THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO
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AMCNO Reviews Doctor-Ranking Programs with Ohio Attorney General

In October of last year, New York State Attorney General Andrew Cuomo and CIGNA reached an agreement to provide CIGNA members with more information on how it ranks physicians. Cuomo said the deal could set a national standard for physician-ranking systems. Cuomo warned other insurance companies that their physician-ranking programs likely would confuse or mislead members because of problems with the information used to rank physicians. Cuomo also warned UnitedHealth Group to cancel the launch of a similar program or face possible legal action. An agreement was finally worked out that avoided potential litigation between Cuomo and the insurers. Under the agreements, the plans will divide their preferred physician list into three lists — one that ranks by cost, one that ranks by quality and one that uses a combination of both measures. The agreements also require that the plans report to the NY Attorney General every six months and use an outside monitor.

Ohio Attorney General Marc Dann (left) discussed health insurance oversight issues with AMCNO Vice President of Legislative Affairs, ***John A. Bastulli, MD.***

Late in 2007, the AMCNO wrote Ohio Attorney General Marc Dann and indicated that AMCNO leadership has been reviewing this issue. In our letter, we noted Dann's comments to the AMCNO Legislative Committee in April 2007 where Dann stated that he had concerns regarding health insurers and market power. The AMCNO told the AG that if discussions were to take place in the future about adding additional regulations for health insurers in Ohio our organization would like to be involved in this debate.

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AMCNO Meets with CMS Leadership Regarding Electronic Health Record Project

On February 20th, AMCNO staff and physician leadership joined healthcare representatives from area hospitals, health departments and businesses at a meeting with the Center for Medicare and Medicaid Services (CMS) Acting Director Kerry Weems to discuss a new CMS electronic health record (EHR) demonstration project. The meeting was held at the MetroHealth Medical Center, and was hosted by the Aligning Forces for Quality Northeast Ohio Collaborative.

AMCNO physician members spend a moment with Kerry Weems, Acting Director of CMS. Left to right – ***George E. Kikano, MD,*** *AMCNO past president, Mr. Weems,* ***Ronald A. Savrin, MD,*** *AMCNO past president, and* ***Lawrence E. Kent****, AMCNO board member.*

This CMS project is an effort to encourage physician practices to adopt and use electronic health records (EHR) in order to improve the quality of patient care. The project will provide incentives to primary-care physician practices that use EHRs to improve quality as measured by their performance on specific clinical quality measures. The goal of this CMS demonstration project is to revolutionize the way health care data is managed, producing better health outcomes and greater patient satisfaction.

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ADDRESS SERVICE REQUESTED

AMCNO Reviews Doctor-Ranking Programs with Ohio Attorney General *(Continued from page 1)*

AMCNO representatives met again with AG Dann in 2008 to discuss the ranking issues. Although state law in New York differs from law in Ohio, the AMCNO asked for Mr. Dann's input on these agreements — in particular on the plan to provide reports to the NY AG every six months and the use of an outside monitor to assure compliance of the plans. During this meeting, the AMCNO voiced our concern that doctor-ranking programs can be confusing and have the potential to steer patients from quality providers to the least expensive providers. Mr. Dann stated that he would like to discuss this matter further with the Ohio Department of Insurance in an effort to explore whether or not Ohio would be able to incorporate similar consent agreements with health plans in this state, inclusive of plan oversight to assure compliance and/or if this matter merits the introduction of legislation to achieve these goal.

The Ohio AG also mentioned his current initiative regarding hospital charity care. The Ohio AG has a Charitable Advisory Council that is set up by statute with eleven members. AMCNO representatives have attended two of these meetings and the focus of the council seems to be on charitable institutions generally and not hospitals specifically. There is not a physician currently on the Council but the Ohio AG's office has had an initial conversation with the AMCNO about the AMCNO serving as an Ad Hoc member of the Council. The AG plans to set up a work group to specifically address the issue of hospital charity care and he believes that there will also be a need for physician involvement in these discussions. The AMCNO plans to follow up with the Attorney General Dann and his staff on both the health plan and charitable care issues and remain involved in these discussions. ■

AMCNO Meets with CMS Leadership Regarding Electronic Health Record Project *(Continued from page 1)*

The demonstration project is designed to show that widespread adoption and use of EHRs will reduce medical errors and improve the quality of care for an estimated 3.6 million consumers. Over a five-year period, the project will provide financial incentives to as many as 1,200 small- and medium-sized primary-care physician practices that use certified EHRs to improve quality as measured by their performance on specific clinical quality measures. Participating practices will be required to use electronic records to perform specific functions, such as clinical documentation and ordering prescriptions. While the core incentive payments to practices will be based on performance of the quality measures, the bonus will be based on how well integrated the certified EHR is in managing patient care. Total payments under the project may be up to $58,000 per physician or $290,000 per practice.

The meeting in Cleveland was an opportunity for physicians and community leaders to learn more about the project and to determine if the project could be applied in our community. The Department of Health and Human Services will soon open an application period for communities interested in becoming one of the pilot program's 12 sites. The intent is to engage entire communities in identifying primary-care physician practices to participate in the demonstration and to support the efforts of these physician practices. CMS will focus on locations where the demonstration may enhance existing or planned private sector projects related to health information technology and quality reporting initiatives. Eligible communities will include those that can demonstrate active community stakeholder collaboration as well as private sector support; are geographically large enough to have a sufficient number of primary-care physician practices; and are not already participating in a CMS demonstration that conflicts with the EHR project. CMS expects that the demonstration will start with four communities in 2008, with the remainder beginning in 2009.

The AMCNO physician representatives present at the meeting will continue to be involved in the discussions regarding this project in the coming months. To learn more about the new EHR demonstration project, visit: http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/2008_Electronic_Health_Records_Demonstration.pdf ■

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Membership Surpasses 5,000 Physicians

The AMCNO is pleased to announce the addition of the University Hospitals Medical Group (UHMG) and the University Hospitals Medical Practices (UHMP) to our membership roster bringing our membership total to over 5,100 physicians. The physician leadership of the AMCNO welcomes both groups to the organization. The AMCNO is also pleased to once again welcome the Cleveland Clinic main campus group to our membership roster for 2008 as well as the many other individual and group members from across the Northern Ohio region.

Reaching a membership total of over 5,100 physicians establishes the AMCNO as one of the largest regional medical associations in the country and strengthens our ability to advocate on behalf of the physicians in Northern Ohio.

The Academy of Medicine of Cleveland & Northern Ohio is the only regional medical organization that represents the interests of physicians in the Northern Ohio community. We are the VOICE of physicians in Northern Ohio — an organization with a rich history of working on behalf of physicians and the patients they serve for over 180 years — a legacy equaled by no other physician organization in Ohio.

The AMCNO thanks all of our members for their support now and into the future. There is strength in numbers — if you know of a colleague who is not currently a member of the AMCNO please encourage their membership in the organization. For more information on membership, please contact Linda Hale at the AMCNO offices at (216) 520-1000, ext. 101. ■

Northeast Ohio Physician's Pay Higher Premiums

Jerry M. Crawford, Director of Regional Sales, The Premium Group, Inc.

Everyone, including the Ohio Department of Insurance (ODI), agrees that medical malpractice insurance rates have trended downward throughout Ohio. However, there is no disputing the fact that physicians pay a higher premium to practice in Northeast Ohio. We will look at key statistics included in the ODI's January 2008 report "Ohio 2006 Medical Liability Closed Claim Report" and evaluate the information that pertains specifically to Northeast Ohio, comparing that to statistics that reflect experience in the rest of the state.

A brief overview of 2006 shows:

- Actual changes in medical professional liability insurance results brought Ohio increased competition in the insurance industry.
- Insurance carriers reported that claims frequency continued to trend downward.
- The percentage of medical malpractice cases resolved without indemnity payments increased.
- The medical malpractice insurance market is financially secure in Ohio.

Ohio, specifically, reaped the benefits of a competitive market. The Ohio Department of Insurance recently reported that carriers took an average rate decrease of 10.9% in 2007. The combination of insurance companies' willingness to take premium reductions as well as offer additional discounts and credits provided Ohio physicians with a bit of relief on the heels of a hard market and several years of rate increases.

There is, however, a difference in the overall results and experiences of physicians in Northeast Ohio. Tables 1 and 2 compare the closed claims and paid indemnities for 2005 and 2006.

Although the figures indicate that the percentage of claims with paid indemnity and defense costs coming from Northeast Ohio decreased from 51% (of the entire state) in 2005 to 46% (of the entire state) in 2006, there is more to the story. First, Northeast Ohio is still the unwilling recipient of almost 50% of the total costs of medical liability claim results for the entire state. Secondly, a more impressive indication of the difference in Northeast Ohio is discovered when evaluating the $42,691,478 of loss expense (ALAE); this is the cost to defend claims in Northeast Ohio. The average ALAE cost of claims within Northeast Ohio is $26,952 while the remainder of the state averages $23,862; the difference is almost 12% higher in Northeast Ohio. This is obviously going to impact the cost of liability insurance premiums that physicians will experience in Northeast Ohio as carriers look to balance expenses with income.

