. CMS will determine the amount of the upward payment adjustments after the conclusion of the targeted review submission period. All targeted review determinations are final and cannot be appealed.

It is important participants take time to closely review their MIPS data and provide supporting documentation to any request for a targeted review, as it could significantly increase their reimbursement for 2019. ■

CMS Releases “Historic” Proposed Physician Fee Schedule Rule for 2019

The Centers for Medicare & Medicaid Services (CMS) recently published the proposed Physician Fee Schedule Rule for 2019. Officials are saying it would make “historic changes” to the Medicare program, aimed at restoring the doctor-patient relationship. CMS Administrator Seema Verma said officials had listened to physicians and made changes to give them more time with patients. The proposal includes provisions for the Quality Payment Program (QPP) and the physician fee schedule (PFS). Comments on the rule are due to CMS by Sept. 10, 2018.

A brief summary of the Medicare proposals:

- With the budget neutrality adjustment to account for relative value changes, as required by law, the proposed 2019 PFS conversion factor is \$36.05, a slight increase above the 2018 PFS conversion factor of \$35.99.
- Collapse payment for office and outpatient visits. New patient office visit payments would be blended to be \$135. Established office visits would be blended to be paid at \$93. New codes would be created to provide add-on payments to

office visits for specific specialties (\$9) and primary care physicians (\$5).

- CMS will implement new CPT codes and payment for remote monitoring and interprofessional consultations.

A few highlights of the Merit-based Incentive Payment System (MIPS) proposals:

- Retain the low-volume threshold but add a third criteria of providing fewer than 200 covered professional services to Part B patients.

- Retain bonus points for the care of complex patients, end-to-end reporting, and small practices.
- Allow eligible clinicians to opt-in if they meet one or two, but not all, of the low-volume threshold criterion.
- Eliminate the base and performance categories and reduce the number of measures in the Promoting Interoperability category.
- Require eligible clinicians to move to 2015 CEHRT.

CMS has created fact sheets on the major components of the rule; they are available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12-2.html>. ■

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Northeast Ohio Hospital Opioid Consortium Launches Three-Year Strategic Plan

By Lisa Anderson, MSN, RN, Senior Vice President, Member Services, The Center for Health Affairs

The Northeast Ohio Hospital Opioid Consortium announced this summer the launch of its three-year strategic plan, bringing together participants around a focused effort to address the opioid crisis.

The Opioid Consortium formed in 2017 as a joint effort of area hospitals and The Center for Health Affairs and later that year expanded to include the Academy of Medicine of Cleveland & Northern Ohio. University Hospitals, Cleveland Clinic, MetroHealth System, Northeast Ohio VA Healthcare System, and St. Vincent Charity Hospital comprise the hospital membership.

The Consortium operates out of The Center for Health Affairs with oversight by Lisa Anderson, MSN, RN, senior vice president, Member Services. Under the leadership of physician chair Randy Jernejcic, MD, vice president of Clinical Integration, University Hospitals, the Consortium is governed by an executive committee comprising The Center for Health Affairs leadership team and the designated lead physicians or clinicians from the five Opioid Consortium hospitals and the AMCNO.

The involvement of these lead physicians and clinicians is crucial to the success of the initiative. These distinguished individuals, who are active presenters at both local and national conferences, also participate in local, state and federal opiate task forces and support a systems approach to substance use disorder screening throughout the continuum of care.

The opioid epidemic facing the region calls for a multi-pronged approach by organizations throughout the community, from healthcare providers to first responders to law enforcement agencies and many others. The Opioid Consortium creates the opportunity for participating healthcare organizations to leverage and contribute their resources to activities that combat this epidemic.

"Under the new strategic plan, the hospitals, along with The Center and The Academy, are coming together in a collaborative way to utilize their expertise in support of patients by both treating the disease of opioid addiction and working to prevent its spread," said Dr. Jernejcic.

