Physician Ranking Legislation Gains Momentum
Sponsor and Proponent Testimony Presented to Ohio House

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In June, Representative Barbara Boyd provided sponsor testimony to the Ohio House Health Committee on legislation spearheaded by the AMCNO on the issue of physician ranking/designations. At a later committee hearing, **Dr. John Bastulli,** Vice President of Legislative Affairs of the AMCNO, provided testimony on behalf of the AMCNO on HB 122. HB 122 is sponsored by Rep. Barbara Boyd, and Senator Tom Patton has introduced a companion bill in the Ohio Senate. Both bills were drafted through the efforts of the AMCNO and we strongly support the legislation.

Rep. Boyd testified that the legislation is meant to establish standards for physician designations by health care insurers. She stated that the bill creates requirements that health insurers establish a rating system for physicians that are based on cost efficiency, quality of care or clinical performance.

Healthcare insurers would be required to disclose those designations to any individual, with the inclusion of language declaring that the ratings shouldn't be the sole factor in selecting a doctor. Rep. Boyd noted that insurers would be required to notify doctors *(Continued on page 17)*

AMCNO representatives spend time with Rep. Barbara Boyd, sponsor of HB 122, at a recent interested parties meeting on the legislation (left to right - Mr. Mike Wise, AMCNO lobbyist, Rep. Boyd, and Dr. John Bastulli, AMCNO VP of Legislative Affairs).

AMCNO Physician Members Participate in MedWorks Event

Physicians from across the Northern Ohio region including many physician members of the AMCNO volunteered to provide free care at the MedWorks event held on July 25th and 26th.

MedWorks is a volunteer program providing free healthcare to Ohio's uninsured and underinsured population. Volunteer doctors, dentists and eye specialists, as well as general healthcare providers and support workers donated their time to help provide free healthcare services at the event. Medical supplies and equipment were donated from institutions, companies and organizations from around the area. Over 940 patients received care at the event with a total number of appointments with different types of specialists reaching over 1,600 over the two-day event. The event was held at the W.O. Walker Center,

a facility that is jointly owned by the Cleveland Clinic and University Hospitals. Although appointments were needed to obtain medical care at the event, several walk-in patients were also treated. The AMCNO is represented on the MedWorks Board by **Dr. Laura David**, who was integrally involved with the planning of the event and was on hand on both days providing care to OB/GYN patients. The AMCNO plans to continue to work with Medworks on future events. Additional details regarding the MedWorks program and the event are included inside this issue (see page 3). ∎

MedWorks patients wait in a triage area prior to seeing a physician or other healthcare provider at the event.

INSIDE THIS ISSUE

Together, we are transforming healthcare.

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MedWorks

By Karil Bialostosky, Program Director

History of MedWorks

For several years, healthcare professionals from Northeast Ohio traveled together to provide healthcare to people in developing countries. Eventually, these volunteers began to wonder how they could organize themselves to provide such services in their own backyard.

Simultaneously, a local leader conceptualized and planned a one-time mass clinic to provide free health services to the uninsured and the underinsured. The Berea Fairgrounds would be converted into a clinic to service hundreds of individuals over a two-day event. Appointments were not scheduled and individuals knew they were taking a chance that they would not be seen. Still, the need is so great that people from the entire state and beyond were willing to make the trek. In addition, this event would be self-contained and would not provide for follow-up services. Again, people whose health insurance coverage is non-existent or inadequate were willing to take the risk just to meet their immediate needs. Ultimately, that event was canceled because of the threat the H1N1 flu outbreak might pose.

A New Program Emerges

The cancellation of the event allowed program organizers to closely scrutinize what had been envisioned. In addition, over the course of the planning year, the program's founder met with public health and other safety-net providers in the area. Businessman Zac Ponsky grew up with a family of doctors but has no formal medical training or specific experience with the program's ultimate target group. The question of "continuity of health care," not previously part of his lexicon, came to take on significance.

Thus it was that MedWorks was born as a non-profit entity, to improve access to health care to the medically indigent. Mass clinics would take place and people would call in to make appointments for blocks of time. Clinics would make every effort to include follow-up care.

Critical to the success of the organization is the very strong volunteer component that lends itself to buy-in from the entire community and also makes it an affordable endeavor. With only a couple of exceptions, and with funding from the Mt. Sinai Healthcare Foundation and the Cleveland Foundation, everyone associated with MedWorks donates their time and services to the organization.

Our Inaugural Event

On July 25-26, MedWorks opened its doors to the hundreds of individuals who scheduled medical, vision and dental appointments. Doctors, dentists, and optometrists, representing a wide-range of hospital systems, safety net providers, and individual practices were on-hand to help. Approximately 300 lay volunteers, 200 nurses and social workers, and 100 doctors provided logistics and medical support. Approximately 20 specialties — including internal medicine, gynecology, neurology, cardiology, infectious disease, dermatology, ENT, podiatry, urology, and more — were represented. In addition, many of the scheduled vision and dental patients were drawn from the Cleveland Free Clinic and Care Alliance constituency lists.

All told more than 900 people came through our doors, and many of them received multiple services. The clinic provided more than 1600 appointments, x-ray and lab services. Physicians made unscheduled referrals to various specialties on the day of the appointment. Over the course of the weekend, seven people were transported to a hospital by ambulance. Our doctors have followed up with those individuals to check on their disposition.

Every person who came to see us spent time with a social worker who provided counseling and information about follow-up services. The Ohio Benefits Bank was on-hand to offer pre-screening for medical, housing, energy, tax, employment, and other programs. Approximately 100 people availed themselves of this service.

Just over 130 women had Pap tests and nearly 100 women received vouchers for free mammograms. The women who received Pap tests are currently being informed of their status. Approximately 300 people either walked out of our clinic with or will be receiving a brand new pair of glasses and a number of patients received vouchers for follow-up eye care. Approximately 50 people were HIV tested and are now aware of their HIV status.

Some patients were so grateful for their care that they actually stayed after their appointments to volunteer at the clinic. Similarly, a number of medical and lay volunteers were so moved by the publicity that preceded the event that a number of them simply showed up unannounced to provide care.

What Now

Patients who participated in our event underwent a triaging process. Their medical forms were coded as red, yellow or green. The green label signified that the patients received care and needed no additional follow-up. Red labels indicated an emergent situation. All told, fewer than 20 people fell into that category. The week after the clinic, two of MedWorks' volunteer physicians contacted each of those individuals to find out what, if any, follow-up care they had received and help to connect them with additional care. In fact, a couple of individuals are now patients of MedWorks volunteer physicians.

The yellow label indicated that additional follow-up care was needed. By and large these are individuals with chronic conditions who require ongoing, non-emergent care. Included are people with uncontrolled diabetes, asthma, or high blood pressure, just to name a few. Clearly, these cases are the real challenge moving forward.

A MedWorks team, comprised of physicians, social workers and others are evaluating the "yellow" medical forms and will make recommendations for subsequent care.

It is a MedWorks goal to engage the numerous medical volunteers who want to continue to partner with us. As Board member and urologist Dr. Lee Ponsky points out, "If every medical professional in the greater Cleveland area volunteers just four hours a year as part of a program we coordinate, we can provide a great deal of care to those who need it most and have few if any resources to contribute."

MedWorks seeks to assist and partner with existing safety net providers that serve the medically indigent. We have begun a dialog with some of these groups. One possibility is that we will supply our volunteers to help augment their specialty clinics. That way, some of the patients we identify through mass clinics may receive additional attention and we can help reduce some of their waiting lists. The safety net providers' capacity is boosted and everyone benefits from continued care.

The Future of MedWorks

The outpouring of support from the human resources standpoint has been phenomenal. In addition, corporate sponsors and partners have donated medical supplies, equipment, facility space, medications, food, uniforms and more. We are constantly called by past and prospective participants, volunteers and donors.

MedWorks is moving forward on a legislative front as well by exploring, with the Academy of Medicine of Cleveland and Northern Ohio, opportunities to broaden Ohio immunity laws.

As unemployment grows and cash strapped State programs are pushed to the breaking point, the health crisis in Northeast Ohio is already upon us. While we are hopeful and enthusiastic about the prospect of national reform, Ohioans cannot and should not wait to build adaptable, self-help solutions to our community's problems. We invite you to join our cause!

For more information or to volunteer, please contact Karil Bialostosky at (216) 231-5350 or karil@medworksusa.org. You can also log on to our Web site, www.medworksusa.org, to see a complete listing of our sponsors and supporters.

