

Medical Legal Summit Provides Education Opportunities for Physicians and Attorneys

Cleveland's Medical/Legal Summit kicked off on Friday April 11, 2014 at the Global Center for Health Innovation with keynote speaker Dr. Bill Frist discussing *The Future of Health Care Reform and Health Care Costs*. Co-Sponsored by the Academy of Medicine of Cleveland and Northern Ohio (AMCNO), the Academy of Medicine Education Foundation (AMEF), and the Cleveland Metropolitan Bar Association (CMBA), the Summit began with opening remarks by Dr. George Topalsky, President of the AMCNO, Jonathan Leiken, President of the CMBA and Matt Donnelly, Deputy Chief Legal Counsel, Cleveland Clinic, and co-chair of the 2014 Summit. Introduced as "a leading authority on health reform, government policy and politics," Dr. Frist delivered a compelling message about how health care reform and technology are impacting the practice of medicine today.

Dr. Frist outlined his vision for the six major trends impacting health care today – the growth in government sponsored health care, the rise of the healthcare consumer, value based delivery and reference based pricing, movement toward home based palliative care, medical innovations and connective healthcare and the use of medical devices.

Growth in government sponsored care - Dr. Frist began by stating that the biggest change accelerated by the passage of the Affordable Care Act (ACA) was the "shift in risk" in health care. In the past, health care was driven in large part by insurers, employers and government but now the intent is to have health care decisions driven



Dr. Frist discusses health care reform during his keynote presentation.

by providers and their patients. He noted that when he is asked to provide a definition of the ACA he defines it as "insurance reform plus expanded access to care."

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Medicare's Recovery Audit Contractors ("RACS"): Put On Hold

By David A. Valent, Esq.

Health care providers nationwide can expect a short reprieve from medical billing audits conducted by Recovery Audit Contractors. On February 18, 2014, the Centers for Medicare and Medicaid Services ("CMS") announced the temporary winding down of the Recovery Audit Contractor program, while it takes time to implement improvements to the program and to hire new contractors to conduct future audits.

Background

The National Recovery Audit Program was the product of a successful demonstration program that utilized independent, private companies, called "Recovery Audit Contractors," to identify Medicare overpayments (and underpayments) to

health care providers in randomly selected states. The demonstration program ran between 2005 and 2008, and resulted in over \$900,000,000 in overpayments being returned to the Medicare Trust Fund. Only \$38,000,000 in underpayments were identified and returned to health care

providers. As a result of the government's success through the demonstration program, Congress required the Secretary of the Department of Health and Human Services to institute a permanent, national program, to recoup overpayments associated with Medicare services.

Recovery Audit Contractors were thereafter identified throughout the nation to begin

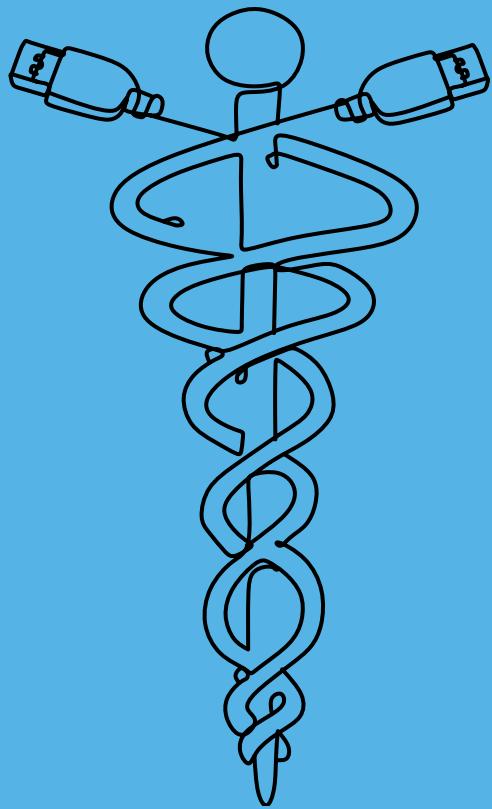
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Dr. Frist stated that at this time there are 16 million people enrolled in exchanges and 16 million in Medicaid and it is predicted that by 2023 the ACA will have resulted in 25 million people obtaining health insurance, but that will still leave around 31 million uninsured. He also noted that with the release of the latest Congressional Budget Office (CBO) numbers, reality is beginning to set in and there is a real concern about how much this is all going to cost. The ACA is a new entitlement and the new CBO estimates show that the total cost of implementing the ACA by 2023 will be over 2.6 trillion dollars. The question is how do we pay for that when we already have a struggling economy and a large debt.

In addition, public opinion is now an issue with recent polls showing that 62% of Americans disapprove of the ACA. Americans consider health care to be the number one issue and for the first time polls are showing that Americans believe that the Republicans can address health care issues better than the Democrats. Dr. Frist is of the opinion that 70% of the ACA is good law and 30% needs to be refined and evaluated further. The key message here is that the passage of the ACA was relatively easy compared to the execution and implementation of the plan.

Rise of the Healthcare consumer – Now that consumers are bearing more of the financial burden and paying high deductibles they are becoming more active in their health care. And the individual consumer is empowered like never before – consumers can utilize technology to get online, input their symptoms and look for a physician to treat them. In addition, before setting up an appointment they can look up what an examination will cost as well as find physicians within a 3 mile radius that are board certified and that are willing to see them on the same day. Dr. Frist mentioned several websites where consumers can attain all of this information along with whether or not the physician takes their insurance, and in some cases whether or not the physician will offer them a discount.

Value based delivery – reference based pricing – The traditional fee for service system is changing and will ultimately be replaced with a value based system and reimbursement models will move in that direction as well. He also mentioned reference-based pricing, noting that this model is a healthcare benefit design through which employers/payers seek to address price variation by placing a cap on clinical services. As an example, if a negotiated rate for a test is set within a certain range, a payer may determine a reference price for that test. Then if a patient receives a test from a provider above a reference price, the patient is responsible for the costs above that price. This model is intended to show cost savings and change patient behavior by shifting costs from payers to patients. Dr. Frist noted that this type of pricing has not yet hit the mainstream in healthcare but he believes that this will be a trend in the future.

Movement toward home based palliative care – At this time over 30% of end of life patients die in the hospital, however, most of them would probably prefer to die at home. Dr. Frist believes that a good palliative system of care could reduce costs, optimize quality of life and relieve suffering for critically ill patients. The U.S. is facing a shortage of physicians and an increase in the aging population so having the ability to provide home visits with 24/7 monitoring coupled with palliative care could be helpful. In addition, there are over 5,000 hospitals operating in the U.S. today and many are at less than 70% capacity, and it is predicted that within the next 7 years the number of hospitals will be reduced significantly as the move to home health care with monitoring eliminates the need for in-patient hospital care.

Medical innovations – Dr. Frist predicted that many of the new medical innovations are going to come from outside of the health care system. To illustrate his point, he outlined how various entrepreneurs and companies run by engineers and other types of specialists are creating devices that will totally change how tests will be conducted, how information will be disseminated and how providers will be reimbursed for their services.

Connective health and wearable devices – Dr. Frist also demonstrated how technology can be utilized to track patients and their health statistics, noting that these devices can give health trends over time at a reduced cost. He also noted that these devices show a huge potential for usage in clinical trials due to the large amount of health information that can be tracked in real-time and monitored.

Dr. Frist's presentation was very well-received and all of the participants commented on the depth of his knowledge and expertise on the topic of health care reform and medical innovation.

Saturday's plenary session began with a *Debate on Tort Reform* between Mr. Brian Atchinson, President of Physician Insurers of America (PIAA) and Professor Max Mehlman from CWRU School of Law. Mr. Atchinson outlined how data has shown that although the majority of claims are closed in favor of the defendant the average cost to defend the claim is \$32,000.00. He stated that the cost to defend claims keeps going up, adding costs to the health care system. In States

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Mr. Ed Taber (right), a member of the 2014 Medical/Legal Summit planning committee, greets Dr. Frist at the podium.

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without tort reform there are higher indemnity payments made and for states with tort reform that include caps on damages, the payments are less. While there are those that debate if damage caps are appropriate, the reality is that 18% of the GDP goes into health care and a significant amount of those costs are due to medical liability issues. He also noted that legislation was just introduced in Congress to address practice guidelines and safe harbors. The premise is if a physician can demonstrate that they practiced within certain guidelines they could have a "safe harbor" against a claim. In rebuttal, Professor Mehlman provided comments on how the medical malpractice system really works. He stated that when medical malpractice insurance rates rise the medical world believes that it is the high rate of claims and payouts that are responsible for the high premiums when in actuality it is due to the medical malpractice insurance cycle. He also noted that nonpayment of claims with merit occurred more often than did payment of claims that were not associated with errors or injuries. Both presenters agreed that open communication with the patient and enhancing the patient/physician relationship can be helpful.

