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First Year Cleveland Releases Strategic Action Plan

For the last four decades, the City of Cleveland and Cuyahoga County have seen an alarming, persistent trend—a high infant mortality rate (IMR). In fact, Cleveland has one of the highest IMRs in the United States; some areas of the city are comparable to many lesser-developed countries.

Leaders from Cleveland and Cuyahoga County—as well as grieving parents and their families, frontline infant caregivers and several other leaders from health systems and organizations, including the AMCNO—decided in 2015 to come together to launch First Year Cleveland (FYC) to address the issue. A three-year strategic action plan to decrease the high IMR was devised and has now been released. It will serve as a collective guide from July 2017 through June 2020.

Comprised of more than 130 local leaders representing more than 40 organizations, FYC is on a mission to ensure every baby born in Cuyahoga County will celebrate a first birthday, and it will work to achieve this milestone by mobilizing the community through partnerships and a unified strategy to reduce infant deaths, including racial disparities. The organization's three-year strategic plan will focus on three specific areas related to IMR—racial disparities, extreme prematurity, and sleep-related deaths—as well as five areas of measurable action: establish shared measurement practices, support coordinated activities, build public will, advance public policy, and secure funding.

African Americans make up 38% of births in Cuyahoga County but represent 69% of infant deaths. The racial disparity persists regardless of education and income. Suggested reasons include structural racism, the mother's environment, nutritional deficiencies, and long-term stress. Last year in Ohio, the IMR for

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AMEF Sponsors Crain's Health Care Forum

The Academy of Medicine Education Foundation (AMEF) was pleased to be one of the many community sponsors of the Crain's Health Care Forum. Held at The NEW Center of the Northeast Ohio Medical University (NEOMED), this forum was convened in an effort to provide attendees with an assessment of the current state of health in healthcare in Northeast Ohio and its future outlook.

Following opening remarks from Dr. Jay Gershon of NEOMED, Elizabeth McIntyre, Publisher and Editor of *Crain's Cleveland Business,* led a panel discussion with local healthcare executives. Panelists included Dr. Brian Donley, Chief of Staff and Chief of Clinical Operations at the Cleveland Clinic; Dr. Bernard Boulanger, Executive Vice President and Chief Clinical Officer from MetroHealth; William Considine, CEO and President of Akron Children's Hospital; Dr. Dan Simon, President, University Hospitals Cleveland Medical Center; and Tom Strauss, CEO and President, Sisters of Charity Health System.

The panelists were asked to address various topics, including caring for the Medicaid population in Ohio. Dr. Donley noted that the Medicaid expansion has allowed access to patients who were in need of care to address chronic disease issues and substance abuse

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Panelists discuss healthcare issues during the forum. (l-r: Moderator Elizabeth McIntyre, Dr. Bernard Boulanger, Mr. William Considine, Dr. Brian Donley, Dr. Dan Simon, and Mr. Tom Strauss)

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First Year Cleveland Releases Strategic Action Plan *(Continued from page 1)*

African Americans was 15.1; the IMR for white babies was 5.5, meaning each African American baby born in Ohio was *three times* more likely to die before his or her first birthday than a white baby. In addition, African American women at every socioeconomic level have higher rates of infant mortality than white women who have not finished high school. FYC will take a leading role in supporting research to determine the sources of the differences as an essential step to developing solutions.

For more than 20 years, prematurity has been the largest contributing factor to infant mortality in Cuyahoga County. In 2015, within the city and county, there were 155 infant deaths—87 babies (55%) did not survive to celebrate their first birthday. Seventy of those babies (45%) were extremely premature, and the vast majority of them were African American. Throughout its action plan, FYC will collect and publish monthly data concerning prematurity, standardize protocol and practices for recording 22 weeks and less gestation birth certificates, host an annual conference on promising practices, and ensure that Cuyahoga County has the necessary resources to be a leader in premature birth research.

Sleep-related infant deaths are the second-leading cause of infant deaths. The three different types of these deaths are defined as sudden infant death syndrome (SIDS), sudden unexplained infant death syndrome (SUIDS) and accidental suffocation. In 2015, there were 27 sleep-related infant deaths in the city and county. FYC's action plan will focus on helping identify individuals and families who are at high risk for preventable sleep-related infant deaths through a risk assessment tool and link them with home visitor services, leading a faith-based, culturally sensitive behavioral modification plan to ensure all babies are put to bed following the ABC guidelines (ie, Alone, on Back, in Crib), and training all city and county employees on ABC to reinforce safe sleep in all home visits.

The Cuyahoga County Executive, Cuyahoga County Council, City of Cleveland Mayor, and Cleveland City Council have made an initial commitment of $2 million to begin to execute the work of FYC. Case Western Reserve University School of Medicine was selected to serve as the fiscal agent through April 2019, and is providing generous in-kind services, including office space for FYC staff, to help launch the initiative. In support of the campaign, the Ohio Department of Medicaid provided $4.86 million to support home visits, group prenatal care, a fatherhood initiative, and faith-based programs in the community.

AMCNO executive staff and Past President Dr. Laura David have been on board with FYC since the initial stages and will continue to participate in FYC meetings. The AMCNO will provide our members with reports on the progress of this campaign as new information becomes available. ■

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AMEF Sponsors Crain's Health Care Forum *(Continued from page 1)*

and addiction problems—noting that there is a need to improve access in order to reduce the burden of the cost of care. Dr. Simon agreed with these points and also noted that Medicaid expansion had an impact on bad debt and free care and it has helped to improve the financial stability of hospitals. Mr. Considine stated that there are 2.4 million children in Ohio, and 1.3 million of them are on Medicaid. Because Medicaid is the number one pediatric payer of healthcare in the county, he is concerned about the future of pediatric healthcare coverage. All of the panelists agreed that Medicaid expansion and enhanced coverage has improved the management of chronic health conditions and that there would be a great deal of uncertainty in the healthcare market if Medicaid coverage was cut back.

When asked about how patient access could be improved, the panelists agreed that there is a need to bring resources closer to the community—through primary care networks and partnerships. There is a real need to provide patients access to care where they live, shop and work. Patients want local access to their physician and they do not want to travel great distances to obtain that care. All of the panelists agreed that the issue of infant mortality has to be addressed as well—this can be done by creating partnerships with local governments and non-profits and working collaboratively with members of the community on education initiatives.

