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The AMCNO Joins Other Healthcare Organizations in Filing Brief to Preserve the Smoke Free Workplace Act

In early April the Ohio Supreme Court made the decision to take up a case regarding the constitutionality of the Smoke Free Workplace Act. After reviewing the case the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) board of directors agreed to join other healthcare organizations in filing an amicus brief in this case.

The case involves Bartec, which operates under the name Zeno's, a bar in Columbus. The Ohio Department of Health (ODH) cited Zeno's numerous times from 2007-2009 because the establishment continued to allow people to smoke despite the state law. In August 2009, the ODH filed an injunction action against Zeno's and sought to collect over $30,000 in unpaid fines. The trial court denied ODH's request for an injunction, vacated ten final orders, and found that ODH had created a "policy" of strict liability in enforcement of the law. In November 2010, the Court of Appeals reversed the decision of the trial court, and held that ODH investigates claims on a case-by-case basis and that it was improper for the trial court to vacate the final orders. The

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BE SURE TO SIGN UP NOW FOR THE AMCNO THIRD PARTY PAYOR SEMINAR – SEE PAGE 14 FOR DETAILS

Cuyahoga Health Access Partnership (CHAP) Provides Progress Report at Inaugural Annual Meeting

In July the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) physician leadership and staff were pleased to attend the inaugural annual meeting of the Cuyahoga Health Access Partnership (CHAP) program.

Other attendees included representatives from all of the CHAP partners. (*A complete list of the partners is included at the end of this article.)* Representing the CHAP board during the annual meeting presentation were Ms. Kate Nagel, Chair, CHAP Board of Directors, Senior Director, Public Health & Research, Cleveland Clinic, and Ms. Robin J. Bachman, Vice Chair & Interim Chair, CHAP Board of Directors, Assistant Vice President, Government Affairs & Public Policy, Sisters of Charity Health System.

During the meeting, the attendees were provided with detailed information on the status of CHAP. CHAP is a collaboration of public and private organizations that have formed a countywide partnership to provide a coordinated system of healthcare access for Cuyahoga County's low-income, uninsured adults. The stand-alone organization was incorporated in 2009 and was founded on the principle that all stakeholders have a shared responsibility to address the uninsured crisis in Cuyahoga County. CHAP's vision is to provide a system of access for uninsured adults in Cuyahoga County. All participating stakeholders acknowledge the importance of working together to improve the health of our region. Each of the member organizations are committed to serving our community by caring for the uninsured and working toward the common goal of increasing healthcare access.

Dr. Michael Anderson (left) and Dr. Lawrence Kent spend a moment prior to the start of the CHAP annual meeting.

CHAP's first major initiative has been to establish an access plan that connects participants to a primary care site or "medical home." This will help patients manage their health more effectively, and in turn, improve health outcomes. The access plan will

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Cuyahoga Health Access Partnership (CHAP) Provides Progress Report at Inaugural Annual Meeting *(Continued from page 1)*

improve efficiency across the healthcare system by promoting care coordination, reducing episodic care, duplicative care and unnecessary evaluations. Initially the access plan will be open to all uninsured adults at or below 200 percent of poverty. Program enrollment will be limited to Cuyahoga County residents between the ages of 19 and 64 who do not qualify for public healthcare programs and are without an employer-sponsored insurance option.

Under the access plan, CHAP members will be enrolled where they receive primary care and complete one eligibility screening to become a CHAP member. Income eligibility redetermination will occur every 90 to 180 days depending on HCAP requirements for hospitals and primary care providers will refer CHAP members to specialty care as needed. There will be common protocol for financial eligibility with web-based software storing financial documentation which can be accessed from all sites, eliminating multiple determinations at different provider organizations. Provider organizations will accept the same proofs of residency and income and will maintain their individual sliding-fee systems. A specialty network will be available through a CHAP service directory – a web-based searchable tool that will be utilized by staff at provider organizations to facilitate referrals to participating specialists.

Presenters noted that according to the 2008 Ohio Family Health Survey, roughly 142,000 people in Cuyahoga County, or 1 in 6 working adults (18-64), were without health coverage. The uninsured population includes many people with chronic health conditions such as asthma, diabetes, and hypertension that will worsen without regular medical care and could lead to more costly care and hospitalizations. As a result, an individual may be unable to work or function in his or her family and community.

A highlight of the annual meeting was the introduction of Ms. Sarah Hackenbracht, the new CHAP Executive Director. Sarah comes to CHAP from the Greater Dayton Area Hospital Association where she was Vice President of Public Policy. She is responsible for CHAP's strategic operations related to program development, communications, finance, and fund development. In cooperation with the CHAP Board of Directors, Ms. Hackenbracht will focus on CHAP's mission to provide access to primary and specialty health care services for the area's low-income, uninsured population. She also plans to work to expand CHAP's primary care capacity and identify gaps in specialty care based on CHAP utilization data, recruit physicians to participate in CHAP, and partner with other organizations to improve community health within the CHAP population.

Editor's note: *The AMCNO is proud to be a participating organization in CHAP with representation on both the CHAP Executive Committee and Board of Directors. AMCNO members interested in obtaining additional information about CHAP may contact the AMCNO at (216) 520-1000.* ■

PARTICIPATING ORGANIZATIONS

The Academy of Medicine of Cleveland & Northern Ohio
Care Alliance Health Center
CareSource
City of Cleveland
Cleveland Clinic
Cuyahoga County
Kaiser Permanente
MetroHealth System
Neighborhood Family Practice
Northeast Ohio Neighborhood Health Services
North Coast Health Ministry
Saint Luke's Foundation
Sisters of Charity Health System
The Free Medical Clinic of Greater Cleveland
University Hospitals

The AMCNO Joins Other Healthcare Organizations in Filing Brief to Preserve the Smoke Free Workplace Act *(Continued from page 1)*

Court of Appeals held the case should be remanded with instructions for the trial court to issue an injunction against Zeno's.

Zeno's appealed this ruling to the Ohio Supreme Court and filed its brief. The pleadings can be found at http://www.supremecourt.ohio.gov/Clerk/ecms/ by entering the name "Bartec" as a party to the action. Zeno's has three main propositions of law including: (1) the ODH's enforcement of the ban violates separation of powers, (2) the ban extinguishes property rights, and (3) that Ohio's declaratory judgment statute enables previously cited Ohioans to challenge the constitutionality of the statute.

The Amici refute each of Zeno's key arguments noting that the Amici share a common interest in providing relevant evidence on the health effects of tobacco use to the Court as it considers this important case concerning the exposure of Ohioans to the detrimental effects of secondhand smoke. The Amici address health effects, economic impact, and some key legal issues regarding secondhand smoke. There are 15 Amici in total including the AMCNO. The brief was filed on behalf of the Amici by McTigue & McGinnis, LLC, from Columbus, Ohio.

The Amici include the American Cancer Society, East Central Division, the American Cancer Society Cancer Action Network, the Academy of Medicine of Cleveland & Northern Ohio, the American College of Cardiology, Ohio Chapter, the American Heart Association, Great Rivers Affiliate, the American Lung Association of the Midland States, American Medical Association, Americans for Nonsmokers' Rights, the Association of Ohio Health Commissioners, Inc., the Campaign for Tobacco-Free Kids, the Cleveland Clinic, the Ohio Asthma Coalition, the Ohio Osteopathic Association, the Ohio State Medical Association and the Tobacco Free Legal Consortium.