The second General Session entitled *The Effect of Social Media on Physicians and Lawyers*, featured Sara Simrall Rorer, Taft Stettinius & Hollister, LLP, and David L. Marburger, Baker Hostetler, LLP. Ms. Rorer outlined the HIPAA compliance risks for physicians (or other "Covered Entities") when they or their employees use social

media to talk about their patients. She outlined the current enforcement environment for these cases, steps that physicians and hospitals must take if a HIPAA violation is detected, and steps physicians can take to minimize potential sanctions if a violation occurs, providing information on actual cases that have occurred in Ohio. Mr. Marburger led a lively presentation on what physicians can expect to occur in the court system if they dispute comments a patient posts on a website or online. Based upon the information he provided it was clear that it can be somewhat difficult for physicians to utilize the legal system to refute an adverse online posting.

Attendees were given the choice of four breakout sessions, all of which were designed to address the different issues facing physicians and their legal counsel in the current medical environment. A session entitled *The Use of OARRS When Prescribing Narcotic Prescriptions* featured a panel consisting of Judge David Matia, Cuyahoga County Court of Common Pleas, Dr. Thomas Gilson, Medical Examiner of Cuyahoga County, Ohio Rep. Robert Sprague, Ms. Kim Anderson, representing the State Medical Board of Ohio, and Paul Schad, representing the Ohio Board of Pharmacy. Mr. Schad outlined what is contained in an OARRS report and how to access an OARRS report noting that OARRS only tracks prescriptions for controlled substances and Tramadol. Ms. Anderson outlined when a physician is required to access OARRS noting that this could change with the passage of HB 341 – legislation currently under review in the Ohio legislature. She also explained the purpose of the morphine equivalent dosage (MED) information included in the OARRS report stating that this threshold was determined by experts participating in a task force set up by Governor Kasich. Rep. Sprague pointed to statistics showing the large amount of opioids that are still prescribed in Ohio and he stated that HB 341 is intended to make checking OARRS mandatory for prescribers except under certain circumstances. Judge Matia mentioned that it is important to ascertain who is overprescribing and finding a way to inform these prescribers that they need to be aware of OARRS and whether or not their patients are doctor shopping to obtain prescriptions. Dr. Gilson provided an



Judge David Matia moderated the session regarding OARRS.

overview of a recent study he conducted regarding the heroin epidemic in Cuyahoga County stating that deaths associated with heroin (DAH) have increased and heroin is now identified in half of all overdose deaths. However, he also noted that a prescription for legal controlled substances was noted in 64% of DAH with the most common medications being opioid pain relievers and benzodiazepines which he believed clearly showed a need to address prescribing practices.

Members of the audience raised questions as to the confidentiality of the OARRS report in the patient record and Ms. Anderson noted that the physician is expected to note in the chart that OARRS was accessed but the actual report should not remain in the chart due to confidentiality concerns. Several audience members commented that instead of having physicians and other providers check OARRS on every patient it would be much simpler and make more sense to link the OARRS system to the patient's electronic health record as protected health information (PHI), and members of the audience strongly suggested that this option be considered in discussions with the legislature.

Another breakout session entitled *Fraud and Abuse and Other Regulatory Issues Facing Physicians* included Mr. Stephen Sozio of Jones Day, Ms. Cathy Hanselman, Special Agent, US Dept. of Health & Human Services, Office of the Inspector General, and Ms. Michelle Heyer, Assistant US Attorney, Civil Division Health Care Unit. Presenters discussed the trends in health care law enforcement noting that fraud matters, civil settlements and judgments have continued to rise over the last 10 years. Mr. Sozio addressed the cases that can end up under review and he also discussed the role of



Attendees listen attentively to Dr. Frist's keynote presentation.

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whistleblowers in these cases stating that compliance departments should be diligent in evaluating these matters. Ms. Hanselman explained the different types of cases reviewed by HHS noting that these cases can involve physicians, hospitals, home health companies, labs, out-patient centers and medical equipment providers. Allegations can range from billing for services not rendered, medically unnecessary treatments, falsification of medical records, upcoding, or billing for unapproved drugs. The main sources for these cases come from data analysis, hotlines, and providers self-disclosing fraud and abuse. Ms. Heyer outlined the issues involved in a Qui Tam investigation noting that Qui Tam lawsuits are a type of civil lawsuit whistleblowers bring under the False Claims Act, a law that rewards whistleblowers if their Qui Tam case recovers funds for the government. Since 2009 these cases have steadily increased with the US Government recovering over 10 billion dollars.

The final sessions of the day consisted of a breakout session covering the topic of *Cyber Liability* which included a well-rounded discussion by presenters Steven Dettelbach and Michael Tobin from the U.S. Attorney's Office for the Northern District of Ohio, Brian McDowell, from University Hospitals, and Whitney Gibson, from Vorys, Sater, Seymour and Pease, LLP. Mr. Dettlebach explained the difficulty of prosecuting large international

hackers and stated that these groups are now targeting health information since they can glean a lot of information from a health record. Other presenters noted that physicians can be attacked in many ways online and in order to combat this issue, presenters opined that it is prudent to have a review and monitoring system set up and if a physician needs assistance it is important to obtain legal expertise or help from their institution. In addition, physicians and hospitals should have an experienced team to call on to address negative online material detected by their monitoring programs. Unfortunately most online reviews come from a negative patient experience therefore, the presenters recommended physicians try to have positive reviews posted, noting there are companies that can provide specialized software that makes it easy to encourage patients to distribute reviews to various rating websites.



Mr. Chris Coburn from Partners HealthCare makes a point during the session regarding physician interaction with the pharmaceutical and medical device industry.



Mr. Steve Dettelbach responds to a question from the audience during the cyber liability session.



Participants received insights into fraud and abuse issues at the Saturday breakout session.

The Physician Interaction with Pharmaceutical and Medical Device Industry session addressed the off label use of pharmaceuticals and generic drugs, and the Physician Payment Sunshine Act and how the law influences innovation concepts at health systems and institutions. This panel consisted of Ed Taber, Tucker Ellis, LLP, Gwendolyn Roberts Majette, Cleveland-Marshall College of Law, and Chris Coburn, Vice President, Innovation, Partners HealthCare. Mr. Taber provided background on new regulations under consideration by the Food and Drug Administration (FDA) that could potentially change the duty to warn for the use of generics. He also outlined some issues related to off label drug use, noting that their use is permissible for physicians if it is within the standards of care – but it is prohibited for marketing with some exceptions. Professor Majette addressed the parameters of the Physician Payment Sunshine Act. This Act was part of the ACA and it requires certain pharmaceutical and device manufacturers to annually report to the secretary of Health and Human Services certain payments or other transfers of value (both direct and indirect) furnished to U.S. licensed physicians and CMS teaching hospitals. The Sunshine Act does not ban payments but requires reporting of payments and transfers of value. Under the Act all companies must report payments and other transfers of value made to U.S. physicians and teaching hospitals. Professor Majette noted that there is a 45-day window for correction of the information that will be published to the public so if an individual or teaching hospital disputes from a manufacturer they

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can request to correct the report before it is posted. Mr. Coburn completed the session by providing information on how to deal with institutional conflicts and concerns and how to assure that physicians and institutions remain in compliance with the Act.

Over 250 physicians and attorneys from across the Northern Ohio region signed up

to attend this informative session and the AMCNO and the CMBA are already setting up the planning committee for 2015. The AMCNO would also like to extend our sincere appreciation to the 2014 planning committee and all of the event sponsors. The 2015 Planning Committee will be meeting in the near future and AMCNO members are encouraged and welcome to submit topics and suggest presenters for the 2015 Medical/Legal Summit. Please submit your comments or suggestions to ebiddlestone@amcno.org. ■

**In accordance with the AMCNO bylaws
the following bylaws amendment which has been
approved by the AMCNO board of directors is published
for review by the AMCNO membership.**

Article IV – Directors

Section 1. The Board.

(D) Extended Term for Officers AND EXECUTIVE COMMITTEE MEMBERS. If the elected term on the Board of Directors of the President-elect should expire prior to that officer's succession to the office of President, the officer's term on the Board shall automatically extend for the duration of the term as President. The same consideration shall apply to the Immediate Past President who shall serve as a voting member of the Board of Directors for an additional year should that officer's term of office as President terminate after a regular term on the Board of Directors is completed. In addition, the Secretary-Treasurer appointed by the Board shall, by virtue of office, also be a member of the Board of Directors during that term of office. THE BOARD TERM OF THE TWO (2) MEMBERS APPOINTED BY THE PRESIDENT TO THE EXECUTIVE COMMITTEE AS WELL AS THE VICE PRESIDENT OF LEGISLATIVE AFFAIRS (APPOINTMENT TO BE FILLED BY THE LEGISLATIVE CHAIRMAN OF THE AMCNO) MAY ALSO EXTEND DEPENDENT UPON THEIR TERM ON THE EXECUTIVE COMMITTEE.