- Average cost of claims with ALAE in Northeast Ohio: $26,952
- Average cost of claims with ALAE in the rest of the state: $23,862
- Average difference representing increased costs in NE Ohio: $ 3, 090
- Percentage difference representing increased costs in NE Ohio: 12%

Another difference to note is in the dollar total of ALAE claims in Northeast Ohio; this total shows that Northeast Ohio increased from 47% of the state in 2005 to 48% in 2006. This was despite reductions in the total number of claims by 21% in all of Ohio and 26% in Northeast Ohio.

To illustrate the impact of these costs on physicians in Northeast Ohio, let us look at the costs the physician may incur.

TABLE 1

	Ohio 2005	Northeast Ohio	N.E. Ohio %
Closed Claims	5,051	2561	51%
Claims with Indemnity Payout	1,046	492	47%
Paid Indemnity (to claimants)	$ 281,764,938.00	$ 146,129,183.00	53%
Claims with Investigation and Defense Costs (ALAE)	4831	2383	51%
ALAE - cost	$ 113,194,555.00	$ 53,265,564.00	47%
Total of Indemnity and ALAE	$ 394,959,503.00	$ 202,394,747.00	51%

TABLE 2

	Ohio 2006	Northeast Ohio	N.E. Ohio %
Closed Claims	4,004	1996	47%
Claims with Indemnity Payout	784	377	47%
Paid Indemnity (to claimants)	$ 228,735,572.00	$ 101,699,092.00	44%
Claims with Investigation and Defense Costs (ALAE)	3433	1584	46%
ALAE - cost	$ 88,131,139.00	$ 42,691,478.00	48%
Total of Indemnity and ALAE	$ 316,866,711.00	$ 144,390,570.00	46%

Table 3 (see next page) depicts the difference in medical malpractice insurance premiums between Cuyahoga County and the remainder of the state. The figures used in this table show the base filed rates of a variety of carriers and do not reflect any potential discounts or credits which may be realized when working with a qualified agent. These actual rates are filed with the Ohio Department of Insurance by admitted insurance companies. For purposes of example, we have used the largest differences in a few common specialties.

As Table 3 indicates, a physician in Cuyahoga County could pay as much as 64% more for their medical malpractice insurance than their colleagues in other areas of the state. Are the rates in Cuyahoga County justified? Our brief look at the statistics in the 2005 and 2006 Ohio Medical Liability Closed Claim Reports supports the reasons that carriers submit, and the department of insurance approves,

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Northeast Ohio Physician's Pay Higher Premiums

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rates that result in Northeast Ohio physicians paying higher premiums.

On a more global scale, the American Medical Association has, for years, included Ohio on its annual list of medical liability crisis states. And even though the AMA has softened their rating of Ohio this past year, a quick study of the data above indicates that Northeast Ohio, as compared to the state as a whole, is a more expensive jurisdiction (from a medical liability cost standpoint) to practice medicine; the number of claims, indemnity payouts and defense costs are higher than in any other area of the state.

The good news is that the medical malpractice insurance industry, as a whole, is in excellent financial shape; this leads to increased capacity and an appetite for new business. The caveat is that physicians in Northeast Ohio need to be much more diligent in understanding the reasons for the medical malpractice insurance premiums they are charged. Northeast Ohio physicians need to work closely with their associations, their malpractice insurance agency and, more specifically, their agent who has the capability and drive to diligently pursue the best solutions for their insureds. Additionally, these physicians should continue to vote for representation that will support them in their quest to reduce costs and increase reimbursements to acceptable levels.

TABLE 3

Specialty	Cuyahoga County	Remainder of State	Difference
Family Practice	$ 24,383.00	$ 15,755.00	65%
Internal Medicine	$ 28,747.00	$ 18,566.00	65%
OB/GYN	$ 128,881.00	$ 82,184.00	64%
Orthopedic Surgery (no spine)	$ 81,800.00	$ 53,273.00	65%
General Surgery	$ 93,254.00	$ 59,794.00	64%
Gastroenterology (minor surgery)	$ 37,569.00	$ 24,116.00	64%
Anesthesiology	$ 38,138.00	$ 23,948.00	63%

*The above premiums represent specific insurance carriers and do not represent the market in its entirety.

The Premium Group, Inc. continuously strives to support the physicians in Northeast Ohio. We have been instrumental in bringing two new "A" rated carriers and a new program as a partner with an "A" rated carrier to Ohio in the last six months alone. The Premium Group, Inc. continues to pursue standard and alternative options for physicians throughout Ohio. If you have any questions, or would like further information regarding this article, please contact The Premium Group, Inc., (440) 542-5020.

Editor's Note: This article illustrates that although tort reform does work, the landscape for physicians practicing in Northeastern Ohio has not changed. This data clearly shows that physicians in our region are still paying some of the highest medical malpractice rates in the state and that the majority of the claims are in Northeast Ohio. The AMCNO believes that there is still more work to be done to alter the medical liability trends in Northeastern Ohio. The AMCNO plans to continue to work toward finding an alternative to the current tort system in Ohio if possible. ■

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Correction: In the January/February issue of the *Northern Ohio Physician* magazine in an article regarding the AMCNO mini-internship program, Dr. Shashidar Kusuma was incorrectly identified in a photo caption. AMCNO regrets the error.

CLASSIFIEDS

The Ohio Department of Insurance (ODI) Plans Statewide Sessions to Consider Minimum Coverage for the Uninsured

ODI to Arrange Sessions Around Ohio using the CHAT model (Choosing Health Plans Altogether).

Last summer, AMCNO leadership and staff met with the Director of the Ohio Department of Insurance (ODI) Mary Jo Hudson and her health care staff to begin preliminary discussions on the issue of health care reform and the uninsured. At this meeting, the Director of ODI provided detailed information on how the ODI and interested stakeholders from around the state were to be involved in a review process of health plans for the uninsured in the state of Ohio.

At that time, the AMCNO queried the Director and her staff as to whether or not the ODI or the Governor of Ohio planned to survey the uninsured as a part of this study; since it would seem imperative to have data from not only the key stakeholders such as physicians, hospitals, and insurers, but also from the individuals who stood to benefit the most from the implementation of a statewide health plan — the uninsured.

To assist in this endeavor, the AMCNO representatives pointed to a study completed by the California Healthcare Foundation Commission. The Commission conducted a survey of uninsured patients at the federal poverty level of one to 300 percent to seek input on the health policy issues and coverage that would affect the uninsured. The data revealed that the uninsured placed a high priority on preventive care and establishing continuity with a small group of physicians in a medical home concept in order to reduce the need for emergency room visits. The survey also revealed the level of co-payments and premiums that would be acceptable to these individuals. ODI had not considered such a survey and requested more information. As a follow-up the AMCNO sent the data and information to the ODI and asked that the AMCNO be considered as a participant in future discussions on this issue.

As a result of our input, the AMCNO was invited to participate in the "Just Coverage Leadership Session" sponsored by the ODI in early 2008. The purpose of the session was to query the community, healthcare and policy leaders who are: considering coverage expansion proposals, assessing healthcare priorities and trade-offs and fostering team building and collaboration on the topic of health care for the uninsured.

A key component of this session is for the participants to design a basic benefits package using a computer-based game program called CHAT (Choosing Health Plans Altogether) — a game about insurance. In two-hour meetings of between 10-15 people, participants design healthcare benefits packages in separate rounds: one is completed on your own based upon your experiences; the second round is done in groups with an opportunity to discuss options, and the last round is conducted with the entire group creating a basic benefit plan that all of the participants agree upon. For this exercise, participants were told to assume that health care coverage would be mandated for individuals without employer-based coverage, and that the plan they were going to design was to be available only to adults without insurance and would not include the Medicare population or children.

Built into CHAT's design is the need to make trade-offs, reflecting the realities of today's environment. For example, CHAT participants had only 50 "markers" to spend among 16 categories of healthcare services, but there were over 80 places to put them. Participants had to weigh various limitations — increased cost-sharing, restricted choice, less convenience and reduced services — as they considered the range of options. A Health Event Lottery presented participants with medical scenarios, depicting common and uncommon illnesses and accidents. These events illustrated the services and cost consequences of participants' coverage decisions. Each CHAT group had to reach consensus in designing a common benefits package, a process requiring negotiation and compromise.

This "Just Coverage Leadership Session" was intended to bring together leaders from around the state to go through the CHAT process and learn how the CHAT game works. The next step planned by the ODI is to obtain a license for the usage of the CHAT model. Once that license is obtained the ODI plans to take the CHAT process around the state in an attempt to obtain broad-based input from key stakeholders in order to use the data to develop a health care plan in Ohio. ODI plans to meet with and conduct CHAT sessions in specific regions of the state, including Northern Ohio, with the intention of involving healthcare leaders, legislators, small businesses, and, most importantly, the uninsured in the CHAT process. The information obtained from these statewide sessions will be utilized by the ODI as they continue their review of healthcare coverage reform in Ohio.