Editor's note: *The AMCNO is a supporter of the MedWorks project and we are listed on their web site.* ■

H1N1 Vaccine Update

The AMCNO has participated in several conference calls with the Department of Health and Human Services as well as local health department meetings regarding the H1N1 vaccine. HHS has indicated that the first doses of the vaccine should be available on or about October 15th.

The federal government is purchasing the vaccine and making it available to healthcare providers free of charge along with all of the necessary supplies to administer the vaccine. Since the vaccine will be paid for by the federal government physicians can charge an administrative fee only for administering the vaccine to their patients. Currently the Centers for Disease Control (CDC) is recommending the following PRIORITY population to receive the H1N1 vaccination first until the vaccine is available for all recommended groups: pregnant women, people who live or care for children younger than 6 months of age, health care personnel with DIRECT patient contact, children 6 months through 4 years of age, and children 5 through 18 years of age who have chronic medical conditions.

Once the recommended PRIORITY population is vaccinated or additional vaccine supplies are available, the following groups will be targeted: persons between the ages of 5 through 24 years of age, people from ages 25 through 64 years who are at higher risk because of chronic health disorders or compromised immune systems. Any provider who is interested in participating in providing H1N1 vaccine to patients is encouraged to contact the Ohio Department of Health for more information. In addition, the CDC is working on getting information from all 50 states and plans to provide a compilation of the state resources on their web site.

Additional Resources: www.flu.gov – information is posted there not only on H1N1 but on seasonal flu as well. You can also access toolkits at this Web site. The Centers for Disease Control (CDC) continues to track the outbreak of human cases of the H1N1 virus and prepare for the upcoming flu season. The CDC has produced a number of documents to help physicians, including an H1N1 flu vaccination planning guide and a list of clinical and public health guidance on the virus. For the entire collection of CDC information on swine flu, go to http://www.cdc.gov/h1n1flu/ The Ohio Department of Health (ODH) H1N1 (swine flu) information line remains open. Please call 866-800-1404 between 8 a.m. and 5 p.m. Monday through Friday. For more information from the ODH on the virus, go http://www.odh.ohio.gov/landing/phs_emergency/guidclin.aspx. ■

Innovative Partnership Brings Doctors and Lawyers Together

By Mallory Curran, JD (Legal Aid)
Robert Needlman, MD (MetroHealth)
Dale Cowan, JD, MD (Cleveland Clinic)

Cleveland has long been considered an innovator in the areas of health and law. Building upon that tradition, Cleveland is also a leader in the new and rapidly expanding field of medical-legal partnership. In 2002, The Legal Aid Society of Cleveland and The MetroHealth System developed the Community Advocacy Program (CAP) to better serve individuals and families living in poverty by removing legal barriers to health.

The Legal Aid Society of Cleveland is the law firm for low income persons in Northeast Ohio, dedicated to providing high quality civil legal services to persons who are unable to afford an attorney. Legal Aid has been serving Greater Cleveland for more than 100 years.

The MetroHealth System is comprised of MetroHealth Medical Center and the MetroHealth Center for Community Health's network of nine neighborhood-based community health centers. MetroHealth serves patients from all walks of life and is nationally known for its care in the areas of trauma, rehabilitation, stroke, and obstetrics. A core MetroHealth mission is to provide high quality medical services to all members of Cuyahoga County, regardless of ability to pay. MetroHealth has been serving Cuyahoga County for more than 170 years.

Through the Community Advocacy Program, MetroHealth physicians and other medical providers are able to refer patients to Legal Aid lawyers on-site at MetroHealth when a legal problem is getting in the way of their patients' optimal health. These legal services are provided at no cost to patients who qualify.

Currently, the Community Advocacy Program lawyers serve the Department of Pediatrics at MetroHealth's main campus, pediatric patients at the Broadway and Buckeye Health Centers, elderly patients at the Buckeye Health Center, and patients of all ages at the Thomas F. McCafferty Health Center. In addition, a Legal Aid paralegal teams with physicians and social workers from the Broadway Health Center to serve formerly incarcerated persons with chronic health conditions who are returning to the Cleveland community.

Why Medical-Legal Partnership Works

A Physician's Perspective
Robert Needlman, MD

As a developmental and behavioral pediatrician at MetroHealth Medical Center, I work with many families who bear the heavy burdens of poverty, which often has enormous negative impact on health. My medical training has provided me with many tools to help children and families in need — for example, I know which medication will help ease a child's asthma, what interventions will help improve a child's behavior, and which immunizations are necessary to keep a child safe from communicable diseases.

However, as I began to practice medicine, I realized — as many of us do — that my medical training left me ill-equipped to deal with many problems which had a direct impact on health. I felt I was spinning my wheels trying to solve problems such as getting special education for a patient with a learning disability, getting my patient back on health insurance when Medicaid coverage was terminated seemingly without reason, preventing an illegal eviction, and advising a grandmother how to obtain legal custody of her grandchildren when they came to live with her.

As a pediatrician, I am a primary care provider who works in partnership with a variety of specialists. As do other primary care providers, when I am concerned that my patient has cancer, I refer his family to an oncologist. When I am concerned that my patient has a serious heart defect, I refer her family to a cardiologist. What I did not realize until the Community Advocacy Program came to MetroHealth was that I needed another kind of specialist in my practice: a lawyer.

Although many consider doctors and lawyers to be natural adversaries, my colleagues and I have welcomed having a Legal Aid lawyer on our health care team. In addition to providing direct legal services to patients and their families, the Community Advocacy Program staff also educates MetroHealth staff so that we are better able to spot legal issues facing our patients. This instruction — which ranges from immigration law to family law, education law to public benefits law — helps fill in the gaps of our medical training. With this guidance, we learn about remedies to problems we may not even have realized had a legal solution. Special education is a good example of this.

Furthermore, having the Community Advocacy Program at MetroHealth helps us better educate the next generation. Medical students and medical residents now have access to trainings on these social issues as part of their standard curriculum. Many of us remember well the "noon lectures" of our residencies. However, with the Community Advocacy Program, one day residents might have a training on epilepsy and seizure disorders by a neurologist; the next day they might have a training on housing law by one of the Community Advocacy Program lawyers. Learning about social determinants of health is much more meaningful when doctors and lawyers analyze them together.

At MetroHealth we work hard to gain the trust of our patients, many of whom have been battered by "the system." Some patients, especially those with disabilities, come to view MetroHealth as a second home. Having the Community Advocacy Program on-site at MetroHealth allows our patients to access the legal assistance they need in a place where they feel safe.

At this point, it is hard for my colleagues and me to remember what we did before we had lawyers on our team.

A Lawyer's Perspective
Mallory Curran, Esq.

As a Legal Aid lawyer, I work with individuals and families who face not just one legal problem, but often three or four legal problems simultaneously. They are forced to navigate complicated bureaucracies on a monthly (and often weekly or daily) basis. While their legal problems are often paramount, they also have non-legal problems, including health problems. Furthermore,

Innovative Partnership Brings Doctors and Lawyers Together
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many legal problems are made worse by health problems. For example, untreated asthma might cause a client to miss important appointments such as with the caseworker who approves food stamps for the clients' family. I cannot imagine serving my clients without the support of the health care teams at MetroHealth.

When physicians and other lawyers hear that I work at MetroHealth, they frequently assume that I work in risk management, the general counsel's office, or medical malpractice defense. They are often intrigued when I explain that my version of "health law" involves using the law to solve specific legal problems which are keeping patients from optimal health.

Because all of my clients are referred to me by a MetroHealth doctor, nurse, social worker, psychologist, or any other staff member, I automatically have an ally in advocating for my client. Because I have an office on-site at MetroHealth, I have developed long-term, positive relationships with the doctors and other medical staff. As they have observed our successes, they have come to trust that my legal colleagues and I act in the best interest of their patients.

Because of the trust relationship Community Advocacy Program staff have with MetroHealth medical staff, we are able to engage medical providers in the regular course of their days. We page them for quick questions, grab them for a consultation when we pass in the hallways, meet with them during administrative time, and see them at faculty and staff meetings. The value medical providers add to the cases includes educating the lawyer on how medical problems impact legal problems. For example, a doctor can explain how a disability may be impacting a child's ability to learn or how exposure to mold and other environmental hazards makes asthma worse.

These close relationships greatly benefit our clients. Having quick access to medical records and expert medical opinions speeds up the resolution of legal problems. In the area of public benefits, for example, these relationships have cut weeks, months, and even years off the wait time for crucial safety net services for which families qualify but have been denied improperly.