Thus, the Board of Directors may be made up of additional members, as circumstances require.

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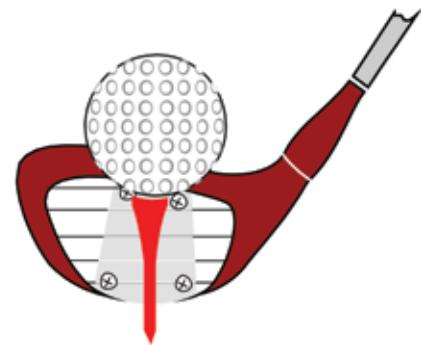
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Medicare's Recovery Audit Contractors ("RACS"): Put On Hold

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conducting audits of health care providers, in all 50 states, starting in 2010. The country was divided into 4 regions, A through D, with Ohio being part of Region B. The Company known as CGI, Inc. was the private company selected to serve as the RAC auditors in our area. Incidentally, this is the same company that was initially chosen, but later removed, from running www.healthcare.gov — which is a key piece to the implementation of the Affordable Care Act.

The National Recovery Audit Program was designed so that RACs would take a contingency fee based on the percentage of any dollars they were able to collect on behalf of the government. Although this recovery program was touted as being an effective vehicle to recoup improper payments, and to help balance the federal budget, there have been some growing pains with the program since it began running nationwide.

Reasons For Changing / Pausing Audit Program
After a RAC audit / determination is made, providers have the right to challenge that determination. A review of the current National Recovery Audit Program indicates that the system is backlogged and not able to handle the volume of claims and/or appeals being processed through these nationwide audits.

For example, there are 65 administrative judges working on RAC appeals. Appeals are being filed in the range of 15,000 claims per week, despite the fact that it is estimated these judges only have the capacity to handle 2,000 claims. The process has become so backlogged that the Department of Health and Human Services office on Medicare Hearings and Appeals has begun informing hospitals that they cannot submit new appeals until the current backlog is cleared.

This backlog comes as a result of a growing number of hospitals taking steps to challenge RAC audit determinations. According to the American Hospital Association's latest "RACTrac Survey," U.S. hospitals participating in the survey are appealing 49% of all RAC denials, with almost half of those appeals being overturned in their favor.

Some estimates suggest the backlog of cases at the Administrative Law Judge could be as high as 465,000 cases waiting to be decided. As a result of the backlog, some providers have waited up to three years after an appeal is filed to get a hearing with an Administrative Law Judge. And, after a hearing with an Administrative Law Judge, there are still additional options for appeal, which can take further time. The system is simply not running as efficiently and effectively as originally intended, and CMS is taking note of this problem.

Current Status Of RACs

February 18, 2014, CMS announced the winding down of the work currently being performed by

the independent companies initially hired as the nation's RACs. CMS also announced it is working to begin the process of entering into new contracts with the next group of companies who will serve as RACs when the program returns. Presumably, some new companies will be identified, and some previous companies will be forever relinquished of their responsibilities. CMS says pausing the audits will allow time to "refine and improve" the recovery audit program.

In winding down the current RACs, CMS has posted the following dates:

- February 21, 2014 is the last day a recovery auditor may send a post payment Additional Documentation Request (ADR).
- June 1, 2014 is the last day a recovery auditor may send improper payment files to MACs for adjustment.

To that end, although the date has passed for RACs to issue Additional Documentation Requests, RACs may continue with their "automated reviews" (reviews that do not require soliciting medical documentation from providers) through June 1, 2014.

During this "transition" between the previous RACs, and the yet to be identified new RACs, CMS has stated that in general, it will not conduct post payment status reviews for claims with dates of admission of October 1, 2013 through October 1, 2014.

CMS also notes that it is extending the current RAC contracts only for the limited purposes of work on appeals of claims that these RACs have already denied. The extension of such contracts goes through December 31, 2015, for RACs already in the midst of active appeals.

Anticipated Changes

When new RACs are identified and the audit recovery system is reinstated, the expected changes considered by CMS will include the following:

- The "discussion period" will continue even after an appeal is filed. Currently, RACs stop the 30 day discussion period designed to try to mediate the claim once the provider enters the appeal process. The new RACs are anticipated to allow 30 days of discussion, before sending the claim to the MAC for adjustment, regardless of whether the finding is appealed.
- Notice of the discussion period will be acknowledged more quickly by the RACs. The new RACs will be required to confirm receipt of a discussion request within three days.
- Contingency fee payments will be held from RACs until later in the process. The new RACs will not receive contingency fees until the claim has moved past the second level of appeal.
- Additional Documentation Request ("ADR") limits will be adjusted, to lessen the burden on smaller provider groups and/or smaller departments within larger health systems. Also, providers with lower denial rates will have lower ADR limits, than those with higher denial rates.

These changes are in response to criticism CMS has received relative to the program. It is hoped that these changes, among others, will ease the burden on providers, and increase the efficiency of the program — allowing for faster negotiation and resolution of disputes between providers and RACs.

Conclusion

The future remains somewhat uncertain with regard to the Recovery Audit Contractors. CMS seemingly recognizes some of the issues and/or inefficiencies with the current program, and is taking steps to make improvements. In the meantime, this means a short reprieve from RACs.

Importantly, providers should still work to be diligent and accurate with processing claims for payment to CMS, as such claims may still be the subject of future audits and/or other efforts by the government to recoup improper payments. Although the RACs are being put on hold, the system will not be paused for long. And, providers can still find themselves subject to other audits and/or investigations, such as those conducted by Medicare Administrator Contracts (MACs) and Zone Program Integrity Contractors (ZPICs).

If you have any questions regarding this article, or other health care compliance issues, please contact David Valent, Esq., at (216) 430-2196, in the Health Care Law practice group, at Reminger Co., L.P.A. ■

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THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

6100 Oak Tree Blvd., Suite 440,
Cleveland, OH 44131-2352
Phone: (216) 520-1000 • Fax: (216) 520-0999

STAFF Executive Editor, Elayne R. Biddlestone

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Partners Rally Together to Develop the First Community Health Improvement Plan for Cuyahoga County

By Nichelle Shaw, M.P.H., Cuyahoga County Board of Health, Supervisor, Prevention & Wellness Services

Health is more than just the absence of disease and having access to quality health care. According to the March 26, 2014, Robert Wood Johnson County Health Rankings, www.countyhealthrankings.org, Cuyahoga County ranks 65th in health outcomes out of 88 counties within the State of Ohio, but ranks 6th in clinical care. Despite the fact that Cuyahoga County is home to premier healthcare systems, it ranks close to the bottom quarter of Ohio counties in poor health outcomes. Many ask why.

Similar to other metropolitan regions, Cuyahoga County's inequities are geographically concentrated in the urban core (this includes the City of Cleveland and the suburban communities that share a border with the City of Cleveland). It is in the urban core where there is the highest concentration of poverty, as well as the highest concentration of African Americans and Hispanics. Minority and ethnic communities disproportionately suffer from chronic diseases leading to health disparities in these disadvantaged communities. They also have less access to healthy food, experience higher rates of crime, attend underperforming schools, are more likely to live near vacant properties and reside in substandard housing, and have less access to clean and safe greenspaces such as parks and playgrounds. These and other social and environmental factors contribute to poorer health outcomes and lower life expectancy in the low income minority communities when compared to the general population.

Specifically, there are areas in the county where differences in life expectancy vary by more than 20 years (see map on page 9). Many of these areas also have significant differences in socioeconomic factors (such as poverty rates, high school graduation rates, and the rates of minority populations). Many ask if these socioeconomic factors are directly responsible for observed differences in life expectancy. Unfortunately, the reason is quite complex. However, the literature suggests that by looking at the broader context of health and bringing together diverse segments of the community, significant impact can be made to address the problem of health inequities.

The broader context includes looking "upstream" at what contributes to and shapes our health and quality of life, as opposed to looking solely at the "downstream" consequences of morbidity and mortality. This includes examining factors that are outside of the medical care system. While access to medical care is vitally important, only a small portion

(15–20%) of overall health and longevity can be attributed to clinical care. The best predictor of a person's health status is their zip code; where they live, learn, work and play. Everyone should have the opportunity to make choices that lead to better health, regardless of the neighborhood they live, their income, their race and ethnic background, or their education. Consequently, multi-sector collaborations are essential in creating conditions in the community that support good health.