In response to a query about how to combat the rising cost of health care, the panelists said that population health can help reduce the demand for costly medical services—that is, focus on patients before they are really ill and build on population health strategy. If you can find a way to keep patients out of the hospital and focus on efficiency of care and care coordination while still keeping a watchful eye on quality and patient safety that can take the cost out of care, per the panelists. It was also noted that in the future the success of a hospital or system will depend on their ability to deliver value to patients and the purchasers of care.

Ms. Mcintyre from Crain's moderated the session and asked the panel about the health of healthcare providers—noting that we are reading more and more about burnout of those who have worked decades in the healthcare industry—and she asked the group if there has been an increase in burnout and, if so, why.

Mr. Considine noted that the pace of everything we do has skyrocketed—and the types of patients coming through the doors with different social determinants of care are at an all-time high. The challenges and the responsibilities of caregivers have grown—and the people who choose to work in the healthcare field have big hearts and give of themselves regularly, and many times they do not know when they have gone too far in terms of taking care of themselves and their own health. We need to talk about this in our organizations and have our eyes open, he said. "In our training program we send residents home after certain things happen. If something horrific occurs in the emergency room there is an emotional drain—we need to take care of the caregiver. One thing that has been successful is having caregivers talk about their experience to an auditorium of fellow workers. They talk about their frustrations and what happened. If you do not talk about it or have a vehicle in your culture or organization, you need to," Mr. Considine said.

Dr. Boulanger indicated that at Metro they are concerned about the wellness of their caregivers. They are buried under regulations, documentation requirements have increased and the electronic health record usage is an issue. The sound of medicine and nursing should not be the click of the mouse—we need the laying on of hands and looking at patients, he said. At Metro they are using EPIC's provider proficiency tool—they can see when providers are preparing notes and orders and doing other work in EPIC—so that executives can review these issues and try to free up the providers' time.

Dr. Simon noted that we also have to recognize that the expectations of millennial fellows and residents are different—especially pertaining to their work life balance expectations. During interviews for faculty positions the interview questions center around things such as how many vacation days do I have and how often am I on call. This tells us that the work life balance is very important—and wellness of our workforce is critical—so we need to have breaks and vacations. We need to change—if we do not, we will not have the workforce, he said.

Dr. Donley noted that this type of conversation is actually a healthy change. Some of the issues causing burnout are rules and regulations in health care, which have created a lot of work, but some of these are unnecessary and we need to reduce some of them. And then there is the explosion of knowledge that is available—machine learning and deep learning will help us deal with some of these issues, he said. But when we talk about people in health care they do not mind working hard—they have been doing that for many years—but what they care about is that they are losing some of the meaning and purpose in their work. So we need to try and restore that, Dr. Donley said.

The panel also discussed how to better partner with social agencies to affect change and responded to specific questions from the audience.

The keynote panel discussion was followed by "Stat Chats" on the topics of mental health, opioid and drug abuse, behavioral health and the workplace, and the aging population. Each topic area was led by an expert discussing the issue's current status and impact. Case study presentations followed, during which attendees had the chance to learn about some of the innovative solutions taking place in Northeast Ohio. Audience discussion and table talk took place after each expert/case study.

The final presentation was a discussion between a medical student and a professor from NEOMED focused on the changing healthcare sector, its challenges and opportunities.

The AMEF was pleased to sponsor this important community event.

To view Crain's coverage of this event go to www.crainscleveland.com/hcforum17 ■

AMCNO Registers New Medical Student Members at CWRU School of Medicine Society Dean Mixer

The AMCNO and Academy of Medicine Education Foundation (AMEF) were pleased to once again co-host the Case Western Reserve University School of Medicine Society Dean Mixer for first-year medical students. The event was held at the Cleveland Botanical Gardens during the summer.

AMCNO President Dr. Fred Jorgensen was a guest speaker and talked to the students about the work of the AMCNO and AMEF as well as the many benefits of being an AMCNO member, even as a medical student. He encouraged them to sign up for AMCNO membership and to become involved in the organization. He concluded his presentation by welcoming the students to the profession.

Several other AMCNO members attended the event, including Immediate Past President Dr. Robert Hobbs, President-Elect Dr. Bruce Cameron, Past President Dr. Bill Seitz, Jr., and AMCNO Board Member Dr. Pauline Kwok. They enjoyed having the opportunity to mingle with the students and society deans, discussing the organizations and recent activities, and answering any questions that the students had about their career and specialty choices. Many students also expressed an interest in learning more about the two organizations.

AMCNO staff was on-hand to provide membership information, and we are happy to report that more than 130 medical students signed up for membership. We welcome them to the organization!

You can view additional photos from the event on the AMCNO Facebook page. ■

AMCNO President Dr. Fred Jorgensen addresses the medical students gathered at the mixer.

Medical students attending the event sign up for AMCNO membership.

Physicians-in-Training Analyze Pollen Samples

On July 10, a pollen course taught by Nicole Tierney of Jordan, MN, was held at the Allergy/Immunology Associates clinic. During the one-day course, fellows and interns were taught how to use the Rotorod Sampler, an aerobiology sampling device located near the clinic that collects pollen, mold and other particles on small plastic rods. The rods are brought inside every day and analyzed using a light microscope. The attendees were shown how to prepare, mount and stain the rods in order to see the microscopic pollen and mold more clearly. They also learned how to identify various types of tree, grass and weed pollen to provide a volumetric pollen count to the public. The pollen count takes into consideration the percentage of the plastic rod that is analyzed, the amount of time the rods are exposed to the air and the duty cycle of the Rotorod Sampler. The pollen count is calculated Monday through Friday at the clinic and reported as a low, medium or high level via the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Pollen Line.

The AMCNO Pollen Line service has been assisting those with seasonal allergies for more than 50 years. It helps provide a line of defense to many who suffer from sneezing, itching, running noses, and watery eyes when the pollen starts to fly. The AMCNO would like to thank Allergy/Immunology Associates for providing the daily pollen counts for 2017, as they have been doing for the AMCNO for many years.

Nicole Tierney instructs the fellows and interns on how to use the Rotorod Sampler device.

The group gathers for further instructions on how to analyze the pollen samples.