The AMCNO is pleased to be a participant in this process and applauds the ODI for making the decision to obtain additional information from key constituents, in particular the uninsured population. The AMCNO is planning to work closely with the ODI to assist them in setting up CHAT sessions in the Northern Ohio region with key stakeholders from the healthcare sector. The AMCNO also plans to work with other groups to arrange sessions with legislators, small businesses and the uninsured.

For more information on this initiative, please contact AMCNO staff Ms. Elayne R. Biddlestone at (216) 520-1000, ext. 100. ■

AMCNO representatives meet with the Ohio Department of Insurance (ODI) to Review Health Care Models

*AMCNO physician leadership with ODI representative Mr. Douglas Anderson. Left to right – **John A. Bastulli, MD,** Mr. Anderson, and **James S. Taylor, MD,** AMCNO president.*

The State of Ohio, under the auspices of Governor Strickland and the Ohio Department of Insurance is reviewing various types of health care "reforms" to further the Governor's goal of significantly reducing the number of uninsured citizens in the state. The healthcare coverage reform goals are: 1. To provide access to affordable health insurance coverage to all uninsured Ohioans with an initial goal of providing coverage to 500,000 more Ohioans by 2011; 2. To increase the number of small employers who are able to offer coverage to their workers.

The Governor has engaged myriad stakeholders in an open transparent process to get an idea on how to best cover the uninsured in Ohio. The AMCNO is an active participant in the review of health care models for Ohio. Ohio has received a grant from the Robert Woods Johnson Foundation for a "coverage institution" — to come up with effective reforms. The Ohio team consists of 12 representatives, including several legislators. In addition, ODI has also hired an actuarial group to conduct an actuarial study to review the alternatives for coverage reform.

Over the last few months, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has been meeting with the Ohio Department of Insurance (ODI) regarding their health care coverage reform initiative. We have learned that systems in use in Massachusetts and New York are among those getting a close look from the actuarial firm and an economist under contracts with the state. The review, overseen by the Department of Insurance and funded through a $500,000 budget line item, is a component of the Governor's Healthcare Coverage Reform Initiative.

Information gleaned by the Dallas-based Lewis & Ellis firm and economist Ken Thorpe, of Emory University in Atlanta, will ultimately be employed by the 12-member committee to craft recommendations to the governor and General Assembly on how to best address the estimated total of more than 1.2 million residents, or about 11% of the state's population, who lack health insurance.

ODI representatives believe that the new data will provide policymakers with a general update of Ohio's current situation. Researchers are expected to report back to the state in the near future. The refinement of recommendations will follow, with the timetable dependent on the nature of the findings and other factors. The health care study committee plans to review the following:

- The Connector Model employed by Massachusetts, which is a public/private program under which the state sets rules for benefits and rates while subsidizing lower-income residents.
- A "reinsurance" program for small employers and individuals, or stop-loss system under which the state puts up a portion of the claims, patterned after the Healthy New York initiative.
- A system with rates and coverage set by the state that requires insurance companies to offer basic benefit plans and includes mandates on workers.

Additionally, the health care reform committee is considering the state employee system as a model for health care along with a variety of other insurance law changes aimed at improving affordability. The plan is to develop recommendations that can be reviewed and then develop a plan in order to prepare legislation to accomplish the goals. There is no distinct deadline for the introduction of legislation; however, ODI hopes to have some results from the actuarial firm by early 2008 as to how the various reform scenarios could impact coverage. Researchers are expected to report back to the state in the near future. The AMCNO will continue to work with the stakeholders and groups involved in this initiative and report back to our membership.

Editor's Note: Recently the ODI responded to a request from the AMCNO that the ODI consider surveying the uninsured as a part of their health care reform initiative in order to obtain detailed information from this population on their viewpoint. The ODI has decided to proceed with this initiative. For more information go to page 5 of this issue. ■

Anthem Partnership Plan for Covered Families and Children (CFC) State Contracts Comes to an End

The Bureau of Managed Health Care (BMHC) has notified the AMCNO that Anthem Blue Cross/Blue Shield (BC/BS) intends to end its provider agreement with the Ohio Medicaid Program and will no longer serve Medicaid consumers in the Covered Families and Children (CFC) managed care program effective March 31, 2008. Anthem will, however, continue to serve Aged, Blind and Disabled (ABD) Medicaid consumers without any interruption.

This change WILL IMPACT physicians and their Medicaid patients in Northeast Ohio region because Anthem has 87,011 Medicaid consumers listed as members in this region. Other regions affected include the Central and Northwest regions of the state.

Plans are underway by the Ohio Department of Jobs and Family Services (ODJFS) to notify Anthem members to assist them in transitioning to new health plans in their region. ODJFS plans to send a notification letter to the 87,011 Northeast Ohio Anthem members on February 25, 2008, with a reminder letter to be sent out on March 10, 2008. The anticipated enrollment transition date is April 1, 2008.

For members who do not make an affirmative choice of a new managed care plan, ODJFS will automatically assign them to the managed care plan (MCP) with the best overlap with their historic relationships with primary care providers. Any member who is dissatisfied with the auto-assignment to an MCP may switch within 90 days by contacting the Ohio Medicaid Managed Care Enrollment Center at 1-800-605-3040. Currently there are two other MCPs operating in the Northeast Ohio region that Anthem Medicaid consumers may choose from at this time — CareSource and WellCare.

Anthem has issued a news release indicating that continuity of care will be the responsibility of the receiving MCP. The new MCP and providers may contact the Anthem Partnership Plan for assistance with CFC Medicaid patients who require a continuity of care plan for qualifying conditions. Contacts may be made to the Anthem Utilization Management Department at 1-866-896-6580.

Anthem will continue to reimburse providers for eligible CFC Medicaid claims with dates of service up to and including midnight of March 31, 2008. Service dates beginning April 1, 2008 will be the financial responsibility of the members' newly assigned MCP.

If you have Medicaid patients in your practice who are currently enrolled in Anthem you may wish to review whether or not your practice is also contracted with one of the other MCPs still operating in the Northeast Ohio region.

Questions Raised by AMCNO

The AMCNO contacted ODJFS because of our concern about continuity of care issues as Anthem Blue Cross Blue Shield Partnership Plan (Anthem) exits from the Covered Families and Children (CFC) Managed Care program in the Northeast Ohio market. The AMCNO queried the ODJFS about how they planned to assure a smooth transition regarding the continuity of care for Anthem members, and more specifically how the ODJFS planned to respond when an Anthem member was seeing a physician(s) not currently a part of either of the remaining health plan's networks.

The ODJFS responded to the AMCNO that their department is aware of the need to assure the smooth transition of members from Anthem to the remaining CFC-participating plans in the Northeast Region, CareSource and WellCare. In terms of continuity of care, the ODJFS informed that AMCNO that a number of things are happening to help with this transition. ODJFS stated that both CareSource and WellCare are working to expand their healthcare networks to increase the overlap of network providers. ODJFS hopes that this activity will allay concerns about CFC consumers who may be seeing providers who are not currently in either of the networks. The ODJFS is hopeful that by the time the consumer is required to select a new plan, their provider of choice may be participating with one or more of the remaining health plans.

In addition, as the ODJFS begins the process of permitting CFC consumers to choose a new plan, the ODJFS has implemented an assignment algorithm that looks for previous experience with a primary care provider. In the event the CFC consumer does not make a new health plan choice and that person is then assigned to a new plan, the algorithm will make its best attempt to assign the consumer to health plan which includes in its network a primary care provider(s) with whom the member has had previous experience.

Another step in the ODJFS continuity of care transfer process will occur once the enrollment transfer is complete. The ODJFS plans to share with Anthem information regarding those health plans to which their CFC membership is being transferred. Anthem will then be responsible for sharing with the new health plan information on outstanding scheduled treatments, prior authorizations for: a) private duty nursing; b) durable medical equipment; c) home care services; d) pharmacy; e) vision; f) dental; and g) prenatal care services for members in their third trimester of pregnancy, and those members who were under case management. The ODJFS expects that whenever possible, the Anthem information will identify the authorized provider for prior authorized services.

And finally, the ODJFS has informed the AMCNO that as a consumer-driven fail safe mechanism, members will continue to have the right to change their health plan selection within the first 90 days of enrollment should they wish to do so. The ODJFS noted they are confident these activities and processes will help assure a smooth transition for affected Anthem members who are required to select a new health plan. Physicians should remember that Anthem will continue as a participating health plan in the ABD managed care program.