Consequently, the public health community of Cuyahoga County embarked upon a community health improvement planning process in 2009, known as Health Improvement Partnership Cuyahoga (HIP-C) using a framework developed by the Centers for Disease Control and Prevention (CDC) and the National Association of City and County Health Officials (NACCHO). This planning template known as MAPP (Mobilizing for Action through Planning and Partnerships), is a community-driven strategic planning process for improving community health. MAPP provides a strategic framework that illuminates the root causes of health inequities to achieve optimal health for all people. This framework ultimately helps communities apply strategic thinking to prioritize issues and identify ways to address them. The MAPP framework can be broken down into six (6) major phases that include organizing, visioning, conducting assessments, developing strategic issues, and formulating goals/strategies in moving to action. Currently, there are over 50 organizations/agencies and individuals involved in HIP-C, including the local health departments, local government, health care providers, philanthropy, city/county planning, academia, school districts, community-based organizations, health and human service agencies, and community members.** This comprehensive process yielded two (2) overarching strategic issues and four (4) priority health issues. The two strategic issues are *providing safe supportive environments across all levels of community, and providing*

access to quality and equitable care for all within the community in a variety of settings. The four health priorities include: 1.) Improving coordination between clinical and public health to improve population health; 2.) Improving chronic disease management through engagement of various sectors; 3.) Increasing access and opportunity for improved nutrition and physical activity; and 4.) Eliminating structural racism as a social determinant of health.

Eliminating structural racism was selected as a health priority by the community, given the longstanding and substantial gaps in health outcomes across race in Cuyahoga County. Structural racism refers to the interaction between institutions, policies, and practices that inevitably perpetuates barriers to opportunities and racial disparities. People of color experience a wide range of serious health issues at higher rates than whites, including diabetes, heart disease, and late stage cancer diagnosis. Class also plays a role, but structural racism has been proven to be a factor affecting health, independent of class. Multiple research studies indicate that the experience of racism increases chronic stress and results in worse health outcomes. As the measurable goals and intervention strategies for the priority health issues are developed, efforts that focus work on these high need communities to promote health equity and reduce factors associated with structural racism are considered.

We are currently in the Action Cycle of the process, which includes the activities of Planning, Implementation and Evaluation. Based upon the four priority health issues, subcommittees were formed. On March 5th, 2014, each of the four subcommittees provided a summary of their action plans to the entire HIP-C partnership for discussion and feedback. These action plans will be completed by mid-April and the partnership plans to roll out the new improvement plan to the community in the Fall and move to the implementation phase at the beginning of 2015.

As we move towards action, we will be using the Collective Impact Framework of FSG (www.fsg.org), which includes the coordination of partnerships, the alignment of priorities and action, and the mobilization of resources. There are five conditions for Collective Impact success: 1.) Common Agenda – a shared vision for change; 2.) Shared Measurement – collecting data and measuring results consistently; 3.) Mutually Reinforcing Activities – participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action; 4.) Continuous Communication

AMCNO PUBLIC HEALTH ACTIVITIES

– consistent and open communication; and 5.) Backbone Organization – a separate organization to serve as the backbone for the entire initiative and to coordinate participating organizations and agencies.

Community engagement means that we will elicit "authentic" community participation by actively involving community members in planning, decision-making and actions.

Health and Equity in All Policy, a focus of our work, references collaborating to improve the health of all people in Cuyahoga County by incorporating health and equity into decision-making across sectors, systems and policy areas.

HIP-C will be engaged in the following activities during the remainder of 2014:

1. Writing the draft Community Health Improvement Plan (CHIP);
2. Obtaining input on the draft CHIP from partners and the community;
3. Rolling out the CHIP to various targeted audiences over a period of a few months;
4. Developing a plan to measure and evaluate HIP-C;
5. Finalizing the CHIP and holding an event to celebrate the release of the final plan prior to full implementation in 2015; and
6. Transitioning the current HIP-C Planning Committee to the HIP-C Consortium as we prepare for action.

This is a very exciting time for Cuyahoga County, as we develop the first-ever community health improvement plan and chart new territory utilizing non-traditional public health means to achieve optimal health for all in Cuyahoga County. As resources inevitably become more limited, the CHIP can be used by the entire community to serve as a guide to influence the health of our residents. We must remember that when a portion of our community suffers from poor health outcomes, we all suffer, and we must work together in ways that we have never worked before to address those matters at the root of poor health.

The Health Improvement Partnership-Cuyahoga has been funded by the National Association of City and County Health Officials, the Saint Luke's Foundation, and the Mt. Sinai Health Care Foundation.

**The AMCNO is pleased to be one of the organizations participating in the HIP-C. ■

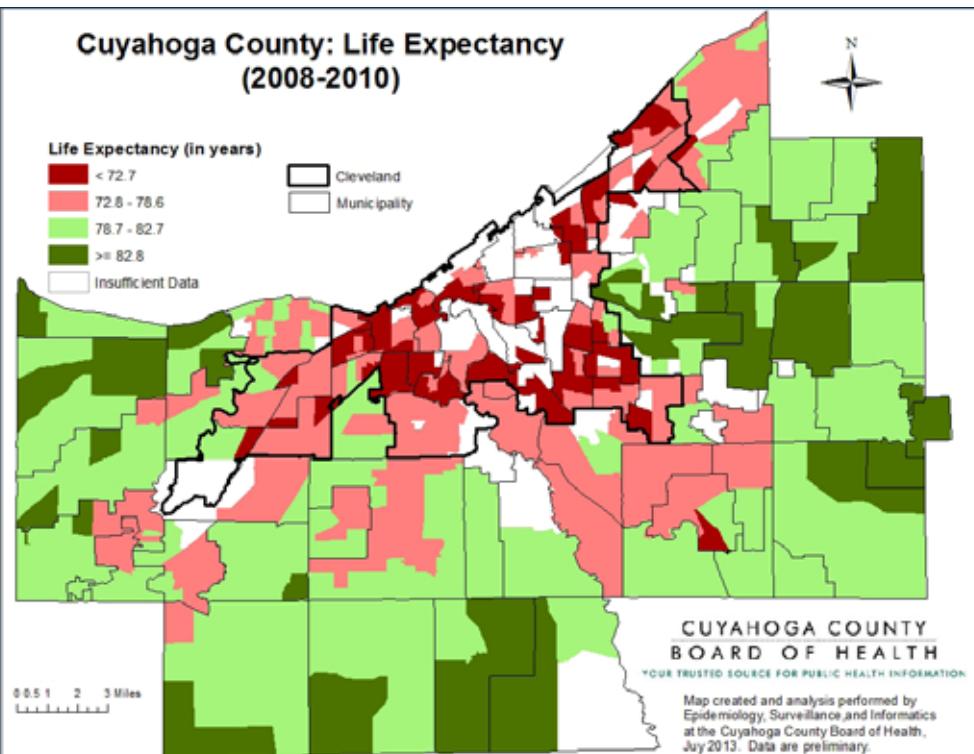
HIP-Cuyahoga is Guided by:

Committee Vision

"Cuyahoga County is a place where all residents live, work, learn and play in safe, healthy, sustainable and prosperous communities"

Committee Mission

"HIP-Cuyahoga utilizes a community driven process to conduct health and social assessments, identify priorities, and implement a comprehensive and collaborative approach for carrying out & funding health improvement strategies"



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AMCNO Legislative Update

Governor Kasich Unveils Mid-Biennium Review (MBR)

In March, Governor Kasich unveiled his Mid-Biennium Review (MBR) which included across the board income tax cuts, new tax relief for low and middle income Ohioans, and expansions in education and training programs to enhance Ohio's workforce. The MBR also included funds to increase support to Ohioans with mental illness and addiction, drug abuse prevention and tobacco cessation.

Immediately after the release of the MBR, Speaker Bill Batchelder (R-Medina) announced his caucus would separate the governor's Mid-Biennium Review (MBR) into 14 different bills that were assigned to 11 different committees.

The Ohio House has now placed its final stamp of approval on the MBR appropriations bill and sent it off to the Senate for further consideration. House lawmakers approved HB 483 along party lines. HB 483 underwent changes before final approval including the removal of an amendment regarding return to play language that would have authorized chiropractors to determine if a youth athlete can return to a sport following a concussion.

The return to play language had been added as part of an omnibus amendment, and immediately drew opposition from medical organizations from across the state including the AMCNO. The AMCNO submitted written testimony outlining our concerns with the amendment noting that this issue was discussed at length by both the House and Senate during the 129th General Assembly and resulted in the passage of HB 143. Under HB 143, when a child shows signs of a concussion he or she is immediately removed from the field of play and must be evaluated and cleared by a healthcare professional before returning. Athletic trainers, physical therapists, chiropractors, and other non-physician practitioners must work with a physician during the return to play timeline; and this requirement is in line with standards of care for a concussion and is in the best interest of the child. HB 143 established a widely supported concussion management standard that passed the legislature with near unanimous support. In addition, an amendment to allow chiropractors to independently return youth athletes to play after suffering a concussion was added to House Bill 59, however, that amendment was vetoed by Governor Kasich after the AMCNO

and other medical associations voiced our concern with the language. The AMCNO was pleased that this amendment was removed from HB 483 and we will remain vigilant to assure that this type of amendment is not added to future budget bills.