AMCNO State Legislature and Administration Update

Budget Signed by Governor Kasich – Veto Overrides Take Place

In the July/August issue of the *Northern Ohio Physician,* we informed our members on the status of HB 49—the FY 18-19 biennium budget. Things have changed since the publication of that issue, so here's an update on the bill: On June 27, the Senate passed the Conference Report to HB 49 and the House voted to approve the Conference Report. The bill was then sent to Gov. John Kasich, who signed the bill into law on June 30—but only after he had issued 47 line-item vetoes.

In an unprecedented move, the House held a special session on July 6 and voted to override 11 of the governor's vetoes, most of which involved different aspects of the Medicaid program. The House made it clear that they may, at a later date, vote to override additional vetoes that were left pending. As of August 22, the Senate voted to override six budget vetoes; most of the items are Medicaid-related and two concern the authority of the Controlling Board to authorize expenditures.

On July 5, the day before the House vote, the AMCNO staff was on hand at the "Save Medicaid, Save Lives Rally" held at the Statehouse. More than 1,500 people showed their support for Medicaid expansion enrollment, urging lawmakers not to override Gov. Kasich's veto in the budget bill and place a freeze on enrollment.

The rally was organized by the Ohio Medicaid Coalition, which originally formed in 2013 to support Gov. Kasich's initial proposal to expand Medicaid under the Affordable Care Act and is comprised of more than 200 organizations—including the AMCNO, which has been a member since the coalition's inception. The group continues to focus on the goal of retaining coverage for the hundreds of thousands of Ohioans who have obtained coverage under the Medicaid expansion.

The moderator of the rally, Reverend Tim Ahrens, tells the crowd that "Medicaid coverage is the right thing to do."

AMCNO staff attends the "Save the Medicaid" rally at the Statehouse.

Several speakers discussed the positive impact of the Medicaid expansion during the rally. Advocates have vowed to continue to educate elected officials on the cost of a freeze on enrollment to the healthcare economy and the overall health and safety of the state and its citizens.

For now, the House has not chosen to override the veto on this portion of the bill (see below). As noted, the House may come back before the end of 2018 and discuss a potential veto, however, and the Senate could also consider additional overrides. The AMCNO will continue to follow this issue and report back to our members when updates are available.

Overview of Ohio House Decision to Override Several Budget Vetoes; Medicaid Freeze Not Included

The House voted to override 11 of Gov. John Kasich's 47 line-item vetoes in the biennial budget bill (HB 49); not among the vetoes, however, was the governor's elimination of a provision that would freeze new enrollment in the Medicaid expansion group on July 1, 2018. The AMCNO applauds this decision. As reported in the article above, the AMCNO attended a Medicaid rally at the Statehouse to show support of preserving the Medicaid expansion.

Of note, the legislative rebuff of the governor's changes to the budget marked the first time the House has voted to override multiple vetoes from a governor in 40 years.

Following are just a few of the House and Senate overrides pertaining to Medicaid as of August 22:

- The state Controlling Board, a legislative spending oversight panel, is not permitted to approve unexpected revenue influxes of more than 0.5% of the general revenue fund, or about $165 million.
- The Department of Medicaid is prohibited from covering any new, optional groups unless expressly permitted by state law.
- The state must set Medicaid rates for certain neonatal and newborn services at 75% of Medicare rates. And, rates for other services must be reduced to avoid an overall increase in Medicaid spending.
- The administration must get Controlling Board approval to cover the state share of Medicaid expansion.

Although the House and Senate did not vote on the Medicaid freeze at this time, they can still do so at any time until the end of this General Assembly, which would be in 2018.

Based upon some of the items contained in the budget there is a possibility there will be rate adjustments made in future Medicaid reimbursements. The AMCNO will continue to follow this issue and report back to our members as more information becomes available.

SMBO Implements Prescribing Rules for the Treatment of Acute Pain

As previously outlined in this magazine, the State Medical Board of Ohio (SMBO) has been working on new prescribing rules for the treatment of acute pain. The rule has gone through the appropriate review process and became effective as of August 31, 2017. Physicians should review their practice to be sure they are in compliance. Here is an overview of the final rule:

For the treatment of acute pain, the physician shall comply with the following:
Extended-release or long-acting opioid analgesics shall not be prescribed for treatment of acute pain; and before prescribing an opioid analgesic, a physician should first consider non-opioid treatment options.

If opioid analgesics are prescribed for acute pain the following will apply:

- There is a 7-day limit for adults with no refills. There is a 5-day limit for minors with no refills, and written consent is required prior to prescribing to a minor.
- Physicians can prescribe opiates in excess of the 7-day limit but only if they provide a specific reason that shows why the limits are being exceeded AND that a non-opioid medication was not appropriate to treat the patient's condition–this information must be documented in the patient's record.

The total MED (morphine equivalent dose) of a prescription for acute pain cannot exceed an average of 30 MED per day, with the following exceptions:

- The patient suffers from medical conditions, surgical outcomes or injuries of such severity that his or her pain cannot be managed within the 30 MED average limit as determined by the treating physician based upon prevailing standards of medical care, such as: traumatic crushing of tissue, amputation, major orthopedic surgery, or severe burns.
- The physician determines that exceeding the 30 MED average limit is necessary based on the physician's clinical judgment and the patient's needs.
- The physician shall document in the patient's medical record the reason for exceeding the 30 MED average and the reason it is the lowest dose consistent with the patient's medical condition.
- Only the prescribing physician for the conditions listed above may exceed the 30 MED average. The prescribing physician shall be held accountable for prescriptions that exceed the 30 MED average.
- In circumstances when the 30 MED average is exceeded, the dose shall not exceed the dose required to treat the severity of the pain as noted above.
- Prescriptions that exceed the 5- or 7-day supply or 30 MED average daily dose are subject to additional review by the SMBO. The dosage, days supplied, and condition for which the opioid analgesic is prescribed will be considered as part of this additional review.

The requirements of this rule apply to treatment of acute pain and do not apply when an opioid analgesic is prescribed to an individual who is a hospice patient or in a hospice care program, receiving palliative care, diagnosed with a terminal condition, or cancer or another condition associated with the individual's cancer or history of cancer.

This rule does not apply to prescriptions for opioid analgesics for the treatment of opioid addiction utilizing a Schedule III, IV or V controlled substance narcotic that is approved by the Federal Drug Administration for opioid detoxification or maintenance treatment. This rule does not apply to inpatient prescriptions.