The physicians and other medical staff at MetroHealth have also proved first-rate at screening for unmet legal needs. As they gather a family and social history at a visit, they are often the first non-family member to learn of a pending eviction, the need for a domestic violence restraining order, loss of health insurance, or possible foreclosure. Having doctors and other medical staff screen for unmet legal needs is especially important in areas not commonly thought of as having legal solutions, such as special education for students with disabilities.

Patient confidentiality is obviously a major concern from both the MetroHealth and the Legal Aid perspective. The General Counsel's office at MetroHealth has been involved in the planning and implementation of the Community Advocacy Program since its inception. The two organizations have a memorandum of understanding outlining each organization's responsibilities, detailing the limits to access of both medical and legal files, and trying to plan ahead for any potential conflicts.

Finally, working in partnership with MetroHealth has taught me the lessons of "preventive medicine" which I apply to "preventive law." Many private attorneys already practice "preventive law" — advising a corporation on how to avoid liability or drafting a contract which clearly spells out the expectations of both parties. In civil poverty law, however, lawyers often practice "emergency room law" — trying to fight an eviction or foreclosure at the last minute, trying to reinstate benefits after they have already been terminated, and trying to appeal an expulsion once a child is already out of school. Throughout my tenure at MetroHealth, I have moved closer to the "preventive law" model so that the advice and counsel I provide to clients at an early stage prevents them from having to come to the "legal emergency room" in crisis.

CASE EXAMPLE

Ms. Smith's four children have been seen at their neighborhood MetroHealth clinic since they were born. At a routine wellcare visit, Ms. Smith shared concerns with the pediatrician that 8-year-old Maggie was not making progress in school, especially in writing. The pediatrician referred Ms. Smith to the Legal Aid attorney who helped Ms. Smith get the school to do a Multi-Factored Evaluation of Maggie. The results of the Evaluation confirmed Ms. Smith's suspicions — Maggie has a learning disability. Maggie now has an Individualized Education Plan ("IEP") in place to accommodate her learning disability and help her overcome it.

The Legal Aid attorney also represented Ms. Smith and Maggie in an appeal of Maggie's SSI denial. The Legal Aid attorney was able to gather Maggie's medical records from colleague physicians at MetroHealth and submit them with a brief to the Social Security Administration. Maggie's SSI was subsequently approved. With the lump sum back payment Ms. Smith received, she purchased a computer for Maggie to use for homework, one of the recommendations on her IEP. Maggie is now doing well in school.

Ms. Curran is an attorney with The Legal Aid Society of Cleveland. Dr. Needlman is a pediatrician with The MetroHealth System. Dr. Cowan is a physician with The Cleveland Clinic Foundation.

For more information about the Community Advocacy Program, contact Melanie Shakarian at (216) 861-5217 or e-mail melanie.shakarian@lasclev.org.

Editor's note: *The AMCNO Medical Legal Liaison Committee met with representatives of the CAP and agreed to provide information on this service to the AMCNO membership.* ∎

Peripheral nerve field stimulation for treatment of chronic non-malignant pain

By Salim Hayek, MD, PhD
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   Chief, Pain Medicine Division

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   Perioperative Medicine
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Introduction

Chronic peripheral non-malignant pain affects a large percentage of population and is often inadequately treated which results in low quality of life, medication abuse, and establishment of mood disorders. A variety of conservative treatments do not provide complete or lasting pain relief and furthermore there are significant side effects associated with long term consumption of agents used to manage chronic neuropathic pain such as membrane stabilizers, tricyclic antidepressants, anticonvulsants or opioids. Neuromodulation by means of electrical stimulation has been a useful alternative as a method for treating chronic pain. It has been evolving tremendously since the "gate theory" developed by Melzac and Wall in 1965 opened the door for this application. Manipulation of pain pathways by neuromodulation can occur at many levels from peripheral nerve endings, large peripheral nerves, spinal cord tracts, deep brain centers and up to the motor cortex.

Neuromodulation for peripheral neuropathic pain

Shealey, working out of University Hospitals Case Medical Center, pioneered the use of dorsal column stimulation (DCS), now known as spinal cord stimulation (SCS), for the control of chronic pain in 1967. Almost in parallel, and looking at ways to improve the technique with new modalities of neuromodulation to treat patients failing SCS, peripheral nerve stimulation was developed. While SCS targets dorsal columns of the spinal cord, peripheral nerve stimulation (PNS) targets fibers of the peripheral nerve along its path. Correct placement of leads close to the nerve trunks requires an incision, nerve exposure and alignment along or wrapping of the nerve trunk depending on the leads used. Additionally, there have been no specific leads developed for that application and the procedure is not without complication and not always effective. In some cases, percutaneous spinal cord stimulation leads are introduced through a needle in close proximity to target nerves. The latest application developed in this direction, peripheral nerve field stimulation (PNfS), involves placement of electrodes subcutaneously and not necessarily in close proximity to known nerves, with a goal of achieving paresthesia coverage at the specific topographic area of pain. The nomenclature is somewhat confusing since only surgical placement of leads close to the nerve can be considered bona fide PNS while percutaneous peripheral nerve stimulation could be considered similar to PNfS. In PNfS spinal cord stimulator leads are placed subcutaneously in the area of pain to stimulate the region of the affected nerves or the dermatomal distribution of these nerves, which then converge back on the spinal cord. To date the exact mechanism of action of PNfS is not known; however it is believed that the principle behind PNfS is the same as with SCS but the target is different (small peripheral sensory nerve endings at the painful area). Generally, the most important effect (but not the only one) of stimulation is central, by stimulating ascending pathways and effecting neuronal inhibition. Demonstration that stimulation of higher pain centers (that result in inhibition of pain pathways) can be achieved as effectively by PNfS like SCS is lacking. A recent study demonstrated increase in brain activity by fMRI in the somatosensory cortex upon median nerve stimulation which means that likely there may be a central effect from PNfS. Other authors have considered theoretically that a local effect of electromagnetic field generated by PNfS on small peripheral sensory nerve fibers could lead to neuromodulation of pain pathways and pain relief. Retrograde effects of PNfS as well as effect on local vasculature have not been explored at all. In conclusion, even though it has gained a fairly wide use lately, the basic mechanisms by which PNfS results in effective pain relief remain unknown and its true effects unproven as studies up to this point are largely anecdotal.

Indications for peripheral nerve field stimulation

Recently, effective treatment of various neuropathic pain syndromes using percutaneous PNfS has been reported in a growing list of clinical settings, primarily in the head and neck regions, but also the low back, limb and inguinal areas as well. PNfS is being applied in individual cases where conventional treatments have failed to control pain or optimal paresthesia coverage by SCS cannot be achieved. However, there is no consensus yet as to what are indications for this novel form of neuromodulation. This has led sometimes to an unreasonable overuse of this technique. PNfS is applied in a combination with SCS or as a stand alone application. Few case reports and limited published experience indicate that this form of neuromudulation may be used in refractory cases for the following indications:

a) Chronic low back axial pain post lumbar spine surgery. While SCS is a widely accepted and increasingly used treatment modality for "failed back surgery syndrome" (FBSS), many practitioners reserve SCS to treat primarily radicular leg pain rather than axial low back pain because SCS is often inadequate in achieving low back paresthesiae or relieving truncal pain. Even when low back paresthesias are achieved, the perception threshold (PT, is the lowest threshold of electrical stimulation to achieve paresthesiae) is fairly close to discomfort threshold (DT, is the threshold above which discomfort motor fiber activation occurs) since usually unpleasant chest and abdominal wall stimulation may occur. A combination of SCS and PNfS has been shown to be successful in a limited observational study by Bernstein in 2008. Using both spinal cord stimulation and PNFS in conjunction for lower back and leg pain they concluded that a combination of the 2 techniques provided greater benefit than either alone.

b) Occipital neuralgia. This probably is the major application for PNfS and the procedure is referred as ONS (occipital nerve stimulation). Even though a wide range of syndromes are characterized as "occipital neuralgia" encouraging results have been published regarding the effectiveness of ONS in providing pain relief, decreasing number of acute episodes and decreasing analgesic medication consumption. Still, the technique needs to be perfected since complications such as neck tightness, infection or muscle spasms lead to significant number of explants or failed procedures. In general, ONS may be effective in carefully selected patients suffering from migraine, occipital neuralgia, cervicogenic headache, cluster headache and facial pain.

c) Postherpetic neuralgia. PHN sometimes is characterized by severe pain along the distribution of the affected nerve and dorsal root ganglia that is not amenable to conservative treatment.