Strategic Plan Priorities

The three-year plan, which covers 2018 through 2020, organizes the Consortium's work into seven areas: communication,

education and patient management, harm reduction, treatment, prevention, data, and public policy. Goals include:

- Creating educational programs and resources for nurses and frontline staff, patients and the public, and high-level providers such as primary care physicians, advance practice registered nurses (APRNs) and physician assistants (PAs).
- Increasing access to and the use of nasal Narcan.
- Expanding access to a variety of patient care resources, including medication-assisted treatment (MAT), addiction consultation services, and opioid treatment programs.
- Improving prescribing and pain management practices within and among providers.
- Developing and utilizing primary and secondary data sets to measure impact and improve outcomes.

Nurse & Frontline Staff Education

Already, the organization has made progress in a number of areas. Camille Zalar, MHA, BSN, RN, CARN, was hired in July 2018 as director of education and initiatives for the Consortium. Zalar is responsible for overseeing the Consortium's education programming, including the initiatives related to nurse and frontline staff education. To date, a review of existing educational practices and resources has been conducted and the development of a standardized curriculum is in progress. Outlines have been created for each component of the curriculum, and existing quality resources, as well as curricula gaps, have been identified.

The curriculum will cover wide-ranging topics that include:

- The disease of addiction and its physiology.
- Opioid risk tools and withdrawal assessments.
- Utilization of AUDIT-C and CAGE-AID screening tools and the SBIRT (screen, brief intervention, referral to treatment) model.
- Communicating with and treating patients with substance use disorder (SUD).

- Managing patients with medical complexities and co-occurring SUD.
- Managing patients with difficult behaviors, as well as family members and visitors.
- Pain management and addiction certifications.

Contact hours will be available to those participating in the education programming.

Zalar, who brings with her a background in nursing, addiction treatment, and education, will soon begin to assemble the curriculum, identify methods for delivering education to staff, and create the evaluation tools including outcome measures, survey, and content evaluation. Zalar is working with the Consortium's Education Subcommittee, which includes hospital nursing administrators, to develop a rollout plan, beginning with a pilot prior to full release.

High-Level Provider Education

Beginning in early 2019, the strategic plan calls for the Consortium to expand its efforts around education to include high-level providers. The process will begin similarly to the nursing and frontline staff education initiative, with the collection, assessment and synthesis of current provider education resources and content to create a standardized program for non-physician providers, including APRNs and PAs. A separate effort will aim to do the same for primary care physicians, with a focus on managing patients with medical complexities and co-occurring SUD, managing patients with difficult behaviors, and managing families and visitors.

Later in 2019, the Consortium plans to work toward including at least one physician faculty member certified to provide MAT in every outpatient site in each Consortium hospital that trains residents or medical students, including general practice, internal medicine, obstetrics and gynecology, pediatrics, and psychiatry.

Already, educational activities are being provided to help prescribers fully incorporate state and federal opioid prescribing guidelines. Additionally, a review and implementation of Ohio State Medical Board and Centers for

(Continued on page 10)

Northeast Ohio Hospital Opioid Consortium Launches Three-Year Strategic Plan *(Continued from page 9)*

Disease Control and Prevention guidelines for acute and chronic pain management is underway to ensure hospitals are utilizing internal controls to monitor compliance.

Access to Nasal Narcan

Among the goals of the Consortium is to increase access to and the use of nasal Narcan. Work in support of this goal includes assessing availability of Narcan in hospital departments, developing educational resources and toolkits for patients and families, implementing strategies to increase the prescribing of Narcan by primary care physicians, and assessing the feasibility and potential to expand the availability of nasal Narcan take-home kits in hospital retail pharmacies and emergency departments.

Currently, the Consortium is in the process of establishing a pharmacy workgroup to assist with determining the availability of nasal Narcan in inpatient and outpatient departments, hospital retail pharmacies and emergency departments. By early 2019 the Consortium aims to provide the following resources:

- Guidelines to identify at-risk patients and recommendations for prescribing nasal Narcan.
- Physician talking points for at-risk patients.
- Educational resources providers can distribute to patients and families about acquiring and utilizing nasal Narcan as

well as treatment options for the disease of addiction.