SMBO Reviewing Draft Rules Regarding the Creation of a Confidential Monitoring Program

In April of this year, the SMBO circulated to interested parties draft rules regarding the creation of a confidential monitoring program that would allow licensees with mental or physical illnesses, other than substance use disorders, to be monitored by the SMBO without being subjected to formal public disciplinary action. The program, as proposed in the rules, is intended to be entirely within the SMBO's investigative process and overseen by the Secretary and Supervising Member of the SMBO.

Several physician organizations, including the AMCNO, submitted comments opposing many of the provisions contained in this draft rule. Specifically, we are concerned that the program as drafted determines entry into the confidential monitoring program based on diagnosis or condition and not conduct, is not confidential, could exacerbate existing mental or physical health conditions, and does not include appropriate due process.

After reviewing the comments on these draft rules, the SMBO decided to table the draft rules and hold a meeting with stakeholders to more fully understand our concerns. The physician organizations who voiced concerns about the SMBO's proposed draft will be meeting soon to discuss this issue further and we will provide any updates to our members as information become available.

Ohio Board of Pharmacy Rule Moves Forward with ICD-10 Compromise

The State of Ohio Board of Pharmacy (BOP) rules requiring prescribers to report the ICD-10 code and specific condition for an opioid prescription have been through the appropriate review process and will be implemented in the near future; however, there will be a delay in implementation for certain parts of the rule.

The BOP rules require prescribers to include the ICD-10 diagnosis code when documenting the prescription of a controlled substance in the Ohio Automated Rx Reporting System (OARRS). The AMCNO joined the Ohio State Medical Association (OSMA) and other healthcare associations across the state in expressing our concerns that this requirement would cause an administrative burden for prescribers, because the ICD-10 system includes a large number of codes for very specific conditions.

Although the AMCNO fully supports the efforts of the State Medical Board of Ohio (SMBO) to develop acute pain prescribing rules, as well as Gov. John Kasich's initiatives to tighten up the prescribing regulations for opioids when treating acute pain, we expressed concern that the BOP rule goes above and beyond the intent of these efforts, considering these rules address more than just prescribing opioids for acute pain—the rule will require an ICD-10 code whenever a physician writes a prescription for any controlled substance.

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AMCNO State Legislature and Administration Update *(Continued from page 7)*

The AMCNO had submitted written testimony to the Joint Commission on Agency Rule Review (JCARR) outlining our concerns, but pulled our testimony after a compromise was reached by the governor's office, SMBO, BOP, Ohio Hospital Association, and the OSMA. Under the compromise, hospitals and physicians' offices would report the first four digits of an ICD-10 code on prescriptions for opioids once the rule is implemented, but they would have an additional nine months to begin reporting the first four digits of an ICD-10 code on all other controlled substance prescriptions. This means that the BOP has agreed to adopt a resolution to delay the enforcement of the diagnosis code requirements for opioid drugs for 120 days, to Dec. 29. For non-opioid controlled substances, the requirement will be postponed until June 1, 2018.

AMCNO Joins Coalition Opposing Drug Pricing Proposal

The AMCNO has joined Ohioans Against the Deceptive Rx Ballot Issue, a broad-based coalition of Ohio organizations and associations that opposes the November 2017 ballot initiative that would affect prescription drug costs.

The AMCNO evaluated the independent reviews of this measure and concluded that despite the claims of its supporters, this initiative would likely increase—not lower—state prescription drug costs.

Healthcare policy experts, including three former Medicaid Directors, studied the proposal and determined that this initiative would, in fact, increase the costs of prescription drugs for many Ohioans and could potentially reduce patient access to medications.

The AMCNO is deeply concerned about the affordability of prescription drugs, and we want patients to have access to the treatments they need. The AMCNO also supports reform to protect consumers and lower drug costs, but this ballot measure is not the right solution and could result in negative consequences for the very patients it seeks to help. For more information on this ballot initiative visit www.deceptiverxissue.org.

Ohio Prescription Monitoring Program Connects with Pennsylvania – All Five States Bordering Ohio Now Connected with OARRS

Ohio prescribers and pharmacists can now request patient prescription information from Pennsylvania through Ohio's prescription monitoring program, known as the Ohio Automated Rx Reporting System (OARRS). The ability of OARRS to connect with Pennsylvania's Prescription Monitoring Program (PA PDMP) means that Ohio healthcare providers can now access patient information on controlled substances that were filled in Pennsylvania without having to use two separate systems. This new feature will further enhance the ability of providers to prevent the misuse and diversion of controlled substances.

Sharing information with Pennsylvania means OARRS users can now access controlled substance prescription information from prescription monitoring programs in each of Ohio's border states. In addition, OARRS users can access patient data from Arizona, Arkansas, Colorado, Connecticut, Idaho, Kansas, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, South Carolina, South Dakota, and Virginia. For more information on OARRS, visit www.pharmacy.ohio.gov.

Medical Marijuana Rules Receive Legislative Approval

Ohio's medical marijuana program is moving forward, with implementation expected to take effect in the fall of 2018.

The bulk of the administrative rules—which were created by the State Medical Board, Pharmacy Board and Department of Commerce—cleared the Joint Committee on Agency Rule Review more than a month ahead of the deadline imposed by state law. They cover dispensaries, processors, testing facilities, patients, caregivers, physicians and the form and method of administration. Rules for cultivators, promulgated by the Department of Commerce, have already been approved.

The medical marijuana program rules are required to be in place by Sept. 8, and the whole system is expected to be operational one year from that date.

For more information on the medical marijuana control program, go to www.medicalmarijuana.ohio.gov.

AMCNO Reiterates Our Position on Healthcare Reform

The future of the Affordable Care Act (ACA) remains uncertain. The AMCNO, however, is continuing to monitor any changes to the ACA as well as any additional federal proposed healthcare reform policies.

In addition, the AMCNO Board of Directors has adopted a healthcare reform policy statement, which you can view in its entirety in the March/April issue of the *Northern Ohio Physician* magazine or on our website at www.amcno.org.

In essence, the AMCNO believes that health insurance coverage and access to quality healthcare is of utmost importance. To that end, our organization and the physicians we serve recognize the need for health system reform and have long advocated for change in the healthcare delivery system. For years, the AMCNO has voiced its support for the funding of patient-centered medical homes, enhanced access to care for all Americans, changes in health insurance company behavior, and support for prevention and wellness programs, among others. And we remain as committed as ever to improving healthcare access and health insurance coverage for the patients in our community.