Peripheral nerve field stimulation
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Because usually pain is confined to a distinct dermatome good results have been reported by use of PNfS.

d) Carpal tunnel syndrome. Chronic neuropathic pain due to the constriction and mechanical damage of the median nerve results in severe disability. There is some evidence that PNS of the median nerve and/or its branches is effective and results in pain relief and some improvement of function.

e) Inguinal nerve neuralgia following herniorrhaphy or chronic post-incisional pain (previous abdominal surgeries or thoracotomies). It is not unusual for chronic neuropathic pain phenomena to occur in patients post surgical procedures since during surgery some nerve fibers are cut or damaged. Occasionally, painful neuromgas are formed at the tip of truncated nerve branches. PNfS along the incisional lines has been shown to be somewhat promising even though there is very limited evidence.

In general, the following nerves are most commonly targeted by percutaneous nerve stimulation: occipital nerve, supraorbital, infraorbital nerves, median, or axillary nerve, intercostals, ileoinguinal, iliohypogastric, cluneal, common peroneal, saphenous, lateral femoral cutaneous and superficial peroneal nerve.

Surgical Technique
Implanting the hardware for PNfS is usually straightforward with a similar set of guidelines to SCS. In order to perform PNfS, the nerve and the area of pain is mapped out by exam, and the skin is prepped and draped. Local anesthesia is applied in a limited fashion and the needle is placed. The electrode delivery is achieved percutaneously through a needle inserted subcutaneously not very deep (usually not more than 10 mm). The area of desired coverage is mapped and the needle is placed sometimes in the middle of the painful field or along the previous surgery incision lines. Leads are introduced and the needle removed. If the leads are placed too deep it is likely the targeted nerve fibers are missed. If the leads are placed too superficial lead erosion through the skin can occur. Lead (s) is connected to a programmable external generator for the trial period which usually lasts from 2-7 days. Amplitude, frequency, and shape of electromagnetic field can all be manipulated to achieve optimal pain relief. The trial is considered successful if significant pain relief is achieved (usually for PNfS over 70%). After a successful trial the permanent leads are placed, anchored appropriately to fascia, and the generator internalized at an optimal anatomical space decided by the surgeon according to the patient's characteristics and the topography of the lead placement (different IPG placement for different lead locations). The risks of this procedure are limited to superficial infection, rarely peripheral nerve injury or dysfunction of the implanted system.

Discussion
Appropriate use of implantable technologies for pain management should be based on extensive knowledge of pathophysiology of pain, clinical presentation of pain syndromes and evidence of effectiveness of the treatment modality. Technological advances on hardware are far exceeding our understanding of pain pathways and the effects of electrical modulation of the nervous system. Even the terminology used to describe various techniques does not accurately reflect the procedures. Percutaneous placement of leads for electrical stimulation may make the PNS and PNfS applications very similar.

There are significant advantages in using PNfS: a) the procedure is performed

expeditiously under local anesthesia and the surgical site is quite superficial; b) the rate of complication appears to be very low; c) technically there are no issues with steering of leads (as is done for SCS) since they are delivered through the needle to the desired location and sought paresthesiae are often readily obtained; d) there may be less problems with lead migration (as in SCS); e) similar to SCS, patients undergo a trial giving physicians valuable information on whether PNfS will be effective or not; f) if used in combination with SCS all leads may be connected to the same IPG, depending on the number of electrode contacts used.

The occipital nerve, ilioinguinal/iliohypogastric nerve, cluneal nerve and the intercostal nerves may be receptive to stimulation of their peripheral fibers instead of stimulation the larger trunks. Preliminary published studies suggest that a significant proportion of patients with certain intractable pain syndromes may benefit from peripheral nerve stimulation. The evidence that the benefits from PNfS are long-lasting is limited at this time.

Sometimes more than one electrode is placed to achieve coverage on discontinuous small areas of pain; however careful consideration should be given on the benefits of placing multiple leads versus the option of SCS placement. Nonetheless, outcome data are necessary to compare the benefits of the procedure as a stand alone, in combination with SCS or in comparison with TENS unit.
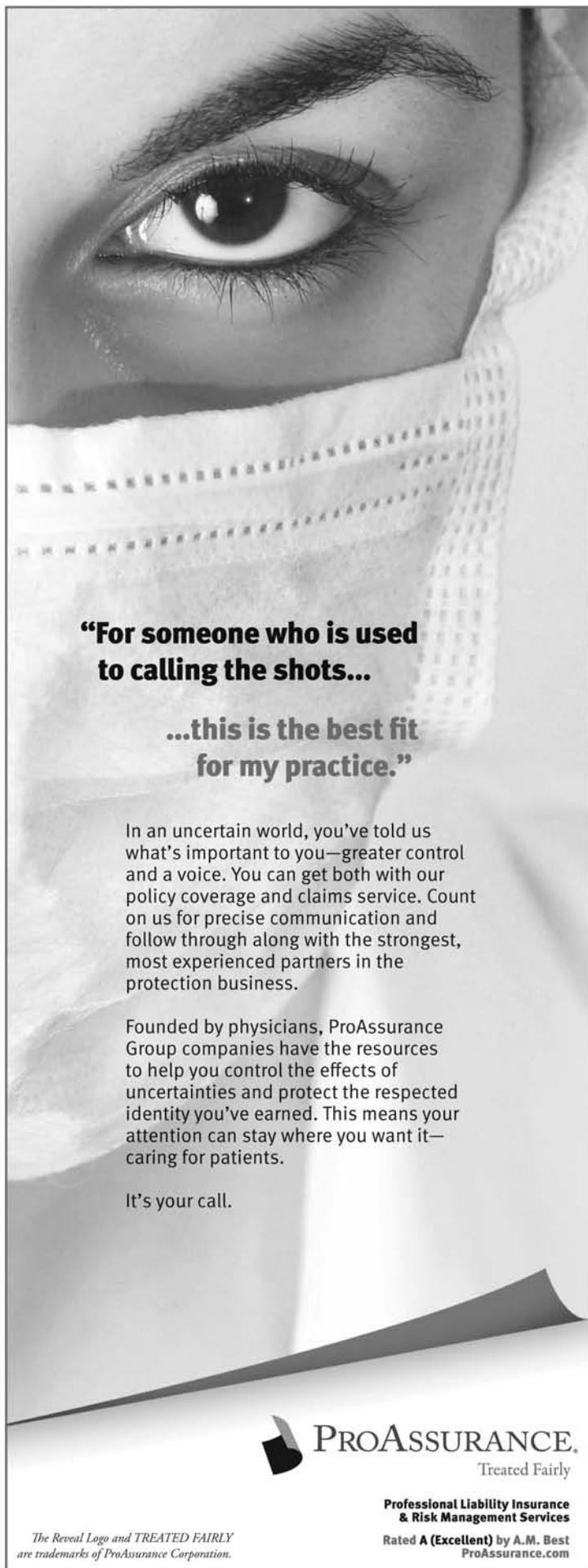
Clinical experience with dorsal column stimulators has demonstrated that a decrease in efficacy might occur over time. So far, it is unknown whether similar phenomena occur with PNfS. Regardless it is necessary to explore whether loss of sensitivity develops long-term post implant of PNfS systems.

Future

To date there are no randomized clinical trials conducted on PNfS; so the evidence supporting this application is fairly weak only Class III or IV. Because the technique is simple with minimal side effects and because there are no established indications based on well defined scientific evidence there has been an increase in use of PNfS by some practitioners. To be able to achieve the most benefits from this technique and avoid overuse and abuse it is imperative that research is performed on both fronts: 1) exploring the mechanism by which PNfS effects peripheral and central nervous system; and 2) clinical trials need to be conducted to determine the effectiveness in different neuropathic and other chronic pain conditions and formulate guidelines for use of this method of neuromodulation. Although data pertaining to peripheral neuromodulation for pain are encouraging, well-designed, large prospective randomized double blind studies are necessary to demonstrate the benefits of this procedure. Furthermore it is necessary to have long-term follow-up of these patients if the evidence is to become compelling. Equally as important, cost-benefit analyses will be necessary to justify the expanded use of this technique. The efficacy of the procedure needs to be compared with the degree of improvement achieved with other conventional treatments.

Editor's note: The AMCNO welcomes article submissions from our members. The Northern Ohio Physician does not obtain medical reviews on articles submitted for publication.