The AMCNO will continue to monitor this situation for our members as the transition process moves ahead over the coming months. If AMCNO member have questions or concerns, contact the AMCNO and we will bring these issues to the attention of the ODJFS. ■

amcno
THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

Medical Records Fact Sheet Update Effective January 2008

Retention of Medical Records

Medical considerations are the key basis for deciding how long to retain medical records. Rules relating to the maintenance of patient records are to be found in the American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics. Current Opinion **7.05.** Under Ohio Law (R.C. §**4731.22 (B)(18)**), violations of the AMA ethical rules can result in disciplinary action by the Ohio State Medical Board. Most states, including Ohio, do not have a general state law that requires records be kept for a minimum length of time. Ohio Revised Code §**2913.40 (D)** mandates the retention of records associated with Medicaid for a period of at least six (6) years after reimbursement for the claim is received by the physician. It is recommended that records relating to a Medicare patient be kept for at least six (6) years after the physician received payment for the service. Medicare's Conditions of Participation requires five (5) year retention. Managed care contracts should be consulted to see if they provide any specified period of retention of medical records. In all cases, medical records should be kept for the length of time of the statute of limitations for medical malpractice claims. Under Ohio Law an action for medical malpractice must be brought within one year after the cause of action "accrues" (R.C. §**2305.113**). However, there are various exceptions or special rules. For example, the statute of limitations in wrongful death cases is two years after the date of death. In the case of a minor, the statute of limitations does not begin to run until the minor has reached his or her 18th birthday. The statute can be "tolled" or otherwise extended in other situations, and the date on which a cause of action "accrues" can vary. As a practical matter, all of this makes it difficult to define the Ohio statute of limitations with absolute certainty. If you are discarding or destroying old records, patients should be given the opportunity to claim the records or have them sent to another physician. The AMCNO recommends that physicians keep medical records indefinitely, if feasible.

Update on Charging for Copies of Medical Records

A physician who treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient, or, except in limited circumstances, refuse to make them available to the patient or a patient's representative (not an insurer). A written request signed by the patient or by what the law refers to, as a "personal representative or authorized person" is required. Ohio Revised Code §**3701.74** obligates a physician to permit a patient or a patient's representative to examine a copy of all of the medical record. An exception arises when a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, in which case the physician is to provide the record to a physician chosen by the patient. Medical records should not be withheld because of an unpaid bill for medical services. Ohio law establishes the maximum fees that may be charged by health care provider or medical records company that receives a request for a copy of a patient's medical record. Ohio law provides for certain limited situations in which copies of records must be provided without charge, for example, where the records are necessary to support a claim by the patient for Social Security disability benefits. EFFECTIVE JANUARY 2007, the maximum fees that may be charged, are as set forth below.

(1) The following maximum fee applies when the request comes from a patient or the patient's representative.

a) No records search fee is allowed;
b) ***For data recorded on paper:*** $2.74 per page for the first ten pages; $0.57 per page for pages 11 through 50; $0.23 per page for pages 51 and higher
For data recorded other than on paper: $1.87 per page
c) Actual cost of postage may also be charged

(2) The following maximum applies when the request comes from a person or entity other than a patient or patient's representative.

a) A $16.84 records search fee is allowed;
b) ***For data recorded on paper:*** $1.11 per page for the first ten pages; $0.57 per page for pages 11 through 50: $0.23 per page for pages 51 and higher
For data recorded other than on paper: $1.87 per page
c) The actual cost of postage may also be charged

Ohio Law requires the Director of Health to adjust the fee schedule annually, with the adjustment to be completed no later than January 31st of each year to reflect an increase or decrease in the Consumer Price Index over the previous 12-month period. If you have any questions regarding this fact sheet or other practice management issues, please contact the AMCNO at (216) 520-1000 ext 103.

How to Manage Legal Issues

Impacting the Practice of Medicine

Wednesday, April 2, 2008 – Lakewood Country Club, or
Wednesday, April 9, 2008 – Mayfield Country Club
5:00 p.m. – 8:30 p.m.

Jointly sponsored by:

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THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

AMEF
Academy of Medicine Education Foundation

Program Format

5:00 p.m. – 6:00 p.m.
Dinner

6:00 p.m. – 6:30 p.m.
Current trends in Malpractice Allegations and Risk Management
Joe Farchione, Esq
Sutter, O'Connell and Farchione Co.

6:30 p.m. – 7:00 p.m.
Practice Pitfalls – HIPAA Compliance and Informed Consent Issues
Edward Taber, Esq.
Tucker, Ellis & West LLP

7:00 p.m. – 7:30 p.m.
Electronic Health Records/Technology Issues and Patient Communication
Amy Leopard, Esq.
Walter & Haverfield LLP

7:30 p.m. – 8:00 p.m.
Stark III Compliance
Marilena DiSilvio, Esq.
Reminger & Reminger Co., L.P.A.

8:00 p.m. – 8:30 p.m.
Panel Discussion/Question and Answer

Call (216) 520-1000 for more information or to register by phone or visit our Web Site at www. amcnoma.org.

Meet the Presenters

JOE FARCHIONE has been defending health care professionals for over twenty years. His firm is dedicated exclusively to the defense of medical malpractice claims and suits.

EDWARD E. TABER is a partner in the Cleveland office of Tucker Ellis & West LLP. His focus is on litigation including medical malpractice, pharmaceutical litigation, products liability, business litigation, toxic tort and legal malpractice.

AMY S. LEOPARD is a partner at Walter & Haverfield LLP and a member of its management committee. She counsels physicians, group practices, and entrepreneurs on licensing, payment, regulatory and technology issues.

MARILENA DISILVIO began her career as a registered nurse, which makes her an invaluable leader in Reminger & Reminger Co., LPA's Medical Malpractice and Healthcare Law Practice Group. Marilena has significant experience in the representation of healthcare providers and healthcare facilities.

REGISTRATION FORM

____ **April 2, 2008**
Lakewood Country Club
2613 Bradley Road
Westlake, Ohio 44145

____ **April 9, 2008**
Mayfield Country Club
1545 Sheridan Road
S. Euclid, Ohio 44121

Name_____

Address_____

City_____

State_____ Zip_____

Phone_____

Fax_____

FEES:
$15.00 – Residents/Medical Students
$35.00 – AMCNO Members
$50.00 – Non-member Physicians/Staff

Return this form with your check made payable to The AMCNO and mail to: AMCNO, 6100 Oak Tree Blvd, Ste. 400, Independence, Ohio 44131

You may also fax back this form with a credit card payment. Fill in the information below and fax to (216) 520-0999.

MasterCard _____

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Expiration Date of Card_____

LEGISLATIVE ISSUES

By Michael Wise, JD, AMCNO Lobbyist
McDonald Hopkins, LLC

Ohio Politics

The big news in Ohio was the Governor's recent announcement that Ohio is facing almost a billion dollars in deficits for the next fiscal year. Ohio's fiscal year begins on July 1, 2008 and the runs through June 30, 2009. Cuts have already been announced and there will likely be legislation this spring to finish balancing the budget. The budget reduction will be realized from cost savings, management strategies, program cuts and operating efficiencies, Governor Strickland said. The job cuts will come from not filling vacant positions, early retirements and layoffs. If budget conditions worsen, Strickland said he would tap into the state's $1 billion rainy day fund to cover any budget shortfall. Among the biggest budget reduction is $67 million from the Department of Job and Family Services, which administers the state's Medicaid program. Of importance to Ohio physicians, however, is the decision by Governor Strickland to increase Medicaid reimbursement rates to physicians by 3% beginning July 1, 2008. With the budget issue looming it may be difficult to pass meaningful legislation from now through 2008.

SB 59 – Mandatory Arbitration and Medical Malpractice Rates

In February 2008, the American Medical Association (AMA) unveiled new research that proves medical liability reforms such as caps on noneconomic damages are effective in lowering medical liability premiums, resulting in an increased supply of physicians to care for patients. In states without reforms, many physicians are forced to make difficult practice decisions to limit the care they provide simply because they can't afford to pay sky-high medical liability premiums driven-up by escalating jury awards. Regardless of the case's merit, runaway jury awards for non-economic damages can reach millions of dollars, driving up premiums and putting access to care at risk for patients. The AMA supports caps on the noneconomic damages of jury awards, and unlimited payments for economic damages. While premium rates have largely stabilized, they remain at the highest levels in history.

The AMA research is supported by the recent report from the Ohio Department of Insurance on medical malpractice claims (see page 3 for related story). However, Northeast Ohio continues to trend behind the rest of Ohio. Because of this fact, the AMCNO continues to push for a pilot mandatory arbitration program that would focus on Northeast Ohio. However, the fact that attorneys have come out in full force against the Bill in conjunction with the current political landscape in Ohio, SB 59 has stalled. This situation may put the brakes on the Bill for this General Assembly. Senator Coughlin is attempting to broker a compromise and we will report on those results next issue.

Judicial Branch Issues

The Ohio Supreme Court (OSC) recently upheld the constitutionality of a law that limits the amount of damages that may be awarded to injured persons who win product liability lawsuits. Justices said in a 5-2 opinion that caps on noneconomic and punitive damages do not violate a right to jury, due process, equal protection, or the single subject rule of the Ohio Constitution. Chief Justice Moyer wrote the lead opinion and concurring were Justices Evelyn Stratton, Maureen O'Connor, Judith Lanzinger, and Robert Cupp. Justice Terrence O'Donnell dissented in part. Justice Paul Pfeifer dissented.

What Justice Moyer did in this case (known as the Arbino case) is to raise the bar for future courts. His opinion reviews all of the previous tort reform activity in the Ohio Supreme Court, cases that made the foundation for the Arbino ruling. Moyer is trying to force future courts to either uphold Arbino or have to rule unconstitutional a whole line of previous cases. Justice Moyer is telling future courts that in order to invalidate Arbino, they will have to also ignore *stare decisis.* This term is Latin and means to "stand by that which is decided." Nothing is foolproof or forever in the law but Justice Moyer and the four justices do their best to protect this opinion.