The AMCNO also believes that in order to avoid any disruption in patient care that policymakers should lay out, in detail, what they believe should replace current healthcare policies so that stakeholders can review the new plan before it is implemented to determine if it meets the needs of the American public. As the healthcare debate continues in the future, the AMCNO stands ready to work with legislators to strive for changes in the healthcare system that will address access to affordable health care for all Americans, and establish a more efficient and complete healthcare delivery system while preserving the physician-patient relationship.

The AMCNO has made our position known to members of Congress in both the Senate and the House on several occasions. As the debate continues on this issue, AMCNO members who wish to send similar comments or comments of their own to Congress are encouraged to do so. ■

Marijuana In Patient Care – Nine Model Guidelines

From The Federation of State Medical Boards[1]

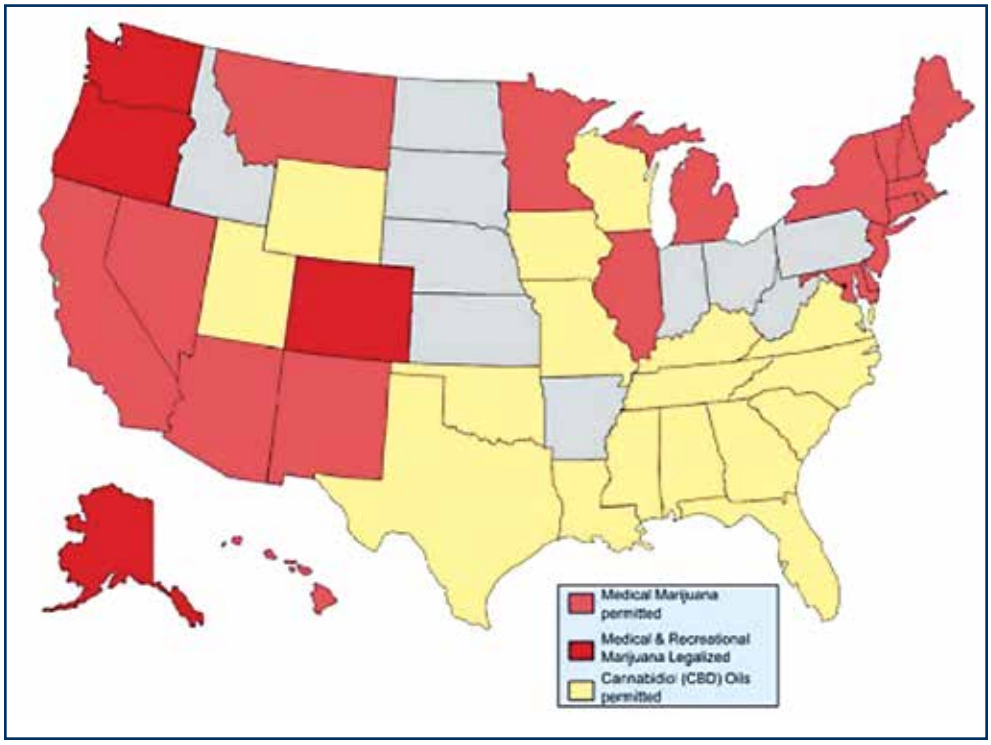
By Isabelle Bibet-Kalinyak, Elizabeth Sullivan, and Richard C. Cooper, McDonald Hopkins LLC

Over the past two decades, beliefs, attitudes, and laws in the United States have grown more tolerant toward the use of marijuana—medical or otherwise. Between 2001 and 2013, the number of adults using marijuana has doubled.

On the clinical front, medical marijuana has become an increasingly popular choice for treatment of symptoms of a wide variety of debilitating medical conditions, including cancer, HIV/AIDS, Alzheimer's disease, post-traumatic stress disorder, and epilepsy. Since the passage of Proposition 215 in California in 1996, 23 other states have established medical marijuana programs, including Ohio (See Figure 1), and 17 states have enacted laws permitting the limited use of cannabidiol ("CBD") oils[2] for the treatment of specific diseases. As a result, State Medical and Osteopathic Boards in nearly half of the nation are now required to regulate physicians who recommend marijuana-based treatment options to their patients. Crafting such rules is a balancing act with very high stakes. States can learn from one another to permit the use of medical marijuana while protecting patients and public safety.

To that effect, J. Daniel Gifford, the chair of the Federation of State Medical Boards, designated the Workgroup of Marijuana and Medical Regulation (the "Workgroup"). The Workgroup evaluated current medical and osteopathic rules and regulations dealing with marijuana and drafted nine model guidelines (the "Guidelines") to assist State Medical Boards in regulating physicians who are licensed to *recommend* marijuana treatment options such as marijuana or marijuana-infused products to patients. The following summarized Guidelines were not created to encourage marijuana treatment, rather, they intend to provide guidance to physicians and State Medical Boards consistent with accepted professional and ethical standards of practice. In light of the paucity of data regarding the safety and effectiveness of marijuana, the Workgroup urged providers and state regulators to continue to monitor the usage and adverse effects of marijuana. **Thus, the Workgroup cautioned that, under federal law, marijuana in all its forms is still a Schedule I substance—making it illegal for recreational and medical use. Marijuana has not been evaluated by the U.S. Food and Drug Administration and possessing, distributing, or aiding someone to possess or distribute marijuana is still a violation of federal law. Physicians, therefore, cannot prescribe medical marijuana or cannabidiol oils—they can only *recommend* their use in certain states under certain circumstances.**

Figure 1: State Map of Marijuana and Cannabidiol Oils Laws[3]



1. **Physician-Patient Relationship:** Prior to providing a recommendation, attestation, or authorization for use of marijuana to a patient, the physician must document that the proper physician-patient relationship has been established. A mutual understanding that the patient's health care is the priority should be the basis of the relationship between the physician and the patient. However, under no circumstance should a physician recommend or authorize marijuana for themselves or any family member.
2. **Patient Evaluation:** Before deciding whether or not to recommend the use of medical marijuana to a patient, the physician should perform and document an in-person medical evaluation of the patient. The medical evaluation should include at least a physical exam, the patient's history of present illness, social history, past medical and surgical history, previous alcohol and substance use, family history with emphasis on addiction, mental illness, and psychotic disorders. Further, prior to establishing the diagnosis requiring the use of medical marijuana, the physician should include in the medical records documentation of all therapies used with inadequate response.
3. **Informed and Shared Decision-Making:** Both the patient and the physician should collaborate to come to the decision to use marijuana for treatment purposes. If the patient is a minor or is not capable of making a decision on his or her own, the decision-making process should include the legal guardian. The physician has a responsibility to discuss the risk factors and the benefits of using medical marijuana. A major drawback is that the patient will not be capable of driving or operating heavy machinery while using marijuana.
4. **Treatment Agreement:** The healthcare professional should document the recommended treatment plan to alleviate the patient's suffering caused by the

underlying terminal or debilitating medical condition, including all the following:

- Evidence that other measures were taken to ease the suffering of the patient that did not involve the use of marijuana.
- Other options that could be used to manage the terminal or debilitating medical condition of the patient.
- Evidence that the patient with a terminal or debilitating medical condition may in fact benefit from the use of medical marijuana.
- Warning about the potential risks of using marijuana including: (a) the variability of quality and concentration of marijuana; (b) the risk of cannabis use disorder; (c) exacerbation of psychotic disorders and adverse cognitive effects for children and young adults; (d) adverse events, exacerbation of psychotic disorder, adverse cognitive effects for children and young adults, and other risks, including falls or fractures; (e) use of marijuana during pregnancy or breast feeding; (f) the need to safeguard all marijuana and marijuana-infused products from children and pets or domestic animals; and (g) the need to notify the patient that the marijuana is for the patient's use only and the marijuana should not be donated or otherwise supplied to another individual.
- Other diagnostic evaluations or planned treatments required.
- A specific duration for the marijuana treatment—not to exceed 12 months.
- An ongoing treatment plan to monitor progress and follow-up with the patient, as medically appropriate.

5. **Qualifying Conditions:** Considering the paucity of evidence establishing the efficacy of marijuana in treating certain medical conditions, recommending marijuana is solely at the physician's discretion. The indication, appropriateness, and safety of recommending marijuana for treatment should be evaluated within the context of state laws, rules, and regulations.
6. **Ongoing Monitoring and Adapting the Treatment Plan:** Physicians should monitor the patient's response to the marijuana treatment in accordance with the treatment plan and document efficacy and potential side effects. Numerous states that permit the recommendation of medical marijuana have established registries to track and monitor the utilization of marijuana in patient care. Therefore, recommending marijuana also carries risks for physicians. Physicians have to register with an oversight agency and provide information every time a recommendation to use marijuana is made. In turn, the oversight agencies determine when physicians should be referred to the State Medical or Osteopathic Board for review and potential sanctions. Common factors used by oversight agencies are: (a) physician caseload as determined by the number of patients for whom marijuana is recommended. A high caseload is considered to be 3,521 or more patient recommendations per year for a general practitioner; (b) the plant and ounce recommendations made by the physician, ie, dosing. Physicians recommending an amount of marijuana above the standard set within a state's statutes will generally be referred to the State Medical Board for review; (c) the age demographics of the patient caseload[4]. Physicians for whom more than one-third of the patient caseload is under the age of 30 may be recommended for referral; and (d) such other circumstances as determined by the agency.
7. **Consultation and Referral:** If a patient has a history of substance abuse or a mental health disorder, further assessment and treatment by a specialist may be required. The physician should refer the patient to a pain management, psychiatric, or mental health specialist, as needed.
8. **Medical Records:** The physician should keep accurate and complete medical records that include at least the following:
   - The patient's medical history.
   - Results of the physical examination, patient evaluation, diagnostic, therapeutic, and laboratory results.
   - Other treatments and prescribed medications.
   - The authorization, attestation, or recommendation for marijuana must include the date, the expiration date, and any additional information required by state statute.
   - Instructions to the patient, including documentation about the disclosure of the potential risks and benefits, side effects, and variable effects of marijuana.
   - Results of the ongoing assessment and monitoring of the patient's response to the marijuana treatment.
   - A copy of the signed treatment agreement, including instructions on safekeeping and the prohibition on sharing with others.
9. **Physician Conflicts of Interest:** A physician who recommends marijuana should not be physically located at a dispensary or cultivation center nor should he/she receive any form of financial compensation from, or hold a financial interest in, a dispensary or cultivation center. Thus, the physician cannot be a director, officer, member, incorporator, agent, employee, or retailer of a dispensary or cultivation center.

As illustrated by the Guidelines, the decision to recommend medical marijuana to patients is riddled with pitfalls for providers and their employers. They should, therefore, not only carefully weigh the risks and benefits for their patients but for themselves as well. On the background of the opioid crisis in many states such as Ohio, the specter of medical marijuana adds yet another layer of complexity to an already complex healthcare equation. ■

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1. Report of the Federation of State Medical Boards ("FSMB") Workgroup on Marijuana and Medical Regulation, available at https://www.fsmb.org/Media/Default/PDF/BRD_RPT_16-2_Marijuana_Model_Guidelines.pdf.
2. Cannabidiol oils encompass processed cannabis plant extracts, oils, or resins that contain a high percentage of cannabidiol, but a low percentage of tetrahydrocannabinol.
3. The states and territories that have enacted comprehensive marijuana programs are: Alaska (AS 17.37.070), Arizona (A.R.S. § 36-2801), California (Cal. Health & Safety Code § 11362.7 et seq.), Colorado (Colo. Rev. Stat. § 25-1.5-106), Connecticut (Conn. Gen. Stat. §420f-21a-408), Delaware (Del. Code tit. 16 § 4901A et seq.), District of Columbia (D.C. Code § 7-1671.01 et seq.), Guam (10 Guam Code Ann. § 122501 et seq.), Hawaii (Haw. Rev. Stat. § 329-121), Illinois (410 Ill. Comp. Stat. § 130/10), Maine (Me. Stat. tit. 22, § 2422 et seq.), Maryland (Md. Code, Health Gen. § 13-3301 et seq.), Massachusetts (105 Code of Mass. Regs. 725.000), Michigan (Mich. Comp. Laws § 333.26423), Minnesota (Minn. Stat. § 152.21 et seq.), Montana (Mont. Code Ann. § 50-46-301 et seq.), Nevada (NRS 453A), New Hampshire RSA 126-X), New Jersey (N.J.S.A. C.24:6I-3), New Mexico (N.M. Stat. § 26-2B-1 et seq.), New York (NY Pub Health Law § 3360), Oregon (Or. Rev. Stat. § 475.300 et seq.), Rhode Island (R.I. Gen. Laws § 21-28.6-3), Vermont (18 V.S.A. § 4472 et seq.), and Washington (RCS 69.51A).
   Recreational Marijuana Ballot Initiatives: Alaska (2014); Colorado (2012); District of Columbia (2014); Oregon (2014); Washington (2012).
   The states that have enacted laws permitting limited use of cannabidiol oils are: Alabama, Florida, Georgia, Iowa, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.
4. According to the CDC, older adults have a significantly higher prevalence of chronic conditions than younger adults.

