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Health Services Advisory Group, Inc. Ohio's New Medicare Quality Innovation Network-Quality Improvement Organization

By Howard Pitluk, MD, MPH, FACS and Mary Ellen Dalton, PhD, MBA, RN

More than four years have passed since the Affordable Care Act (ACA) was signed into law, and the United States healthcare system continues to undergo the transformation proscribed by this landmark act. Physician practices are experiencing a transparent, patient-centric evolution as well with the implementation of value-based purchasing and electronic health record use progressing according to plan. The Medicare Quality Improvement Organization (QIO) program, which performs a major role in implementing these broad changes, has itself undergone a major reorganization.

Since 1979, QIOs have served as trustworthy partners for the continued improvement of the health and healthcare of Medicare beneficiaries. QIOs are skilled in applying advanced analytics and evidence-based interventions that bring Medicare beneficiaries, providers, and communities together. This is accomplished through data-driven initiatives which increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality while lowering costs through shared practices and collaborations.

Starting August 1, 2014, the Centers for Medicare and Medicaid Services (CMS) has restructured the QIO program leading to a more efficient organizational arrangement. In so doing CMS has divided the duties of the QIO while focusing on partnerships among patients, providers, and practitioners that occur across cultural and geographic boundaries to improve clinical outcomes.

AMCNO physician leadership spends a moment with key staff representatives from HSAG (l to r – George Topalsky, MD, AMCNO Immediate Past President; Kimberly Harris-Salamone, PhD, HSAG; Howard Pitluk, MD, CMO for HSAG; and Debra Nixon, PhD, HSAG).

QIO Program Transformation

The most significant modification of the QIO Program separates Medicare beneficiary

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AMCNO Shares Insights on Creating a Successful Navigation Program at NEOPNC Event

The Critical Components of a Successful Navigation Program seminar was held Oct. 10 at St. Vincent Charity Medical Center. The event was co-sponsored by the Northeast Ohio Patient Navigation Collaborative, the Center for Health Affairs, St. Vincent, and the Academy of Medicine of Cleveland & Northern Ohio (AMCNO).

Dr. James Coviello, AMCNO president; Ms. Carol Santalucia, vice president of CHAMPS Patient Experience; and Ms. Lisa Triska, a healthcare navigator at St. Vincent's welcomed the group. Dr. Coviello said that he is committed to creating awareness in the community to improve health outcomes. The goals of a successful navigation program, he

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Dr. James Coviello, AMCNO President, provides opening remarks at the patient navigation event.

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quality-of-care concerns and appeals from the quality improvement work carried out in provider and community settings. This separation has resulted in the formation of two separate types of QIOs; Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) addressing beneficiary quality-of-care concerns and appeals and the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) that work with providers and communities on data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care and transparency at local, regional, and national levels.

Ohio KePRO, which previously served Ohio as the Medicare QIO, has transitioned to become a BFCC-QIO. Health Services Advisory Group, Inc. (HSAG) is the new QIN-QIO for Ohio having been awarded a five year contract by CMS, and is already actively engaged in improving the quality of healthcare for the almost 1 million Ohio Medicare beneficiaries. To assure continuity of services and maintain the highest level of support for our partners, stakeholders, and the Ohio communities we serve, HSAG has transitioned strategic KePRO staff into our organization. Therefore, many of the names and faces you have come to associate with Medicare quality improvement will remain unchanged.

HSAG is not new to Ohio. Since 2003, HSAG has been Ohio's Medicaid contracted External Quality Review Organization (EQRO) with offices in Columbus and has a large knowledge and experience with providers, stakeholders and state healthcare agencies and services. Since its founding by physicians and nurses in Arizona more than 35 years ago, HSAG's mission has been to improve the quality of healthcare for Medicare beneficiaries. We have grown to become a multi-state (and territory) QIN-QIO (Arizona, California, Florida, and the U.S. Virgin Islands) and with the addition of Ohio, serve approximately 25 percent of the nation's Medicare beneficiaries.

This multistate reach brings a sharpened focus to quality improvement by fostering national collaborations that improve efficiencies through the sharing of resources, services, and best practices across geographically diverse areas. HSAG's experience of combining the synergies found in a multistate model has resulted in a wide array of evidence-based, quality improvement initiatives that benefit providers and stakeholders while allowing us the flexibility to address the specific needs of local community partners.

A Sharpened Focus on Quality

As Ohio's QIN-QIO, HSAG is committed to driving rapid, large-scale patient centric change that results in better patient care, better population health, and lower costs through improvement. This work is grounded in quality principles that align with the goals of the CMS Quality Strategy: (1) eliminating disparities, (2) strengthening infrastructure and data systems, (3) enabling local innovation, and (4) fostering learning organizations. For the next five years, HSAG will build on this platform to accomplish these major goals in Ohio.

The ACA's National Quality Strategy and CMS' Quality Strategy both stress the importance of engaging patients and families as partners in their care. To promote a unified approach, QIN-QIOs will expand the number of stakeholders with whom they work and focus on bringing the voices of beneficiaries and families into the center of healthcare quality improvement initiatives. This is vital to not only help providers and patients understand and improve the care experience, but also help reduce significant health disparities that exist among Ohioans across the state.

HSAG understands the integrated patchwork of services that constitute healthcare and is ready to leverage the strong, diverse partnerships it is establishing throughout Ohio and the other states it serves to improve quality care for Medicare beneficiaries. This knowledge coupled with our community partnerships forms the foundation for success in achieving the objectives of the new QIN-QIO contract. The goals and tasks for this work can be summarized as follows:

Promote effective prevention and treatment of chronic disease. QIN-QIOs will focus on improving beneficiary health by reducing cardiac healthcare disparities, reducing disparities in diabetes care, and improving disease prevention utilizing health information technology. Learning and Action Networks (LANs) will also be convened to engage communities of providers, patients, and stakeholders in an all teach/all learn effort that results in heart attack and stroke prevention and diabetes self-management.

Make care safer by reducing harm caused in the delivery of care, and promote effective communication and coordination of care. This work focuses on patient safety issues through improved care coordination between settings and the reduction of healthcare-associated infections and healthcare-acquired conditions in hospitals and nursing homes. The goals include, lowering hospital admission and readmission rates, decreasing the number of Clostridium Difficile, catheter associated urinary tract and central line associated blood stream infections, and preventing falls, pressure ulcers and antipsychotic medication use in nursing homes.

Make care more affordable. The ACA has mandated that value-based payment, quality reporting, and the Physician Feedback Reporting Program become the basis for provider payment reform. HSAG will assist physicians to understand and adopt these changes by utilizing webinars, teleconferences, on-site technical assistance, community collaboratives, and other virtual and face-to-face techniques to help drive improvement and bring evidence-based knowledge and tools to their practices.

HSAG is honored to be in Ohio as the QIN-QIO and continue the work of our predecessor to ensure that healthcare transformation and the preservation of the Medicare trust fund will endure for future generations. Over the months and years to come, our highly trained staff of clinical quality specialists will engage Ohio Medicare providers, stakeholders and beneficiaries in the important work of healthcare quality improvement. We look forward to beginning the journey with you as partners in achieving better care for individuals, improved health for populations and communities, and lower healthcare costs for all Ohioans.

For more information about HSAG and the QIN-QIO program, please visit our website at www.HSAG.com

Howard Pitluk, MD, MPH, FACS, *is Vice President, Medical Affairs & Chief Medical Officer;* **Mary Ellen Dalton, PhD, MBA, RN,** *is Chief Executive Officer; and* **Keith Chartier, MPH,** *who assisted with this article, is Communications Project Manager at Health Services Advisory Group, Inc.*

Editor's note: The AMCNO has asked to work collaboratively with HSAG on physician education and Learning and Action Networks. We have also asked HSAG leadership to provide the AMCNO with information and articles to provide to our members. ■

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AMCNO Shares Insights on Creating a Successful Navigation Program at NEOPNC Event

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said, are to prevent admissions and readmissions, decrease lengths of hospital stays, and increase access to support.

The first presenter, Sarah Fay, MBA, director of operations of CHAMPS Patient Experience, said that she understands organizations are eager to create navigation programs but she suggested that administrators take a step back first and do a needs assessment before implementing a program.

Then, when building the program, she said, there are five important steps: create goals, assess and then break down barriers and challenges, choose how you want the program to operate (create a workflow), establish the role of the navigator (and do you need more than one, clinical and/or lay?), and create a physician champion to rally members of the care team to help make the program successful.

Also, identify metrics at day 1 to determine how you'll be able to measure success, such as quality and safety, financials, employee engagement, patient satisfaction, and outcomes.

Next, Dr. Coviello talked about "Gaining Physician Buy-in Support for Lay Patient Navigation." He said that physicians only want what's best for their patients—a shared goal among the healthcare team. He currently works with a clinical navigator at his practice, and, although they're "learning as [they] go," he's already seen the benefits of having a navigator on the team.

The national quality strategy set goals in 2011 for the direction in which healthcare reform should go—a "triple aim of healthcare:" better care, healthy people/communities and affordable care.

Physician reimbursements are based on the formula "value equals quality divided by cost," and "better quality at a lower cost makes your value go up." Physicians and administrators are taking a look at this formula.

He defined three important items that should be relayed when encouraging physicians to buy-in to a successful navigation program:

1. Stress that the care team concept is important
2. Create an understanding of the navigator's role
3. Show the value of having a navigator on board

The panel fields questions during a Q&A session at the end of the program. Seated l to r – Sarah Fay, Jillian Sprenger, Dr. James Coviello, E. Mary Johnson, and Jacquelyn Adams.

Patient navigators define patient-centeredness, execute care plans, identify/resolve barriers (such as transportation issues and medication costs), improve care team and institutional efficiency, engage patients to achieve better outcomes, and engage the care team to bring about better job satisfaction for all team members, he said.