The Amici have urged the Court to reject Zeno's assignment of errors to protect the health and welfare of Ohio's citizens noting that a ruling which upholds the regulations issued by ODH protects the lives of Ohioans, particularly restaurant, bar and lounge employees and patrons, is consistent with the intent of the voters, and preserves Ohio's economic resources. The brief includes points from a healthcare perspective noting that environmental tobacco smoke, more commonly known as secondhand smoke, kills people because secondhand smoke is highly toxic. The brief states that the Smoke Free Workplace Act is a vital law that saves numerous lives each year and provides for a better work environment. The Amici argue that the Ohio Department of Health must not be restrained from exercising reasonable authority to protect the health and welfare of its citizens. Because secondhand smoke plays a significant role in the incidence of tobacco-related cancer, cardiovascular disease, lung disease and other respiratory maladies, ODH is uniquely situated to adopt regulations to protect its citizens from its devastating impact. Reducing the incidence of illnesses caused by secondhand smoke will save thousands of lives each year and improve the economic landscape of Ohio. The Amici ask the Ohio Supreme Court to uphold the decision of the Tenth District Court of Appeals as ODH's enforcement of the Ohio Smoke Free Workplace Act does not violate the separation of powers principles and does not unreasonably impede property rights.

This challenge to the Smoke Free Workplace Act could have far reaching implications. The AMCNO will follow the discussion on this case and provide additional information to our members as the case moves forward. ■

AMCNO responds to CMS Proposed Rule – Physician Payments, Reporting and GPCI Calculation at Issue

On behalf of our membership, the AMCNO has submitted comments to the Centers for Medicare and Medicaid Services (CMS) in response to the proposed 2012 changes to payment policies and rates under the Medicare Physician Fee Schedule (proposed rule CMS-1503-P). Our comments focused on the issue of the flawed sustainable growth rate (SGR) formula currently utilized by CMS to calculate physician payments under Medicare, the Physician Compare website and items contained in the proposed rule relative to the geographic practice cost indices (GPCI) utilized by Medicare in Ohio.

Physician Payment Updates

The AMCNO commented to CMS that since 2002, the SGR formula has annually called for reductions in Medicare reimbursements. Payments were cut by 5 percent in 2002. Congress has intervened on 12 separate occasions since then to prevent additional cuts from being imposed. The current formula outlined in this rule calls for cuts of 29.5 percent on January 1, 2012. The AMCNO also noted we remain very concerned that all patients will be adversely affected by these proposed payment changes because Medicaid and private insurers use Medicare rates as a resource for their reimbursement rates.

The AMCNO further noted that while we realize that ultimately the administration and Congress will have to act in order to replace the SGR, we believe that CMS and its' administrators have the ability to review comments from physicians, physician organizations and other healthcare providers regarding the proposed payment and policy changes to find ways to improve physician payment without adding to overall Medicare costs. We also noted that recently the CMS Administrator, Dr. Donald Berwick, acknowledged that an additional cut in Medicare physician payments would have serious consequences. The AMCNO concurs with his comments and we have urged CMS and Congress to work toward a solution to this ongoing issue and finally pass a permanent SGR fix in order to solve this problem once and for all.

Physician Compare Website

As a part of the Affordable Care Act, CMS must develop a Physician Compare Internet website with demographic and performance information on physicians enrolled in the Medicare program. The AMCNO commented to CMS that as we have been working on legislation in Ohio to address the issue of physician ranking by insurance companies, we have stressed the importance to provide patients with accurate information when selecting a physician. We believe that the crux of the issue is to balance the rights of physicians to have accurate and relevant reporting of their practice with the desire of consumers to have access to information about their treating physician. We strongly urged CMS to assure that the physician information provided to the public on the Physician Compare website is based on quality data versus cost and claims data, and that the data is accurate. The AMCNO also urged CMS to provide physicians with the ability to appeal their data prior to posting any information on the website. The AMCNO further offered to work with CMS to ensure that public reporting of performance information is accurate, relevant and useful to patients.

Geographic Practice Cost Indices (GPCI) Locality

At this time, CMS uses 89 physician payment localities among which fees are adjusted however; the AMCNO strongly believes that Medicare's geographic payment adjustment formula does not accurately reflect practice costs in Northern Ohio. Currently, the state of Ohio is designated as a statewide locality. The AMCNO commented that this is problematic for our physician members practicing in Northern Ohio because CMS has not revised the geographic boundaries of the physician payment localities since 1997. Also, since that year, CMS has indicated that the only mechanism the agency has set forth to modify the payment localities is for the state medical association to petition for change by demonstrating that the change has the overwhelming support of the physician community. We also noted that this mechanism for change in the payment localities seems biased since the state medical association does not represent all of the physicians in the state of Ohio.

The AMCNO has been sending comments to CMS for a number of years outlining our concerns with the geographic payment adjustment formula so we were pleased to learn that CMS has asked the Institute of Medicine (IOM) to evaluate the accuracy of the geographic adjustment factors used for Medicare physician payment. The AMCNO has reviewed the June 2011 IOM report and noted that the IOM has recommended utilizing geographic health sector data from the Bureau of Labor Statistics, expanding wage data to account for all types of health workers in private practice, and using the same number of geographic market areas for physician and hospital payments. The IOM committee also concluded that the program should be using more accurate data when adjusting pay rates based on where physicians and hospitals are located. Geographic adjustments to Medicare payments are intended to accurately and equitably cover regional variations in wages, rents, and other costs incurred by hospitals and individual health care practitioners. The report also stated that the program should employ the metropolitan statistical areas (MSAs) developed by the Office of Management and Budget for both hospitals and physicians. The IOM report also mentions that MSAs reflect information on where people live and work and decisions made by employers and employees that define labor markets' boundaries.

AMCNO Advocacy At Work

The AMCNO has advocated for geographic adjustment reforms for many years and we included in our comments to CMS that the IOM recommendations validate the AMCNO concerns and we agree that a payment option should be based on geographic areas as defined by the Office of Management and Budget, and one which uses Metropolitan Statistical Areas (MSAs) and Metropolitan Divisions (MDs) to form localities in each state. The AMCNO believes that this option is viable due to the fact that it is based upon the localities used to pay other Medicare providers, such as hospitals, skilled nursing facilities and ambulatory surgery centers, which allow for a more focused recognition of geographic cost differences. We informed CMS that if implemented, this option would create additional localities in Ohio and would be of benefit to the physicians in our area of the state as well as other metropolitan areas in Ohio.

Due to the timing of the release of IOM's report and the fact that CMS does not yet have the second supplemental report on the GPCIs, CMS was unable to address the full scope of the IOM recommendations in this proposed rule, however, the AMCNO has asked CMS to carefully review and evaluate the IOM reports and make changes in the Medicare program to use more accurate data when adjusting pay rates based on where physicians and hospitals are located.

The AMCNO physician leadership will continue to monitor these issues and provide additional information to our membership as it becomes available. ■

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and the Academy of Medicine Education Foundation (AMEF) Meet and Greet First Year Medical Students

The AMCNO and AMEF were pleased to host the Case Western Reserve University Society Dean's Mixer for first-year medical students held at the Cleveland Botanical Garden. Physician leadership from both the AMCNO and AMEF mingled with the more than 200 medical students and the society deans who attended the event providing information and answering questions about the activities of the AMCNO and AMEF. AMCNO President, **Dr. Lawrence Kent**, provided brief comments to the group and encouraged the first year medical students to become involved in organized medicine and specifically in the AMCNO. He explained that the AMCNO is a group of dedicated physicians who are working to improve quality of care, while providing education and community outreach in our community. He also mentioned the advocacy activities of the AMCNO and noted that the students should consider getting involved because the association and affiliation with doctors in practice can clearly help them to focus on what their career has to offer and how to move toward their goals. Last he noted the activities of AMEF mentioning the scholarship opportunities offered to medical students.