Although this decision does not involve medical malpractice caps or claims as noted above this opinion could have an impact on this type of case in the future. More than a dozen organizations filed friend of the court briefs on behalf of plaintiffs and defendants in the case. The AMCNO supported enactment of the limits and was listed along with others as a member of the Ohio Alliance for Civil Justice (OACJ) on their Amicus Brief.

Key Legislation

House Bill 125 –
the Healthcare Simplification Act
The intent of this bill was to implement reforms that would provide for ease in the health insurance contracting process, fairness in contracting, a standardized credentialing process and Web-based eligibility verification. However, after many hearings and interested party meetings, the Bill has been changed radically since it was first introduced.

Interestingly, the Ohio Manufacturers Association (OMA) is now weighing in on HB 125. OMA believes that the Bill has the potential to cause major disruptions in the administration of Ohio health care plans — including self-insured plans. OMA states "this legislation dictates certain terms of the contracts between all types of medical providers (including hospitals) and contracting entities (i.e., insurance companies, third party administrators (TPAs), etc.). Even if they agreed to, providers and insurers would not be given the leeway to voluntarily negotiate those provisions mandated by the Bill. Proponents have drafted HB 125 with the intent to make it apply to employer-sponsored, self-insured plans typically protected from state mandates by ERISA preemption. If the Bill is not changed, OMA indicates that self-insured employers may be forced to go to court to stop the application of this Bill to their plans and TPAs. At press time, the Bill was still undergoing changes and more information on the Bill will be included in the next issue.

House Bill 456 – Ohio C.A.R.E.
A bill introduced by Representative Jim Raussen would require the state to subsidize health insurance claims for people with chronic medical conditions and offer tax

credits for poor adults that don't qualify for Medicaid. In February Rep. Raussen provided sponsor testimony on the legislation noting the key aspects of the bill, which includes provisions that would increase eligible age for family policy dependents from 22 to 29; offer BWC premium discounts to small businesses that don't offer insurance but meet certain criteria; subsidize the uninsured through tax credits for individuals and families; and focus reinsurance for the uninsured with chronic conditions into three categories.

The bill would also subsidize uninsured Ohioans below 100% of the federal poverty level that don't qualify for Medicaid; increase salaries for nursing instructors at state universities; expand the 340b Federal Drug Pricing Program in prisons; increase the role of public dentistry and allow more flexibility in providing services; require the Department of Education adopt nutrition rules and ban trans-fat from schools; increase purchasing of pharmaceutical benefits for state programs; and use and expand on the Governor's executive order for a Health Information Technology board.

Also included in the bill are changes in contracting language between Medicaid Managed Care companies, a request that nonprofit hospitals define charitable care/community benefits; a requirement that certain hospitals post their tax liability as compared to their charitable care on their Web site; and a requirement for ambulatory surgical facilities to annually report certain data to the Director of Health.

The reinsurance plan outlined in the bill is based on the Healthy New York model, and would define participants into three high-risk categories based on the severity of their preexisting conditions. The program would begin by targeting individuals with lower levels of risk that meet certain eligibility requirements. In addition, the state would offer "stop-gap coverage" by subsidizing claims between $15,000 and $50,000 annually, a measure in the bill that would enable people with chronic conditions to purchase private insurance. The state would have authority to audit the claims.

As far as the cost of the program goes, reinsuring claims for those with preexisting conditions would initially cost between $100-150 million to implement in fiscal year 2009 and once fully implemented would likely cost between $450-$500 million annually, but the cost would be limited to the amount the state collects through the tax on insurance premiums. Under the bill, the Ohio C.A.R.E. plan would provide tax credits of $2,500 per individual and $4,000 for families living below 100% of the federal poverty level that aren't eligible for Medicaid, he said. About 30% of the state's uninsured fall into that category.

The AMCNO plans to review the bill in detail and provide input on the legislation. The inclusion of wellness discount programs along with the provision to adopt nutrition rules in schools and eliminate trans-fat are important public health issues, however, other key issues in the bill that will warrant the attention of the AMCNO include the changes in contracting language between Medicaid Managed Care companies; the request that nonprofit hospitals define charitable care/community benefits; the requirement of certain hospitals to post their tax liability as compared to their charitable care on their Web site; the requirement that ambulatory surgical facilities annually report certain data to the Director of Health; as well as a need to review how the discounts on premiums will be implemented for BWC employers who offer health and wellness programs. Also of interest to the AMCNO will be the pilot program and advisory board that will be responsible for exploring the use of health information technology in Ohio. As the testimony on this legislation continues, the AMCNO will keep our members apprised of its' progress in the legislature.

AMCNO involved in legislative initiative on tobacco products tax

In keeping with the AMCNO goal to advocate for our members and their patients on public health issues the AMCNO has agreed to participate in a new legislative initiative known as the Investing in Tobacco-Free Youth Coalition. The Coalition has already begun their kick-off of a campaign to reduce the use of non-cigarette forms of tobacco. The group is dedicated to reducing the problem of non-cigarette tobacco produced, called "other tobacco products" (OTP). The group is seeking to make these products less appealing to youth by correcting the inequity between the OTP tax and the cigarette tax. The revenue generated would be used to fund youth and community tobacco prevention programs around Ohio whose long-term existence is now threatened.

When legislators increased the cigarette tax in 2003 and 2005, they failed to also raise the other tobacco products tax. The Coalition is asking the General Assembly to correct this error so that the other tobacco products tax equals 55% of wholesale price, equivalent to the current cigarette tax. (The current OTP tax rate is 17%.) The legislature should then link the other tobacco products tax to the cigarette tax, so that no corrections will be needed in the future. Statistics offered by the Coalition show that the correction would decrease the overall consumption of other tobacco products by over 13%, and cause a 25% reduction in use of these products by youths. While Ohio has seen a significant decrease in high school students' cigarette use from 2000 to 2006, there has been no similar reduction among this population for smokeless tobacco or cigar use, according to the Ohio Youth Tobacco Survey. Studies of Appalachian Ohio show that one-third of males use smokeless tobacco compared to the statewide male prevalence rate of seven percent.

The AMCNO has endorsed this concept and plans to participate as a member of the Coalition steering committee — which would entail offering in kind services through our lobbyist and staff. In addition, the AMCNO has been asked to participate in the Coalition's planned Advocacy Day in Columbus to educate legislators on the need for this type of legislation. For more information on this initiative contact E. Biddlestone at the AMCNO offices at (216) 520-1000, ext. 100.

The AMCNO has a comprehensive tracking system of all health care related legislation in the General Assembly. If you are interested in receiving a copy of this document, please contact Elayne Biddlestone at (216) 520-1000. In addition, AMCNO members should note that this issue of the magazine contains a copy of the most recent Legislative Directory prepared by the AMCNO lobbyists. Please keep a copy in your office for quick reference in the event you want to contact your area legislator. ■

SAVE THE DATE

The Academy of Medicine of Cleveland and Northern Ohio (AMCNO) invites you to attend our 2008 Annual Meeting

Friday, April 25, 2008

Ritz-Carlton Cleveland 1515 West Third Street

6 p.m. Reception • 7 p.m. Dinner

Black Tie Optional

Induction of the
2008-2009 AMCNO President,
Raymond J. Scheetz, Jr., MD

Presentation of 50 Year Awardees and Academy of Medicine Education Foundation (AMEF) Scholarships to medical students from Case School of Medicine, Cleveland Clinic Lerner College of Medicine and the Northeastern Ohio Universities College of Medicine.

AMCNO 2008 Honorees

John A. Bergfeld, MD
John. H. Budd MD
Distinguished Membership Award

George E. Kikano, MD
Charles L. Hudson MD
Distinguished Service Award

Victor M. Bello, MD
Clinician of the Year

Dale H. Cowan, MD
Special Honors Award

John D. Clough, MD
Outstanding Service

Jim Mehrling
Special Recognition

Please join us in congratulating our medical scholarship recipients and awardees on April 25th.

Health Information Technology, Health Insurance Exchanges, and Health Policy Research in Ohio Subject of Recent Policy Conferences

By Jason Sanford, Director of Communications, HPIO

Health information technology and exchange, health insurance exchanges, and the state of research in Ohio were the focus of several recent conferences hosted by the Health Policy Institute of Ohio (HPIO).

The first conference, "Health Information Technology & Exchange in Ohio: Where are we? Where are we going?" was held in Columbus in late October 2007. The conference brought together representatives from physician groups, businesses, hospitals, health plans, consumer groups, and more to both discuss and work toward common ground around health information technology (HIT) and health information exchange (HIE) efforts in Ohio.