E. Mary Johnson, patient navigator for the Center for Health Affairs, spoke about "Maximizing Caregiver Roles." Patients are more complex than ever, she said, with many of them having multiple co-morbidities. Patient safety is key—engage and educate patients to help them safely self-manage their chronic diseases. Patient satisfaction means giving them access to quality care and letting them be heard.

The reality of healthcare in Ohio is that it's very complex, Johnson said, and lay navigators can help ease the burden. In Ohio, about 1 million patients are uninsured and are going to need care at some point. It's also estimated that there will be a 36% increase in the Medicare population in the near future. And, by 2020, it's predicted that Ohio will experience a 5,000-physician shortage, creating a crisis of access into care. New healthcare delivery systems are necessary, and here is where Johnson sees lay navigators becoming an important link in the healthcare team.

Jillian Sprenger, BS, cancer patient navigator at University Hospitals Seidman Cancer Center, discussed "Integrating into the Care Team." She shared her own personal experience with integrating into the UH team. The approach she took: identify standards and values, and develop and implement training. During the process, Sprenger found three necessary values for a high-functioning team are honesty, discipline and modesty. And standards for team-based care are: shared goals, clear roles, mutual trust, effective communication, and measurable processes and outcomes.

Jacquelyn Adams, BS, community outreach & patient navigator for the Cleveland Clinic Stephanie Tubbs Jones Health Center, talked to the group about "Maintaining Navigator Engagement." Through its navigation center, employees work with community partners to provide services to patients in need. For example, the center offers community outreach (e.g., health screenings), financial services (e.g., patient qualifications for insurance), navigation services (e.g., coordination of the patient's needs across the continuum of care), and clinical services (e.g., internal medicine).

Editor's note: The AMCNO is proud to be a partner and a collaborator in the Northeast Ohio Patient Navigation Collaborative. We will continue to work with this group and provide information to our members and the public about patient navigation programs. ■

Navigators Explained

By Kirstin Craciun, Community Outreach Director, Center for Health Affairs

Introduction

As medical care has grown more complex, and rates of chronic illness have risen, patients increasingly need someone to help guide them along the healthcare continuum to ensure they receive timely, high-quality care. Enter navigators—experts at helping guide patients around and through barriers that stand in the way of obtaining the right care at the right time in the right setting.

As the field of navigation has evolved, and multiple navigator roles have been created, many people have been left scratching their heads trying to figure out which navigators serve which roles. This Policy Snapshot aims to clarify the roles that each type of navigator serves in the healthcare system.

Navigators Defined

Sometimes the lexicon in the healthcare field can create confusion. The various healthcare roles served by "navigators" are a perfect example of this. There are two types of patient navigators—clinical and lay. There is also a third type of navigator—known as an insurance or marketplace navigator—that serves in a different capacity than patient navigators. While the job tasks that all three types of navigators perform are varied, it is helpful to think about anyone serving in a navigator role as someone who helps guide patients through and around barriers that stand in the way of obtaining timely healthcare services.

Patient Navigators

Unlike other healthcare fields, such as nursing or occupational therapy, the patient navigation field is relatively young. Pioneered by Dr. Harold P. Freeman in 1990, the first patient navigation program was created in Harlem with the goal of reducing disparities in access to diagnosis and treatment of cancer, particularly among uninsured and poor patients. Specifically, this patient navigation program originally focused on the crucial window of opportunity to save lives from cancer by eliminating barriers to timely care between the point of abnormal results and diagnosis and treatment.[1]

Despite being a relatively new field, patient navigation is quickly becoming established as one way to help patients experience the best of the healthcare system. Patient navigators can be used in many areas of a hospital to prevent patients from falling through the cracks.

Lay Navigators

In the past, a traditional care team might have been comprised of several individuals including physicians, nurses, pharmacists and social workers. Fast forward to 2013 and it is more and more common for care teams to include a newer member of the team—the lay navigator.

The lay navigator works to connect the patient with members of the care team. Lay navigators are often the first point of contact for a patient when questions or concerns arise. If the lay navigator is unable to answer the patient's questions or address their concerns, either because they don't know or it is outside their scope of work, they will triage the patient to the appropriate care team member. Individuals serving in the lay navigator role do not necessarily need to have a clinical background, such as a nursing degree.

The lay navigator helps determine if there are barriers to the patient accessing care, and if so, helps to remove those barriers. For example, a patient who has recently been discharged from the hospital may not fully understand their discharge instructions or what they need to do for follow-up care. A patient navigator can help the patient schedule follow-up appointments, ensure their prescriptions are filled, and direct them to the appropriate person when further care is needed. Sometimes transportation barriers stand in the way of patients being able to come to doctor appointments. Lay navigators can help patients figure out bus schedules or train schedules to make sure they can keep their appointments. For patients with childcare responsibilities that make it difficult for them to keep appointments, lay navigators can help connect patients to childcare resources so that they don't have to miss important appointments.

Key lay navigator job tasks:

- Connecting patients to different resources and information in the healthcare system and the community
- Coordinating screenings and appointments
- Removing barriers to accessing care in a timely manner
- Reducing the burden of overwork for providers

Clinical Navigators

Sometimes, when a lay navigator is not available, navigation tasks are carried out by other professionals that have some type of clinical training. Clinical navigators are generally healthcare professionals—such as social workers, nurses, or physicians—that take on additional navigation responsibilities. Aside from the key distinction of having clinical training, clinical navigators do more hands-on work and they are typically compensated at a higher rate than lay navigators.

When individuals with clinical training take on the important role of patient navigation, it means they must spend less time providing clinical care or services that require licensure. Relying on highly-trained, often costly clinical professionals to provide non-clinical services is not the most efficient use of limited healthcare resources. Lay navigators can carry out these important tasks while freeing up clinical professionals to focus their time and attention on the core aspects of their role. Since lay navigators are not required to have a clinical degree, they are also a less expensive way for hospitals and healthcare providers to ensure their patients are accessing the treatment they need.

Key clinical navigator job tasks:

- Assisting patients with treatment and prevention-related tasks
- Applying their clinical knowledge to help patients understand treatment and care options, as well as discharge instructions
- Providing individual, family and caregiver counseling

Insurance Navigators

Passage of the 2010 Affordable Care Act (ACA) created additional confusion about the navigator role based on a provision in the law that created insurance navigators. Individuals and entities serving as insurance navigators differ significantly from lay navigators and clinical navigators in that they are primarily focused on helping connect individuals and families with health insurance. While this seems straightforward, the federal government as well as most news articles and other publications typically refer to insurance navigators simply as "navigators."

The role of insurance navigator was created by the ACA to provide individuals and families with the information necessary to determine

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Navigators Explained

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which health insurance option best fits their needs and then help them enroll in their plan of choice. Specifically, insurance navigators are tasked with helping enroll consumers in coverage available through health insurance exchanges, also known as Marketplaces, as well as determine if they qualify for tax credits, cost sharing reductions, or Medicaid coverage. Exchanges are described as competitive health insurance marketplace(s) where people and small businesses can shop for and buy affordable private health insurance.

Health insurance exchanges are slated to begin enrolling consumers on Oct. 1, 2013 and insurance navigators will play an important role in helping consumers understand their coverage options. Once consumers have chosen and enrolled in their plan of choice, insurance navigators step out of the picture.

Key insurance navigator job tasks include:

- Providing individuals and families with impartial information necessary to determine which health insurance option best fits their needs
- Helping individuals and families enroll in their plan of choice

Navigation Now and In the Future

While insurance navigators are the newest navigators on the block, patient navigators have been in place in various healthcare settings for the past twenty years. The concept of patient navigation was pioneered to address gaps in the care of cancer patients; however, the patient navigation field has grown and is now a nationally recognized model that extends beyond cancer care.

Implementation of HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems)—the national, standardized, publicly reported survey of patients' perceptions of their inpatient care—is another reason healthcare providers have been taking a closer look at patient navigators. While there is no direct correlation between patient navigation and HCAHPS, there is no denying that providing patients with a better experience will positively impact a hospital's HCAHPS scores.

Beyond the potential to boost HCAHPS scores, the presence of both patient and insurance navigators offers an opportunity to ensure that care is culturally and linguistically appropriate. Providing care that is linguistically and culturally sensitive can help erase disparities in health outcomes among disadvantaged populations. The health literature has clearly shown that poor and uninsured patients, as well as those who are culturally different, face more barriers to healthcare. As the number of barriers to healthcare increase, the likelihood of poorer health outcomes and disparities in health outcomes increases. Looking to the future, both patient navigators and insurance navigators are expected to play a central role in removing barriers that stand in the way of patients having health insurance and accessing timely healthcare services.

The Center's Role in Advancing Patient Navigation

The Center, in collaboration with the Academy of Medicine of Cleveland and Northern Ohio, has initiated the Northeast Ohio Patient Navigation Collaborative. The group is comprised of representatives from healthcare systems, hospitals, payers, and community organizations who collectively advance patient navigation in Northeast Ohio by sharing expertise, proactively promoting patient navigation and helping to identify solutions to system issues related to patient navigation.

The Collaborative recently created the Patient Navigation Networking Group (PNNG), which is comprised of patient navigators or those working in comparable roles. The PNNG supports patient navigators as a career path by:

- Providing networking opportunities for navigators to discuss common is¬sues, learn from each other and share resources
- Providing educational opportunities and programming that interest patient navigators
- Leveraging technology to support navigation

Conclusion

All navigators—lay, clinical and insurance—play an important role in improving the patient experience. Patient navigators educate patients and families, reduce anxieties and remove barriers to care. Insurance navigators are expected to boost health insurance rates by connecting individuals to health coverage options and helping them enroll in suitable health coverage. In all of these ways, navigators are making a difference in healthcare today.