During the event, the students asked AMCNO physician representatives about the activities of the AMCNO and AMEF, how they could get involved in the organization and how to engage with physicians in the community. The students also conversed with the AMCNO representatives about quality and patient safety issues including quality reporting measures, value-based purchasing and other matters. The AMCNO staff was on hand to provide all of the students with membership information and application forms and encouraged all of them to participate as student members of the AMCNO. ■

Dr. Laura David, AMCNO Immediate Past President, chats with a group of students.

Dr. Ronald Savrin, AMCNO Past President and AMEF board member, talks with the first year medical students.

Dr. Pamela Davis, spends a moment with a group of students.

Dr. Lawrence Kent, AMCNO President, provides welcoming comments and encourages the medical students to join the AMCNO.

AMCNO Resident Recruitment a Success

It was a busy summer both for new graduates beginning their residencies and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) in one facet of its membership efforts by welcoming new physicians-in-training into Northeast Ohio's professional medical society. In all, more than 400 new physicians joined the AMCNO as resident members this summer from the following institutions: Cleveland Clinic Foundation, Fairview Hospital, Huron Hospital, MetroHealth Medical Center, University Hospitals, St. John Hospital, St. Vincent Charity Hospital and South Pointe Hospital. AMCNO membership entitles these new physicians to many benefits. These include receiving updates on all manner of health care related news as well as legislative and regulatory updates under review by the Ohio General Assembly and the United States Congress, legislative representation at the Statehouse by AMCNO lobbyists, listing in the membership directory, seminars, publications and opportunities to serve on AMCNO committees and more.

Welcome to all new medical students and resident members!

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

Alexandria Howard, a former AMEF scholarship recipient, signs up for an AMCNO resident membership at the University Hospital resident orientation.

A group of residents from Metro take the time to fill out AMCNO membership applications at their orientation event.

Save Money on Your Workers' Compensation Coverage

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is pleased to offer a Workers' Compensation group rating plan to our members that can help you save money on the premiums you pay to the Ohio Bureau of Workers' Compensation. This plan is made possible through our longstanding partnership with CompManagement, Inc., (CMI) a Sedgwick CMS Company. CMI has begun the review process for 2012 group participation, which means you can find out how much you can save! AMCNO practices already enrolled in the AMCNO Group Rating Program will receive a letter regarding review for renewal with the program as well as contact information for CompManagement.

A free, no obligation quote can be obtained for the 2012 policy year through CompManagement or AMCNO one of three ways:

FAX: Click here http://www.amcnoma.org/webpages/AMCNO_AC3.pdf to obtain a copy of the application form from the AMCNO website. Complete the form and fax it back to CompManagement at (866) 567-9380.

ONLINE: Go to http://resources.compmgt.com/AC3/GroupRating.aspx?Organization=AMCNO to access and complete the application online.

PHONE: Complete the application over the telephone by contacting the CompManagement Customer Support Unit at (800) 825-6755, option 3.

CompManagement will review the application and determine your potential savings and contact you with a cost analysis. If you decide you want to participate, all you need to do is sign and send in the enrollment paperwork included in your cost analysis. This is a no-cost, no obligation review. If you are currently a member of another medical association in the state and participating in a group rating plan other than through the AMCNO you are probably paying higher member dues to remain in that plan.

Upon review, you may find that the AMCNO dues are substantially less per member and we provide group discounts which cost effectively enables our physician members to take advantage of the worker's comp group rating program along with other AMCNO benefits and services at reduced cost. If you have questions regarding the program contact Ms. Linda Hale at the AMCNO offices at (216) 520-1000, ext. 101. ■

LAWYER REFERRAL BROCHURE

If you are in need of legal counsel in a specific area of expertise this brochure could be of assistance to you.

When legal questions or issues arise, the AMCNO believes it is important for its members to obtain sound advice from legal counsel who are knowledgeable in relevant areas of the law and who have a commitment to the effective representation of physicians and their practice groups. This brochure is the product of our effort to identify such attorneys. We encourage our members to make use of these lawyers (or other practitioners similarly qualified) whenever they encounter significant legal issues.

If you would like a FREE copy of the AMCNO Lawyer Referral Brochure please contact the AMCNO staff at (216) 520-1000, ext. 101.

ATTENTION AMCNO RESIDENT MEMBERS
SAVE THE DATE FOR OUR FREE RESIDENT SEMINAR

Preparing for the Business Aspects of Medicine

OCTOBER 26, 2011

Presented by:
The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)
McDonald Hopkins LLC • Sagemark Consulting • Squire Sanders • Walthall, Drake & Wallace LLP

Sponsored by
The William E. Lower Fund and The Academy of Medicine Education Foundation

Wednesday, October 26, 2011, 6:00 PM
Location: AMCNO
6100 Oak Tree Blvd., Independence OH
Ground Level Meeting Room

This seminar will provide residents with valuable information on estate planning, how to develop a personal financial plan, the business and tax aspects of a medical practice, and will cover important legal matters and other issues for new physicians joining a practice. This informative session has been provided to AMCNO resident members for over 12 years by legal and financial consultants from the Northern Ohio area. Residents are encouraged to bring questions and join us at the AMCNO offices for an evening packed with valuable information. Spouses welcome. This seminar is FREE to all AMCNO resident members.

To obtain a copy of the seminar flyer go to www.amcno.org
For registration information contact lhale@amcno.org or phone (216) 520-1000 ext. 101.

AMCNO Legislative Report to Members

Ohio Budget Overview

From January through July most of the legislature has been focusing on the Ohio budget. With the state facing an estimated $5 to $8 billion budget deficit and Gov. Kasich's pledge to not raise taxes, the House and Senate presented the Governor a bill that cut spending, cut taxes, and was loaded with policy changes to transform government. The bill also allowed for the sale of state assets to generate revenue and offset the budget deficit. On June 30th, Gov. John Kasich signed the $55.7 billion two-year state operating budget (HB 153).

Some of the more notable cuts in HB 153 included a $340 million cut in Medicaid funding for nursing homes, a $535 million cut from the local government fund, and a $3 billion reduction in spending for K-12 education. HB 153 also eliminated the Ohio Estate Tax which will cost the state and local governments about $300 million annually.

In the healthcare arena, Gov. Kasich implemented a mixture of cuts and policy changes to address the budget shortfall. In addition, the administration has made preventative care a priority in order to improve the overall health of the Medicaid population with the intent to cut long-term healthcare costs.