AMCNO members interested in submitting an article for publication in the magazine may contact Ms. Debbie Blonski at the AMCNO offices at (216) 520-1000, ext. 102. ∎

Selecting an Electronic Health Record System

By Gary R. Pritts, MBA

The American Recovery and Reinvestment Act (ARRA), commonly known as the stimulus bill, includes incentive payments ("the carrot") to most practices of up to $44,000, per physician, for those who implement electronic health records (EHR). Further, the bill includes a "stick" — reductions in Medicare payments that could grow to as much as 5% for physicians who do not use this technology. Taken together, these two factors have changed the game so that many now view implementing electronic health records (EHR) as a "must do" for practices.

This new imperative to implement electronic records leaves many physicians feeling daunted. With hundreds of vendors touting their wares, health reform and uncertain change on the horizon, and colleagues' stories of EHR disasters, the task can seem frightening and overwhelming. Here is a roadmap for moving forward.

1) **Know the government rules.** Government money is a big part of the new financial equation. Most physicians who treat Medicare patients will be eligible for up to $44,000, paid out over 5 years, beginning in 2011. A different formula applies to physicians who treat a high percentage of Medicaid patients. Here is what we know at this writing:
   a. To get paid, physicians must demonstrate **"meaningful use"** of their system. The government hopes to officially define "meaningful use" by late 2009. You can see a draft definition — go to http://healthit.hhs.gov, click on "Health IT/Recovery" and then "Meaningful Use." This preliminary definition calls on physicians to perform 28 specific functions with their EHR software and to submit 29 quality measures to CMS to qualify for the first of 5 annual payments. The bar will be raised in 2013 and again in 2015 — to keep getting paid, physicians must improve clinical performance on key health outcomes.
   b. Physicians must buy a **"certified"** software package. The Bush administration set up the Certification Commission for Health Information Technology, or CCHIT, to certify EHR software. You can get the list of current CCHIT-certified software packages at www.cchit.org. However, ARRA does not specifically name CCHIT, and CCHIT has its detractors. The Secretary of Health and Human Services will decide whether to bless CCHIT or to come up with some other certification.
   c. E-prescribing bonus. This is a separate program that gives physicians a bonus equal to 2% of Medicare payments for 2010. The guidelines are available now.

   This formula puts a big responsibility on physicians — you must successfully implement the system in order to get the government payments. So point #1 — get the rules when they come out so that you know what you need to accomplish in order to earn the government payments.

2) **Get organized and get educated.** Get the right people from the practice on-board at the beginning. Then, get educated. Two good places to start are on the Web, The Center for Health IT (www.centerforHIT.org) and Health Information Management Systems Society (www.himss.org). These sites contain references to numerous other resources that will get you up to speed. Your professional society may provide educational programs. A number of good books are available. Learn from others who have gone before you.

3) **Consider getting help.** Since the road to electronic record success is littered with failed projects, cost overruns and disappointments, consider hiring a reputable consultant to lead you through the process. Another source of help will be the "Regional Extension Centers", educational and technical assistance agencies that will be government-funded through ARRA. Extension Centers are tasked with helping physicians with selection, implementation and achieving meaningful use of their EHRs. Extension Centers as a priority will help:
   a. Primary care physicians in small groups
   b. Physicians in rural areas, and physicians who serve large numbers of uninsured and underinsured patients (such as poor urban areas)
   c. Physicians practicing in FQHCs

   For prioritized physicians, help may include a government-funded consultant who will come on-site. Some help will be provided to all providers. Watch for news of this resource.

4) **Know yourself and where you are going.** Preparation and self-assessment is the foundation for EHR selection and implementation success. Before getting buried in the morass of technical details of EHR features and functions, here are some key areas to consider:
   a. **Alignment.** For many reasons, more and more physicians are aligning in large groups, IPAs and/or with hospital systems. In some cases, independent physicians sell their practices to the hospital system and become employees. In other cases, the practice remains independent while establishing common treatment protocols, referral networks, and other "clinical integration" functions with a health system partner. In still other cases, a practice may be strong enough to remain independent and interact with multiple hospital systems. Consider your future — what your alignment will be over the next few years. Tight alignment might necessitate that you use the same EHR. If you think that you will be casting your lot with a big partner, strongly consider using the EHR they are promoting.
   b. **PMS/Outside Billing Service.** Your EHR shares much data with your Practice Management System (PMS) and/or your outside billing service. Patient Demographic information, scheduling information, and charges are used by both. Does your PMS vendor and/or billing service market an EHR that is already interfaced or integrated with your current PMS? If you like your current PMS/billing service, look carefully at the systems these vendors sell and/or recommend.
   c. **Specialty.** Most EHR functions are similar for all specialties — they schedule patients, record your E&M coding, document prescriptions and orders, etc. A few functions may be specific and/or unique to your specialty. For example, a pediatrician needs to

display growth charts and an oncologist must manage chemotherapy regimens. Know any unique functions that are important to your specialty.

5) **Hosting.** Consider outsourced vs. in-house hosting of your server:
   a. **ASP Model.** With the Application Service Provider, or ASP model, the vendor assumes responsibility for the management of the software and server including maintaining a secure data center, updating the software, and performing daily system backup. Many practices, including both solo physicians and large multi-location practices find this model attractive since small practices lack staff to handle ongoing operational responsibilities, and multi-location practices save telecommunications costs.
   b. **In-house Hosting.** The traditional in-house server keeps the programs and data in your office, giving you more control and responsibility for your operations. This technology may offer faster response time, it allows you to keep sensitive data in-house, and frees you from total reliance on your internet connectivity.

6) **EHR Functions / Your Priority List.** Now it is time to dive into EHR details. Develop a list of features/functions that are important to you. One list that can help you get started is the *Concise Guide to CCHIT Certification Criteria* available on the CCHIT Web site (www.cchit.org). This 9-page document is a good laundry list of features — check off the functions that are most important to you. Add to this list anything important to you that is not listed, for example, any specialty-specific functions.

Inventory other software and clinical equipment installed in your practice — practice management software, PACS, pharmaceutical dispensing, diagnostic equipment with computer interfaces, or other software. Prioritize which should be interfaced to your EHR.

Achieving "meaningful use" will include creating working connections with outside parties. Make a list of outside parties and systems your EHR should interact with — labs, hospitals, imaging facilities and others. Your EHR should connect to the outside parties with whom you do the highest volume

of activity. Watch the news for a "Health Information Exchange", or electronic clearinghouse, that will help physicians in this area lower the cost of interconnecting with multiple entities.

7) **Develop a list of vendors.** Consider vendors related to your PMS software or billing service and your major hospital system partner. Consider specialty-specific vendors which serve oncology, orthopedic surgery and many other specialties. Consider systems your colleagues recommend. Consider vendors that emerge from EHR selection tools that you may find on the Web. Narrow these candidates down to no more than 3 to 8 vendors for a more in depth review. To narrow the list ask about number of installed clients, the financial strength of the company, references, and client satisfaction survey results. Be aware that many smaller companies may not survive.

8) **System Demo / Proposals / Financial Analysis / Decision**. The physician will be intimately wedded to the EMR, so take the time to view an in-depth demonstration. You may start with a "canned" demo to get to know the "look and feel" of the system. This step may allow you to cut some vendors and proceed with an in-depth, customized demo of 2 or 3 systems. For these demos, use your priority list developed above, and ask the vendor to show you how each of your priority tasks is

accomplished. Verify that the vendor has worked with others in your specialty and has templates available. Get a proposal that includes a sufficient quantity of support hours to allow you to achieve "meaningful use." Get details of costs for 5 years. Check references including visits to users of these systems. Estimate the financial benefits that you will achieve (supply cost reductions, improved reimbursement through better coding, reduced labor) and the other practice costs you will incur (such as reduced billing due to lower productivity while learning, labor costs to convert paper charts, and other costs). Beware of "lowball" estimates of technical support time and costs.

Take a deep breath as you ponder the true dollar cost, the lengthy time frame and significant effort for implementation. Make your decision. The hard work is just starting. Know that the time you spend up-front building support from the key people, assessing your needs, developing realistic expectations of time and cost, and preparing for a new way of practice will pay dividends by improving odds of your ultimate satisfaction and implementation success.

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FTC to delay 'red flags' enforcement until Nov. 1

The Federal Trade Commission has decided to once again postpone the implementation of the "red flags" enforcement rule. The rule will now take effect on November 1st. This rule will require physicians and hospitals to adopt written plans for tracking and responding to indicators of identity theft in their billing operations.