HIT and HIE are a nationwide effort to promote the use of technology to improve medical care, reduce costs, and provide a more patient-centric focus to better health. According to reports, the adoption of effective HIT and HIE systems in the United States could help prevent up to 98,000 hospital patient deaths from avoidable medical errors each year while also saving hundreds of billions of dollars by eliminating unneeded and redundant medical tests and reducing administrative waste. To accomplish this, HIT and HIE would use technology systems to unite health providers, payers, and patients to ensure that everyone gets the right care at the right time. An example of an HIT and HIE initiative would be the creation of electronic health records, meaning patients would have access to their medical records no matter which physicians or hospital they go to.

The conference keynote speaker was Governor Ted Strickland, who discussed his recent executive order creating an Ohio health care information advisory board. The goal of the board is to reduce the growth in health care costs by improving the exchange of health information between providers and patients. The board will do this in part by working to implement the *Strategic Roadmap and Policy Options for the Effective Adoption of Health Information Technology and Exchange in Ohio* (which is available on HPIO's Web site).

The conference also focused on issues such as how health care consumers view HIT/HIE efforts, the health care quality and cost benefits of HIT/HIE, if a standard HIT/HIE permission form should be used around the state, and where HIT/HIE efforts will go in the coming years. In general, participants agreed that while they don't want the state government to run Ohio's HIT/HIE systems, they think it is vitally important that the state government and Ohio's different health care groups and organizations work together for system interoperability. Otherwise, Ohio could end up with a number of different HIT and HIE systems which are unable to communicate and interact with each other, thereby negating any positive benefits of using HIT and HIE.

Let's Talk About a Health Insurance Exchange: Is it Right for Ohio?

On January 7, 2008, HPIO held a short luncheon conference to discuss the viability of a Health Insurance Exchange in Ohio, which allows individuals, families, and businesses who lack access to large group heath insurance policies to still be able to purchase affordable health insurance.

Well over 100 healthcare and policy professionals from all over Ohio met in Columbus to see the presentation by Stuart M. Butler, Ph.D., and Edmund Haislmaier from the Heritage Foundation. The two speakers discussed how Health Information Exchanges could help substantially alleviate the number of Ohioans uninsured while returning control of health insurance, price sensitivity, authority, and quality to the consumers. They stated that this significant paradigm shift shouldn't increase the cost of health insurance, but rather simply change who makes what decisions and how.

The topic of a possible Health Insurance Exchange in Ohio was well received by all in attendance and will likely be considered by state policymakers and leaders in the foreseeable future. In addition, several national candidates for President have expressed interest in the idea.

Ohio Health Data and Research Conference

In December HPIO, in conjunction with the Health Foundation of Greater Cincinnati, hosted "Bridging Policy and Practice: The 2007 Ohio Health Data and Research Conference" in Columbus. This goal of the two-day conference was to enhance the application of Ohio-specific research and policy through exposure to health data sources and information contained within Ohio.

Topics covered included health systems data, health information technology, access to care, public health, mental health, health disparities, family violence, health surveys, and Medicaid. Among the specific issues discussed were policies around researching child health issues, the use of Geographical Information Systems for health research, the upcoming 2008 Ohio Family Health Survey, accessing Medicaid information and data, and more.

"We were pleasantly surprised to see such a strong turnout among so many policy leaders in the state," said Timothy Sahr, Director of Research at the Health Policy Institute of Ohio. "The conference was a first for Ohio in terms of so many policy people being exposed to professionals in the clinical health, preventative health, and political and private health sectors."

The conference concluded with a luncheon honoring the recipients of the 2007 Health Policy Institute of Ohio Awards for Health Policy Research. The winners were:

Dr. Lisa Simpson of the Cincinnati Children's Hospital Medical Center, Dr. Jeffrey A. Bridge of the Research Institute at Nationwide Children's Hospital, Ellen Yard of the Ohio State University College of Public Health and Dee Roth and the Ohio Department of Mental Health.

Editor's Note: The AMCNO is an active participant in HPIO events and meetings. The AMCNO will continue to ask the HPIO to provide our members with regular updates on the HPIO activities around the state of Ohio. ■

CMS 9th Statement of Work for Quality Improvement Organizations

By Ronald A. Savrin, MD, MBA

The Centers for Medicare & Medicaid Services (CMS) directs the activities of Medicare's 53 Quality Improvement Organizations (QIOs) by defining their Statement of Work (SOW). The 9SOW defines the QIO activities for the three-year period beginning August 1, 2008. In response to suggestions from the Institute of Medicine (IOM) and the Government Accountability Office (GAO), new goals and operational changes will be implemented. CMS has structured the 9SOW as a business model, seeking both a positive return on investment (ROI) and sustainability.

The 9SOW encompasses four themes: (1) Prevention, (2) Patient Safety, (3) Care Transitions and (4) Beneficiary Protection, with a total of 10 individual components. Of equal importance are three well-defined crosscutting priorities that must be integrated into all aspects of the 9SOW. The first priority is to reduce healthcare disparities. QIOs are required to set this priority as a defined goal, monitor the impact of their intervention on disparities of care, and take immediate action if such disparities increase (unintended consequences) rather than decrease. A second priority is the adoption of Health Information Technology (HIT) to yield a true healthcare "system" with interoperability and universal access. The third priority is the promotion of value driven healthcare (VDHC), defining, measuring and disseminating information on both quality and price. The QIOs will integrate these priorities into each of the following themes.

PREVENTION *(THREE COMPONENTS)*

1) Core Prevention – The prevention theme emphasizes evidence-based care and best-practices to prevent illness or detect disease in early, more effectively treatable, stages. This initiative has three distinct but related components.

Influenza Immunization – According to the Centers for Disease Control and Prevention (CDC), each year 5-20 percent of the population get the flu, over 200,000 hospitalizations are required for flu complications, and about 36,000 die from the disease (http://www.cdc.gov/flu/keyfacts.htm [accessed 1/29/2007]). Annual vaccination is effective in reducing the incidence of influenza and reduces both hospitalization and mortality. In 2005 only 48 percent of Ohioans 65 and older received influenza vaccination, and the rate was significantly lower (30 percent) in black than in white (50 percent) residents. Medicare covers annual flu vaccination for all Medicare beneficiaries.

Pneumococcal Pneumonia Immunization – The incidence of invasive pneumococcal pneumonia as reported by the CDC is over 50 per 100,000 in the 65 and older population, resulting in over 21,000 hospitalizations annually. Vaccination is recommended for all persons 65 years and older and for other at-risk populations. The penetration of pneumococcal vaccination in Ohio (1991-2005) was only 48 percent in the age 65 and over group and was higher in whites (49 percent) than in blacks (35 percent). Medicare pays for a pneumococcal vaccination for all beneficiaries.

Mammography – The risk of breast cancer increases with age, and the Surveillance, Epidemiology and End Results (SEER) Program estimates that 12.7 percent of women born in the U.S. today will develop breast cancer. Medicare pays for one baseline mammogram for women with Medicare between age 35 and 39, and for annual screening mammograms beginning at age 40. In Ohio, Medicare claims (4/1/05 – 3/31/07, excluding HMOs) show that 52 percent of women ages 52-69 had a biennial mammogram.

Colorectal Cancer Screening – Colorectal cancer (CRC) is the second most common cause of cancer death in the U.S. About six percent of the population will develop CRC with 91 percent of cases first diagnosed after age 50. Medicare covers the cost of CRC screening for all beneficiaries over the age of 50: fecal occult blood test (FOBT) every year, flexible sigmoidoscopy every four years, barium enema every four years (two years if high risk), or colonoscopy every 10 years (two years if high risk). In Ohio, only 51 percent of Medicare patients had any ONE such test over a seven-year period.

2) Diabetes Focused Disparities – Ohio is one of 33 states selected for this initiative, based on the number of diabetic medically underserved beneficiaries. Three specific measures will be targeted: (1) HbA1c determination annually, (2) diabetic eye exam annually, and (3) lipid testing annually. QIOs will work with physician practices meeting two criteria: Medicare-underserved diabetics represent ≥ 25 percent of the diabetics cared for by the practice, and the practice performs in the lower 50 percentile for the state on the above three measures.

3) Chronic Kidney Disease (CKD) – CMS will fund 13 QIO organizations to improve the quality of care for patients with chronic kidney disease. Efforts will be directed at (1) improving timely testing for kidney disease (e.g., microalbuminuria), (2) slowing the progression of CKD by using ACE-I or ARBs to treat hypertension in diabetic patients with CKD, and (3) promoting the use of AV fistulas as the preferred method of angioaccess for hemodialysis.

PATIENT SAFETY *(FIVE COMPONENTS)*

1) Surgical Care Improvement Project (SCIP) – CMS has identified nine specific measures in the SCIP that will be targeted for improvement in the 9SOW. These first seven are perioperative measures: SCIP Inf 1 – antibiotics within 60 minutes before incision; SCIP Inf 2 – appropriate antibiotics; SCIP Inf 3 – discontinue antibiotics within 24 hours of surgery; SCIP Inf 4 – glucose control in cardiac surgery; SCIP Inf 6 – appropriate hair removal; SCIP Inf 7 – postoperative normothermia in colon surgery; and SCIP Card 2 – perioperative beta-blocker. The final two measures are VTE 1 – recommended VTE prophylaxis, and VTE 2 – prophylaxis within 24 hours of surgery.