HB 153 includes several items related to healthcare which will:

- Eliminate the Ohio Healthcare Coverage Quality Council – this council was set up under Governor Strickland through the Ohio Department of Insurance and has been dissolved.
- Allow the Ohio Department of Health (ODH) director to adopt rules that define what constitutes a health home for the purposes of any healthcare provider that provides care coordination services
- Eliminate the 3 year moratorium on Most Favored Nation clauses
- Require the Ohio Department of Job and Family Services (ODJFS) to establish a Medicaid Managed Care Performance Payment Program to make payments to MCOs that meet performance standards
- Prevent cuts to the Medicaid reimbursement schedule except when a Medicaid rate is greater than what Medicare pays for the same service
- Reduce the Medicaid programs reimbursement rate for nursing and aide services at healthcare facilities and providers of home care
- Allow the Ohio Department of Job and Family Services (ODJFS) to seek federal payment for Help Me Grow program services
- Require the ODJFS and the Ohio Department of Health (ODH) to develop a proposal for coordinating the medical assistance provided to families and children under Medicaid while they wait to be enrolled in Medicaid managed care in order to achieve efficiencies in the delivery of medical assistance.
- Mandate the ODJFS to reduce the complexity of the eligibility determination process for Medicaid, which includes 9 federally-mandated coverage groups and 7 optional coverage groups
- Allow for presumptive eligibility for pregnant women seeking prenatal care while waiting to obtain a Medicaid card
- Give incentives to assist hospitals with the expense of implementation of the use of electronic health record technology
- Create a $130 million Medicaid reserve fund to allow the Office of Budget and Management to transfer funds when needed
- Enroll 37,000 Ohio ABD Medicaid children into managed care organizations and allow children's hospitals to develop pediatric accountable care organizations for ABD children as an alternative to Medicaid managed care
- Allow for the establishment of a process for physician assistants to enter into a Medicaid provider agreement and require Medicaid reimbursement rates for physician assistant services.
- Eliminate Medicaid payments for provider-preventable conditions
- Allow for the automatic suspension of Medicaid provider agreements under certain conditions
- Continue hospital assessments

The AMCNO has been and plans to remain active in many of the initiatives taking place in Columbus, on both the legislative front and on the administrative side, inclusive of working with the Kasich administration on the implementation of the new policies and programs.

Legislation to Begin Moving in September

Over the last eight months there have been a number of bills introduced in the Ohio General Assembly that will impact physicians and healthcare providers. Now that the budget is completed the legislature will come back from their summer recess and start to focus on legislation.

AMCNO continues to work on the physician ranking legislation. The legislation is currently in the Ohio Senate Insurance and Commerce and Labor Committee and State Senator Tom Patton, the sponsor of the bill, has presented the committee with sponsor testimony. When the members of the Ohio Senate return from their summer break the AMCNO will be presenting proponent testimony on this important issue.

The AMCNO is also working with the staff from the Ohio House of Representatives and the Legislative Service Commission to draft legislation which would institute changes in the state law related to providing immunity to physicians, hospitals and other health care providers for reports of drug abuse or conditions suggesting unsafe driving. This issue has been under review by the AMCNO medical legal liaison committee for several months. The legislation will pertain to physician liability for reporting a patient in certain circumstances which at this time could constitute a violation of HIPAA laws. More information on this legislation will be included in future issues of the *Northern Ohio Physician*.

SB 83 — the prescriptive authority legislation — has already passed out of the Ohio Senate and now moves to the Ohio House for debate and discussion. This bill provides advanced practice nurses (APNs) with the authority to prescribe schedule II controlled substances, in addition to adding a course of study in advanced pharmacology for APNs, as well as imposing additional duties upon the Committee of Prescriptive Governance and the Board of Nursing. The AMCNO is closely monitoring this legislation and will keep its members informed as it moves through the Ohio House.

SB 129 would grant civil immunity to physicians providing treatment under the Emergency Medical Treatment and Active Labor Act or as the result of a disaster. This bill has had two hearings and has the support of close to ten members of the Ohio Senate. The AMCNO strongly supports this bill and we are monitoring this legislation as well.

The Ohio legislature has also been debating issues related to the federal Patient Accountability and Affordability Act. SJR 1 was introduced with the intent to remove the provision which would mandate the purchase of health insurance in Ohio. The resolution, if passed, would have resulted in placing an option on the November ballot whereby voters would decide if the issue should become an amendment to the Ohio Constitution. SJR 1 moved through both the Ohio Senate and Ohio House and then through a dramatic turn of events was defeated on the floor of the Ohio House along partisan lines. As a result, an independent group has circulated petitions and gathered the necessary signatures to have the amendment placed on the ballot. Therefore, this amendment will appear on the November ballot as Issue 3.

Administration to Begin Work on Implementing Changes

The AMCNO has been working with the Kasich administration as it implements rules and takes

AMCNO LEGISLATIVE UPDATE

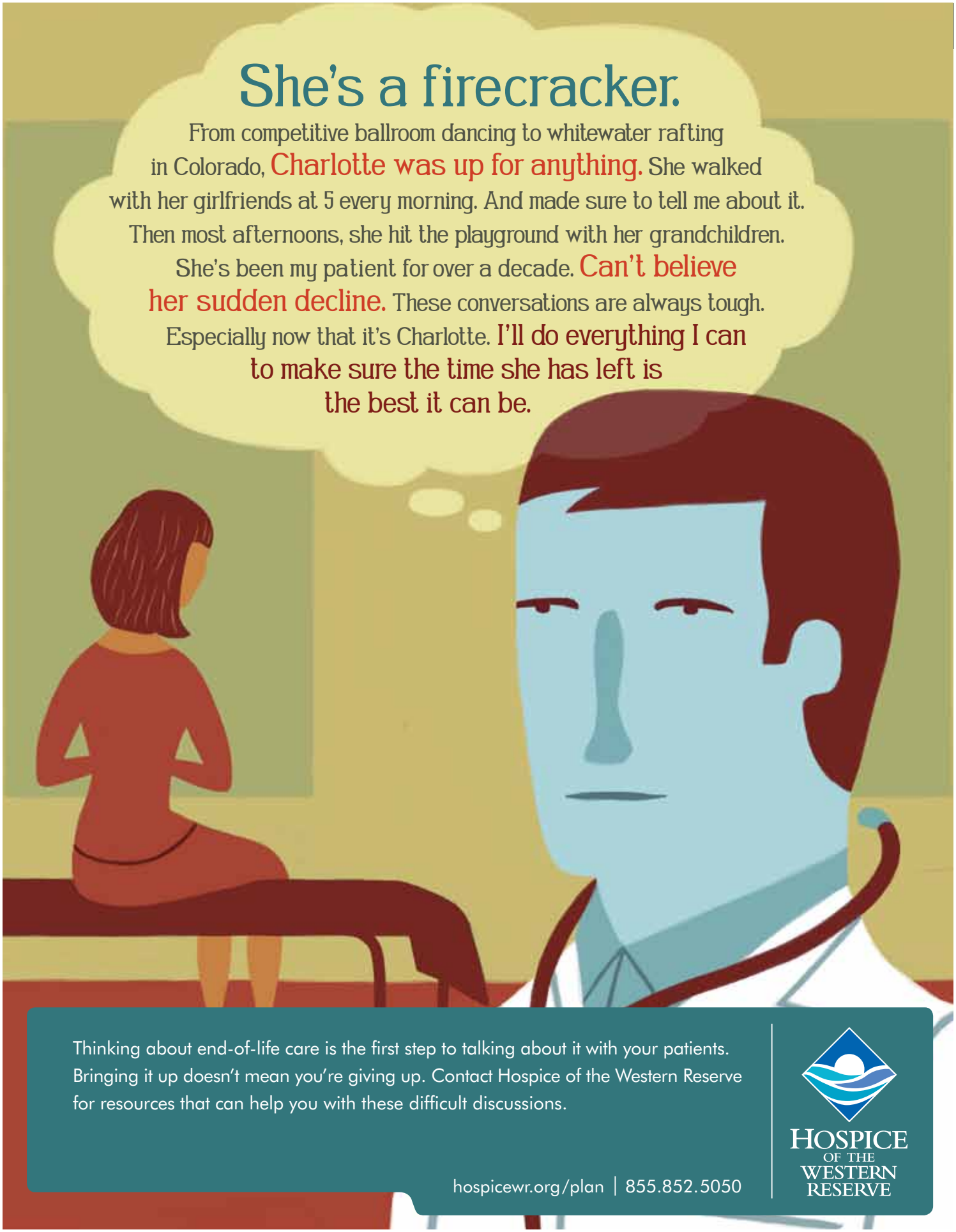
on new initiatives. Currently, the AMCNO is working with the Ohio Department of Job and Family Services and the Department of Health as it creates and implements rules and procedures for its Health Home initiative. The work groups have been meeting over the summer months and a report will be provided in the fall. The AMCNO will keep our members apprised on this initiative.