Treatment Initiatives

Also on the agenda is expanding utilization of MAT and other opioid treatment options in the region. This work is slated to begin later this year, with a target completion date of mid-2019. According to the U.S. Department of Health and Human Services, at a national level only 30 to 35% of the prescribers who have a waiver to prescribe MAT are actually prescribing it. Consortium plans include determining MAT waiver prevalence along with barriers to prescribing MAT, as well as developing provider education around MAT benefits and expanding MAT training in residency programs.

The Consortium also seeks to expand hospital use of peer support programs and is exploring the feasibility of partnering with other organizations to accomplish this. Looking out to 2020, plans include creating or expanding telehealth solutions that incorporate SUD treatment.

Policy Agenda

The strategic plan also calls for efforts to influence public policy in ways that will make treatment more accessible to patients, improve reimbursement for providers, and prevent the spread of opioid addiction. The Consortium's policy agenda includes the following:

- Treatment – expanding access to MAT, maintaining and expanding public and private insurance coverage, and testing of alternative pain management protocols specific to EDs.
- Reimbursement – eliminating barriers to treatment for Medicare and Medicaid enrollees and improving reimbursement for opioid alternatives.
- Prescribing, data tracking and electronic health record utilization – investing in and enhancing prescription drug monitoring programs, facilitating utilization of suboxone and of naloxone take-home kits, and eliminating questions about pain in patient satisfaction surveys.
- Education – supporting policy efforts around medical and dental prescriber education, including the U.S. Department of Health and Human Services development of a national curriculum for opioid prescribers.

The strategic plan is the culmination of work by the Opioid Consortium executive committee and will serve as the organization's blueprint through 2020.

"The strategic plan gives us a clear path forward and will enable Opioid Consortium member organizations to make a real, positive impact on the opioid crisis," said Lisa Anderson.

The complete strategic plan can be found online at <https://neohospitals.org/Community-Outreach/Northeast-Ohio-Hospital-Opioid-Consortium>. ■

Fellows and Interns Receive AMCNO Pollen Line Training

On July 9, Nicole Tierney of Jordan, MN, held a pollen course at Allergy/Immunology Associates. During the one-day course, fellows and interns learned how to use the Rotorod Sampler, an aerobiology sampling device located near the clinic that collects pollen, mold and other particles on small plastic rods. The rods are brought inside every day and analyzed using a light microscope. The attendees were shown how to prepare, mount and stain the rods to see the microscopic pollen and mold more clearly. They also learned how to identify various types of tree, grass and weed pollen to provide a volumetric pollen count to

the public. The pollen count takes into consideration the percentage of the plastic rod that is analyzed, the amount of time the rods are exposed to the air and the duty cycle of the Rotorod Sampler. The pollen count is calculated Monday through Friday at the clinic and the levels are reported via the AMCNO Pollen Line, which has been assisting those with seasonal allergies for more than 50 years. The AMCNO thanks Allergy/Immunology Associates for providing the daily pollen counts, as they have done for the AMCNO for many years.



Nicole Tierney instructs the fellows and interns on how to collect the pollen samples.



The group is shown what the pollen samples look like under the light microscope.

Safe Sleep Progress in Cuyahoga County

By Bernadette M. Kerrigan, Executive Director, First Year Cleveland

First Year Cleveland (FYC) is helping to tackle the challenge of high infant mortality rates (IMR) in Cuyahoga County. FYC has three priority areas: reduce racial disparities, address extreme prematurity, and eliminate preventable sleep-related deaths.

This collaborative initiative draws on the wisdom of the community across Greater Cleveland from grassroots efforts to executive leadership. The goal is to reduce infant deaths, particularly among African American babies. Case Western Reserve University School of Medicine serves as fiscal agent for the initiative.

One area showing improvement in decreasing the overall infant mortality rate is preventable sleep-related deaths. Those numbers have dropped from 27 sleep-related deaths in 2015, to 21 in 2016, and 13 in 2017. That equates to a 38% drop year-over-year in sleep-related deaths between 2016 and 2017.