HB 483 also included amendments submitted by the Ohio State Board of Pharmacy providing for a one-time appropriation to upgrade the Ohio Automated Rx Reporting System and a narrowed exemption for terminal distributor of dangerous drugs licensure.

In addition to HB 483, HB 369 also cleared the Ohio House and moves onto the Senate for review. Both bills included addiction treatment and recovery measures to direct funding to development of recovery housing beds and regional "step-down crisis centers," and to give county governments more time to comply with a mandate that they have to provide all the addiction treatment services deemed important for successful recovery. HB 369 also earmarks the \$47.5 million previously allocated to county boards of mental health and addiction services for various drug treatment and behavioral supports, as well as making other changes. Rep. Robert Sprague, sponsor of HB 369, noted that this bill will ensure that these treatment services exist across the state, especially in rural areas, providing detoxification services and follow-up treatment where needed.

HB 485 - the human services part of the MBR is also headed to the Senate for consideration. The measure would create the Office of Human Services Innovation in the Department of Job and Family Services and a substitute version also included a pilot program for the State Medical Board to host teleconference committee meetings and authorized the Ohio Board of Pharmacy to collect additional health information such as immunization records through OARRS — the state's automated prescription reporting system. The AMCNO will continue to monitor this amendment and how it could impact physicians.

In addition, the House Health and Aging Committee Chairman, Rep. Lynn Wachtmann worked to assure that three previously approved opiate-related measures were also added to the substitute version of HB 485. The three measures added to the bill are HB 314, HB 341 and HB 366. HB 314 deals with opioid prescriptions issued to minors. The measure

establishes in the Ohio Revised Code explicit informed consent requirements for prescribers who prescribe to minors controlled substances that contain opioids. The measure also includes penalties to physicians for non-compliance and notification requirements to children's services in certain circumstances. The AMCNO opposed this bill as written and discussion on this matter continues. HB 341 mandates prescriber review of patient information in OARRS when prescribing or personally furnishing opioids or benzodiazepines. The AMCNO worked with interested parties on HB 341 and at this time we support the provisions contained in this bill. HB 366 requires a licensed hospice care program that provides hospice care and services in a patient's home to establish a written policy and adopt certain practices for preventing the diversion of controlled substances containing opioids. The AMCNO supports this legislation as well. It remains to be seen if these bills will remain in the MBR once the bills reach the Senate for debate.

In all, there have been thirteen prescription pain bills introduced in the 130th General Assembly. The AMCNO has taken a position on each of these bills as follows:

- HB 92 – Syringe Exchange – to authorize a local board of health to establish a syringe exchange program – AMCNO position: Support.
- HB 170 Drug Overdoses – the bill allows certain licensed health professionals to prescribe, administer, dispense or furnish Naloxone – a medication used to reverse the effects of opiate overdoses to the following individuals: a person who is experiencing an opioid-related overdose or a family member of friend who can assist a person experiencing an opioid overdose. This bill has been enacted and the AMCNO strongly supported the bill.
- HB 314 – Minor Prescriptions – Requires a prescriber to obtain written informed consent from a minor's parent, guardian, or other person responsible for the minor before issuing a controlled substance prescription to the minor and to establish sanctions for the prescriber's failure to comply with this requirement. AMCNO position – Oppose
- HB 315 – Hospital Reporting of Neonatal Abstinence Syndrome – To require hospital reporting of Neonatal Abstinence Syndrome. This bill has been enacted and the AMCNO supported the bill.

AMCNO LEGISLATIVE ACTIVITIES

- **HB 332 – Standards for Prescribing Opioids** – to establish standards and procedures for opioid treatment of chronic, intractable pain resulting from noncancer conditions and to require that professional disciplinary action be taken for failing to comply with those standards and procedures. – AMCNO position – Oppose.
 - **HB 341 – Controlled Substances** – To prohibit a controlled substance that is an opioid analgesic or benzodiazepine from being prescribed or dispensed without review of patient information in the State Board of Pharmacy's Ohio Automated Rx Reporting System – AMCNO position – Support.
 - **HB 359 – Prescription Drugs Disclosure of Addictive Nature** – To require the director of health to develop a one-page information sheet explaining the addictive nature of Schedule II controlled substances or any prescription drug that contains an opioid. The bill also would require a prescriber to provide a copy of the sheet to any patient to whom the prescriber prescribes or personally furnishes these drugs – AMCNO position – Oppose.
 - **HB 363 – Good Samaritan** – Prevents a person acting in good faith who seeks or obtains medical assistance for another person who is experiencing a medical emergency as a result of ingesting drugs or alcohol from being arrested or charged for a minor drug possession offense – AMCNO position – Support.
 - **HB 366 – Controlled Substances, Hospice Care Program Procedures** – To require hospice care programs to establish procedures to prevent diversion of controlled substances that contains opioids – AMCNO position – Support.
 - **HB 367 – Drug Abuse Prevention, Health Curriculum in School Districts** – To require the health curriculum of each school district to include instruction in prescription opioid abuse prevention – AMCNO position – Support.
 - **HB 369 – Medicaid Coverage of Addiction Treatment and Services** – To require the Medicaid program and health insurers to cover certain services for recipients with opioid addictions; to establish requirements for boards of alcohol, drug addiction, and mental health services regarding treatment services for opioid addiction to help defray payroll costs associated with a court's employment of drug court case managers; to provide a state share of the capital costs of recovery housing projects – AMCNO Position – Support
 - **HB 378 – Opioid Addiction Treatments** – To prohibit a physician from prescribing or personally furnishing suboxone, naltrexone or methadone to treat opioid dependence or addiction unless the patient is receiving appropriate behavioral counseling or treatment – AMCNO position – Under advisement.
 - **HB 381 – Retail Terminal Drug Distributor Verify ID, Controlled Substance or Tramadol** – To require a retail terminal distributor of dangerous drugs to verify identification when dispensing a controlled substance or tramadol – AMCNO position – Support.
- The AMCNO continues to work with state and local organizations, institutions, and health departments to provide information aimed at providing physicians and the community with resources on the proper use and handling of opioids. We are currently planning a session for physicians with the Cuyahoga County Board of Health regarding the prescribing of prescription opioids – additional information will be provided in future publications.
- Aaron Haslam Resigns as Executive Director of the State Medical Board of Ohio**
- At the April State Medical Board of Ohio (SMBO) monthly meeting, Mr. Aaron Haslam, the executive director of the SMBO announced his resignation. Mr. Haslam was appointed executive director of the SMBO on July 1, 2013. The SMBO will now begin another search for a new SMBO executive director. Mr. Jonathan Blanton, SMBO Director of Enforcement has been named SMBO Interim Director while the search for a new director takes place.
- Joint Medicaid Oversight Committee (JMOC) Appointments Made – Committee Meets for the First Time**
- House Speaker Bill Batchelder and Senate President Keith Faber have made their appointments to the new Joint Medicaid Oversight Committee. This committee was created by the Medicaid overhaul legislation which was signed into law in December 2013. The JMOC is charged with reviewing Medicaid-related policies, as well as the effectiveness of the health care entitlement in Ohio. The committee will review the basics of Medicaid and may focus on legislation related to addiction and skilled nursing facility quality measures and reimbursements.
- The JMOC kicked off its inaugural meeting by setting the search parameters for an executive director. JMOC has a startup budget of \$350,000 in fiscal year 2014 and \$500,000 in FY 2015. According to the approved job listing, candidates must have acquired a degree in public policy, public administration, public affairs, economics or a related field. At least five years of experience in one of those fields is preferred, as is experience in the executive or legislative branches of Ohio government.
- Legislation Under Review in the Ohio Legislature**
- As always, the AMCNO is tracking all health care related bills as they are introduced and move through the Ohio legislature. Several bills that were supported by the AMCNO have moved through the legislature and have either been signed by the Governor or are on their way to his desk for signature. These include:
- 
- Rep. Anne Gonzales discusses HB 123 – the telemedicine legislation – at the Ohio Health Information Technology Day in Columbus April 3.
- HB 123 – Telehealth Services** – the passage of this bill has Ohio joining 38 other states by requiring Medicaid coverage of emerging telehealth services. Such services improve access, quality of care and lower costs of consulting clinical experts especially in rural areas where patients do not have ready access to specialists. Legislators believe that increasing access to telehealth services will save money by decreasing improper care and reducing unnecessary admissions or extended hospital stays. In addition, it is anticipated that telehealth services will serve to reduce transportation costs previously necessary to move a patient to a larger medical center where specialists are available. The bill does the following:
- Requires the Department of Medicaid to establish Medicaid payment standards for the provision of telehealth services.
 - Specifies that the following are included in the laws pertaining to the proceedings of peer review committees of health care entities: accountable care organizations; hospital groups owned, sponsored, or

(Continued on page 12)

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(Continued from page 11)

managed by single entities; and combinations of health care entities.