Gov. Kasich has publicly stated that he has a reform agenda in mind and his priorities include: pension reform, Bureau of Workers Compensation reform, public pension reform, revisions to the Consumer Sales Protection Act, and school funding and education reform. Gov. Kasich has also mentioned the possibility of a capital appropriations bill that could provide for construction of new projects and even be used as a policy vehicle for more changes to issues not addressed in HB 153. With the majority of cuts in the state operating budget occurring in the second year, Gov. Kasich may also consider exploring another state budget bill.

Also on the agenda for this fall is legislation that will redraw Ohio's congressional districts. As a result of a population loss in the 2010 census, Ohio will drop from 18 members in the U.S. House of Representatives to 16. The population in Northeast Ohio is of particular concern since there has been a decrease in our population while Southwestern and Central Ohio have seen population growth. As a result, Northeast Ohio's representation in Congress will be reduced. This issue will cause a great deal of debate since Ohio will now have to eliminate two Congressional districts.

Another task coming up for the state apportionment board is the redrawing of Ohio's 99 statehouse and 33 senate districts. And again, due to population shifts Northeast Ohio will lose influence in Columbus. It is anticipated that Cuyahoga County is going to lose at least one member of the Ohio House of Representatives dropping our delegation from 13 to 12 members.

The AMCNO is gearing up for a busy legislative session starting in the fall and we will be keeping our members apprised of our activities. If members have any questions about this legislative report of any of the legislation mentioned in this article please contact the AMCNO offices at (216) 520-1000. ■


She's a firecracker.
From competitive ballroom dancing to whitewater rafting in Colorado, Charlotte was up for anything. She walked with her girlfriends at 5 every morning. And made sure to tell me about it. Then most afternoons, she hit the playground with her grandchildren. She's been my patient for over a decade. Can't believe her sudden decline. These conversations are always tough. Especially now that it's Charlotte. I'll do everything I can to make sure the time she has left is the best it can be.
Thinking about end-of-life care is the first step to talking about it with your patients. Bringing it up doesn't mean you're giving up. Contact Hospice of the Western Reserve for resources that can help you with these difficult discussions.
hospicewr.org/plan | 855.852.5050
HOSPICE OF THE WESTERN RESERVE

ICD-10 Straight Talk: Overview

By Angela "Annie" Boynton, BS, RHIT, CPC, CCS, CPC-H, CCS-P, CPC-H, CPC-P, CPC-I

The need to move to ICD-10 is a well-known and ongoing saga. The current standards: ICD-9-CM Volumes I, II and III are over thirty years old and are becoming increasingly outdated. Several factors including old terminology, obsolete technology, limited upgradability, and a lack of accurate international data exchange, have all furthered the need for an overhaul of the clinical classification system.

As a result of the Final Rule on January 15, 2009 the United States is implementing the diagnostic subset: ICD-10-CM (International Classification of Disease 10th Revision with Clinical Modification) concurrently with the procedural subset: ICD-10-PCS (International Classification of Disease Procedure Code System). The federal implementation compliance deadline for covered entities is October 1, 2013.

It is a well-established fact that the United States is one of the last economically developed nations to undergo the transition to ICD-10. Furthermore, the United States will be implementing the most comprehensive version of ICD-10 with a little over 155,000 codes in ICD-10-CM and ICD-10-PCS. Many countries (Germany, Canada, Australia, and New Zealand) implemented customized versions of ICD-10 tailored to their single payer health systems. By the time the October 1, 2013 implementation mandate arrives, almost 20 years will have passed since the first of our international neighbors underwent their ICD-10 transition process.

The single greatest challenge many physicians will have falls within improving documentation, which will require physicians to spend additional time to document better. The increased documentation needs alone are going to be a challenge. However, it is important to remember that the rules for documentation are not changing with ICD-10. Ask any physician/coder team who have been audited, and they will tell you that the documentation guidelines in ICD-9 are very specific, but the codes do not keep up with the documentation requirements. This is because the ICD-9 codes have not been specific enough. For the first time, with ICD-10, we will have a clinical classification system that is sophisticated and granular enough to keep up with the regulations.

The revenue and productivity impacts surrounding the transition are real and could be very significant if practices do not start building their implementation plan early-on. It is an industry accepted fact that revenue will be impacted in 2013. The severity of the impacts and to what extent is unknown, but the industry agrees that physicians, facilities and payers should plan for at least 6 months of revenue and productivity impacts. This is why early planning is so important for the ICD-10 transition.

As part of your ICD-10 implementation planning all medical practices should ask themselves the following:

- Does your practice have enough savings to sustain itself through 6 months?
- How will you provide training to your coders to ensure productivity and revenue impacts are mitigated as much as possible?
- Will your payers be ready? Who have you spoken with within your payer organizations to confirm this?
- Will your practice management system be ready for the transition, and will your vendor take care of the update for free?

The banking industry has become more involved with the national transition to ICD-10. Many banks and financial leaders have informed healthcare organizations and industry stakeholder groups such as, The Workgroup for Electronic Data Interchange (WEDI), and The Health Information Management Systems Society (HIMSS) that practices worried about their post-ICD-10 implementation revenue should consider financial options available to them now, and not wait until 2013. This is sound advice, which also requires additional planning. Hoping that ICD-10 will go away or ignoring the transition is a guaranteed means to failure.

The key to tackling ICD-10 is to analyze business processes, people and technology within your practice that currently use ICD-9 codes. Having thorough understanding of how, where and why the codes are used will better enable physicians to understand the extent to which work will need to be done to transition to ICD-10 successfully. Early planning is the key to success.

Coding Spotlight ICD-10-CM:

The ICD-10-CM, the diagnostic subset, does have some additions, and changes, the most startling is the look of the code, up to seven alphanumeric characters which is quite different for the current 5 character system we use today. Physicians should expect the learning curve for ICD-10-CM to be much smoother than the procedural counterpart. The rules, conventions and guidelines in ICD-10-CM are very similar to what is currently in ICD-9-CM with only a few changes.