Hundreds of Physicians-in-Training Sign Up for AMCNO Membership during Local Resident Orientation Events

During June and July, the AMCNO participated in resident orientation events at three local hospitals, and thanks to recruitment efforts, we have welcomed hundreds of new resident members.

These new members from the Cleveland Clinic, MetroHealth Medical Center and University Hospitals now have access to numerous benefits, including opportunities to serve on an AMCNO committee to hone their leadership skills, invitations to networking events, and notifications of the latest information on the AMCNO's work and activities through the *Northern Ohio Physician* magazine and email blasts.

Physicians-in-training visit various stations in addition to the AMCNO table during orientation.

A physician-in-training signs up for membership during resident orientation at the Cleveland Clinic.

If you know of a physician-in-training who would be interested in free AMCNO membership, you can direct him or her to apply online, using this link: http://amcno.org/index.php?id=267.

Photos from the resident orientations are available on the AMCNO Facebook page. ■

AMCNO's Annual Mini-Internship Program

The AMCNO will hold its annual Mini-Internship program October 23-25, 2017. The program, which was established in 1989, is designed to improve understanding and communication between the medical profession and those in the community who influence, establish and report on healthcare policy in Northeast Ohio. During the two-day program, interns have the opportunity to spend time with four physicians, accompanying them through their daily work schedule, which can include office visits and surgery.

The goal of the program is to create an information exchange to help broaden the perspectives of all participants. Through the experience, interns can witness first-hand the demands and rewards of the medical profession during a typical physician workday.

To learn more about the program, you can view a video interview between Past President Dr. Anthony Bacevice, Jr., and the program's lead physician, Dr. William Seitz, on our website www.amcno.org.

The AMCNO is asking its members to participate in the program and act as faculty for the interns. If you are interested in participating in this year's event, contact Abby Bell at (216) 520-1000, ext. 101, or email her at abell@amcno.org. ■

CliniSync Update: Interconnectivity and Enhanced Services

By Anthony E. Bacevice, Jr., MD, AMCNO Past President

The Academy of Medicine of Cleveland and Northern Ohio (AMCNO) continues its active involvement with CliniSync, the Health Information Exchange (HIE) of the Ohio Health Information Partnership (OHIP). We participate in the Clinical Advisory Council, meeting every other month to advise CliniSync on both operational and strategic matters that may affect the clinical utility of the HIE. Members of the Clinical Advisory Council represent hospital systems, medical practices, payers and other end-user organizations.

The HIE provides for electronic transfer of patient information among providers, sources of clinical data (such as laboratories and imaging centers), hospitals and other entities that provide care. The Clinical Advisory Council has been engaged in providing assistance to CliniSync in the development of policies and processes for this data exchange. Items such as patient consent of information exchange, confidentiality of data and appropriate interchange of information to facilitate payment are among the topics that the Advisory Council considers.

Information that is exchanged among sources and users of data contributes to what is known as the Community Health Record (CHR). This is a longitudinal view of a patient's most recent encounters at sources of care. The CHR includes information from medical practices. The information is delivered through the continuity of care document (CCD). The CCD contains patient demographics, as well as current medications, allergies, family history, procedures performed, recent results and other pertinent information. As this information is updated by medical practices, it is then pushed out to the CHR, making it available to other users with a need to know. So, when a patient then presents to a hospital or emergency room that has CliniSync access, the CHR is available to provide important history and relevant clinical information. Furthermore, information about the encounter can then be moved to the CHR, updating the record for accuracy and completeness.

As the role of HIE expands, the CHR can be utilized to provide an appropriate subset of data for payers. This can result in more timely claims analysis and payment to providers. In addition, a subset of data that has been properly de-identified can be used for quality analysis. The continued focus on quality of care requires that both providers and hospitals get valid information about the care that is delivered and how it compares to relevant benchmarks.

Besides the basic interconnection of electronic record systems, CliniSync provides enhanced services that can improve patient care. One of the more intriguing services offered is *Notify. Notify* sends an electronic message to providers when one of their patients is admitted or discharged from a hospital or emergency department. Often, a patient will receive care in an emergency department (ED) or in a hospital without the provider's knowledge. Several days or even weeks go by before that information gets back to the provider. This break in the continuity of care places the primary care provider at a disadvantage, not having the most up-to-date information about a patient. Another important benefit of *Notify* is the ability to have a patient follow-up with a provider in a more timely fashion after hospital or ED discharge. Transitions of care management in a timely fashion can improve a provider's reimbursement for services. Also, in the era of pay for performance, avoiding hospital readmissions by notifying a provider of a patient's presence in the ED can help to avoid revenue loss for both a provider's practice and the hospital. More information about *Notify* can be found at CliniSync's website.

Health information exchanges such as CliniSync are now in a position to facilitate transfer of information from a patient who is in the hospital receiving acute care to a skilled nursing facility (SNF) or a long-term acute care facility (LTAC) where extended care can be continued. Oftentimes, assembling the amount of information necessary to complete the transfer of care (sometimes communicated in the "Goldenrod" form) can be incomplete or untimely. In those cases, a delay in transfer may result. If the delay is prolonged, the precertification process may need to be repeated, further delaying the transfer. SNFs and LTACs have both shown interest in the capabilities of data exchange through CliniSync. This becomes a "win-win" situation for both the hospital, as it struggles to decrease length of stay, and the receiving institution, as it needs the most accurate and complete data to provide appropriate care. The number of SNFs and LTACs interested in CliniSync and the HIE continues to grow.

As of the end of July, 151 total active hospitals were using CliniSync. In the same period, more than 400 organizations and more than 4,800 live users were participating in the CHR through CliniSync. More than 2 million information queries were transmitted across the HIE in the same period. Contributors to the CHR include hospitals, ambulatory centers, social service organizations, long-term care facilities, behavioral health facilities, pharmacies and, of course, providers.