Endnotes

The information in this Policy Snapshot came primarily from one of The Center's business affiliates, CHAMPS Patient Experience. ■

[1] Freeman, H.P. and Rodriguez, R.L. "History and Principles of Patient Navigation." *Cancer,* vol. 117, Issue Supplement 15. August 1, 2011. http://onlinelibrary.wiley.com/doi/10.1002/cncr.26262/pdf

Legislative Update

Lame Duck Legislative Session

The 130th General Assembly will be in full swing following the November elections in the "lame duck" legislative session. There will be a number of legislative maneuvers as legislators work to get bills approved and passed before the end of 2014. This is because anything that is not approved and passed by the end of the year will have to be re-introduced in 2015 in the 132nd General Assembly. The AMCNO plans to monitor and closely watch the activities taking place in the lame duck session and provide updates to the AMCNO membership.

Joint Medicaid Oversight Committee Update

Although the legislature has been in recess for the past few months and will not return until November for the lame duck session, the Joint Medicaid Oversight Committee (JMOC) has continued to meet to review issues related to Medicaid. Created by the passage of Senate Bill 2016, the JMOC has been working with the state Medicaid agenda to better control Medicaid spending and to provide legislators additional oversight of the state's Medicaid program. The JMOC meetings have focused on presentations from the Department of Medicaid and the Office of Health Transformation on various topics including an overview of the Medicaid program, and an overview of the actuarial research that calculates Medicaid's capitation payment rates for Medicaid Managed Care plans. The Director of the Department of Medicaid, John McCarthy, has also provided JMOC members with a summary of the state's plans for implementing the MyCare Ohio program. MyCare Ohio is a new managed care program designed for Ohioans who are eligible for both Medicaid and Medicare benefits. Ohio was the third state in the country to receive federal approval for its plan to integrate care delivery between Medicare and Medicaid.

MyCare will integrate physical, behavioral and long-term care services for Ohio's approximately 182,000 dual-eligible residents, who currently experience very little coordination between their Medicare and Medicaid benefits. Currently, Ohio's dual-eligible individuals make up just 14% of the state's Medicaid population, but account for 34% of Medicaid spending. MyCare Ohio aims to improve health outcomes for these individuals while identifying new ways to reduce the overall cost of care provided by both payment systems.

The new dual-eligible program will operate under a capitated managed care model through five insurance plans across the state including Aetna, Buckeye, CareSource, Molina and UnitedHealthcare. These plans will begin enrolling dual-eligible individuals who live in seven demonstration regions across 29 counties in the state. Dual-eligible individuals who live in demonstration counties must enroll in a MyCare plan if they are over the age of 18 and if they are eligible for Medicare parts A, B, D, and all Medicaid benefits. Enrollment in MyCare plans is currently available on an opt-in basis through December 2014 so that individuals have time to decide which plan best fits their health care needs. Beginning January 2015, individuals who have not yet selected a plan will be automatically enrolled in one of the MyCare Ohio managed care plans.

Office of Health Transformation (OHT) Director Greg Moody presented before the JMOC on efforts to move Ohio toward a value-based healthcare payment system. Although Director Moody did not give specifics about the OHT budget proposal, he did highlight OHT's effort to improve Ohio's healthcare system and offered background on what the administration is planning for the future. Starting this November, the OHT plans to start an episode-based payment model with a multi-payer agreement involving Medicaid, state employee and commercial health plans. Ohio has applied for a $98.6 million federal grant to assist in this effort; however, Ohio plans to proceed with the effort even if the grant is not obtained. The intent of the OHT is to design and implement new healthcare delivery payment systems that reward value of healthcare services, not the volume.

With an eye toward the upcoming budget cycle, the JMOC is also looking at Medicaid spending in the current budget cycle, as well as national estimates for future spending trends. JMOC Executive Director Susan Ackerman, in her presentation before the joint panel, noted that total Medicaid spending reached more than $20.8 billion in FY14 - $731 million below projections. Spending variance highlights in the Medicaid budget included underestimates in MyCare Ohio, health homes, and overestimates in the newly eligible population, and nursing facilities. Ackerman noted that key factors contributing to the variances were the timing and implementation of new programs, as well as lower caseloads than estimated.

At their October meeting, JMOC received a preliminary analysis of Ohio's Medicaid program that suggested long-term spending reductions for the healthcare entitlement could be achievable. The report, which is required under the Medicaid overhaul legislation, projected that per member, per month (PMPM) rates will see a growth trend between 1.2% to 2.6% in fiscal year 2016 and 2.2% to 4.4% in FY17 if no changes are made in state policy. An analysis, which was completed by Optumas, an actuarial firm based in Arizona, suggested that the PMPM rate midpoint will be $630 in FY2015—1.8% below the Department of Medicaid's midpoint. There were limitations in the data for this analysis because member/aid category-level information was not available for non-managed care and only summarized annual base data was available for managed care. Future reports, which will be released at a later date, will provide detailed data.

Medicaid Funding Debate to Continue in 2015

Medicaid funding is expected to once again dominate budget debates early in the next General Assembly and if reelected, Governor Kasich is planning to continue Medicaid expansion in the next two-year budget. When Medicaid expansion was introduced in the last budget cycle in an effort to expand Medicaid coverage up to 138% of the federal poverty level it created friction with the legislature. Ultimately, the Kasich administration moved the policy forward through a state plan amendment and Controlling Board funding approval. The more than $2.5 billion in funding approved by the Controlling Board for Medicaid expansion covers extended program eligibility through FY2015, so the debate will continue in 2015.

In order to access the federal funding available to states for newly eligible Medicaid beneficiaries, additional legislative action is necessary. Under federal law, Medicaid expansion is 100% federally funded from 2014 through 2016, and then decreases to 95% in 2017, and continues to decrease by 1% annually until 2020, after which time the federal government will pay 90% of the cost of coverage.

Medicaid reauthorization is necessary to ensure that Ohioans now covered by this program do not lose coverage and increase uncompensated care costs.

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Legislative Update

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Medicaid Patient Stories Needed

As you know, the AMCNO worked with other associations and community leaders to advocate and achieve a statewide expansion of the Medicaid program last fall. Now, more than 300,000 Ohioans have access to quality medical care.

However, despite this success, the fight for access in Ohio is not over. When Medicaid expansion was approved, it was done in a time-limited manner. If the Ohio legislature does not reapprove the program, many Ohioans could lose coverage and be uninsured once more. That is why, as we did when Medicaid expansion went through, it is necessary to begin now to garner support for continuing this program.

As part of a larger statewide effort, the AMCNO has been asked to reach out to our physician members for input. We are asking that you reach out to your Medicaid patients and have them describe how this new Medicaid coverage has changed their lives. The AMCNO is asking you to work with your staff to collect those stories for this critical impending decision in Columbus.

Stories are being collected through OhioSPEAKS, which is headed up by Advocates for Ohio's Future. If you know of a Medicaid patient who would be willing to submit their story to "OhioSPEAKS" they may post their story to Advocates for Ohio's Future through the Medicaid story submission link.

The name of the patient will not be used or published without their permission; however, the stories will be posted in an effort to show how expansion of the Medicaid program has changed the lives of thousands of patients in Ohio.

The statewide coalition leading up this effort has prepared some before-and-after questions that patients can utilize when preparing their stories. To view a copy of these questions, go to http://amcno.org/index.php?id=867.

It is important that legislators hear from patients about how Medicaid coverage has changed their lives and their healthcare situation. If you have Medicaid patients that would be willing to tell their story, please direct them to the website noted above. If you have any questions about this initiative, please contact Elayne Biddlestone at ebiddlestone@amcnoma.org.

Medical Board/Administration Updates

"Start Talking!" Form Required Starting September 17

On September 17, Ohio law required a "Start Talking!" consent form for prescribing opioids to minors before a prescriber issues the first prescription containing an opioid to a minor, unless it is a medical emergency or a specific exception applies. This requirement is included in Section 3719.061, Ohio Revised Code, enacted through HB 314. The Start Talking! form is separate from any other document used to obtain informed consent for treatment provided to the minor. The law also created Section 4731.22 (B)(48), Ohio Revised Code, which makes failure to comply with the Start Talking! requirements a basis for disciplinary action by the medical board. The State Medical Board of Ohio has developed a model Start Talking! consent form that licensees may use to meet this new requirement. To obtain a copy of the Start Talking! consent form, go to the State Medical Board of Ohio website at www.med.ohio.gov.

Lyme Disease Testing Notice to Patients

On September 15, Ohio law required that a written notice must be given to patients when ordering a test for Lyme disease. The notice must be signed by the patient or patient's representative and kept in the patient's record. The form informs patients that the healthcare provider has ordered a test for the presence of Lyme disease noting that current testing for Lyme disease can be problematic and may lead to false results. The form also informs patients that if they are tested for the disease and the results are positive, this does not necessarily mean that the patient has contracted Lyme disease. In the alternative, if the results are negative, this does not necessarily mean that the patient has not contracted Lyme disease. A copy of this form may also be obtained on the SMBO website: www.med.ohio.gov. Several medical organizations and health systems recently issued a joint letter urging representatives to repeal the written consent requirement. The AMCNO will inform our members if the use of the form is repealed.

State Medical Board of Ohio Considering Changes to One-bite Reporting Exemption

Over the past several months, the State Medical Board's Policy and Legislation Committee has been reviewing the one-bite reporting exemption for physicians for the purpose of exploring possible changes to the one-bite rule. Currently, Section 4731.224 (B) of the Ohio Revised Code states that an individual with drug and alcohol issues is not required to notify the State Medical Board if he or she meets the following conditions: examination at an approved treatment provider, if diagnosed with impairment, the individual completes treatment in accordance with the medical board requirements; and the individual has not violated the board's statutes or rules, other than those relating to impairment.