- Provides that the release of any information produced or presented during peer review committee proceedings, or created to document such proceedings, does not affect the confidentiality of any other information produced or presented during such proceedings or created to document them.
- Specifies that the laws governing the confidentiality of peer review committee records do not preclude health care entities from sharing information, as long as the information is used only for peer review purposes.

HB 315 – Hospital Reporting of Neonatal Abstinence Syndrome – To require hospital reporting of neonatal abstinence syndrome. This bill requires the reporting of neonatal abstinence syndrome, which is the result of exposure to addictive illegal or prescription drugs while in the womb or through breast milk. Drugs such as amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, opiates

and narcotics such as heroin, pass through the placenta to the baby during the pregnancy, which can result in babies born addicted to drugs. Exposure to certain drugs can lead to birth defects, low birth weight, premature birth and sudden infant death syndrome. The bill does the following:

- Requires maternity units, newborn care nurseries, and maternity homes to report to the Ohio Department of Health (ODH) the number of newborns diagnosed as opioid dependent.
- Authorizes local boards of health to grant maternity homes variances from or waivers of ODH rules regarding the operation of such homes.
- Replaces the chemical name for a type of controlled substance.

HB 296 – Epinephrine Autoinjectors – this bill was introduced in an effort to better prepare schools to handle severe allergic reactions among students, staff and visitors. The drug, which would be available for use with anyone experiencing a severe allergic reaction, would be used in line with protocol established by the district and be administered by properly trained personnel.

The bill does the following:

- Permits public and chartered and noncharted nonpublic (private) schools and camps to procure epinephrine autoinjectors without a license for use in specified emergency situations, and specifies procedures for those that do so.
- Permits a school district to deliver epinephrine autoinjectors it receives to a school under its operation.
- Grants public and private schools and camps, as well as and their employees and contractors, qualified immunity from liability in civil actions for damages allegedly arising from the procurement, maintenance, accessing, or use of an epinephrine autoinjector.
- Permits drug manufacturers to donate epinephrine autoinjectors to public and private schools and explicitly authorizes schools and camps to receive financial donations from individuals for the purpose of purchasing epinephrine autoinjectors.

For more information on AMCNO legislative activities or items covered in this article, please contact the AMCNO executive offices at (216) 520-1000. ■

NOMPAC Participates in Event to Support Dr. Steve Huffman for the Ohio House of Representatives

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) through our PAC the Northern Ohio Political Action Committee (NOMPAC) was pleased to participate in a House of Medicine fundraiser in support of Dr. Steve Huffman. The event was held in Columbus at the Capital Club and hosted by the American College of Emergency Physicians, Ohio Chapter, and was supported by several other House of Medicine organizations including the AMCNO, the Ohio Coroner's Association, the Ohio Osteopathic Association, the Ohio Psychiatric Association and the Ohio State Medical Association.

Dr. Huffman is a candidate for the 80th House District, a seat which is currently held by Representative Richard Adams who is not seeking another term. The 80th District comprises all of Miami County and part of Darke County. Dr. Huffman is currently serving in his first term as Miami County Coroner and is a physician and shareholder with Premier Health Care Services. Dr. Huffman also serves as the Assistant Director for Wright State University's School of Medicine at the St. Elizabeth Family Practice, Residency Program and has volunteered and practiced medicine in St. Lucia, Queensland, Australia, Bahamas, Belize, Bermuda, St. Thomas, St. Croix, Cameroon, Guatemala.

Having a strong physician voice in the legislature is critical to the House of Medicine's advocacy efforts. At this time there is only one other physician in the legislature, Dr. Terry Johnson from Scioto County. The AMCNO would like to see another physician in the Ohio legislature and we will continue to offer our support to Dr. Huffman in his campaign. ■



Ms. Elayne Biddlestone, AMCNO EVP/CEO, spends a moment with Dr. Huffman and other medical association representatives (l to r) – Jon Wills, Ohio Osteopathic Association (OOA) Executive Director, Dr. John Lyman, Ohio ACEP President, Laura Tiberi, Ohio ACEP Executive Director, Dr. Steve Huffman, and Dr. Peter Bell, OOA.

AMCNO Pollen Line Kicks Off Allergy Season

By Erin C. Toller-Artis, DO; Kathryn Ruda Wessell, DO; and Robert Hostoffer, DO

The AMCNO Pollen Line opened for business this year on April 15th, with an immediately heavy call volume due to the quick rise in temperatures of early spring. Through the years of the AMCNO providing this important service, members of the Northeast Ohio community have come to depend upon the Pollen Line to help themselves better manage the allergy season.

As the winter struggles to come to a close and spring keeps peeking its' head around the corner, many Northern Ohioans are more than ready for spring to settle in. However, allergy sufferers could be the only people who may not necessarily mind the freezing temperatures lasting a little longer. Will the cold temperature help? What does this brutal winter mean?

Many news organizations have been reporting that the recent frigid and snowy winter we had this year will have a significant effect on the allergy season. There is likely some truth to this. The more precipitation there is, from rain, snow, or ice; the more nourished trees, plants, grass and weeds will be. This leads to increased pollen production and thus higher pollen counts. Precipitation also encourages more fungal growth with subsequent release of mold spores leading to an increase in the mold count. This allergy season may be difficult, but we will likely see a narrow, yet steep, spike in tree pollen in early spring followed by a robust grass in late spring and early summer. In order to maximize protection, medications should be on board prior to feeling symptoms. The best defense for allergy season is an early offense, so allergy sufferers should make their appointments and get the appropriate coaching to be fully prepared for a possibly tough season!

Hot off the press! There is a new oral option for immunotherapy available called Grastek. This medication was just recently approved by the FDA. It was specifically designed to help the patient build a tolerance to one type of grass, timothy. Unfortunately, most people are sensitive to multiple types of grass, so this medication may not be the most effective treatment for everyone with a grass allergy. For this reason, patients should be evaluated by an allergist prior to starting this medication to ensure it is the best option for the treatment of their allergies.

AMCNO Pollen Update

In preparing for the allergy season this year, the AMCNO staff proactively reached out to both the local news media as well as the national weather channel in an effort to promote the Pollen Line and to offer this free service for their use in providing accurate pollen counts in our area. The only stipulation was that they include the AMCNO as the source of the data in their report.

Allergists and AMCNO Members from Allergy/Immunology Associates, Inc., are once again providing daily pollen counts along with

preventative methods to help allergy sufferers cope with the sniffling and sneezing brought on by the season through October 1. The Pollen Line is updated weekdays by 8:00 a.m. with the counts available either via the phone recording or online at www.amcnoma.org and on Twitter. The public can call the free hotline at (216) 520-1050, accessible 24-hours a day, to hear this recorded report on the density of the allergens, probable effects on those sensitive to such agents, and what precautions to take.

In addition, Dr. Robert Hostoffer recently was featured on the Academy of Medicine Education Foundation (AMEF) Healthlines program discussing the pollen season and promoting the use of the Pollen Line. This interview can be heard at www.amefonline.org. ■



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AMCNO Physician Leadership Activities

Zohydro Approval Sparks Response from Regional Task Force – Legislation Under Review in Ohio

It is well-known that Cuyahoga County is experiencing a public health crisis due to the use of prescription opioids and the subsequent crossover into heroin use. In October of 2013, the Food and Drug Administration (FDA) approved a drug called Zohydro, a non-combined, time release formulation of hydrocodone that could have a dosage of up to 10 times the current formulation of Vicodin. This formulation has raised concerns around the country and various medical organizations have expressed their concerns to the FDA and the Office of National Drug Control Policy.

Locally, the Greater Cleveland – Cuyahoga Community Wide Heroin/Opiate Task Force, which includes the AMCNO, sent a letter voicing our concerns with the public release of Zohydro and we asked that the release be halted until such time as a more abuse resistant formulation is completed, tested and approved.

The State Medical Board of Ohio has also sent a letter outlining their concerns and strongly encouraging the Office of National Drug Control policy to work with the FDA, Drug Enforcement Administration (DEA) and other interested federal agencies to restrict the availability of Zohydro until the manufacturer develops an effective, tamper resistant formulation and if the drug cannot be temporarily removed from the market, the SMBO asked that the FDA require a risk evaluation and mitigation strategy (REMS).

In addition, Ohio Rep. Robert Sprague has introduced HB 501, Schedule I Controlled Substances – a bill that would add the drug Zohydro to the list of Schedule I controlled substances in the State of Ohio. While the AMCNO agrees that the federal government and the Food and Drug Administration should seriously consider halting the release of Zohydro until a more abuse resistant form has been completed, we also believe that the FDA is best suited to make decisions about classifying drugs for use by the medical community and this is not something that should be legislated state by state. The AMCNO is concerned that passage of HB 501 could create a precedent and result in states reviewing the use of other drugs that may be addictive but have the ability to help certain patients with pain and we will continue to monitor the discussions on HB 501.