Almost all of the 200 sleep-related deaths in Cuyahoga County in the past 10 years have been due to accidental suffocation.

An August 2018 cleveland.com editorial piece noted, "The good news is that preliminary work to tackle this problem [of infant mortality] by First Year Cleveland—an unprecedented local public-private coalition of elected officials, hospitals, religious institutions, medical providers, educators and health researchers—is making inroads. Cuyahoga County's infant mortality rate fell last year *to 8.11 deaths per 1,000 live births*, still too high." For comparison, the infant mortality rate was 10.5 in 2015, and 8.7 in

2016. The national IMR was 5.9 in both 2016 and 2017.

Several programs already in place do appear to be reducing the number of sleep-related deaths, and more programs are being added. The MetroHealth System, in partnership with University Hospitals and Cleveland Clinic, is leading a new First Year Cleveland workforce campaign that will leverage internal company platforms to teach safe sleep to employees.

Sandi Hoch, Childbirth Education Coordinator at The MetroHealth System, has led safe sleep training for several hundred MetroHealth employees. She stresses the importance of reaching both medical and non-medical community members. "We're reaching large numbers of new people," Hoch said. "For example, we reached 1,200 men around Cuyahoga County in 2017 through talks about safe sleep held by Tim Greenwood, Bootcamp facilitators, and myself, supported by CareSource. MetroHealth and the Ohio Department of Health also ran a large number of high-profile ads to support safe sleep practices.

"Every person who is in a baby's life needs to be sure to remember the Safe Sleep ABCD's: Alone, on her Back, in a Crib, and Don't smoke. We can all be Safe Sleep Heroes for our babies."

Notes Lorrie Considine, RN, Program Manager at Cuyahoga County Board of Health, "We've done safe sleep education, training, and community conversations for many levels of hospital staff in all the hospital systems, as well as for childbirth educators, home visitors, faith-based groups, CenteringPregnancy™ groups, in-home day care providers, and community groups. Agencies such as DCFS [Department of Children and Family Services] have developed their own safe sleep program to review with their clients. We also have Cribs for Kids programs that provide individual conversations about safe sleep before participants receive a pack-n-play. All of these need to be ongoing to reach families because when babies are born we have new parents and new caregivers every day."

There are eleven Action Teams supporting First Year Cleveland's three priority areas. Action Team 10, the Safe Sleep Heroes team, is launching the safe sleep training this fall. Employers are encouraged to offer the digital training to all of their employees to spread the message of safe sleep. The training will be modeled around what MetroHealth has been doing internally with their employees and in the community over the past year and a half. If you're interested in training information, please email SafeSleepHeroes@case.edu.

First Year Cleveland's goal is for Safe Sleep Heroes to become a community movement that will train 10,000 Safe Sleep Heroes by the end of 2019. It has the potential to touch every person in a baby's life—mom, dad, grandparents, childcare providers, aunts, uncles, cousins, brothers, sisters, teachers—making sure every baby sleeps safely, every nap and every bedtime.

Learn more about First Year Cleveland at <https://firstyearcleveland.org/>. Anyone who would like to promote safe sleeping for babies can sign up to learn how to become a Safe Sleep Hero at <https://firstyearcleveland.org/safe-sleep-heroes/>. ■

Editor's Note: The AMCNO is pleased to be a community partner of First Year Cleveland. We have been involved with this initiative since its inception.



Sleep-related deaths dropped 38% from 2016 to 2017.

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Election Guide 2018



After extensive consideration of candidate histories, careful review of candidate questionnaires, and some additional candidate interviews, the OSMAPAC has made its selections for the 2018 election year.

The OSMAPAC Board of Directors selected endorsed candidates in appreciation of their commitment to physician and patient issues, based on recommendations from local physicians, and following interviews with candidates and review of questionnaires. Selected candidates have shown dedication to a positive impact in the myriad of issues faced by Ohio physicians, such as managed care reform, prior authorization, Medicare and Medicaid reimbursements, scope of practice, medical liability concerns and public health issues.