Rule 4731-15-01C of the Ohio Administrative Code states that non-impairment violations do not have to be reported if all acts or omissions occurred while the practitioner was impaired; there is not criminal conviction; and there is no adverse impact on other individuals. The SMBO currently has internal guidelines in which the following situations are considered to be within the reporting exemption: alcohol use, illegal drug use, a DUI conviction, taking drugs from a source that does not involve patients, and issuing prescriptions in own name or false name.

The board is revisiting the current reporting exemption because it believes that the one-bite exemption is confusing to practitioners and treatment providers. In addition, the SMBO is concerned that some individuals who do not qualify for the one-bite exemption fail to report to the board and there may be a lack of consistency in applying the one-bite exemption. Also, certain facts that would take the individual out of the one-bite exemption status may be known only to the Board, such as an open-board investigation, and acts constituting a felony are not reported to the board if there is not a criminal conviction and the acts occurred while the individual was impaired. In an effort to address their concerns, the board is considering revisions to the rule that would require all individuals diagnosed with chemical dependency or substance abuse to complete a confidential notification to the State Medical Board. The Board's Compliance Manager, Secretary and Supervising Member would then review each notification to determine if the reporting exemption requirements are met. If yes, the individual's name will be flagged in the board's internal, confidential computer system so that the investigation and enforcement staff would be aware that the individual was under the exemption status. A letter would then be sent to the individual advising him or her of the

treatment requirements under the board's statutes and rules. If the individual does not meet the requirements of the reporting exemption, then a complaint will be filed and investigated. The AMCNO has concerns with these proposed rule changes, in particular that these revisions could discourage physicians from seeking treatment when necessary. The AMCNO is working with other physician organizations to research rules from other states to recommend an alternative approach that will result in physicians getting treatment when needed.

Hydrocodone Combination Products Reclassified

Effective October 6, all hydrocodone combination products were classified as Schedule II controlled substances pursuant to a rule adopted by the United States Drug Enforcement Agency (DEA). The Ohio State Board of Pharmacy created a guidance document to assist in complying with state and federal controlled substance requirements. Cough syrups that contain hydrocodone will also be classified as schedule II controlled substances when this rule takes effect.

To ensure compliance with state and federal controlled substance requirements, the Ohio State Board of Pharmacy advises that all pharmacists and prescribing practitioners adhere to the following requirements for Schedule II drugs:

- Security: HCPs are subject to Schedule II security requirements and must be handled and stored pursuant to 21 U.S.C. 821 and 823, and in accordance with 21 CFR 1301.71- 1301.93 as of October 6, 2014.
- Prescriptions: No prescription for HCPs issued (i.e., when provided by a prescriber to the patient) on or after October 6, 2014, shall authorize any refills. Any prescriptions for HCPs that are issued before October 6, 2014, and authorized for refilling, may be dispensed in accordance with 21 CFR 1306.22-1306.23, 1306.25, and 1306.27, if such dispensing occurs before April 8, 2015. After April 8, 2015, no refills on HCPs issued prior to October 6, 2014, are permitted. A store may transfer a prescription to another pharmacy if it has refills and is written before October 6th, 2014. Please note: According to the DEA, the refill must be treated like a refill on a C-III prescription, meaning a pharmacy CANNOT issue new C-II prescriptions and then tie those back to the original prescription to cover refills. Additionally, transfer of refills must be treated as a C-III prescription.

Additional information about this issue can be obtained on the Ohio State Board of Pharmacy website at http://pharmacy.ohio.gov.

Change in Ohio Revised Code Allows Prescribers to Access OARRS to Address Neonatal Abstinence Syndrome

Per Ohio Revised Code Section 4729.80(A)(12), as enacted by Ohio HB 483 of the 130th General Assembly, physicians or their delegate are now authorized to request information from the Ohio Automated Rx Reporting System (OARRS) relating to the mother of a patient, if the prescriber or their delegate certifies that it is for the purpose of providing medical treatment to a newborn or infant patient diagnosed as opioid dependent. This change was adopted by the Ohio General Assembly to address the growing issue of neonatal abstinence syndrome (NAS) in Ohio newborns. NAS is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb.

According to data from the Ohio Departments of Health & Mental Health and Addiction Services, approximately 5,100 hospitalizations resulted from (NAS) in inpatient and outpatient settings between 2004 and 2011. In 2011 alone, there were 1,649 admissions to both settings, which equates to nearly five admissions per day. The rate of NAS grew six-fold from 14 per 10,000 live births in 2004 to 88 per 10,000 live births in 2011. The most common conditions associated with NAS were respiratory complications, low birth weight, feeding difficulties, and seizures. If you have not already done so, you may register for OARRS by visiting: www.ohiopmp.gov.

Governor's Cabinet Opiate Action Team (GCOAT) Meets to Address Treatment of Acute Pain

The Opiates and Other Controlled Substances Reforming Practices Committee (OOCS) of the Governor's Cabinet Opiate Action Team (GCOAT) has been working diligently to develop and disseminate responsible opioid prescribing practices for Ohio's clinicians. A critical area of focus for the group has been identifying where clinician support is needed to achieve appropriate pain management. To date, the stakeholder group has developed practice guidelines for clinicians practicing in emergency and urgent care settings and those caring for patients who are experiencing chronic, non-terminal pain. The group is now broadening their focus and will begin working to ensure that providers are effectively and safely managing patients who need care for acute pain. The first meeting of this new GCOAT committee occurred in September. The committee plans to reconvene in the near future with the intent come up with definitions and standards around the treatment of acute pain. The AMCNO will continue to be involved in these discussions and will provide updates to our membership.

Concussion and Head Injury Return to Play Guidelines Committee Appointed

The Ohio Director of Health, Richard Hodges, made six appointments to the Concussion and Head Injury Return to Play Guidelines Committee. In accordance with Ohio's new youth sports concussion law, the Director of Health is required to establish a committee regarding concussions and head injuries sustained by athletes participating in interscholastic youth sports activities. The concussion committee is charged with developing guidelines for youth sports concussions. The appointees to the committee are: Andrew N. Russman, DO, representing a physician who practices as a neurologist at the Cleveland Clinic; Kim G. Rothermel, MD, representing the State Medical Board of Ohio; Brian S. Wilson, DC, representing the State Chiropractic Board; William A. Ramsey, DC, representing a chiropractor in sports medicine; Eric D. Griffin, DC, representing a chiropractor with a background in neurology; and Jason P. Dapore, DO, representing sports medicine. The new law specifies that the committee develop and publish guidelines addressing issues with regard to athletes exhibiting signs, symptoms, or behaviors consistent with having sustained a concussion or head injury while participating in an interscholastic athletic event or an athletic activity organized by a youth sports organization by March 2015. The first meeting of the committee was held in October. The AMCNO will continue to monitor the activities of this committee and provide information to our membership. ■

Infant Mortality in Ohio: Encouraging Safe Sleep

By Robert E. Falcone, MD, Vice President Population Health, Ohio Hospital Association

Infant mortality is defined as the death of a baby before their first birthday. The infant mortality rate (IMR) is the number of babies who died in the first year of life, per 1,000 live births. This rate is considered an important indicator of the overall health of a society.

Neonatal infant deaths occur in the first month of life when babies are born too small and too early (preterm births are those before 37 weeks gestation), born with a serious birth defect, or die from maternal complications of pregnancy. Post neonatal deaths occur in the next eleven months of life from Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death Syndrome (SUIDS), Unsafe Sleep, or victims of injuries. These top five leading causes of infant mortality together accounted for 63 percent of all infant deaths in Ohio in 2011.

The CDC Ranked Ohio 47 out of 50 states for IMR with a rate of 7.71 in 2010. During this time Cuyahoga County had an IMR of 9.07 with 94 neonatal and 43 post-neonatal deaths (many of these 43 were sleep related). Ohio hospitals and clinicians are ideal partners to help address the state's high IMR and engage patients and the community with effective clinical and professional resources. In February 2014 the Ohio Hospital Association Board approved an aggressive plan to engage hospitals to help lower Ohio's Infant Mortality rate by 5% year to achieve a 2020 target IMR of 6.0. The areas of focus are listed below.

OHA Areas of Focus (2014-2016)

- Safe sleep
- Eliminate elective deliveries before 39 weeks
- Progesterone for high risk mothers
- Eliminate health disparity
- Safe spacing
- Access to prenatal care
- Breast milk

Safe Sleep is our first hospital based initiative. Partnering with the Ohio Department of Health (ODH), Ohio Collaborative to Prevent Infant Mortality (OCPIM), Cradle Cincinnati, March of Dimes, the American Academy of Pediatrics (AAP), Ohio Medicaid and many other organizations, the Ohio Hospital Association (OHA) is providing the logistics to deploy a statewide hospital-led education and cultural awareness campaign on the importance of safe sleep. **Safe Sleep is GOOD-4-BABY** was launched on April 1, 2014. Using the local hospital as a focus for education and distribution, new mothers and their families will receive safe sleep counseling and products, such as a safe sleep jumper. More importantly, hospitals will be asked to participate in the campaign by naming an internal sleep champion, developing safe sleep committees and infrastructure, adopting (and auditing) in-hospital safe sleep practices and instructing employees, parents, families and the community on appropriate safe sleep practices. OHA plans to track these initiatives' processes and outcomes metrics through a regional score card. As of July 15, 2014, 98 of Ohio's 109 Maternity Hospitals and all of Ohio's six Pediatric Hospitals have committed to the program. Listed below are safe sleep recommendations modeled after American Academy Of Pediatrics guidelines by the ODH.