AMCNO Supports Appropriations to Enhance Overdose Protection Education and Naloxone Distribution

This year the Labor, Health and Human Services-Education Committee (LHHS) of the U.S. Congress, which decides how funding gets allocated for health services, will be reviewing drafted language that marks \$5 million for Substance Abuse and Mental Services Administration (SAMHSA) – Center for Substance Abuse Treatment and \$5 million to the Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control. Both of these appropriations are earmarked to support community-based opioid overdose fatality prevention efforts.

The AMCNO has sent a letter to Ohio Congressional Rep. David Joyce, a member of the LHHS committee urging his support for Fiscal Year 2015's LHHS Appropriations of \$5 million for SAMHSA and \$5 million for the CDC to fund community-based organizations and health departments to provide overdose prevention education, training and naloxone distribution.

Our letter noted that Ohio's Cuyahoga County Project DAWN (Deaths Avoided with Naloxone), an overdose education and naloxone distribution (OEND) program has signed up over 500 program registrants and has helped to save at least 32 lives through the training and distribution of naloxone kits. Programs such as theirs have existed in the U.S. since 1996 and have grown in the past several years as a response to the overwhelming epidemic of opioid overdose fatality. Research has shown that communities that have OEND programs have reduced opioid overdose mortality as compared to those communities that do not have OEND programs. As of February 2012, there were 188 OEND programs across the country, but there are still many communities who do not have access to naloxone.

The AMCNO informed Rep. Joyce that physicians in Northern Ohio take their role in combating the prescription drug problem very seriously and that the AMCNO has worked on various projects within the region and with state government to address this issue. We believe that additional funding is necessary to combat this epidemic and we asked for his support of these appropriations to fund community-based organizations and health departments to provide overdose prevention education, training and naloxone distribution.

AMCNO Writes Congress Regarding Medical Part B Drug Reimbursement Program

The AMCNO joined several statewide and national organizations in sending a letter to Congressional representatives urging opposition to any Congressional action that would make further cuts to the Medicare Part B drug reimbursement program. The letter expressed concerns about the effect that cuts to the program are having on seniors with cancer and other life-threatening illnesses and the medical professionals who treat them noting that the application of sequester cuts to the Medicare reimbursement rate for drugs is seriously impacting beneficiaries. The President's budget contemplates further cuts, which would make the situation even worse.

The medical organizations sending the letter were particularly concerned with injectable or infused medications. A number of serious diseases require such treatments, including cancer, rheumatic conditions, advanced chronic kidney disease, and AIDS. These medications must be administered under the supervision of a health care professional to be safe and effective. As our medical knowledge advances and more targeted therapies are developed through genetic research, this type of treatment will become even more common.

In the Medicare Modernization Act of 2003, the reimbursement rate for Part-B covered drugs was set at the Average Sales Price (ASP) plus 6 percent. The 6 percent supplement to the ASP was meant to reimburse physicians for shipping; storage and handling in compliance with FDA guidelines; the costs of preparing the drugs on a patient-specific basis for administration; and the cost of clinical monitoring. In reality, few if any of those expenses are actually recouped.

Physicians and clinics are absorbing costs ancillary to the actual drug purchase, and it is not unusual for a physician to pay more for an injectable or infusible drug than Medicare reimburses. That was the situation before the 2 percent sequester cuts were applied to the reimbursement rate for Part B drugs. Now, some providers actually lose money on the purchase of certain drugs their patients need. Therefore the letter asked that Congress make no further cuts to the drug reimbursement rate under Medicare Part B. ■

FEDERAL UPDATES

Medicare Physician Payment Cut Postponed Again – ICD-10 Implementation Delayed

The Senate has passed H.R. 4302, the “Protecting Access to Medicare Act of 2014,” which postpones the 24 percent Medicare physician payment cut for 12 months, until April 1, 2015. Although many Senators spoke against passing this 17th Medicare payment patch, the Senate passed the bill 64 to 35. The House passed an identical version of the bill by voice vote on March 27, and President Obama has signed the legislation into law.

The \$21 billion bill delays the next SGR cut and maintains current rates until April 1, 2015. The bill also includes a broad array of other items and policy changes to offset costs associated with implementing the bill. Some of the other provisions of H.R. 4302 include:

- The geographic adjustment (GPCI) “floor” of 1.0 for physician work in the Medicare fee schedule would be extended for 12 months.
- Implementation of the ICD-10 diagnosis coding set would be delayed one year, until October 1, 2015.
- The Secretary would have discretion to continue suspending RAC post-payment audits under the “2-Midnight” policy through June 2015.
- Annual targets of 0.5 percent in savings from misvalued Medicare physician payment schedule services would be established from 2017 through 2020, for an estimated savings of \$4.0 billion.
- Revisions to the payment system for diagnostic tests and the laboratory fee schedule, based on market-based private sector rates, would be made for an estimated savings of \$2.5 billion.
- Payments for using CT equipment that does not meet certain dosage standards and implementation of appropriate use criteria for advanced imaging services would save an estimated \$0.2 billion.
- Revisions to the Medicare sequester in 2024 that effectively amplify the sequester’s impact on all Medicare providers in that year would save an estimated \$4.9 billion.

The AMCNO and many other physician organizations urged members of Congress to vote against H.R. 4302 and instead pass bipartisan comprehensive reforms that have been developed in Congress over the past year that would have eliminated the SGR and reform the Medicare physician payment system. Enactment of H.R. 4302 represents the 17th time that Congress has chosen to extend rather than solve the SGR payment problem. The AMCNO and many other medical organizations on both the national and state level will continue to urge Congress to address this issue.

Centers for Medicare and Medicaid Services (CMS) to Provide Additional Physician Information to the Public

The Centers for Medicare & Medicaid Services (CMS) is now providing the public with unprecedented access to information about the number and type of health care services that individual physicians and certain other health care professionals delivered in 2012, and the amount Medicare paid them for those services.

The new data is intended to provide a picture of how physicians practice in the Medicare program, and the payments they receive. This data contains information on more than 880,000 health care professionals in all 50 states who collectively received \$77 billion in payments in 2012 for services delivered to beneficiaries under the Medicare Part B Fee-For-Service program.

CMS believes that this data can help consumers compare the services provided and payments received by individual health care providers.

When the data was released in early April it received extensive media coverage, with some major U.S. newspapers carrying front-page stories on the topic and some devoting multiple stories to the subject. Medicare claims data is complex and can be confusing and the manner in which CMS is broadly releasing physician claims data, without context, can lead to inaccuracies, misinterpretations and false conclusions.

In order to ensure that the information reported is helpful, accurate and complete, the AMA urged the media to take into account the following points when reviewing the data:

1. **Errors:** Data being released may contain errors because there is currently no mechanism for physicians and other providers to review and correct their information.
2. **Quality:** The data does not include explicit information on quality of care provided or quality measurement. It solely focuses on payment and utilization of services so it cannot be used to evaluate the value of care provided.
3. **Number of Services:** Residents, physician assistants, nurse practitioners and others under a physician’s supervision can all file claims under that physician’s National Provider Identifier (NPI); the data may not properly detail the services performed and who performed them. Additionally, there are several instances in which it can appear that two surgical procedures were done when in fact there was only one. For example, when there are co-surgeons or an assistant at surgery, the procedure should be counted as only one surgery, not two.
4. **Charges vs. Payment:** Medicare and other payers pay fixed prices for services based on fee schedules; therefore the amount paid to

physicians is generally far less than what was charged and is not an accurate portrayal of payment.

5. **Patient population:** The data being released is an incomplete representation of the services physicians provide, as it is not risk adjusted. Additionally, it does not include care for private insurance patients or Medicaid beneficiaries, making it a limited view of the patients a physician cares for.
6. **Site of service:** Payment amounts vary based on where the service was provided. To reflect a difference in practice costs, Medicare pays physicians less for services provided in a hospital outpatient department than for services in the physician’s office. However, for services in the outpatient department, another payment is made to the facility to cover its practice costs so that, in reality, the total costs to Medicare and to the patient may be higher when a service is provided in a facility setting.
7. **Provider comparisons:** There is a lack of specificity in specialty descriptions and practice types in the data, which could be misleading when making comparisons between physicians. In some cases, physicians who appear to have the same specialty can serve very different types of patients, thus impacting the mix of services provided.
8. **Missing information:** The data does not account for patient mix and demographics or drug and supply costs.
9. **Coding and billing changes:** Any analysis using the data should take into account changes in Medicare’s coding and billing rules that may be different over time and across regions of the country (e.g., local coverage determinations). ■



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State and Federal Requirements Concerning Disclosures of Medical Records and Information

John Mulligan, Esq., McDonald Hopkins, LLC

Physicians are regularly requested to provide health information related to their patients. Both the Ohio Revised Code, and the provisions of HIPAA and its regulations (collectively, "HIPAA"), contain provisions obligating or permitting the physician to provide information and, in other cases, impose restrictions or requirements on the disclosure of patient information. In a number of respects the provisions of Ohio law and HIPAA are not consistent. As a general rule, in any particular situation a physician would need to comply with the more "stringent" of the two. In effect, what this means is that where Ohio law would permit the disclosure, but HIPAA would not, then HIPAA would control. Where HIPAA would permit the disclosure, but Ohio law would not, then Ohio law must be complied with.