2) MRSA – QIOs will work with hospitals to (1) reduce the Methicillin-resistant *staphylococcus aureus* (MRSA) infection rate and (2) reduce the MRSA transmission rate.

3) Drug Safety – Emphasis will be placed on instituting system changes (e.g., policies, procedures, and guidelines) that reduce the incidence of drug-drug interactions and prevent the administration of inappropriate medications.

4) Pressure Ulcers – QIOs will work with hospitals and nursing homes to reduce the incidence and prevalence of pressure ulcers.

5) Physical Restraints – This initiative will endeavor to reduce the daily use of restraints.

Under the 9SOW, QIOs will concentrate their efforts on facilities with the greatest opportunity for improvement in each individual measure. CMS has identified these hospitals, and QIOs will help specific facilities — nursing homes and hospitals — in need of improvement on specific quality measures posted at Nursing Home Compare and Hospital Compare Web sites.

(Continued on page 16)

NEO RHIO – Bringing Connected Healthcare to Northeast Ohio Update to AMCNO Members

By: Brian F. Keaton, MD, FACEP – Acting CEO, NEO RHIO

The Northeast Ohio Regional Health Information Organization (NEO RHIO) is an inclusive, multi-stakeholder collaborative dedicated to improving the quality, safety, and efficiency of healthcare in Northeast Ohio through the use of information technology and the secure exchange of health information. NEO RHIO is grounded in the need to make all necessary healthcare information available to patients and providers where and when it is needed. Its first project will make patient data in all participating hospitals available to emergency physicians caring for a patient in any NEO RHIO emergency department. As it grows, NEO RHIO will expand the sources of data, the users of data, and the services provided to participants and the community. When mature, NEO RHIO will enable patients to have more control over their health and healthcare. It will lessen administrative burdens, improve efficiencies, enable important public health functions, facilitate research, and enhance the economic viability of our region.

This has been a somewhat quiet period as we are engaged in the hard work of taking NEO RHIO from being a good idea to a functioning health information exchange (HIE). Many NEO RHIO participants have expressed interest in partnering with an established HIE. Our CEOs have almost uniformly made it clear that they would be much more comfortable with a staged regional implementation of a proven HIE solution rather than pilots of homegrown development efforts. Because of this input, we've paid special attention to existing exchanges. The Technical Selection Committee spent several months defining our technical needs, researching potential vendor partners and products, narrowing the choices to three finalists, and selecting our preferred vendor partner. We are now in contract negotiations with the Indiana Health Information Exchange (IHIE). IHIE, which is one of the nations oldest and most successful HIE efforts, functions in a region that is very similar to ours using technologies and business processes very closely aligned with those identified in our business plan.

Our meetings with hospital CEOs and senior management teams have been productive. There are no longer questions about why a hospital or doctor should participate in HIE. The conversations now focus much more on how, how much, what are the liability risks, and how do I protect or expand my competitive advantage in the market. There is also much more discussion about how the RHIO can be used to facilitate integration both inside and outside an enterprises firewalls. We have been actively exploring the role of RHIOs in connecting office EHRs to the outside world. Potential services include clinical messaging, electronic prescribing, medication reconciliation, eligibility testing, etc.

In September, 2007, Gov. Strickland issued an Executive Order which created the Ohio Health Information Partnership Advisory Board. This board will provide for statewide coordination and facilitation of HIE efforts such as ours. The state has made it clear that they plan to enable and support existing efforts and do not plan to develop a single state-wide system. Representatives of NEO RHIO are actively engaged in this process.

In November 2007, the Federal Communications Commission (FCC) announced the grant recipients for its $417 million Rural Healthcare Pilot Program. This program focuses primarily on developing the infrastructure necessary to foster connectivity between rural healthcare providers and their urban partners. NEO RHIO and OneCommunity were awarded $11.3 million for a project called HealthNet which will provide high capacity fiber optic broadband connectivity to nineteen rural hospitals in the 22 counties of Northeast Ohio. In reality, it will provide a resource that will significantly enhance connectivity and decrease cost for all healthcare providers across the region. Because of the way the project is designed, it will not only benefit our region's medical community but will also have huge impact on education, government operations, and economic development efforts.

NEO RHIO is well on its way to transitioning from being a good idea to a functional entity. We have formally incorporated in the state of Ohio, ratified our first code of Regulations, and installed our first Board of Directors. We are actively engaging potential vendor partners, meeting with potential grant funders, and participating in state and national HIE forums. Several hospitals have committed funding to the project and are prepared to be the first sites for the ER linking project.

This promises to be an exciting year as NEO RHIO brings connected healthcare to our region. We look forward to AMCNO's partnership in the process. ■

CMS 9th Statement of Work for Quality Improvement Organizations

(Continued from page 15)

CARE TRANSITIONS *(ONE COMPONENT)*

The QIO work under this theme aims to improve the quality of care for Medicare beneficiaries transitioning from one care setting to another. Transitions are fraught with risks of miscommunication, omission, and error. A variety of provider and community based systems will be engaged to improve patient care at this critical juncture as measured by three specific criteria: (1) patient assessment of hospital discharge, (2) physician visit within 30 days of hospital discharge, and (3) global re-hospitalization rate.

BENEFICIARY PROTECTION *(ONE COMPONENT)*

In a continuing effort, QIOs will maintain their role in protecting Medicare beneficiaries and the Medicare Trust Fund. Increasing emphasis will be placed on coordinating case review with quality of care efforts. QIOs will continue to administer the complaint process and will be responsible for beneficiary satisfaction.

Ohio KePRO, the QIO for Ohio, understands that physicians, nurses, and all healthcare personnel strive to practice the highest quality of medicine and provide the right care for every patient every time. In the 9SOW, Ohio KePRO will continue to work collaboratively with physicians, hospitals, nursing homes, and other providers to assist them with attaining this professional goal. If you have any questions regarding these quality care initiatives or if we can assist you in meeting the objectives discussed above, please contact me at Ohio KePRO [(216) 447-9604] at your convenience. ■

Northeast Ohio Regional Health Information Organization – HealthNet Project

The Federal Communications Commission Rural Health Pilot Program

In 2006, the Federal Communications Commission (FCC) adopted the Rural Health Care Pilot Program Order (RHCPP), which established a rural health care pilot program to encourage the provision of telehealth and telemedicine services throughout the nation. Under the pilot program, selected applicants will receive up to 85 percent of the costs associated with:

1. Building state and regional high-speed broadband networks;
2. Connecting those networks to Internet2 or National LambdaRail, Inc. (dedicated nationwide backbone providers); and
3. Providing advanced telecommunications and information services to the network.

In November 2007, the FCC dedicated over $417 million for the construction of 69 statewide or regional broadband telehealth networks in 42 states and three U.S. territories under the RHCPP. Northeast Ohio was awarded $11,286,200 of that funding. The award was granted to the Northeast Ohio Regional Health Information Organization (NEO RHIO) and OneCommunity. The anticipated total cost of this project is $16,123,143.00 and the NEORHIO and OneCommunity are currently coordinating fundraising efforts for the remaining project balance with key civic, government, medical and private sector stakeholders across the impacted 22-county region. The 22 counties are: Ashland, Ashtabula, Carroll, Columbiana, Cuyahoga, Erie, Geauga, Guernsey, Holmes, Huron, Jefferson, Lake, Lorain, Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, and Wayne.

The funds will be used to expand OneCommunity's existing high-speed network to initially connect 19 additional medical facilities. Planned network expansion will provide coverage to include a 10,000 square mile area spanning 22 counties, with an impacted population of about 4.6 million.

Actual construction of the basic network itself will be incremental, with a current estimate of approximately 12 months to complete (August 2009). OneCommunity will be able to prioritize the deployment by stages, and will bring up critical network segments earlier than the complete network build-out.

The benefits for the participating hospitals are that they will have greater access to network tools and telemedicine applications. Rural hospitals will have the ability to leverage telemetry, improved diagnostics, health monitoring, distance learning, clinical data, and complete patient records. In addition the network will enable real-time physician, hospital-to-hospital, patient-to-hospital, and patient-to-physician connectivity.

The objectives of the NEO RHIO HealthNet are to connect rural hospitals located in NE Ohio over a dedicated fiber network and extend rural healthcare providers access to urban and national providers via the region's existing fiber network. This will also enable the secure and confidential exchange of health information between providers and provide a framework to enable secure and confidential exchange of health information between providers. Another objective is to provide a framework to enable secure telemedicine applications such as chronic disease management, continuing education and remote consultation.

All healthcare facilities in the 22 counties of NE Ohio, both urban and rural, will have an opportunity to participate in NEO RHIO HealthNet. Those not covered by the FCC grant will be expected to pay for the expense of connecting them to the network, and for network services provided. The 19 rural facilities included in the award will be expected to pay for subsequent services they use on the network, although it is anticipated that fees will be at a discounted rate. The fee structure is still being finalized.