Safe Sleep Recommendations (Ohio Department of Health)

ALONE: Always put baby in crib alone. They shouldn't sleep in a bed or have anyone else in theirs.

BACK: Always put the baby on their back to sleep—at night or even when they're just napping.

CRIB: Always make sure the only thing on their firm mattress is a fitted sheet. No blankets or stuffed animals.

- Place infants to sleep wholly on the back for every sleep, nap time and night time.
- Use a firm sleep surface. A firm crib mattress with a tight-fitting sheet in a safety-approved crib is the recommended surface.
- Room-sharing without bed sharing – the infant's crib should be in the parents' bedroom, close to the parents' bed.
- Keep soft objects, loose bedding, and bumper pads out of the crib.
- Breastfeeding is recommended.
- Offer a pacifier at sleep time after breastfeeding has been established.
- Avoid overheating by excessive clothing, bundling, or room temperature.
- Avoid commercial devices such as wedges, positioners, and monitors marketed to reduce the risk of SIDS. None have been proven safe or effective.
- All infants should be immunized in accordance with AAP and CDC prevention recommendations.
- Women should receive regular prenatal and postpartum care.
- Do not smoke during pregnancy. Avoid exposure of infants and pregnant women to secondhand smoke.
- Not a single drop of alcohol or illicit drugs should be consumed during pregnancy.

Dr. Robert Falcone was on hand at a recent AMCNO board meeting where he provided a presentation on the OHA Safe Sleep initiative.

A Child Fatality Review, conducted by each of Ohio's 88 counties and coordinated by the ODH, identified 148 sleep related deaths in 2010. It is not clear how many of these deaths are preventable, however, there is potential for vast improvements to infants saved annually. Over the next 18 months OHA will roll out remaining initiatives on the eliminating elective deliveries before 39 weeks, encouraging breast milk for infants, educating on safe spacing, improving access to prenatal care, providing progesterone to women at risk for premature birth, and advocating for the reduction of disparity.

How can you help?

The hospitals in the Cleveland area have formed a regional workgroup of safe sleep champions to address this issue in a coordinated way. Please encourage and support this group. Help in educating and providing information to your patients and their families on the importance of Safe Sleep when the opportunity arises. Advocate in your community to engage the media and retail business to support safe sleep environments. A number of web-based tools and links are available @ www.ohiohospitals.org/safesleep ■

The Affordable Care Act Recent Developments

By David Valent, Esq.

Provided herein is an analysis of recent developments regarding the implementation and impact of the Affordable Care Act ("ACA").

Medical Groups Challenge ACA Mandate

In October 2014, two medical groups sought to challenge the ACA, and asked the U.S. Supreme Court to review their claim that the ACA violates constitutional property protections.

The case, *Association of American Physicians & Surgeons Inc. v. Sylvia Matthews Burwell, Secretary of Health & Human Services,* alleged that the ACA creates an improper "taking" of an individual's property rights, contrary to the Fifth Amendment. The physician groups argued that the ACA asks healthy individuals to support unhealthy individuals, by requiring healthy individuals to enroll in a health insurance plan, at a premium cost.

The Court documents filed by the physician groups state: "[F]or example, an annual family premium of $12,000 would include approximately $2,000 to subsidize lower rates for others. This is spread-the-wealth payment, as distinct from the typical risk-spreading aspect of health insurance." The physician groups further explained that the ACA requires healthy consumers to purchase insurance that essentially subsidizes less healthy policyholders. They say this is done intentionally to lower premiums of other policyholders, i.e. those with pre-existing conditions, who will pay lower rates because the law requires healthier policyholders to buy coverage.

The argument that this policy creates a "property taking" is based on *Kelo v. City of New London,* a 2005 decision that determined private property cannot be taken from one person for the sole purpose of giving it to another person. The lawyers in this health care case argue that the financial taking of health insurance premium dollars, is the same as a property taking, as described in *Kelo.*

Prior to this appeal, the previous Appellate Court to hear this case noted that such a "taking," as alleged, can only be struck down as illegitimate if it is so arbitrary as to obviously be tantamount to confiscating property. The Appellate Court did not believe this alleged "taking" met that threshold.

A decision from the Supreme Court will soon be forthcoming. If the Supreme Court rules in-line with the Appellate Court that first heard this argument, the challenge to the ACA will fail. Generally speaking, the ACA has survived and/or largely been upheld with regard to every significant Court challenge to date.

The Individual Mandate Requirement of the ACA

In September 2014, the Ninth Circuit Court ruled in favor of upholding the ACA, relative to the "individual mandate" requirement—which is at the heart of that ACA. The requirement at issue provides that individuals must obtain a minimum level of health insurance, or face a penalty.

In *Coons v. Lew,* the Ninth Circuit Court rejected the Plaintiff's claim that the ACA mandate violated Arizona state law. In this case, the challenging party was an uninsured Arizona person who did not want to purchase health insurance. This individual argued that an interpretation of state law allowed a person to abstain from purchasing health insurance, without penalty, and, that forcing a person to purchase insurance infringed on the individual's due process right to medical autonomy.

In following a previous Sixth Circuit decision, this Ninth Circuit Court denied the challenger's claims, and confirmed that the federal law preempts the state law. Also, the Court held that the federal law does not impinge on individual rights. Rather, "the fact that the individual mandate forces Coons to spend funds on either medical insurance or a penalty implicates Plaintiff's economic interests only—a substantive due process that was abandoned long ago by the Supreme Court."

This recent decision is viewed as yet another victory for the ACA, and further solidifies that the individual mandate is likely here to stay.

Improvements are Coming to the "Shop" Marketplace

Pursuant to the ACA, the Small Business Health Options Program (SHOP) Marketplace helps small businesses provide health coverage to their employees. The SHOP Marketplace is open to employers with 50 or fewer full-time equivalent employees (FTEs). If your small business has 50 or fewer full-time equivalent (FTE) employees, you can use the SHOP Marketplace to offer your employees health coverage. If you enroll in SHOP coverage and have fewer than 25 employees, you may qualify for a Small Business Health Care Tax Credit worth up to 50% of your premium costs. The tax credit is available only for plans bought through the SHOP Marketplace.
The federal government is touting improvements to the SHOP Marketplace, for coverage starting in 2015:

- Starting November 15, 2014, employers will be able to apply, compare plans, and enroll in a SHOP plan online, for coverage starting the first of the year.
- Your employees will be able to enroll in your plan online too, making the process easier for both of you.
- When you compare health plans available in the SHOP Marketplace, you can choose from 4 levels of coverage. This makes it easier to find a plan that works for your business and your employees.
- You control the coverage you offer and how much you pay toward employee premiums.
- Health insurance agents and brokers registered with the SHOP Marketplace will have special online features that make it easier for them to help you apply, choose coverage, enroll, and manage your coverage, if you authorize them to help.
- When logged in to the new SHOP online application, you will be able to search by zip code for agents or brokers registered with the SHOP Marketplace.

- New features / tools are also available in Spanish, to make assess better for certain small businesses.

If you are self-employed with no employees, you can get health coverage through the Health Insurance Marketplace for individuals, but not through SHOP. For more information about enrollment and/or tax credits, go to HealthCare.gov.

Re-Enrollment Through ACA Exchanges

The Department of Health and Human Services recently announced that it is moving forward with a policy that will allow consumers who got health insurance through the state and federal exchanges to be automatically re-enrolled for 2015.

The aim of the policy is to prevent care disruption for the 8 million consumers who got coverage through exchange plans during the ACA's first enrollment period, and to avoid losing a large number of them while the administration works to extend coverage to most of the nations uninsured.

The government is likely to release more details soon regarding the re-enrollment policy, to help reduce the risk that folks go uninsured—as the new year approaches.

Second Open Enrollment Starting Soon

The period of time for enrollment through the online Marketplaces for coverage starting in 2015, is November 15, 2014–February 15, 2015. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment.

The Congressional Budget Office has forecast that 13 million people would be enrolled under the ACA in 2015, and 7.3 million enrolled and paid in 2014.

Website Woes Continue

According to investigators from the Government Accountability Office ("GAO"), the federal health insurance marketplace and its gateway website, HealthCare.gov, still suffer from serious problems. The troubled website is a centerpiece of the Obama administration's overhaul of the health care system and provides access to the federal exchange for millions of Americans who do not receive insurance through their employers.

The GAO concluded that the marketplace and the website were over budget and behind schedule, as a result of "new and changing requirements" imposed by the administration.

In testimony prepared for hearing before the House of Representatives, William T. Woods, a senior official at the GAO, warned of significant risks in the next open enrollment period. At the same hearing, Andrew M. Slavitt, a senior official at the Centers for Medicare and Medicaid Services, promised consumers "a better shopping experience" and "continued improvement." As mentioned above, the next open enrollment period begins on November 15, 2014.

For further information regarding the ACA and/or issues that may be specific to your practice, please do not hesitate to contact David A. Valent, Esq. at Reminger Co., LPA: (216) 430-2196, dvalent@reminger.com, 101 Prospect Ave. W, Suite 1400, Cleveland, Ohio 44115. ■

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AMCNO Pollen Line – 2014 Recap

Yoon Mi Kim D.O., Ali Saad D.O., Jason Casselman D.O., Theodore Sher M.D., Haig Tcheurekdjian M.D., and Robert Hostoffer, D.O., Allergy/Immunology Associates Inc.