The AMCNO will continue to participate in the activities of CliniSync by providing input to the Clinical Advisory Council. The AMCNO will also bring back to its membership information about further developments at CliniSync and its utilization in Ohio.

More information about CliniSync can be obtained from their website: www.CliniSync.org ■

Anthony E. Bacevice, Jr., MD, MSE, is Past President of the AMCNO. He is Chief Medical Officer at University Hospitals Elyria Medical Center. Since 2012, he has represented AMCNO on the Clinical Advisory Council for CliniSync. He is a member of HIMSS, the American Medical Informatics Association (AMIA), in addition to other medical societies.

SAVE THE DATE!

2018 Medical/Legal Summit

April 13-14, 2018

Cleveland's Medical/Legal Summit will be co-sponsored by the Cleveland Metropolitan Bar Association, Academy of Medicine Education Foundation, and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO).

Co-Chairs:
- Justin Cernansky, JD, Associate General Counsel, University Hospitals
- Fred Jorgensen, MD, Cleveland Clinic , Fairview Hospital, and AMCNO President

The Summit is intended to bring together doctors, lawyers, health care professionals and others who work in allied professions for education, lively discussion and opportunities to socialize.

For more information, call the CMBA at (216) 696-3525 or AMCNO at (216) 520-1000.

SUMMIT DETAILS

April 13 – CME, CLE TBD
April 14 – CME, CLE TBD

FRIDAY, April 13, 2018 Friday evening Keynote Address and Q&A followed by a networking reception

SATURDAY, APRIL 14, 2018
Continental Breakfast followed by a half day of Plenary Sessions and Breakouts

Location:
ONE CLEVELAND CENTER
1375 EAST NINTH STREET
SECOND FLOOR
CLEVELAND, OHIO 44114

REGISTRATION RATES
$75 CMBA members, AMCNO members and other healthcare providers

$125 Non-Members

$15 Students and Residents

Certain Medicaid Recipients can now Receive Inpatient Treatment in an Institution for Mental Disease

Effective July 1, 2017, Ohio implemented 42 C.F.R. 438.6 in the federal managed care regulations to allow for Medicaid recipients age 21 through 64, who receive their Medicaid benefits through a Medicaid Managed Care Plan (MCP), to receive inpatient treatment in an Institution for Mental Disease (IMD). In addition, the regulation allows MCPs to receive a full monthly capitation payment on behalf of MCP members if stays do not exceed 15 days in any calendar month.

The policy implements 42 C.F.R. 438.6 in the federal managed care regulations that expands the Medicaid-reimbursable inpatient psychiatric provider network to give Medicaid MCP members access to more timely, medically appropriate, and cost-effective services by allowing IMDs to be used in addition to other covered settings, such as inpatient psychiatric units in general medical hospitals.

MCPs will work with their members and provider networks on assessing an individual's need for care to determine both the level of care and the appropriate care setting. MCPs will coordinate with the admitting facility to ensure proper care and transition of members back into the community, which may include coordinating with community mental health services and providers.

Crisis providers will continue to function as they do, but they will need to work with the MCP for coordinating admission to IMD facilities when necessary. MCPs will work closely with providers for coordinating care and services for members. More information is available on MCPs' websites.

For additional details on these IMD updates, refer to the IMD FAQs found on Ohio's Behavioral Health Redesign website at http://bh.medicaid.ohio.gov/. ■

Physician Participants Needed for the PALS Event

The AMCNO is looking for physician participants for our third annual Physicians Are Linked with Students (PALS) networking event. It will be held at the Case Western Reserve University School of Medicine in November.

During the program, second-year medical students will have the opportunity to speak with physicians to learn about the details of practicing medicine and what they can expect if they enter a specific specialty. We would like physicians from various fields to participate, so that the students get a better overview of different specialties and subspecialties.

This event has been a huge success, based on the positive feedback we have received from both the students and the physicians who participated in the program. It is a great opportunity to meet with these young students and aspiring physicians to help give them guidance in their studies. ■

2017 AMEF FUNDRAISER

The 2017 Annual AMEF Golf Outing Participants and Sponsors were in Top Form!

Event proceeds will Benefit Medical Students and our Local Communities

On August 7, golfers teed off for the Academy of Medicine Education Foundation's (AMEF) 14th Annual Marissa Rose Biddlestone Memorial Golf Outing.

This year's event was held at the Chagrin Valley Country Club. Eager foursomes tested their expertise in a shotgun tournament to raise money for AMEF, the foundation component of the AMCNO that was established for charitable, education and scientific purposes. These monies will be utilized for medical student scholarships, annual CME seminars and grants for health-related programs.

The day went smoothly as golfers registered and dropped off their bags, practiced their shots and enjoyed a leisurely lunch in the warm summer air. The shotgun start was at precisely 1 pm, and the game was on!

Our congratulations to the teams that took home the top prizes:

1st Place Team: Dennis Forchione, Kent Krafft, Don Marcello, and Jeff Stanley, DO

2nd Place Team: Jim Doan, Bob Hogsett, Bob McCloskey, and Phil Moshier

3rd Place Team: Alan Hill, Michael Sidoti, Ryan Williams, and David Lum

Skill prizes were also awarded to the following:

Closest to the pin: Peter Bastulli, Tom Epps, Al Santilli, John Bastulli, Jr.

Longest drive: Jon DeArment and Jan Zollinger

Longest putt holed: William Seitz, Jr., MD

Cocktails were enjoyed as everyone relaxed after some challenging holes. Golfers then sat down for a great speech by Dr. John Bastulli, a delicious dinner, awards, and a fun prize raffle.

A special **thank you** to Jim Brown at Classic Auto Group and Dr. Victor Bello for once again sponsoring the hole-in-one contests. And thank you to all the event and hole sponsors who helped make the day such a huge success.

Our thanks to the 2017 Event Sponsors:

Victor Bello, MD
Cleveland Anesthesia Group
Clinical Technology, Inc.
H.C. Murray Group
Industrial First, Inc.
Kellison & Company
Matthew E. Levy, MD
Private Harbour Investment Management & Counsel
Reminger Co., LPA
Sagemark Consulting

Our thanks to the 2017 Hole Sponsors:

The Center for Health Affairs
Mary Frances Haerr, MD
Robert E. Hobbs, MD
Pauline Kwok, MD
James L. Sechler, MD

SAVE THE DATE for next year's AMEF Golf Outing:

August 13, 2018, at Sand Ridge Golf Club. See you there!