This is the third time the FTC has changed the date, and the agency is again promising additional resources and guidance to help businesses understand if the rules apply to them and how to comply. In the FTC's view, hospitals and physicians are creditors for the purposes of the rule because they accept deferred payment for their services. The AMCNO has sent out detailed information to our members regarding compliance with the "red flags" rule in previous publications. The FTC has also created a Web site dedicated to informing businesses about their obligations under the rule. To view the site go to http://www.ftc.gov/bcp/edu/microsites/redflagsrule/faqs.shtm

The Process for Identifying and Recouping Improper Medicare Payments Made to Health Care Providers is Changing in Ohio:

Are You RAC Ready?

By Marilena DiSilvio, Esq.
David Valent, Esq.

Over one billion Medicare claims are processed each year in the United States. Inadvertent errors in filing these claims amount to approximately $10 billion in combined overpayments and underpayments to health care providers annually. In an effort to identify and recoup the costs associated with improper payments, the U.S. Congress passed Section 302 of the Tax Relief and Health Care Act of 2006.

This Act requires the implementation of a permanent and nationwide program consisting of Recovery Audit Contractors (RACs), working in each state to perform post-payment audits on health care providers. RACs are private companies hired by the Centers for Medicare and Medicaid Services (CMS) to identify improper payments. The RACs have the authority to perform random computer based audits, as well as unannounced on-site audits of any health care provider receiving Medicare reimbursements.

As a brief historical perspective, prior to the introduction of the RAC program, CMS did have a system for conducting audits, and that system is still operating in Ohio until the RAC program begins. The current system is much like the new RAC program, with one important exception. The new RAC program awards the private audit company working with CMS a contingency fee for every dollar identified as an improper payment — as opposed to the current system which pays audit contractors a flat rate for their services. With the new RAC program, a contingency fee will be paid to CGI Federal, Ohio's assigned RAC, in the amount of 12.5% of all overpayments identified and recouped. This new contingency fee driven RAC program is scheduled to start in Ohio soon.

Interestingly, the nationwide mandated RAC program first started as a small demonstration program that began using RACs in three states in 2005. In the three state demonstration program, the increase in identification and recoupment of improper payments was overwhelming. In Florida for example, during fiscal year 2007, $124.6 million dollars in overpayments were identified and returned to CMS. Compare that number to the only $9.8 million collected in Florida for fiscal year 2006, which was prior to the RAC program's full implementation. Overall, the demonstration program resulted in over $900 million in overpayments being returned to the Medicare Trust Fund between 2005 and 2008. With these results, it is clear to see why CMS wants to implement this program nationwide.

So, what do you need to know to be RAC Ready?

The start date of the RAC program in Ohio:

CMS initially intended Ohio's RAC program to begin on August 1, 2009. CMS then delayed the program, while CMS and CGI Federal decided to first begin the process of educating health care providers about the RAC program. CMS and CGI Federal are currently hosting forums across the state in which health care providers can attend and ask questions to learn more about the RAC program prior to its implementation. The education outreach program does not have a scheduled ending date, but is expected to be complete at the earliest by October 2009. Although the exact ending date of the education outreach has not yet been determined, it is planned for the RAC audits to begin a short time after the education outreach program is complete.

When the RAC program does start, at the earliest during October 2009, the program will begin on a roll-out basis. Non-complex automated reviews are set to start first. The staggered start will then follow with DRG validation reviews, then complex reviews for coding errors, and lastly DME and medical necessity reviews. The start of each roll-out phase will be staggered by several months, with the specific dates for each phase of the roll-out not yet set.

There is one additional factor to consider when attempting to predict the exact start date of the RAC program in Ohio, and that is the potential of a "black-out period." CMS recently released a decision that the RAC program will be delayed by three months in any state that makes a transition to a new Medicare Administrative Contactor (MAC). In Ohio, it is still unclear if a new company will be awarded the contract to serve as the MAC for Ohio. If this happens, then the RAC program will not begin until at least three months after the date of that transition. The black-out period would allow the new MAC to focus on claims processing activities before having to get adjusted to working with the RACs.

What can I do to prepare for a RAC audit?

1. Educate yourself. Right now, CGI Federal is conducting various education outreach programs throughout the state. Attend these programs to learn more.
2. Conduct a pre-RAC risk assessment by auditing your own files. You may do this in-house with the help of your current staff, or you may hire an outside audit company to assist. A review of your own files and claims will help you make sure your practice is in compliance with all Medicare guidelines.
3. Designate one administrator in your office as the point of contact who is responsible for an unannounced audit. Educate non-designated staff members of the audit process, so that they learn who has been designated the contact person, and so that they do not speak with auditors.
4. Ensure that no one associated with your practice signs any statement certifying the completeness of medical records that are provided to the auditor without your approval.
5. Be aware that if you choose, you can request to have legal counsel present during any conversation with an auditor.
6. Visit the CGI Federal Web site once the RAC program begins in Ohio. The Web site will list areas of "vulnerabilities" for health care providers to study, so that providers may learn from the listed

vulnerabilities the types of common mistakes which result in provider billing errors and improper payments.

What happens if I am audited?

If RACs audit your practice and improper payments are identified, the RACs will issue you an initial demand letter to remit payment. Once you receive this letter, a "discussion period" begins. This allows you the opportunity to speak directly with the RACs regarding their demand. During this time, you may submit evidence to challenge the demand letter if you so desire. Or, you may decide that the demand was legitimate, and issue repayment. It is important to note that this "discussion period" is distinct from the appeal process. The discussion period lasts 40 days, and during this time, you will not accrue interest, nor will CMS attempt to recoup payment.

On day 41 of the process, if you have not yet filed a formal appeal, CMS will begin the recoupment/collections process. Importantly, even though recoupment may begin, you still have up to 120 days from the date of receipt of the initial demand letter to start the formal appeals process.

The appeal process is a five-step process that begins after the discussion period. In the first step of the appeal process, you will make a formal request for "redetermination." Next, you have the right to ask for further "reconsideration." If you are still not satisfied with your results from the first two stages, you may take your issues to be heard before an administrative law judge (ALJ). After the ALJ's decision, you have the right to ask a Medicare appeals council to hear your concerns. The last step of the appeal process is a judicial review in the U.S. District Court. Each phase of this appeal process has specific time limitations for filing, and specific requirements for submitting evidence in support of your defense. Before beginning this process, you must be aware of these requirements to make sure that you are in compliance.

Interesting statistics:

As of March 27, 2008, only 14% of providers had chosen to appeal RAC determinations made during the three state demonstration program. Perhaps this surprisingly low percentage of appeals is due to a lack of awareness providers have regarding their options to challenge a RAC demand.

Getting educated about the RAC process and knowing your rights and options during the audit process is the first step to a successful defense of any demand for recoupment against your practice.

Sources of information:

To answer any questions you might have, we recommend you visit either the CMS Web site (http://www.cms.hhs.gov/RAC), or the CGI Federal Web site devoted to this RAC program (http://racb.cgi.com).

You may also choose to learn more about how you can prevent an unwanted audit and/or defend against an audit already in progress, by calling attorneys in the Reminger, Co. L.P.A. Health Care Law Practice Group.

Editor's note: The AMCNO will continue to update our members on the RAC issue through emails and our Practice Management Matters *publication.* ■

UnitedHealthcare Ramps up Locally Based Provider Services in Northern Ohio

By Mollie Chapman, Director, Physician and Hospital Relations, Ohio

Physicians and hospitals may soon see visitors from UnitedHealthcare in their offices. UnitedHealthcare is introducing a local, personalized provider service to work with UnitedHealthcare network physicians and hospitals in 44 counties in the Northern Ohio region. Physicians and their staffs are central to the delivery of health care and UnitedHealthcare's Provider Advocates will play a key supporting role to the physician.

New Services for Northern Ohio Physicians
With approximately 14,000 network providers in the region, UnitedHealthcare is bringing this program to northern Ohio after successful pilots in several other markets including Cincinnati. Physician Advocates will visit physicians and other medical providers in their offices to offer a variety of services including:
- Educating providers and staff on billing and reimbursement practices
- Training office staff to utilize online tools to streamline administrative tasks
- Conducting periodic training programs
- Assisting in resolution of claims issues

Physician advocates will offer a single point of face-to-face and telephone contact for participating physicians, and make it easier for them to navigate, and interact with, UnitedHealthcare. They will be the go-to person for the physician practice, and are supported by a local team.

UnitedHealthcare is also enhancing the responsiveness and troubleshooting capabilities of its Market Service Agents, who are available by phone. Additionally, there will be a variety of educational programs for office staff and town hall meetings with physicians.