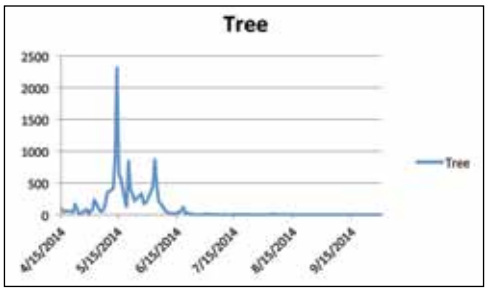
Allergy/Immunology Associates has been dedicated to serving patients of the Greater Cleveland area through the use of the pollen line. As in years past, we have used a Rotorod Aeroallergen device to obtain and then count the pollen levels daily throughout the 2014 pollen season. These pollen counts not only provide insight to patients, but allow allergists and physicians to have an extra tool to better direct therapy for their patients to achieve symptom relief. For those who suffer from allergic rhinitis, allergic conjunctivitis and asthma, the pollen season can be miserable. By following yearly trends, we can predict the timing of certain allergens and prepare our patients so that their quality of life can be maximized.

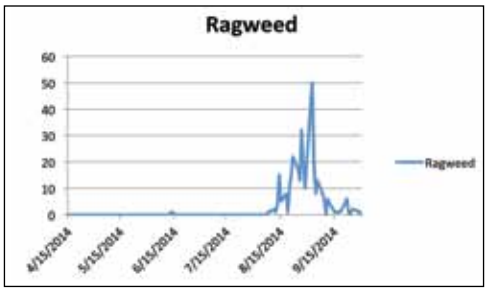
In the Greater Cleveland area, the pollen season begins with trees in April. Similar to last year, it took longer than previous years for the tree pollen to stay elevated. The first spike was in mid- to late-April. This spike was considerably smaller than the spike seen in early May. We believe the delay in spike was in part due to the rain seen in April. Compared to last season, the tree pollen season was shorter and began to decline in mid-June and flattened out in early July. Last season, the pollen count remained elevated through the month of July.

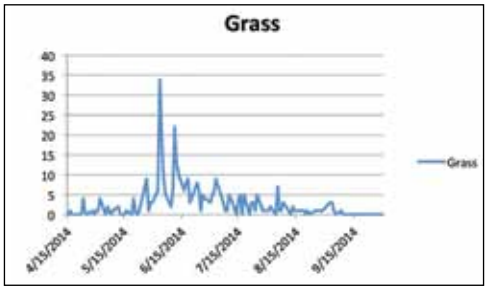
Grass pollen usually begins to rise during the summer months. This year, the pollen count was on the rise in mid- to late-May, which was earlier when compared to last year. Moreover, in contrast to last year, this year's grass season peaked earlier and stayed elevated longer, extending into mid-August. These observations are likely due to the increased temperature and large amount of rainfall to the region during the summer months.

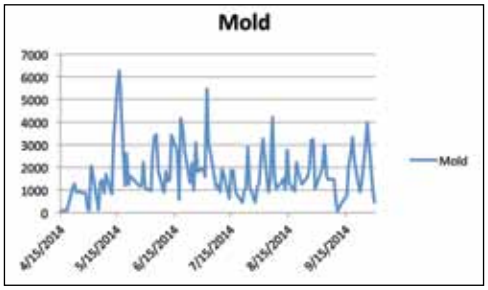
As the temperature starts to cool, we move into fall, also known as ragweed season. Ragweed started to appear around the same time as last year and peaked at the equivalent time as well. We tend to see ragweed every year around August 15, and it continues to climb from there until it starts a downward slope over the first two weeks of September. Although peaking around same time, this year's pollen count was substantially lower in comparison to years past. This observation was likely due to the decrease in rainfall during that period compared to previous years. The levels tapered off by the end of September.

While those who suffer from seasonal allergies look forward to the first frost and the end of pollination, mold spores will still wreak havoc. Mold can be seen to rise after rain at any time during the year, but it is also known to peak in the fall after the leaves have fallen. Damp leaves provide a great breeding ground for mold spores to accumulate. This year, mold started to increase around mid-May, and, compared to last year, stayed pretty constant without any noticeable peaks. Even though levels remained steady, the level was low until the end of August. Since pollen counting was discontinued on September 30, we likely missed the final peak for the mold count, which should occur in October as the colder temperatures set in.









Each year, Allergy/Immunology Associates, in coordination with the AMCNO, is proud to provide the pollen count for the Greater Cleveland area from April 1 to September 30. The counts are made available to the pollen line, (216) 520-1050, as well as www.amcno.org. Stay healthy and warm this winter, and we look forward to helping you prepare for next year's pollen season on April 1, 2015! ■

AMCNO Participates in Region V State Medical Society Meeting

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

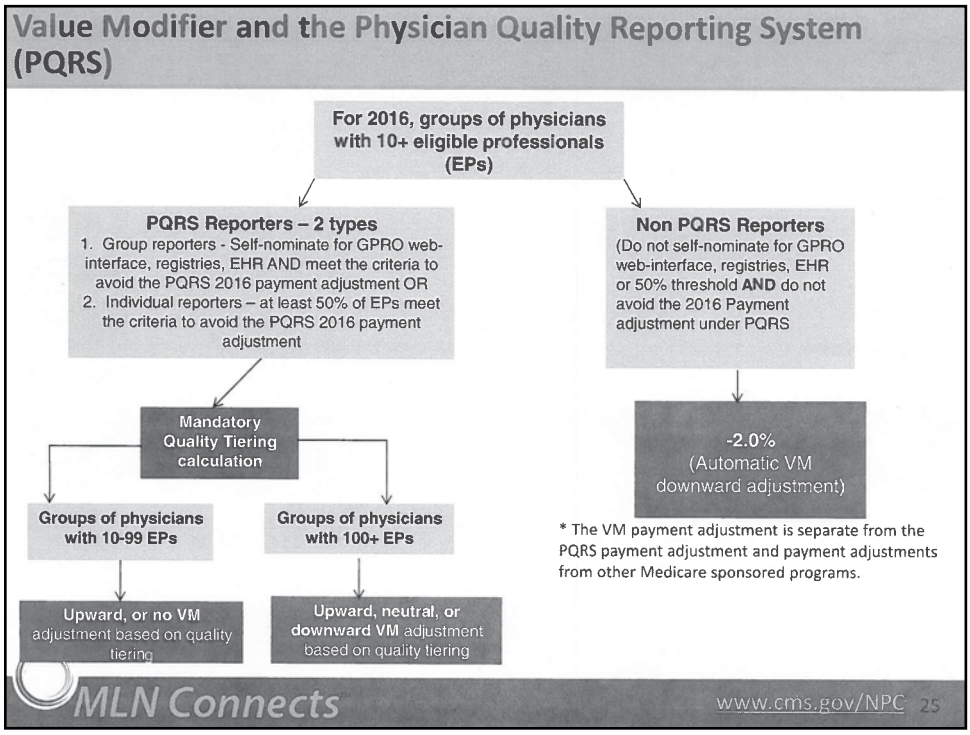
Topics covered included value-based modifiers and 2017 implications for physicians, PQRS and meaningful use alignment, Medicaid/Medicare dual eligibles, Medicare Advantage plans, ICD-10 and the healthcare marketplace.

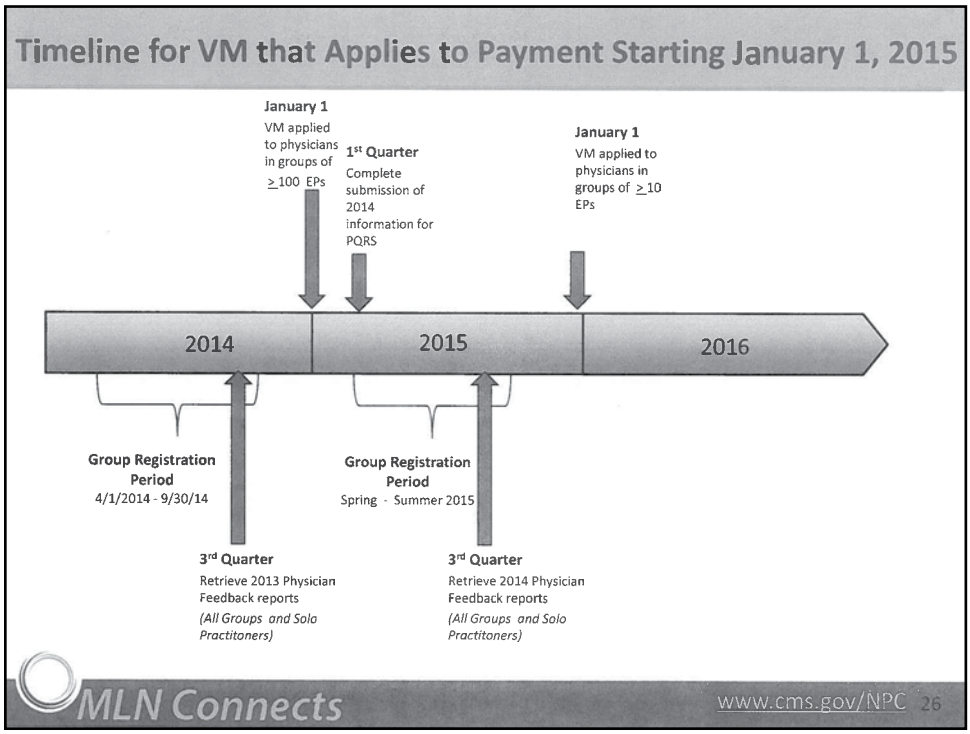
CMS representatives outlined the parameters involved in value-based purchasing (VBP). VBP will reward providers and health systems that deliver better outcomes and health care at lower cost. VBP, using a value modifier (VM), will be applied to physician payments for groups of 10 or more providers in 2016 and will apply to all physicians by 2017. The VM assesses both quality of care and the cost of care under the Medicare Physician Fee Schedule. The VM is a new per-claim adjustment under the Medicare Physician Fee Schedule that is applied at the group (Taxpayer Identification Number (TIN) level to physicians. In 2015, CMS will apply the VM to groups of physicians with 100 or more eligible professionals (EPs) based on 2013 performance; and in 2016 CMS will apply the VM to groups of physicians with 10 or more EPs based on 2014 performance.