Let's use Chronic Kidney Disease (CKD) as an example: currently coders are required to make their code selection based on severity, this does not change in ICD-10. Classification of CKD in ICD-10 continues to be based on severity represented by stages I-V and is assigned from the N18 section. End Stage Renal Disease (ESRD) is still only assigned when it is actually documented and is also assigned from the N18 section. For cases where patients have CKD in conjunction with other diseases like diabetes mellitus or hypertension, the ICD-10 book still directs the coder in the proper sequencing of the codes. Furthermore there are still codes to represent the complications of transplants, but in this area there is greater specificity available to adequately represent complications. A newer concept in ICD-10-CM is the multitude of combination codes available. In ICD-9-CM what took us two or three codes may now only take one combination code in ICD-10-CM. Take a look at this example:

- A patient diagnosed with malignant hypertension and stage 5 chronic renal disease is admitted to the critical care unit. The patient is now in acute renal failure with acute cortical necrosis.
  - o First listed diagnosis: I12.0 Hypertensive chronic kidney disease with stage V chronic kidney disease or end stage renal disease
  - o Second listed diagnosis: N18.5 Chronic kidney disease, stage V

Coding Spotlight ICD-10-PCS:

The procedural subset: ICD-10-PCS, in unlike anything we have seen before. It vastly differs from what we currently use as it is a seven character, alphanumeric code that is table based. The ICD-10-PCS subset will be used highly in the inpatient facility coding arena, but knowledge of the codes at the practices level would be necessary for revenue analysis. The key to building an ICD-10-PCS procedure code is finding the correct table. This will require coders to have a higher level

(Continued on page 12)

ICD-10 Straight Talk: Overview *(Continued from page 11)*

of anatomical and physiological education, and a medical terminology class is no longer enough. Coders will need a college level anatomy and physiology that can help them maneuver through ICD-10-PCS. Take a look at this example:

- An in-patient diagnosed with gallstones opts for an elective laparoscopic cholecystectomy.
  - o Procedure: 0FT44ZZ Laparoscopic Cholecystectomy

Coders will need to understand body systems, root operations, body parts, approach, and devices. Root operations could pose serious issues for coders who do not have thorough understanding of anatomy, and how procedures are performed. For example, coders will be required to differentiate between excision vs. resection, inspection, occlusions vs. restrictions, release vs. division, transplantation vs. administration, etc. Practices can be on the look out for reputable anatomy classes specific for ICD-10; many organizations are conducting or will begin conducting these classes soon. Furthermore, specialty physicians should look to their specialty societies for guidance. Many specialty societies are developing materials to help smaller practices navigate ICD-10 implementation. Bottom-line is that physicians should be engaging in any resources available to them, whether it is from a specialty society or even from a payer. Most payers are further down the implementation pathway and have valuable knowledge and resources to share.

Simply put, if practices are not compliant by the October 1, 2013 deadline they are risking their business. This is not an over-dramatization, it is reality, and avoiding ICD-10 will not make it go away. It will make the process more costly, more difficult, more resource intensive, and more stressful. The only sure way to lessen the costs associated with ICD-10 implementation is to understand the impact that implementation will have on your organization. There are absolutely no signs coming out of Washington D.C. that point toward ICD-10 being delayed. On the contrary, documentation coming out of the Centers for Medicare and Medicaid Services (CMS) states that October 1, 2013 is the final deadline. Therefore, the only sure way that physicians can protect themselves is to begin ICD-10 implementation before it is too late.

Annie Boynton is a multi-credentialed coder and the Director 5010/ICD-10 Communication, Adoption and Training for UnitedHealth Group. She is an adjunct faculty member at Massachusetts Bay Community College and is a developing member of the AAPC's ICD-10 Training team. Annie frequently speaks and writes about coding matters, including ICD-10 and 5010 implementation. ■

News from the Ohio Health Information Partnership

New Brochure and Fact Sheets on Clinisync's Offerings

The Ohio Health Information Partnership has recently announced that Clinisync has produced new resources for physicians on their new statewide health information exchange (HIE). One covers what a master patient index (MPI) is and how it helps link patients to the HIE with a longitudinal record. Another fact sheet describes what direct messaging is and how it works. Direct messaging will allow a physician to talk with other physicians and send information to them through a secure email message if you're not yet ready with your EHR system. The fact sheet also contains pricing and services of CliniSync. The brochures can be obtained online at www.CliniSync.org

The Office of the National Coordinator States that Meaningful Use Stage 2 Likely to be Pushed Back

At a recent ONC regional meeting in Minneapolis, Dr. Farzad Mostashari, M.D., Director of the ONC, said there is every indication that the meaningful use Stage 2 implementation date will be pushed back to 2014.

Some physicians and hospitals are putting off attesting to meaningful use Stage 1 this year since they would have to meet Stage 2 by 2013, whereas if they waited until next year they'd have until 2014.

This is a problem especially for the hospitals, since their meaningful use reporting period coincides with the federal fiscal year. Therefore, a 2013 meaningful use implementation date for the hospitals would mean they would need to meet Stage 2 meaningful use reporting requirements starting in October 2012, the beginning of the 2013 federal fiscal year. Since the new Stage 2 meaningful use regulations would not be finalized until mid-2012, there would be little time to restructure workflow to meet any additional reporting requirements introduced in Stage 2.

A decision by the Office of the National Coordinator for Health IT (ONC) and the Centers for Medicare and Medicaid Services (CMS) is expected by the end of the year or early 2012 after receiving public input, with the rule being finalized next summer. In June, CMS reported that 2,400 physicians and hospitals have received Medicaid incentive checks in the 17 states open for registration, and 560 physicians and hospitals have received Medicare incentive checks. A total of $273 million have been paid to physicians by CMS.

Only 1,000 Free Slots Left for EHR Adoption Assistance

The latest numbers from the Ohio Health Information Partnership show that 4,994 physicians and providers have signed up for free Regional Extension Center services. Since the Office of the National Coordinator for Health IT allotted 6,000 slots for free services to those qualified healthcare professionals who want to adopt or upgrade electronic health record systems, only 1,000 or so slots remain. For more information on the RECs go to www.ohiponline.org ■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Considering the Potential Impact of Limited English Proficiency (LEP) on Informed Consent

By Leslie M. Jenny, Shareholder, Sutter, O'Connell & Farchione

Consider for a moment the changing cultural landscape of Ohio. According to the 2010 United States Census Bureau data Ohio's population was 11,536,504. This data further reveals that 6.1% of Ohio's population (over the age of 5) reported that they speak a language other than English at home. Additionally, 15% of those reporting that they speak a language other than English at home report that they speak English "not well" or that they do not speak English "at all." Thus, approximately 97,000 Ohioans over the age of 5, qualify as "LEPs" or persons of Limited English Proficiency.

A Limited English Proficient (LEP) individual is a person "who does not speak English as their primary language and who has a limited ability to read, speak, write or understand English." Federal law, pursuant to Title VI of the Civil Rights Act of 1964, requires that language assistance and provision of information and services in languages other than English be provided to persons of limited English proficiency. In 2000, President Clinton further solidified these requirements by signing Executive Order 13166 — *Improving Access to Services for Persons with Limited English Proficiency.* This Executive Order required all agencies that provide federal financial assistance to issue guidance on how recipients of that assistance, including hospitals, can take reasonable steps to provide meaningful access consistent with the Title VI regulations.

All healthcare institutions receiving federal financial assistance through Medicare, Medicaid, federal research grants, and other assistance, are all subject to comply. This is true even if only one part of the institution receives federal assistance and these requirements apply to hospitals, primary care clinics, nursing homes, home health agencies, physicians and other providers. Title VI and Clinton's Executive Order have been further explained by separate Guidelines published by the federal government.

The United States Department of Health and Human Services (DHHS) has issued "guidance" to ensure that providers are ensuring "meaningful access" consistent with the above-mentioned regulations. Pursuant to the Guidance providers need to develop comprehensive written policies, including procedures on providing oral language interpretation and the need for offering trained competent interpreters. The Guidance further suggests that written materials, including consent forms and notices of the right to free language assistance, should be translated into regularly encountered languages other than English.