Physician leaders from the **Academy of Medicine of Cleveland & Northern Ohio (AMCNO)**, in conjunction with the **OSMAPAC**, participated in several Northern Ohio state legislator candidate interviews and the AMCNO PAC – the Northern Ohio Medical Political Action Committee (NOMPAC) – leadership is pleased to **endorse** the following Northern Ohio candidates running for the state legislature.

Ohio Senate

SD 13: Nathan Manning
SD 23: Nickie Antonio
SD 25: Kenny Yuko
SD 27: Kristina Roegner
SD 29: Kirk Schuring
SD 33: John Bocchieri

Ohio House

HD 6: James Trakas
HD 7: Tom Patton
HD 16: David Greenspan
HD 37: Mike Rasor
HD 38: Bill Roemer
HD 48: Scott Oelslager
HD 49: Thomas West
HD 55: Gayle Manning
HD 56: Joe Miller
HD 58: Michele Lepore-Hagan
HD 59: Eric Ungaro
HD 60: John Rogers
HD 68: Rick Carfagna
HD 70: Darrell Kick
HD 76: Sarah LaTourette
HD 99: John Patterson

Ohio Supreme Court Candidate Endorsements

The OSMAPAC and the NOMPAC have endorsed **Judge Craig Baldwin and Justice Mary DeGenaro for the Ohio Supreme Court.**

As we have done in previous elections, we seek to endorse candidates for the Ohio Supreme Court that understand judicial restraint, will interpret Ohio law (not rewrite it), and will maintain stability and balance in the Ohio Supreme Court. Judge Baldwin and Justice DeGenaro follow this judicial philosophy. To learn more about these and other judicial races, log on to www.judicialvotescount.org, and click on the “Who’s Running for Judge” link.

To view a complete listing of other OSMAPAC endorsements, visit www.osma.org and click on the Advocacy tab.

Section 501(c)(3) organizations are strictly prohibited from engaging in political campaigning, none of AMCNO’s or NOMPAC’s literature should be distributed in a Section 501(c)(3) facility (e.g., a hospital) or by a physician that is an employee of a Section 501(c)(3) organization in his or her capacity as such.

CliniSync Update and the AMCNO's Involvement

By Anthony E. Bacevice, Jr., MD, AMCNO Past President, and Member of the CliniSync Advisory Council

Those of us who practice medicine today encounter the electronic medical record (EMR) on a daily basis in one form or another. If you practice in a hospital, you interact with the EMR as you place orders into the system, generate progress notes, and read or write consultation notes, operative notes, history and physical examinations as well as discharge summaries. In the office environment, patient interactions are often documented in an ambulatory EMR. Although we have become frustrated by the increased time it takes to enter orders and create patient care documents, the EMR is here to stay.

Despite the challenges of the electronic era, the EMR does provide some significant benefit. One of the most important advantages is the interconnectivity among sources of information that pertain to the given patient for whom we provide care. The interconnected EMR allows us to see and review laboratory results, imaging studies, consultant's notes and hospital summaries. This interconnectivity is driven by the hardware, software and utilization policies that are known as the health information exchange (HIE). In Ohio, the most prevalent HIE is CliniSync, which was developed and implemented by the Ohio Health Information Partnership (OHIP).

Current Status

As of the end of July 2018, CliniSync has connected and exchanged health information on 11.7 million Ohio residents, 154 participating hospitals in Ohio, West Virginia and Kentucky, and more than 500 long-term and post-acute care facilities. In addition, approximately 15,000 independent and hospital-employed physicians were enrolled as CliniSync users. As health plans see the advantage of access to appropriate patient care information, CliniSync has been enrolling them. To date, seven health plans, including five Medicaid managed care plans, have been enrolled. Finally, throughout the CliniSync service territory, 60 electronic health records are exchanging important patient care information.