CMS representatives outlined how participation in PQRS is now integrated into the VBP program (see pullout box to the right for more information). CMS representatives outlined what a physician group or solo practitioner should prepare to do in 2015—namely, actively participate in PQRS. If group reporting, physicians should be prepared to register between spring 2015 – June 30, 2015 (proposed). If a physician is reporting as an individual no registration will be necessary. Physicians should then decide which PQRS measures to report and understand the measure specifications and be sure to obtain their Quality and Resources Use Report—which will be available late-summer of 2015. (To view a timeline for VM that applies to payment, see pullout box.)

The AMCNO and staff from the other medical associations present at the Region V meeting noted that this program is very challenging and may be difficult to apply to individual physicians. CMS staff could not speculate on what the agency is going to do—whether they will decide to follow the same approach or modify the program. Representatives from the AMCNO and the state associations suggested that CMS prepare a simple, easy-to-understand format of frequently asked questions and provide webinars or classes for physicians as this program rolls out. The CMS staff indicated that they were willing to work with the associations to provide physician outreach and educational training. The AMCNO plans to follow up with the CMS staff to be sure that our organization is included in the planning of these sessions.

(Continued on page 16)





AMCNO REGIONAL ACTIVITIES

AMCNO Participates in Region V State Medical Society Meeting *(Continued from page 15)*

Other topics discussed during the Region V meeting included a brief presentation on Medicare/Medicaid dual eligibles. In Ohio, 18,000 patients are enrolled in this program, and these numbers will increase. The concept is to eliminate the shifting of costs between the two programs. There was also an ICD-10 presentation and the basic message to physicians is to be ready, ICD-10 is coming in 2015. Physicians can access information on the CMS/ICD-10 website at www.roadto10.org. Finally, the group received a brief presentation about the health insurance marketplace and the launch of Coverage to Care (C2C). C2C is an effort to help educate consumers about their new coverage and to connect them with primary care and preventive services. To view the roadmap and other C2C educational materials, go to www.marketplace.cms.gov/c2c ■

AMCNO Participates in the Cleveland Museum of Natural History Event

The AMCNO physician leadership and staff were pleased to participate in a recent event for medical professionals at the Cleveland Museum of Natural History (CMNH). Dr. Richard Fratianne, past-president of the AMCNO and an honorary member of the CMNH board, emceed the event where he discussed the AMCNO involvement in establishing the Cleveland Health Museum. The CMNH is planning to renovate over one-third of its space with the intent to integrate human health into their new exhibits. Dr. Fratianne and the staff leadership at the museum would like to see the Northern Ohio hospitals, institutions, and the AMCNO help direct this process of continuing quality health education and driving the future of CMNH. The AMCNO physician leadership and staff present at the event offered support to this concept and the AMCNO plans to continue our legacy of support for a museum in Northeast Ohio that provides information to the public about human health.

Dr. Richard Fratianne, AMCNO Past President provides the opening remarks at the museum event.

Editor's note: The AMCNO and our physician leadership were integrally involved in establishing the original health museum in Northeast Ohio. The AMCNO worked with public groups and the media back in 1936 to build enthusiasm for a health museum, and in that year, the Cleveland Health Museum, the first in the nation, was incorporated.

In 2007, HealthSpace Cleveland, (formally the Cleveland Health Museum) merged with the Cleveland Museum of Natural History (CMNH). As a result of the merger CMNH added human health to their mission and added expanded K-12 health education programs, enhanced traveling exhibits, and live, real-time distance learning, which is now reaching students in 48 states and 7 countries around the world.

Call for 2015 AMCNO Honorees

The AMCNO invites you to nominate an individual who **is a member of the AMCNO** that you believe is deserving of special recognition by the AMCNO. Any physician who wishes to nominate an individual for one or more of these awards should complete the form below and mail it to AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, OH, 44131. You may also FAX your nominations to Elayne Biddlestone at (216) 520-0999 OR you may call her at (216) 520-1000, ext. 100, to provide your honoree nominations over the phone. Deadline for submission:12/31/14.

- JOHN H. BUDD, MD, DISTINGUISHED MEMBERSHIP – This award is bestowed upon a member of the AMCNO who has brought special distinction and honor to the medical profession, to our community and to our physician association as a result of his or her outstanding accomplishments in biomedical research, clinical practice or professional leadership. Often, such an individual has already gained national and/or international recognition because of the importance of his or her contributions to medicine.
- CHARLES L. HUDSON, MD, DISTINGUISHED SERVICE – Awarded to a physician whom the AMCNO deems worthy of special honor because of notable service to and long activity in the interest of organized medicine.
- CLINICIAN OF THE YEAR – Awarded to a physician whose primary contribution is in clinical medicine and whose service to his/her patients over many years has reflected the highest ideals and ethics of, and personal devotion to, the medical profession.

- Your Name: _____
- Your Nomination: _____
- Nominated for the following award: _____

Please include an explanation as to why you are nominating this individual: _____

_____

Are you Interested in Running for the AMCNO Board of Directors in 2015?

Directors are elected to represent their district, which is determined by primary hospital affiliation or at-large for a two-year term. Members of the board are responsible for addressing issues of importance to physicians and the patients we serve, and setting policy for the AMCNO. If you are interested in running for the board of directors, please return this form with your name and contact information to the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, OH, 44131. You may also FAX your information to Elayne Biddlestone at (216) 520-0999 OR call her at (216) 520-1000, ext. 100. Deadline: 12/31/14.

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

Name and contact information: _____

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and the Academy of Medicine Education Foundation (AMEF)

Meet and Greet First-Year Medical Students

The AMCNO and the AMEF were pleased to co-host the Case Western Reserve University Society Dean Mixer for first-year medical students.

The event was held at the Cleveland Botanical Gardens and attending the event representing the AMCNO and AMEF were Drs. James Coviello, Matthew Levy, and James Sechler. The AMCNO physician leadership mingled with the students and the society deans and provided information and answered questions about the activities of the AMCNO and AMEF. The AMCNO president, Dr. James Coviello, provided brief comments to the group and encouraged the first-year medical students to become involved in the AMCNO. He explained that the AMCNO is a group of dedicated physicians who are working to improve quality of care, while providing education and community.

During the event the students asked AMCNO physician representatives about the activities of the AMCNO and AMEF, and they expressed interest in the Affordable Care Act and the impact it will have on the region, from both a patient's as well as physician's perspective; several had questions about their career and specialty choices, while others expressed an interest in volunteering and outreach activities. AMCNO staff was on hand to provide membership information and we are pleased to welcome over 100 new medical student members. ■

Dr. Matthew Levy (far right) discusses the activities of the AMCNO with first-year medical students.

Dr. James Coviello, AMCNO President provided a brief presentation about the AMCNO and AMEF during the medical student event.

AMCNO Resident Recruitment a Success

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) welcomed more than 400 new resident members into the AMCNO during resident orientation events held around the region. The AMCNO welcomes new members from the following institutions: Cleveland Clinic Foundation, Fairview Hospital, MetroHealth Medical Center, University Hospitals, St. John Medical Center and St. Vincent Charity Medical Center.

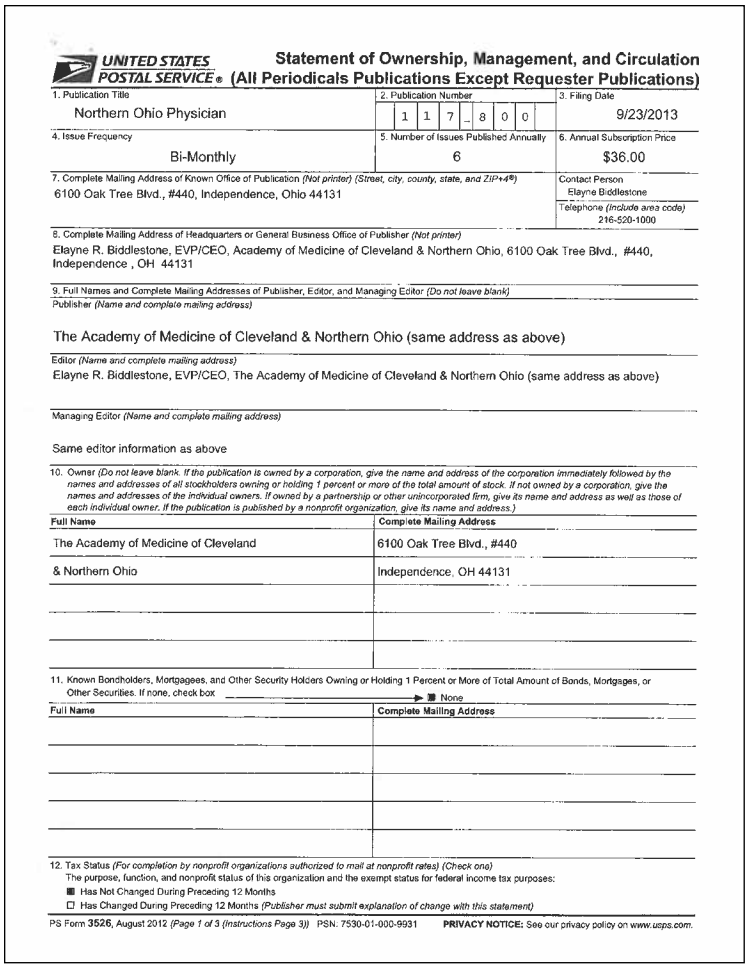
Do you know of a resident interested in free AMCNO membership? Direct them to apply online at www.amcno.org and click on BECOME A MEMBER.

Dr. George Topalsky, AMCNO Immediate Past President, provides remarks to a group of residents at University Hospitals orientation event.