Permitted Disclosures Without Patient Authorization

HIPAA permits a physician to disclose patient information in connection with treatment, payment, or what are known as "health care operations." An example of "health care operations" is the disclosure of patient information to the physician's malpractice defense counsel in a situation where the patient sued the physician for medical malpractice. Ohio does not have a specific statute dealing with the disclosure of health information in the context of treatment, payment, or health care operations.

Responding to an Authorization by a Patient to Disclose Protected Health Information

A patient can give a physician an "authorization" with regard to the disclosure of protected health information of the patient to a third party. Ohio law does not contain a detailed listing of what such an authorization is required to contain.

Regulations issued under HIPAA are detailed with regard to what the "authorization" must include. An authorization is either HIPAA compliant or it is not. Unless it fully complies with HIPAA's requirements, it is "defective" and should not be complied with. It is recommended that if the practice declines to recognize a purported authorization because of a defect, that both

the individual submitting it and the patient who signed it should be advised.

A HIPAA compliant authorization must contain, among a number of things, the signature of the patient or of the patient's attorney-in-fact for health care, guardian, parent (in the case of a minor), or in the case of a decedent, the executor. If the practice has any question as to the authenticity of the signature, efforts should be undertaken to confirm the validity of the signature.

It is recommended that every physician office maintain a standardized authorization form that could be made available to patients. That standardized form could also serve as a guide to the practice in assessing the correctness of authorizations that were prepared by someone else.

When to Disclose Information in Response to a Subpoena, Criminal Investigation, or a Governmental Inquiry

A complete review of the provisions of Ohio law and HIPAA with regard to disclosure in these cases is beyond the intended scope of this article. What is important is that any disclosure made in these situations must comply with both Ohio law and with HIPAA. There are situations in which HIPAA would permit disclosure whereas Ohio law would not. Similarly, there are cases where Ohio

law would permit the disclosure and HIPAA would not, or at least would not permit the disclosure without compliance with a number of HIPAA procedural requirements not found in Ohio law. There are other differences between Ohio law and HIPAA with respect to disclosures. For example, HIPAA contains a "minimum necessary" requirement not specifically found in Ohio law.

A common misconception on the part of physicians is that a subpoena (often issued simply by an attorney or by a court reporting agency) is the equivalent of a court order and must automatically be complied with. Both the requirements of Ohio law and HIPAA must be met in order for the subpoena to be complied with. Physicians regularly report receiving subpoenas that comply neither with HIPAA nor Ohio law.

This is not to say that a subpoena should be ignored. Upon the receipt of a subpoena, efforts should be promptly undertaken to determine whether the subpoena can be complied with. If it is not to be complied with, prompt response should be provided to the issuing person explaining why there will be no compliance. If necessary, a motion to quash the subpoena should be filed.

Charging for Medical Records

As discussed in a separate AMCNO Medical Record Fact Sheet*, both Ohio law and HIPAA address the charges that a physician may make for providing copies of the medical record. Ohio law is very specific with regard to the calculation of fees that may be charged. HIPAA simply requires that the fee be a "reasonable cost-based" fee. HIPAA provides a somewhat generalized explanation of how the "cost" is to be determined. It seems that to the extent that physicians and other health care providers are imposing a charge at all, they are simply using the Ohio limits. ■

*Editor's note: The 2014 AMCNO Medical Record Fact Sheet was published in the March/April issue of the Northern Ohio Physician and should be used in conjunction with this article. The Fact Sheet is also available online at www.amcno.org.

AMCNO PRACTICE MANAGEMENT ACTIVITIES

AMCNO Participates in Program Illustrating How to Create an Exceptional Patient Experience

In March, an event was held at Quicken Loans Arena where the American College of Healthcare Executives of Northern Ohio (ACHE) hosted a program entitled "How to Create an Exceptional Patient Experience." The AMCNO collaborated with ACHE and other organizations to present at the event which also included a networking reception.

Presenters included Dr. George Topalsky, AMCNO President, Ms. Carol Santalucia, Vice President, CHAMPS Patient Experience, Ms. Mary Linda Rivera, Director, Patient Centered Health Care, Office of Patient Experience at MetroHealth, and Mr. Keith Grispo, President, Client Management, Press Ganey Associates, who also moderated the panel discussion.



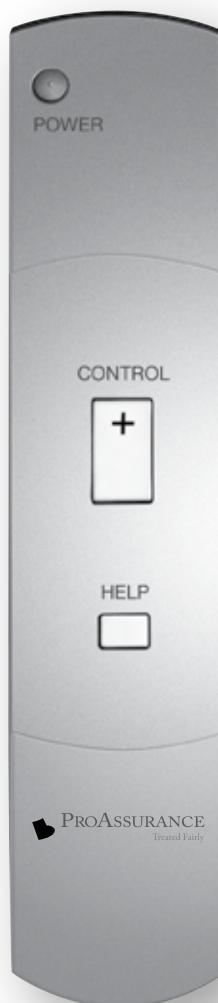
Dr. Topalsky spends a moment with Carol Santalucia prior to the start of the patient experience session.

The moderator of the session began the evening by stating that many consumers today are taking greater control of their purchasing power and healthcare decisions and are demanding excellence in service. The challenge is how to give them the best service in a meaningful way and economic way. The program was developed to give the participants a new way of thinking about an exceptional patient experience in the hospital.

Presentations during the evening included an overview of the Press Ganey business model and how to pinpoint opportunities to reduce suffering and improve the patient care experience based on feedback from every patient, physician and employee. Ms. Santalucia outlined the leaders role in creating an optimal patient experience as well as the need for the leaders commitment to patient experience and building the culture. She noted that the patient experience is not a stand-alone initiative and it must be aligned with other organizational priorities. She stated that patient experience must become part of the organization's culture and that it is everyone's responsibility. Ms. Rivera provided detailed information on MetroHealth's Office of Patient Experience and what type of resources are provided to improve the patient experience. She also outlined how to implement best practices and enhance accountability. Dr. Topalsky completed the panel presentation by offering his insight into a physician's involvement in the patient experience and how to engage physicians in the patient experience discussion.

The AMCNO was pleased to be a participant and collaborator for this important event and we plan to continue to work with the Center for Health Affairs and CHAMPS on their patient experience initiative as well as other regional patient experience initiatives. ■

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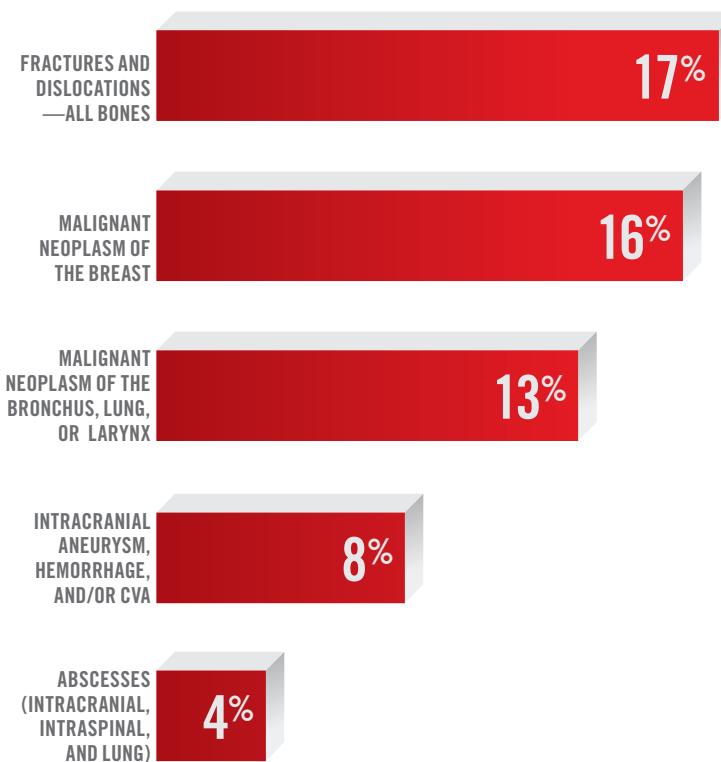
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