To recap, specific aims of this concept will include:

- Connecting rural and urban hospitals located in the Northeast Ohio over a dedicated broadband network:
  - 19 rural hospitals throughout the 22 counties of Northeast Ohio,
  - Clinics and remote healthcare facilities, and
  - Leverage the FCC RHCP $11 MM investment with local investment to maximize the development of the regional HealthNet;
- Extending the OneCommunity/NEO RHIO broadband services to rural providers;
- Creating a regional repository that employs secure telehealth applications for chronic disease monitoring and continuing education services; and
- Implementing sustainable enterprise solutions using HIT for eligible providers in rural and underserved counties. This network is expected to improve the quality of health care and to reduce the cost of health care.

Next Steps

OneCommunity/NEO RHIO will hold a series of workshops to create the final regional fiber network design and establish the Regional Health Information Security and Privacy Committee (RHISPC) underneath NEO RHIO that will be comprised of representatives from the healthcare community, OneCommunity and NEO RHIO. The FCC RHCP grant represents an initial investment that can be leveraged to create a superior nationally recognized regional health network.

If interested in learning more or participating in HealthNet of RHISPC, please contact:
Mark T. Ansboury, Chief Technology Officer – OneCommunity/NEO RHIO
Email: mark.ansboury@onecommunity.org

Editor's Note: The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is one of the organizations contributing to the development of the NEO RHIO. ■

Medical Home: Renewed Interest

Lynda Montgomery, MD, MEd; George E. Kikano, MD,CPE, FAAFP

Background

The term "medical home" was coined in 1967 by the American Academy of Pediatrics (AAP), to describe the coordination of care for children with chronic medical conditions. Over 20 years passed without much attention by physicians or policymakers. In 1992, the AAP formally defined the meaning of medical home as care provided by trained primary care physicians and care that is "accessible, continuous, coordinated, compassionate, and culturally effective." To address increasing difficulties and frustration by family physicians to deliver compassionate care to communities they serve, the American Academy of Family Physicians (AAFP) embarked in a project, The Future of Family Medicine, in 2000. The final report on a new model of care published in the *Annals of Family Medicine* in 2004 included emphasis on the importance of a "Personal Medical Home." In 2006, the American College of Physicians (ACP) introduced the term "Advanced Medical Home." In March 2007, the AAP, AAFP, ACP and the American Osteopathic Association (AOA) authored a consensus statement entitled **Joint Principles of the Patient-Centered Medical Home** — describing an approach to providing comprehensive primary care for children, youth and adults.

Key Elements of the Medical Home

The Medical Home does not refer to a location where patients seek medical advice and care; rather the place that a patient turns to first with concerns about illness and health (wellness) both biomedical and emotional. The home includes, of course the physical space where physicians and patients interact (be it in the office, long-term care facility or home), but also the virtual portals for communication and the team members who help patients and families with health needs. With each iteration, the term has been refined. In the March 2007 joint statement by the different organizations, seven principles of the Patient-Centered Medical Home (PC-MH) were named:

1) ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
2) ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
3) ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; end of life care.
4) ***Care is coordinated and/or integrated*** across all elements of the complex health
5) ***Quality and safety*** are hallmarks of the medical home
6) ***Enhanced access*** – including management of health issues through phone, email, and
7) ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

It is important to note that a medical home is distinct from chronic disease management program. While both elements are patient-centered, chronic disease management programs use case managers to improve care through coordination in the current, disjointed system. It is an attempt to add value to the current system. Chronic disease management programs are geared to manage one condition at a time or multiple co morbid conditions in a parallel way. The personal medical home redesigns the patient's portal to the medical system in a way that meets directly his/her needs.

The Need for a Medical Home

With escalating health care costs, dissatisfaction by patients and providers and an increasing number of uninsured in the United States, the concept of medical home is an old idea whose time has come. Stakeholders are increasing aware of the fragmentation of healthcare services, and the difficulties in managing chronic diseases despite a burgeoning disease-management industry. There is growing evidence that countries whose health system is based on a strong primary care foundation have better clinical outcomes and lower costs. Under the Medical Home model, patients and families are ensured to have a regular source of accessible and coordinated care. They can see their physician in a timely manner, pay attention to preventive services, simplify the care of chronic illnesses and maximize the use of information technology. Outcomes will be measured, reported and benchmarked against best practices. The Medical Home is different from a "gatekeeper" model that was promoted by managed care organizations in the early nineties. It is a more sophisticated entry system where the personal physician (specialist or generalist) is a guide for the patient so that the best care is delivered in a timely and efficient manner.

Though patient-centered and physician-directed, the hallmark of the medical home is a partnership and a team approach to care employing all parts of the health system effectively. Payment structures in the medical home model need to reflect how resources are actually used. Examples include enhanced support for use of health information technology, secure use of email and telephone communication about health, and payment for quality initiatives. Face- to- face encounters must still be reimbursed in a way that accounts for the time and resources they require, but insurers will recognize the value-added services provided by the medical home, and will reimburse physician teams accordingly.

Ongoing projects

Based on the Future of Family Medicine project, the AAFP funded a 2-year project called TransforMED to assist in redesigning physician practices to implement the basic concept of the New Medical Home. The TransforMED team has been working with identified practices of different sizes and in multiple settings to develop and implement models of care to improve access, efficiency, cost and quality. Objective outcomes and lessons learned will be published at the end of this national demonstration project. More recently, the National Committee on Quality Assurance (NCQA) adopted the concept developed by the primary care organizations and started recognition of physician practices that implement this model. The Physician Practice Connection developed by the NCQA is not certification process yet but will identify practices that embrace patient-centered care emphasizing the elements of

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PUBLIC HEALTH

AMEF Funds Make High School Vaccination Program Possible

Through the generous support of the Academy of Medicine Education Foundation (AMEF), a successful *"Vaccinate Before You Graduate"* program was once again held at Bedford High School at the end of 2007, providing free vaccinations to graduating seniors.

In conjunction with the Cuyahoga County Board of Health, AMEF's financial support provides three on-site clinics at the high school. To date, 57 teens have received 168 doses to protect against meningitis, hepatitis B, tetanus, diphtheria, pertussis and chickenpox. The final on-site clinic is scheduled for April 10, 2008. The program was is especially important because many students who are uninsured or underinsured would not have received the inoculations without AMEF's contribution.

The program made Hepatitis B, Tetanus/ Diphtheria, Chickenpox, Pertussis and Meningitis vaccines available at no charge.

In years past, parents were assessed from $85 to $102 per Menactra dose and administrative fees for the other medicines enlisted above.

In a consent letter sent home to parents, the school encouraged parental permission for the program, calling the opportunity "protection you should think about." Specifically, the meningitis vaccine, which is recommended strongly by the Centers for Disease Control and Prevention and the American College Health Association for young adults entering college.

"This program helps kids who are missing doses, have lost records and/or provides newer vaccines that teens may have missed altogether," stated Cindy Modie, supervisor of preventative health at the Cuyahoga County Board of Health (CCBH). "By reaching kids before they leave school we provide vaccination that otherwise may never occur."

The program is supported in part by a donation from the Academy of Medicine Education Foundation in partnership with CCBH.

Editor's Note: AMEF is committed to advancing public health outreach initiatives such as the vaccination program described above. To make a charitable contribution to the AMEF, call (216) 520-1000 ext. 101. ■

COLLEAGUES CORNER

Recognizing outstanding AMC/NOMA members for their honors, awards and achievements, in addition to their work spreading messages of health and wellness to the community.

John D. Clough, MD, longstanding AMCNO member and current board member retires from practice

After 42 years of practice at the Cleveland Clinic, Dr. John Clough has decided to retire. A retirement party in honor of Dr. Clough was held at the Intercontinental Hotel on Monday, January 21st. Many of Dr. Clough's Cleveland Clinic colleagues, administrative and support staff were in attendance at the party. AMCNO physician leadership and staff were also on hand to offer our congratulations to Dr. Clough. Although he is retiring from active practice, Dr. Clough plans to continue on as a consultant to the government relations department at the Cleveland Clinic and he will continue to serve on the AMCNO board and our legislative committee. ■

Dr. Gary Hoffman, Chair of the Department of Rheumatic and Immunologic Disease at the Clinic congratulates ***Dr. Clough*** *and presents him with a retirement gift.*

Medical Home: Renewed Interest

(Continued from page 18)

the medical home model. Both at the federal Medicare and state Medicaid level, there are multiple ongoing pilot projects underway to evaluate the costs, processes, and outcomes of a patient-centered medical home approach.

Future Direction

The need for a paradigm shift is long overdue, and has been acknowledged by many constituents. All stakeholders including employers, policy makers, patients and professionals agree that the current system is unsustainable and that major change is needed. Medical home offers a new model of care that aligns incentives of providers, funders, and patients in a way that capitalizes on the information technology to improve access and health outcomes quality.

It is unclear whether physicians have adequate training to implement this model, nor whether there will be overall cost savings. The strength of the medical home is that patients have a long-term relationship with a physician and health care team who understands their health issues in the context of their lives.

Dr. Lynda Montgomery is an Assistant Professor of Family Medicine at CWRU/UHCMC.

Dr. George Kikano is a past president of AMCNO and Professor and Chair of the department of Family Medicine at CWRU/UHCMC. ■

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