All of this historical information is interesting, but doesn't really reflect the significance of the developing issues with LEPs and the topic of informed consent. In Ohio, Revised Code Section 2317.54 provides some protection to the health care provider where documented "informed consent" has been obtained. Specifically, written consent to a surgical or medical procedure shall be presumed to be valid where the elements of the statute are satisfied. There must also be an absence of proof that "the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, ***or that person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written."***

Many consider communication to be the most fundamental element in the relationship between the health care provider and the patient. When accurate communication is not possible, patient care may suffer. Studies report that more than 1 patient in 10 at large urban hospitals cannot understand English. Further, available literature suggests that the use of available interpreter services by hospital clinical staff is suboptimal, despite evidence that trained interpreters contribute to quality of care and patient safety.

Incidents of professional negligence claims on behalf of LEPs continue to increase. Consider for a moment the case of a 34-year-old Hispanic gentleman who presented for ENT surgery related to his obstructive sleep apnea. This gentleman was non-English speaking. Surgical consent was obtained in the ENT clinic in the presence of a trained interpreter; however, the signed consent form was not executed at that time. This patient was referred for pre-surgical evaluation, including a visit with a member of the anesthesia staff. No interpreter was used at this PSE appointment when anesthesia options, risks and benefits were discussed. At the time of this anesthesia evaluation a family member was present and interpreted for the patient. This patient went to surgery and sustained a catastrophic brain injury related to anesthesia. The lawsuit was filed and, not surprisingly, the family member who had interpreted indicated that she was not proficient in English and did not understand what was explained at time of the informed consent discussion.

Additionally, a problematic case involving a 13-year-old has also been reported. This non-English speaking, young girl reported to the Emergency Room in some obvious abdominal distress. No interpreter was used and the physicians involved mistakenly believed that the patient was pregnant and was suffering from a pregnancy-related issue. Instead, this patient suffered a ruptured appendix and passed away while undergoing unrelated testing in the ED. The lawyer for the family asserted that, had the emergency department staff called for an interpreter, valuable time would have been saved in terms of discovery the nature of the patient's complaints and symptoms.

Both of these reported cases clearly suggest the value in preserving the protections provided to health care providers by Ohio law. In order to take advantage of the protections of Ohio's "Informed Consent" statute, providers must take note to carefully document the use of interpreters, the details of conversations with potential LEP patients and be cognizant of the inherent limitations of using family members rather than qualified interpreters. Practitioners must make themselves aware of the policies and procedures of the hospitals/clinics/facilities in which they practice so as to ensure that their personal practices are consistent with the institutional guidelines and/or requirements. Finally, significant consideration should be given to translating consent forms into frequently encountered languages so as to add an additional layer of precaution. ■

1 Hudelson, P: *Overcoming Language Barriers with Foreign-Language Speaking Patients: A survey to investigate intra-hospital variation in attitudes and practices.* BMC Health Services Research 2009,9:187.

2 Duffy, M: *Overcoming Language Barriers for Non-English Speaking Patients.* ANNA Journal 1999, 507.

United States Supreme Court Rules Against Prescription Data Restriction Law

By Paul W. Smith, Esq., Tucker, Ellis and West, LLP

In an important decision likely to affect the availability of physician-specific, prescriber information to pharmaceutical companies nationwide, the United States Supreme Court has rendered its decision in the case of *Sorrell v. IMS Health, Inc.* In this case, on June 23, 2011, the Court rejected a Vermont statute which forbade pharmaceutical companies from obtaining and using physician-specific, prescriber information in the marketing of their drugs. The Court determined that the statute placed a burden on speech and thereby violated the First Amendment of the United States Constitution.

The case was brought on behalf of an association of brand name drug manufacturers and Vermont "data miners." Data miners are companies who analyze prescriber-identifying information purchased from pharmacies that then produce physician-specific reports on prescribing behavior. Pharmaceutical companies lease these reports from the mining companies and incorporate the information into their marketing strategies. The state of Vermont opposed the lawsuit.

At issue was a section of Vermont's Prescription Confidentially Law enacted in 2007. Title 18 §4631(d) of the law prohibited pharmacists, and other similar entities, from selling records containing prescriber information, or, from permitting such records to be used for the marketing or promotion of drugs without the prescriber's consent. The statute also prohibited pharmaceutical manufacturers and pharmaceutical marketers from using prescriber-identifying information in the marketing of drugs without first obtaining the prescriber's consent. The statute did not, however, prohibit other users such as the State from obtaining and using this data for purposes other than marketing. These purposes included health care research, enforcing compliance with health insurance formulary lists, "care management" communications sent to patients to educate them on different treatment options available to them, law enforcement operations, and for purposes "otherwise provided by law."

The pharmaceutical and data mining companies argued that the statute unconstitutionally violated their rights under the Free Speech Clause of the First Amendment to the United States Constitution. They claimed the statute unjustly imposed restrictions on 'their' dissemination and use of prescriber-identifying information while imposing no similar restrictions on the State. The State of Vermont, on the other hand, argued that the statute did not restrict speech, but only placed a restriction on conduct because the use of prescriber-identifying information and the sales transfer process was conduct, not speech.

The State also argued that if the statute burdened speech, it burdened only commercial speech; a form of speech which may be subject to governmental regulation. They further claimed that any burden §4631(d) placed on speech was necessary to achieve substantial state interests; including, (1) the protection of medical privacy, including physician confidentiality; (2) the avoidance of harassment by pharmaceutical sales representatives; and (3) to achieve public policy objectives of improving public health and reducing healthcare costs.

The Court, however, determined that the State's asserted interests in support of the statute failed to justify the burdens which the statute imposed on speech. They noted that the statute failed to meet the State's alleged purpose of protecting physician confidentiality because pharmacies could still, under the statute, share prescriber-identifying information for purposes other than for marketing and with speakers to whom the State supported. The Court then addressed the State's argument that the statute was needed to prevent physician harassment by sales representatives and stated that the content based statute was unnecessary since physicians could simply avoid this consequence by declining to meet with the representatives.

Finally, the Court addressed the State's argument that the statute had the effect of improving public health and reducing healthcare costs, because without prescriber-information, drug representatives would be less likely to influence or alter prescriber decisions and to pressure prescribers into using high cost branded medications. The Court rejected this argument and said that the State could not seek to achieve its policy objectives by restricting "certain speech by certain speakers," or more particularly, by diminishing pharmaceutical representatives' abilities to influence prescription decisions.

In its 6-3 decision, the Court ruled in favor of the drug mining and pharmaceutical companies and held that the Vermont statute was unconstitutional. The Court determined that "mined" or prescriber-identifying information was "speech" and that speech in aid of pharmaceutical marketing was a form of expression protected by the Free Speech Clause of the First Amendment.

Physicians are likely to have varied responses to the Sorrell *decision. Some will be in favor of the decision as pharmaceutical companies will be able to use "mined" data to tailor their marketing strategies to more efficiently serve physicians' particular needs. Other physicians, however, may be less enthusiastic about the decision and have concerns about the ramifications it may have to their privacy. In any case, the Supreme Court's decision in* Sorrell *is significant because it determined that prescriber-identifying information is a form of speech protected under the United States Constitution.* ■

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Quality Improvement Organization Program 2011-2014

By Ronald A. Savrin, M.D., MBA

The Centers for Medicare & Medicaid Services Quality Improvement Organization Program is implemented locally through Quality Improvement Organizations in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. As we begin the newly defined three-year program (2011-2014), Ohio KePRO is pleased to continue its role as the Quality Improvement Organization for the State of Ohio.