The interconnection of Ohio patients, participating hospitals, providers and other sources of patient care data is the CliniSync community. The HIE does not store records. Rather, it moves information in response to a query from a user (e.g., a physician) to a data source (e.g., a lab). In the background, the requestor, the "requestee" and the patient are all validated. The information is securely transmitted to ensure that the right data on the right patient gets to the right provider—which is no small task, and yet the transaction occurs in nearly real time! In 2017, CliniSync processed 4.6 million queries. That resulted in 8.1 million results delivered to CliniSync users. Most users were providers seeking laboratory data, imaging studies and

information for patients in hospitals, clinics and post-acute care facilities. As of the end of July 2018, 3.1 million queries resulted in 5.8 million results delivered.

The initial users of CliniSync, as suggested, were hospitals, physician groups, independent physicians and laboratories. As the HIE's utility caught on, additional entities expressed interest in participating, such as pharmacies, dialysis centers and post-acute care facilities. Recently, payer groups have also taken an interest in participating. Exchanging appropriate information electronically between providers of a patient's care and the responsible payers can facilitate rapid delivery of data necessary to support a claim, potentially resulting in more timely payment to providers for services rendered. Several health plans are looking to receive notification that their subscribers have presented to an emergency department or a hospital for care. CliniSync and local payer groups continue to work on developing appropriate protocols for the exchange of sufficient patient care data for claim processing. More than 3.7 million lives are currently covered by the payers that are participating with CliniSync. As the benefits of electronic exchange of patient care information becomes more apparent, the community of payers participating in CliniSync will surely increase.

The CliniSync Advisory Council

The expansion and development of CliniSync has not occurred in a vacuum. OHIP management receives guidance and advice from its board of directors and CliniSync Advisory Council (CAC). These groups represent the HIE stakeholders and users. Their advice and counsel have helped guide OHIP in its mission to move healthcare information in an efficient and secure manner among its various users. CAC members represent stakeholders such as physician groups, medical practices, payers and post-acute care facilities. The CAC was based on the idea that those entities that enter into an agreement to participate with CliniSync become, essentially, partners in its operation. The CAC's primary goals, according to its charter, are to advise

the board on operational and strategic improvements; review operational direction, both current and future states; assist in the establishment of a product roadmap; contribute guidance as to policy; assist with the evaluation of HIE development strategies; and create policies for information exchange and the use of the HIE.

The AMCNO has been represented on the CAC since its inception. As CliniSync's strategic and operational issues have evolved, the CAC has been able to provide advice and guidance on matters such as patient consent, utility of information and evaluation of product enhancements. The CAC meets every other month, either by teleconference or in-person meeting. Information from these meetings is reported to the AMCNO during its quarterly Community Relations and Health Information Technology Committee meetings.

CliniSync's success is due to the strategic thinking of its management team, which has been guided by the advice from the OHIP Board of Directors and CAC. Product development that has enhanced the utility of the HIE has increased the value of the EMR in the day-to-day practice of the physician. As we look to the future benefits of electronic health information access, there is a growing focus in the areas of provider reimbursement and population health. Both providers and payers are taking an interest in the use of the HIE as a means to deliver appropriate patient care data to the payer to facilitate procedure authorization and reimbursement. Future opportunities for the HIE include providing data to interested stakeholders regarding population health, such as accountable care organizations (ACOs) and medical homes. As the quality of healthcare delivery begins to be evaluated more on the health of a population that is served, the ability to extract de-identified information about outcomes becomes crucial. The CAC is providing advice and commentary to OHIP as these concepts are being turned into operational policies.

The AMCNO will continue to provide advice to OHIP and report information to its membership about developments in the modern era of medical information communication.

Detailed information about CliniSync, its products and its operation are available at their website www.clinisync.org. ■

AMCNO ACTIVITIES

Hundreds of Physicians-in-Training Sign Up for AMCNO Membership during Resident Orientation Events

During June and July, the AMCNO participated in resident orientation events at the Cleveland Clinic, MetroHealth Medical Center and University Hospitals (UH). Thanks to recruitment efforts, we have welcomed hundreds of new resident members.