The process of decentralizing and localizing customer service is continuing across the country and the customer service team has access to dedicated adjusters to move northern Ohio provider claim's through the system expeditiously. Of particular help will be the enhanced Web-based services for claims navigation (training is available by contacting market service agents or physician advocates).

"We are working to create a new spirit of partnership with physicians and their staffs through the enhancement of our provider services and the introduction of our Provider Advocacy Program," said Giesele R. Greene, MD, market medical director for UnitedHealthcare of Northern Ohio. "We believe these physician-driven enhancements will enable us to be more quickly responsive to physicians and other health care professionals. The physician advocates will be a go-to resource for information-sharing and issue resolution."

How the Program Works
Key elements of the Provider Advocacy Program include:
- Meeting regularly with providers and their staffs (some physicians may be able to meet with their physician advocates as frequently as quarterly, if requested by the physician)
- Facilitating the claims process and troubleshooting claim issues
- Training office staff to utilize UnitedHealthcare's online tools to streamline administrative tasks
- Educating providers on billing and reimbursement practices
- Answering questions related to UnitedHealthcare's quality and affordability initiatives
- Providing regular training programs through Webinars and seminars

The enhanced provider services were instituted about a year ago in Southwest Ohio and several months ago in the Columbus area. The implementation in northern Ohio is scheduled for 4th quarter 2009. Early indications are that these services are having a significant positive impact.

For example, according to preliminary data from Southwest Ohio (which includes Cincinnati and Dayton), turnaround time for claim issue resolution was reduced by more than 50 percent to under 12 days, on average. More than 88 percent of unresolved claim issues are being resolved in less than 20 days, and, ultimately, the program sets a target of 95 percent resolution in less than 20 days.

"The experience in our Southwest Ohio market has been very good," said Dr. Richard Shonk, market medical director for UnitedHealthcare of Southwest Ohio. "The data show how much improvement can be made in a short time, and, anecdotally, we have heard from a number of physicians who have noticed a real difference in the timeliness of claims processing. We recognize that timeliness is a critical metric for physicians, and the overall relationship with our network members improves when we can be more responsive and helpful to physicians."

"As promised last year, UnitedHealthcare is committed to earning and sustaining a trusted clinical and business relationship with physicians and their staffs to facilitate optimal health status for our members," said Rob Falkenberg, CEO, UnitedHealthcare of Ohio. "Our goal is to be the easiest health care organization to deal with while being sensitive to the financial aspects of a medical practice — promoting timely, accurate and fair payment."

Over the next year, UnitedHealthcare will continue unveiling similar physician-driven programs across its markets. The Ohio programs were designed in consultation with the state medical association and the Academy of Medicine of Cleveland and Northern Ohio, among other organizations.

"The enhanced physician services are designed to make us more responsive, proactive, reliable and easier to do business with," said UnitedHealthcare of Northern Ohio's Dr. Greene. "Just as we have seen in other parts of Ohio, we expect northern Ohio physicians to benefit from these additional services quite immediately and on an ongoing basis."
For information about the Provider Advocacy Program, call (513) 603-6744.

Editor's note: Recently, AMCNO physician leadership and staff met with representatives from UnitedHealth Care (UHC) to discuss the imminent rollout of their Provider Advocate Program here in Northeastern Ohio. The AMCNO plans to be involved in the promotion of the program as well as planned participation in town hall and practice management meetings with representatives of the UHC Physician Advocacy staff. ■

The Role of a UnitedHealthcare Physician Advocate

- UnitedHealth Group navigational specialist
- Represent all products (Commercial/Medicare/Medicaid)
- Externally focused — face-to-face contact with physician
- Maximize the medical community's ability to interact with UnitedHealthcare
- Relationship management — build positive relationships/timely communication of changes to physicians

AMCNO Legislative Update

By Connor Patton, AMCNO lobbyist

The biggest news of the summer was the passage of the state budget, which elicited lengthy debate and myriad changes and was passed only after the passage of three interim budgets. Before the state budget bill was introduced in February, the Ohio Office of Budget and Management estimated approximately a $5 billion budget deficit; a significant portion of this deficit was filled with Federal stimulus dollars. In May, after the Ohio House of Representatives and Senate passed separate versions of the state budget, the Office of Budget and Management projected an additional $3.2 billion deficit in the upcoming two-year budget. On June 19th, Governor Strickland announced his "framework" to close the projected deficit by proposing the institution of slot machines at Ohio's seven racetracks, which would raise approximately $933 million in additional revenue over the two-year period. Additionally, the Governor proposed $2.4 billion in additional cuts across state government.

Governor Strickland and Legislative Leaders, many of whom will face re-election in 2010, refused to propose any revenue enhancements (income or sales tax increases). However, if video lottery terminals do not produce the $933 million dollars in revenue, the General Assembly will be forced to find revenue enhancements or make additional cuts. It is also likely Governor Strickland and the General Assembly will be forced to deal with a budget correction bill during the 2010-2011 two-year cycle.

Some of the items included in the final budget were:
- Increased funding for mental health services
- Extended insurance coverage for dependents
- Extended COBRA coverage for individuals whether or not they are eligible for unemployment compensation
- A franchise fee on nursing homes
- A franchise fee on hospitals

As noted above, the budget includes a tax (or fee) of $145 million on hospitals. The new budget calls for the franchise fee to be in place for two years only and imposes an annual assessment on hospitals based on their total facility costs. The bill sets the first annual assessment at 1.27% of a hospital's total facility costs and the second and subsequent annual assessments at 1.37%. The bill also provides:

- That a hospital's total facility costs excludes selling, rather than buying, durable medical equipment as shown on the cost-reporting data used for purposes of determining the hospital's assessment,
- That the amount of the assessment for the second year and each successive year (if any) is to be 1.61% of a hospital's total facility costs only if the federal government denies a waiver for a tiered assessment, and
- Provides, subject to Ohio Department of Job and Family Services, adopting rules that establish a different payment schedule, that 28% of a hospital's assessment is due on the last business day of October, 31% is due on the last business day of February, and 41% is due on the last business day of May.

The budget did include a provision to create a study committee to look at provider franchise fees, since the Medicaid program is growing faster than the General Revenue Fund. This provision is vital because it will involve the stakeholders in the discussion and the recommendations will be used to frame the conversation about what the state might do in light of federal health care reform. The AMCNO plans to monitor the debate of this study committee since this could have an impact on our members. For more information on the budget or other AMCNO legislative initiatives, contact the AMCNO offices. ■

AMCNO Sends Comments to Congress on the health care reform bill HR 3200

The AMCNO executive committee discussed H.R. 3200 at their July meeting and as a result, **Anthony E. Bacevice, Jr., MD,** AMCNO president, prepared and sent a letter to members of the Northern Ohio Congressional Delegation. In his letter, Dr. Bacevice identified several provisions in H.R. 3200 that would benefit physicians and their practice. He also identified several problems in the draft that the AMCNO would like to see addressed during the discussions taking place in Congress. The AMCNO will monitor the debate on health care reform as the legislation moves through Congress.

To view a copy of the AMCNO letter to Congress go to the AMCNO Web site at www.amcnoma.org and click on "Health Care Reform."

Links to additional information regarding health care reform legislation:

The Kaiser Family Foundation (KFF) has also compiled an interactive tool to compare the leading health reform proposals. To view the information provided by KFF go to: http://www.kff.org/healthreform/sidebyside.cfm

To view H.R. 3200 go to: http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.3200:

To view the Congressional Budget Office report on H.R. 3200 go to: http://www.cbo.gov/cedirect.cfm?bill=hr3200&cong=111

Other links to health care reform information: Ohio's State Coverage and Quality Initiative – Access to Affordable Health Care – www.healthcarereform.gov or The Obama Administration's health reform site – www.healthreform.gov

Physician Ranking Legislation Gains Momentum

of their designations before they are published, and gives doctors and others the opportunity to review the method and data used to make the determination. Physicians would also have the ability to appeal their designations.

The AMCNO proponent testimony keyed in on several important points noting that insurers have supported obtaining data in order to tier and quantify cost effective care, and consumers have wanted data to compare quality of doctors. The crux of the debate is balancing the rights of physicians to have accurate and relevant reporting of their practice with the desire of health insurers and consumers to have access to information about their treating physician. Our testimony stressed that many insurers "profile" or "rank" their physicians to analyze and monitor cost of care. The way that insurers do this is calculated through insurer claim databases and analytic software. These systems analyze the actual cost of care incurred by physicians in caring for patients and compare it to the expected and average cost of care. In effect, the insurance company determines its own definitions of "efficiency" based on the difference between expected cost of care and actual cost of care. However, the manner in which insurers define "efficiency" is contentious and requires a better definition. Rather than focusing on the cost of clinical resources for a set of services, there should be greater focus on the overall benefits of care provided, including clinical outcomes.