The Centers for Medicare & Medicaid Services has established three broad aims as the foundation of the program: (1) Better health care, (2) Better health for people and communities, and (3) Affordable care through lowering cost by improvement. The new three-year program includes many new initiatives and opportunities for improvement. Although supporting each of the broad objectives, the Quality Improvement Organizations will focus on the following specific Aims:

1) Beneficiary and Family-Centered Care
   a. Case review
   b. Patient and family engagement
2) Improving Individual Patient Care
   a. Reducing healthcare-associated infections and healthcare-acquired conditions
   b. Reducing adverse drug events
   c. Quality improvement through quality reporting and Value Based Purchasing
3) Integrating Care for Populations and Communities
   a. Improving Transitions of Care
   b. Reducing Hospital Readmissions
   c. Using data to drive dramatic Improvement
4) Improving Health for Populations and Communities
   a. Promoting the adoption and meaningful use of health information technology
   b. Preventive care, including screenings and immunizations
   c. Preventing cardiovascular disease

In support of these aims, Quality Improvement Organizations will employ (1) Learning and Action Networks (2) Focused technical assistance and (3) Care Reinvention through Innovation Spread.

Unique to this new three-year program is the use of Learning and Action Networks to drive change. Ohio KePRO will convene and facilitate a number of collaborative networks in Ohio composed of stakeholders with common goals and interests. One such collaborative, an Electronic Health Record (EHR) Learning and Action Network," would welcome physician organizations such as the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), the Ohio Health Information Partnership and the regional sub-recipient partners, physicians and physician practices, EHR vendors, hospital and long-term care associations, beneficiary organizations and other interested parties. The agendas and the priorities of these networks, in support of both the broad and strategic aims, will be set by the participating stakeholders. Subject matter experts will be identified and made available to participants, toolkits for success will be developed and distributed, successes will be shared among all, failures will be discreetly subject to root cause analysis to seek out effective remedies, and technical assistance will be offered to providers at no charge. The endorsement and promotion of such a collaborative approach by the Centers for Medicare & Medicaid Services is new and refreshing, and validates a methodology Ohio KePRO and the AMCNO have long espoused.

The specific aims of the three-year program seek to address areas we can all agree represent opportunities for quality improvement. We would all like to eliminate healthcare-associated infections and, through a Learning and Action Network, we will work to reduce central line-associated bloodstream infections, surgical site infections, catheter-associated urinary tract infections and *Clostridium difficile* infections. Collaborative efforts will be directed toward reducing healthcare-acquired conditions such as the development of pressure ulcers, the inappropriate use of restraints, and patient falls. Preventing adverse drug events, particularly among patients with diabetes, patients on anticoagulation and other high-risk populations will improve the quality of care and may reduce both Emergency Room visits and hospitalizations. By providing technical assistance to providers and facilities, at no charge, we will facilitate quality reporting and improve provider reimbursements under the new Value-Based Purchasing program.

Improving health for populations and communities is supported by all stakeholders in the healthcare sphere. Through Learning and Action Networks and focused individual and group technical assistance, Quality Improvement Organizations will facilitate the adoption and meaningful use of electronic health records and promote electronic reporting in the Physician Quality Reporting System, increasing physician reimbursement. Recognizing that cardiovascular disease is a major determinant of population health, specific efforts will be undertaken to promote smoking cessation, control hypertension, and reduce LDL-cholesterol.

As the Ohio's Medicare Quality Improvement Organization, Ohio KePRO will, at no charge, support providers in their efforts to improve the quality of care delivered. Within each Learning and Action Network we will cultivate and convene providers, organizations, health departments, administrators, Boards of directors, patients and other stakeholders. We will plan, coordinate and support network meetings and conferences. As part of the national Quality Improvement Organization network and in conjunction with the Centers for Medicare & Medicaid Services, the Office of the National Coordinator for Health Information Technology, and others, we will share aggregate (de-identified) data, results of interventions, patient feedback and other actionable data. We will seek to identify and promulgate best practices and work closely with physicians and others to promote the highest quality of care. The newly defined three-year program establishes a new model for change. Although the Centers for Medicare & Medicaid Services through the Quality Improvement Organization Program will facilitate and sustain the program, the drivers for change will be a decentralized consortium of all stakeholders organized into Learning and Action Networks. As Ohio's Quality Improvement Organization, Ohio KePRO will offer focused technical assistance including on-site visits, intensive consultation and distribution of resources, all at no charge to providers.

If you wish to learn more about the Quality Improvement Organization Program, or wish to participate in one or more Learning and Action Networks please contact Ronald A. Savrin, M.D., MBA, Medical Director, Ohio KePRO, Rock Run Center, Suite 100, 5700 Lombardo Center Drive, Seven Hills, Ohio 44131, rsavrin@ohqio.sdps.org. ■

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The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by the Centers for Medicare & Medicaid Services, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore required no special funding on the part of this contractor. Feedback to the author concerning the issues presented is welcomed.

The AMCNO is pleased to be a founding member of Ohio's Learning and Action Network. The AMCNO is joining Ohio KePRO, the Ohio Health Information Partnership and other healthcare organizations throughout the state to engage in collaborative and educational activities offered through the network. Watch for more information coming to your office soon!

2011 AMEF GOLF OUTING

Eighty-one golfers enjoyed the Mayfield Country Club on August 8, 2011 at the Academy of Medicine Education Foundation's (AMEF) 8th Marissa Rose Biddlestone Memorial golf outing. Foursomes competed in a shotgun start tournament that raised more than $40,000 for AMEF. The funds will be utilized for medical student scholarships, annual CME seminars and the *Healthlines* radio program.

Congratulations to the 2011 Golf Outing Prize Winners

1st Place Team: James Kleinman, Dr. Richard Parker, Tom Pyle and Dr. William Seitz, Jr.

2nd Place Team: Kellison & Co.: Kevin Ellison, Larry Joseph, David Reddrop and David Reddrop

3rd Place Team: Wilson Beers, Mat Mark, Scott Platz and Dr. Matt Levy

Prizes were also awarded for the following:

Closest to the pin: Willie Austin, Anthony Bastulli, Larry Joseph, and Dr. Richard Parker

Longest drive: Wilson Beers, Jason Oblander

Longest putt holed: Larry Joseph

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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Sutter, O'Connell & Farchione

Get your clubs ready for next year's event on August 6, 2012 at Chagrin Valley Country Club.

GIANT EAGLE Pharmacy®

INTRODUCING

Specialty Care Services



A patient-focused approach to complex therapy needs.

With Giant Eagle Pharmacy's new Specialty Care Services, patients are involved as active partners in the care process. We believe this approach helps to optimize adherence to your prescribed treatment plans.

We're committed to helping your patients navigate the complexities of their specialty therapy through comprehensive patient outreach that includes assistance with:

- Prior Authorization
- Insurance Verification
- Patient Copay
- Refill Reminders
- Side Effect Management
- Manufacturer Copayment Support

Plus, what sets us apart from other specialty pharmacies is our network of over 200 in-store pharmacy locations and face-to-face support from the pharmacist and staff that your patients know and trust.

Specialty Care Services are currently available to patients you are treating for:

- Cancer
- Psoriasis
- Crohn's Disease
- Rheumatoid Arthritis
- Anemia and Other Blood Disorders

For more information, contact specialtycare@gianteagle.com