At UH, in particular, AMCNO staff was able to have more hands-on time with the residents, as they used a different format this year—a model similar to what the AMCNO uses for its annual Physicians Are Linked with Students (or PALS) networking event. Staff was able to interact with residents and provide detailed information about the AMCNO and the Academy of Medicine Education Foundation.

All of these new members now have access to numerous benefits, including opportunities to serve on an AMCNO committee to hone their leadership skills, invitations to networking events, and notifications of the latest information on the AMCNO's work and activities through the *Northern Ohio Physician* magazine and email blasts.

If you know of a physician-in-training who would be interested in free AMCNO membership, you can direct him or her to apply online, using this link: <http://amcno.org/index.php?id=267>. ■



AMCNO staff talks with groups of UH residents about the Academy—what the organization does, the benefits of membership, and upcoming events they are welcome to attend.

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Medical Students at CWRU School of Medicine Society Dean Mixer Sign Up for AMCNO Membership

The AMCNO and Academy of Medicine Education Foundation (AMEF) were pleased to once again co-host the Case Western Reserve University School of Medicine Society Dean Mixer for first-year medical students. The event was held at the Cleveland Botanical Gardens in July.

AMCNO President Dr. Bruce Cameron was a guest speaker and talked to the students about the work of the AMCNO and AMEF as well as the many benefits of being an AMCNO member, even as a medical student. He

encouraged them to sign up for AMCNO membership and to become involved in the organization, and he welcomed the students to the profession.



AMCNO President Dr. Bruce Cameron addresses first-year medical students at the Society Dean Mixer.

AMCNO staff was on-hand to provide membership information, and we are happy to report that almost 150 medical students signed up for membership. We are honored to have them join the organization! ■

2018 AMEF FUNDRAISER

The 2018 Annual AMEF Golf Outing Celebrates its 15th Anniversary on a Gorgeous Day!

Event Proceeds Benefit Medical Students and Local Communities

On August 13, golfers teed off for the Academy of Medicine Education Foundation's (AMEF) 15th Annual *Marissa Rose Biddlestone Memorial Golf Outing*.

This year's event was held at the Sand Ridge Golf Club. Foursomes tested their expertise in a shotgun-style tournament to raise money for AMEF, the foundation component of the AMCNO that was established for charitable, education and scientific purposes. These monies will be utilized for medical student scholarships, annual CME seminars and grants for health-related programs.

Golfers were welcomed by AMCNO staff at registration and then enjoyed a delicious lunch on the patio. Participants also had the opportunity to practice their shots before the shotgun start at precisely 1 pm. The Sand Ridge course is located on more than 350 acres of woods, pastures and wetlands. It is the first private course in Ohio, and one of a select few in the world, to be designated as a Certified Audubon International Signature Wildlife Sanctuary.

Everyone enjoyed cocktails on the patio and relaxed after a full day on the challenging course. The golfers then sat down for an amazing dinner, and listened as Dr. John Bastulli provided a wrap-up of the day and thanked everyone for their participation and support. Following his speech, awards were announced and the golfers took part in a fun prize raffle.



Our congratulations to the teams that took home the top prizes:

1st Place Team: Dennis Forchione, Jim Moser, Sam Sidoti, and Dr. Jeff Stanley

2nd Place Team: Dr. John Bastulli, Rich Garcia, and Marc Mingione

3rd Place Team: Scott Balson, Scott Liff, Don Kelly, and John Kluchar

Skill prizes were also awarded to the following:

Closest to the pin: Don Kelly, Scott Balson, Thomas Gattozzi, and Rich Garcia

Longest drive: Jim Brown on #6 and Don Kelly on #18

Longest putt holed: Brian Stanton on #9

A special thank you to Jim Brown at Classic Auto Group and Dr. Victor Bello for once again sponsoring the hole-in-one contests. And thank you to all the event and hole sponsors who helped make the day such a huge success. We look forward to working with all of you next year as well!

Our thanks to the 2018 Event Sponsors:

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SAVE THE DATE for next year's AMEF Golf Outing:
August 12, 2019, at Chagrin Valley Country Club. See you there!