This legislation stresses that health plans must use risk-adjusted data, and base grades and ratings at least in part on nationally recognized quality of care measures and not on cost alone. The legislation also provides physicians with the right to review and appeal their ratings prior to the ratings being released to the public. The AMCNO noted that we also believe that an independent ratings examiner, with expertise in efficiency measurement, should be considered to oversee compliance ranking systems. The AMCNO continues to meet with Rep. Boyd, House and Senate leadership and other interested parties with regard to this important legislation. AMCNO members that have questions regarding the legislation may contact Ms. Elayne Biddlestone at the AMCNO offices. ■

Better Health *Greater* Cleveland: Improving Outcomes and Building a Community of Learning

By Christopher J. Hebert, MD, MS
Director, Quality Improvement Learning Collaborative
Better Health Greater *Cleveland*

Better Health *Greater* Cleveland, a multi-stakeholder partnership whose mission is to improve the health of people with chronic medical conditions in Northeast Ohio, is seeing improvement in outcomes for people receiving diabetes care from our partner primary care practices.

The third Community Health Checkup, released in June 2009 (www.betterhealthcleveland.org), reports result of 361 primary care physicians at 44 clinical practice sites caring for 25,724 adults with diabetes during 2008. We observed a 19% relative increase in achievement on the composite care standard as well as a 7.6% relative increase in our composite outcome standard. In addition, when compared to national performance of health plans on HEDIS diabetes measures reported by the National Committee for Quality Assurance, partner practices were above average in virtually all standards.

A concerning trend, however, is the substantial loss of insurance coverage in the region, an effect of the region's struggles with loss of jobs. We observed 6% fewer commercially insured patients and 19% more uninsured patients within our partner practices in 2008 compared to 2007

(Figure 1). Since poorer health outcomes tend to accompany lack of health insurance, this rise in the uninsured represents a major challenge to community health. The report also reveals continued disparities in health outcomes along ethnic and socioeconomic lines, including patients who are non-white, from poorer neighborhoods or have less education. This information guides our efforts to achieve equity in health outcomes in our region.

The data submitted by our practice partners allows a unique opportunity to identify high performers for the purposes of sharing best practices. The figure below **[Figure 2]** shows site-level changes in overall performance for both the care process and outcomes standards. Sites in the upper-right quadrant demonstrated both better outcomes and better care processes. Insights provided by analyses such as these

are leading to very practical opportunities for learning across organizations and are integral to the design and activities of *Better Health's* Learning Collaborative. The Learning Collaborative facilitates learning among our partner practices and across systems. We envision an ever-expanding community of learners and teachers, consisting of clinicians and others working on the front lines to improve chronic disease care. To this end, we hold twice yearly, day-long Learning Sessions in which providers get together to learn, network and share expertise. At the Learning Sessions, we seek practical knowledge, tools and processes that participants can bring back to their organizations and implement. Examples so far have included a method to improve pneumococcal vaccination rates and a team-based approach to improving control of blood sugar. Our faculty includes experts in quality improvement methods as well as experts in chronic diseases. *Better Health's* fifth Learning Session will be held at Cleveland Clinic's Lyndhurst campus – the former headquarters of TRW - on Friday, September 18, 2009 with the theme of Patient-Centered Care. Limited space may be available to primary care practitioners from non-partner organizations. Contact Carol Kaschube at 216.778.8024 or ckaschube@metrohealth.org for more information.

Editor's note: The AMCNO is a partner in the Better Health Greater Cleveland project. ■
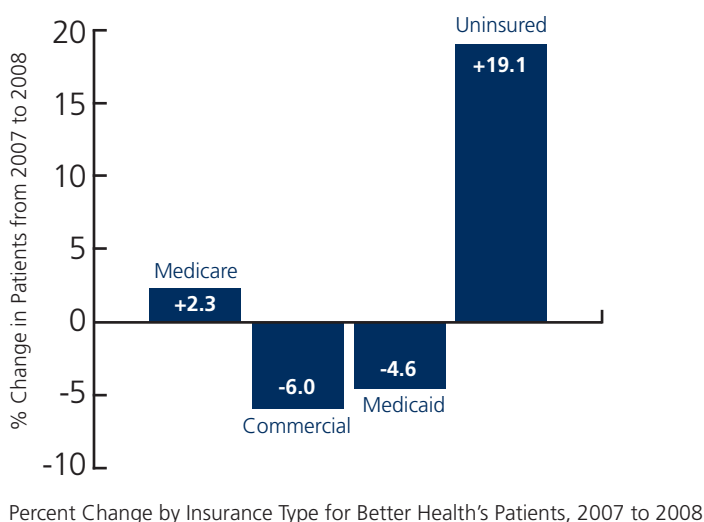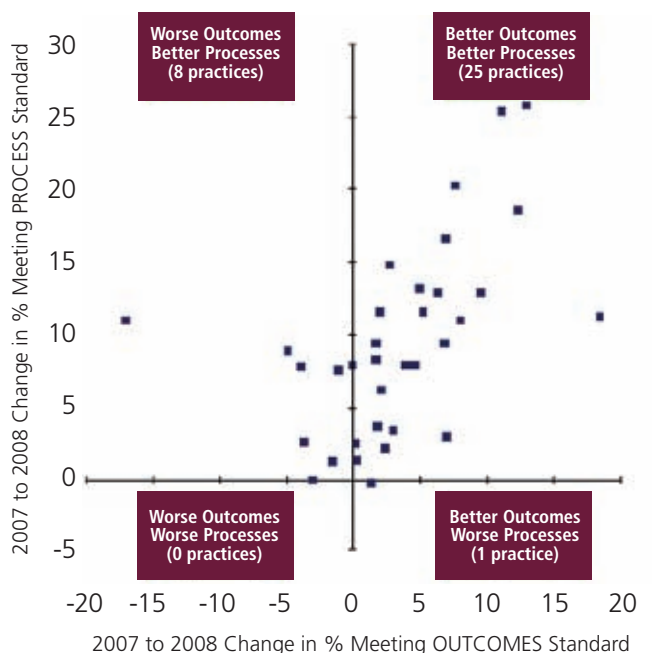
FIGURE 1

Percent Change by Insurance Type for Better Health's Patients, 2007 to 2008

FIGURE 2

2007 to 2008 Change in % Meeting OUTCOMES Standard

2009 AMEF Golf Outing

Eighty seven golfers enjoyed Sand Ridge Golf Club on Monday, August 3, 2009 at the Academy of Medicine Education Foundation's (AMEF) sixth annual Marissa Rose Biddlestone Memorial golf outing. Foursomes competed in a shotgun start tournament that raised more than $38,000 for AMEF. The funds will be utilized for medical student scholarships, annual seminars and the *Healthlines* radio program. The 2009 AMEF scholarship recipients were invited to join the group for dinner. The AMEF 2009 scholarship recipients were: Patrick Blake – CCF Lerner, Edwin Jackson – OU, Syed Mahmood – CWRU, Priya Malik – CCF Lerner, Marisa Quattrone – CWRU, and Rachel Roth – CCF Lerner.

1st Place Team
Mark Gersman, MD; Kurt Lutz; Michael Shaughnessy, MD; Bob Wenz, MD

2nd Place Team
Kindred Hospitals: Jason Adams, John Dobrowski, MD; Richard King, MD; Jim Mosnot
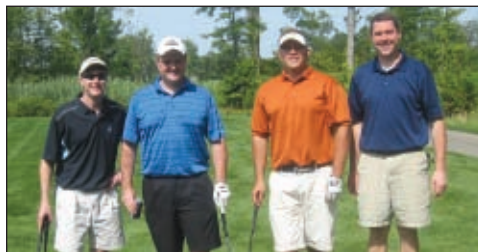
3rd Place Team
University Hospitals Medical Practice and Dr. Matthew Levy: Wilson Beers, Matt Levy, MD; Matthew Mark, MD; Scott Platz

Prizes were also awarded for the following:

Closest to the pin: Jeff Molter, Joe Piero, Michael Shaughnessy, MD; and Mark Mingione

Longest drive: John Moscarino, Kevin Geraci, MD

Longest putt holed: Clay Bacevice

A special thank you goes to all the event, hole and hole-in-one sponsors who helped make the day successful.

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Get your clubs ready for next year's event on August 9, 2010 at the Kirtland Country Club.

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