Member Mentions

Evan C. Howe, MD, PhD, MPH, has received the 2014 Resident Leader Award from the Ohio Academy of Family Physicians. Dr. Howe recently completed his family medicine residency at Cleveland Clinic/Fairview Hospital Family Medicine Residency Program, and he is now practicing at University Hospitals Jefferson Primary Care. A resident board member of the Ohio Academy of Family Physicians, Dr. Howe has served in leadership roles with the AMCNO, Northeast Ohio Academy of Family Physicians, and several committees at the Cleveland Clinic/Fairview Hospital Family Medicine Residency Program.

On Sept. 19, **William H. Seitz, Jr., MD,** was sworn in as the 69th president of the American Society for Surgery of the Hand at the organization's annual meeting in Boston, MA. Dr. Seitz is the chairman of orthopaedic surgery at Lutheran Hospital. He is also a professor of surgery in the Department of Orthopaedics at the Cleveland Clinic Lerner College of Medicine at Case Western Reserve University. This year, Dr. Seitz, who is a past president of the AMCNO, received the John H. Budd, MD, Distinguished Membership Award at the Academy's annual meeting.



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Managing Editor *(Name and complete mailing address)*
Same editor information as above

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Full Name	Complete Mailing Address
The Academy of Medicine of Cleveland	6100 Oak Tree Blvd., #440
& Northern Ohio	Independence, OH 44131

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ■ None

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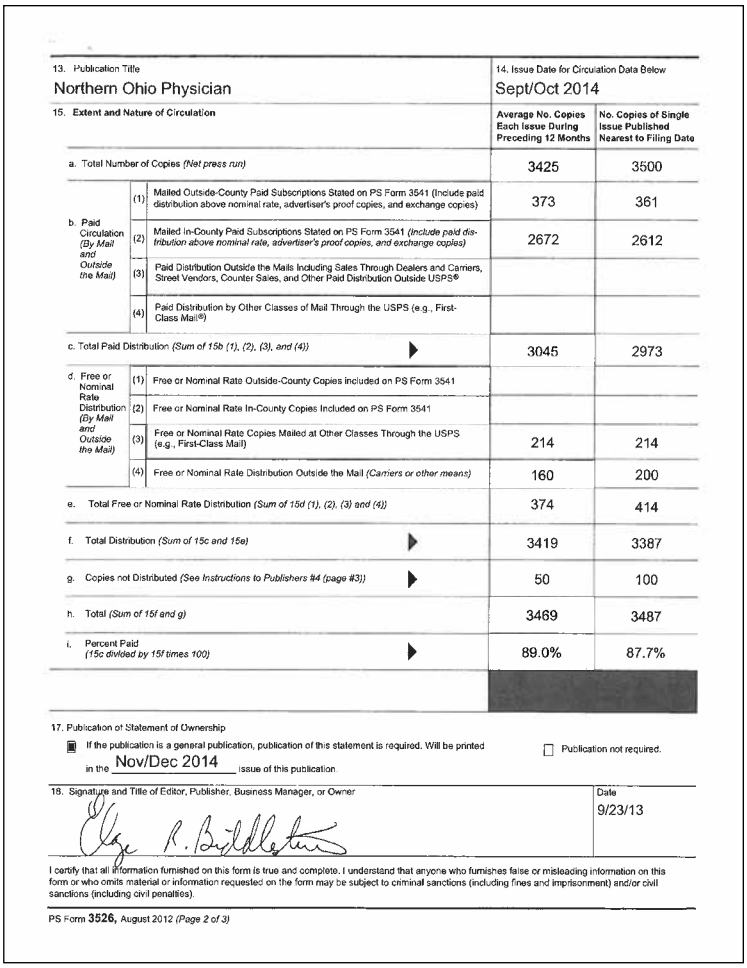
PS Form **3526**, August 2012 *(Page 1 of 3 (Instructions Page 3))* PSN: 7530-01-000-9931 **PRIVACY NOTICE:** See our privacy policy on www.usps.com.



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

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

Ebola Resources

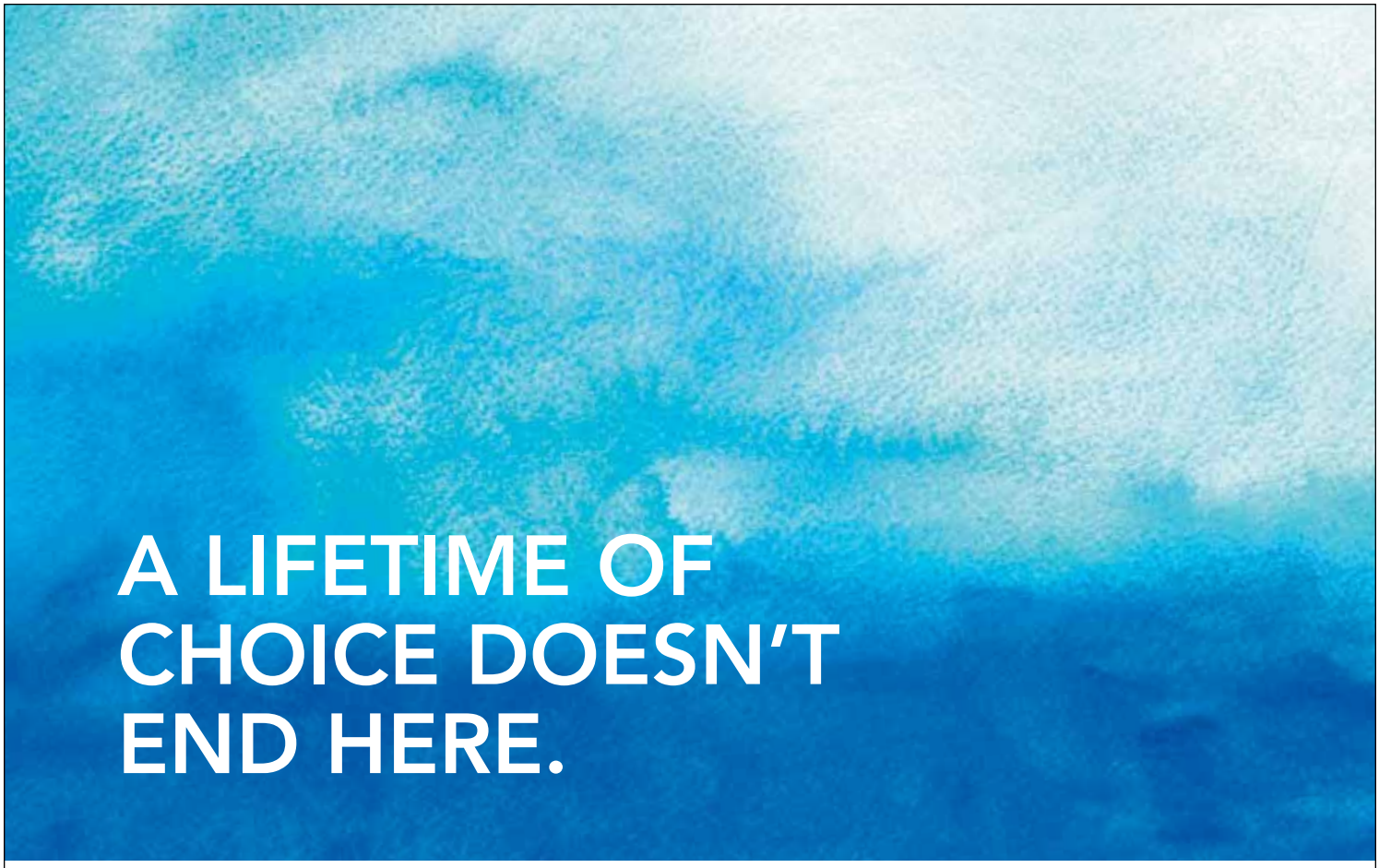
The AMCNO is committed to working with public health representatives and the medical community to assist in any way we can to put together a regional response plan and prepare for the potential of Ebola identification in our community. The Centers for Disease Control and Prevention (CDC) is reviewing protocols and procedures, and continuously distributing updated guidance as new information is received and best practices are developed. Guidance for healthcare workers can be obtained on the CDC website at http://www.cdc.gov/vhf/ebola/hcp/index.html.

Given the recent events surrounding Ebola, the Ohio Department of Health (ODH) has set up a 24 hour-a-day Ebola hotline to answer Ohioans' questions about the disease. The call center, housed in Columbus, is staffed by public health nurses and other public health professionals with infectious disease specialists available as needed. The number is 1-866-800-1404.

The ODH has asked that physicians diagnose patients by telephone, if possible, for Ebola virus symptoms while verifying whether the patient has 1) traveled to West Africa in recent weeks; 2) been in contact with someone who has traveled to West Africa; or 3) had contact with a person ill with Ebola in the United States. If the patient is being diagnosed in person, physicians should check for symptoms such as fever, body aches and fatigue, but should not draw blood, according to Mary DiOrio, MD, state epidemiologist. If the patient has the Ebola virus symptoms and the West African connection, then physicians should contact their local hospital to make arrangements for the patient to be quarantined and transferred to the hospital for additional observation and treatment.

Healthcare workers are reminded of the appropriate use of personal protective equipment (PPE). Ebola is spread through direct contact with the blood or body fluids of a person who is sick with Ebola; objects (such as needles) that have been contaminated with the blood or body fluids of a person sick with Ebola; or touching the body of someone who has died from Ebola. It is not spread through the air, food, or water. For more information from the Ohio Department of Health, go to http://www.odh.ohio.gov/en/odhprograms/dis/orbitdis/ebola/Ebola

The AMCNO will continue to update our website and provide information to physicians regarding the regional response to the disease as it becomes available. Additional Ebola resources are posted on our website at www.amcno.org.



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