

Governor's Cabinet Opiate Action Team (GCOAT) Announces New Opioid Prescribing Guidelines

Prescription opioids account for more fatal overdoses than any other prescription or illegal drug, including cocaine, heroin and hallucinogens combined. The number of Ohio lives lost to unintentional drug overdose has risen from 369 lives in 1999 to 1,765 in 2011, a 440% increase. Prescription drugs are involved in most of the unintentional drug overdoses and have largely driven the rise in deaths. Prescription pain medications (opioids) and multiple drug use are the largest contributors to the epidemic.

Two years ago Governor John R. Kasich formed the Governor's Cabinet Opiate Action Team (GCOAT) to attack this statewide epidemic on multiple fronts. This team's Professional Education Workgroup has reached consensus on recommended clinical guidelines when prescribing opioids to treat chronic, non-terminal pain.

These guidelines use 80 mg morphine equivalency dosing (MED) as a "trigger threshold," as the odds of an overdose are significantly higher above that dose. The clinical guidelines recommend that at the 80 MED range or above the clinician "press pause" and re-evaluate how to optimize therapy and ensure patient safety. This pause

also is a good time to consider potential adverse effects of long-term opioid therapy.

The clinical guidelines are intended to supplement — not replace — the prescriber's clinical judgment. They have been endorsed by numerous organizations including: the **Academy of Medicine of Cleveland & Northern Ohio (AMCNO)**, the Ohio State Medical Association, Ohio Osteopathic Association, Ohio Academy of Family Physicians, Ohio Chapter of the American College of Emergency Physicians, Ohio Pharmacists Association, State Medical Board

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Medicaid Expansion Becomes a Reality Through Controlling Board Vote

With less than three months to go before major provisions of the federal Affordable Care Act (ACA) are set to take effect, Ohio has now been added to the list of states that will expand Medicaid under the ACA. When the legislature failed to act upon Medicaid expansion in the months since it was introduced in the Governor's budget, the Governor made a move to bypass the normal legislative process and expand the program through his own executive powers — specifically, through the Controlling Board.

The Kasich Administration asked the Controlling Board to approve funding to expand Ohio's Medicaid system up to 138% of the federal poverty level and the Department of Medicaid asked the panel for authorization to spend federal funds totaling \$561.7 million in FY14 and nearly \$2 billion in FY15 to extend program eligibility. These requests came after the federal Centers for Medicare and Medicaid

Services approved Ohio's State Plan Amendment to expand eligibility for the entitlement program, thus making funds available Jan. 1.

The Controlling Board is a seven-member panel with the authority to make appropriations outside of the state budget. The Controlling Board panel consisted of six
(Continued on page 15)



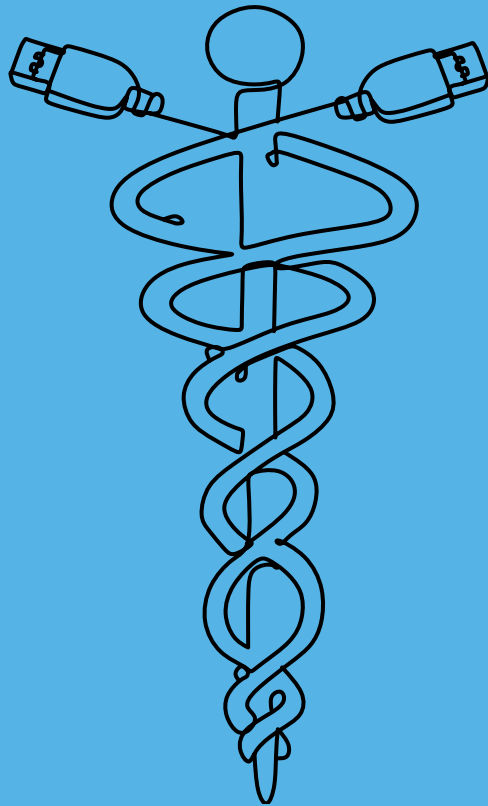
Governor John Kasich discusses the importance of Medicaid expansion at the Cleveland Clinic event.

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AMCNO STATEWIDE ACTIVITIES

Governor's Cabinet Opiate Action Team (GCOAT) Announces New Opioid Prescribing Guidelines

(Continued from page 1)

of Ohio, Ohio Board of Nursing, Ohio State Dental Board, Ohio State Board of Pharmacy, Ohio Hospital Association, Ohio Association of Health Plans, and the Ohio Bureau of Workers' Compensation among others.

Overview – Opioid Prescribing Guidelines for all Prescribers

Research shows that patients who receive higher doses of prescribed pain medications are at increased risk for overdose and need close supervision and periodic reevaluation. Prescribed pain medication doses can be calculated as a Morphine Equivalent Daily Dose (MED), and the odds of an overdose at 50 – 99 MED are three times higher than at a dose under 50 MED.

Rx Guidelines: The new opioid prescribing guidelines recommend that 80 milligrams MED for more than three months for patients with chronic, non-terminal pain should trigger the prescriber to reevaluate the effectiveness and safety of the patient's pain management plan. The guidelines are intended to supplement, and not replace, the prescriber's clinical judgment. (for a complete copy of the guidelines see page 4).

New Prescription Reporting Tools: When prescribing an opioid, pharmacists must record the prescription in the online Ohio Automated Rx Reporting System (OARRS). These new guidelines encourage prescribers to use the data in OARRS so that they will know how much pain medication a patient already is receiving, perhaps from multiple prescribers. A new OARRS tool launched with these prescribing guidelines assists prescribers by calculating a patient's opioid prescriptions into a single MED score for comparison to the 80 MED threshold. (for more about OARRS please see page 5).

Helping Patients Understand Effects of Opiates: Prescribers are strongly advised to optimize therapy and ensure patient safety by reestablishing informed consent, including providing the patient with written information about the potential adverse effects of long-term opioid therapy; reviewing the patient's functional status; reviewing the patient's progress toward treatment objectives; utilizing OARRS as an additional check on patient compliance; considering a patient pain treatment agreement, including consequences of non-compliance; and considering having the patient evaluated by another provider or specialist.

Online Resources for Prescribers: The Professional Education Workgroup developed a prescriber-focused website — opioidprescribing.ohio.gov — to help prescribers learn more about the guidelines. The site also includes resources prescribers can use to incorporate the guidelines into their daily practice; a continuing education video education module, a toolkit and patient resources. A new one-hour online Continuing Medical Education video module outlines the scope of the prescription opioids problem; recommended prescribing clinical guidelines; action steps for healthcare providers; metrics to assess the guidelines; and other resources.

Metrics

From October through December 2013, clinical professional associations and all members of the Professional Education Workgroup will educate clinicians about the new opioid prescribing guidelines. Starting in January 2014, the Professional Education Workgroup will begin assessing the effectiveness of the prescriber guidelines based on established measures and processes.

Collaboration

The new opioid prescribing guidelines were developed through the collaboration of clinical professional associations, clinicians specializing in pain management, state professional licensing boards, state agencies and other stakeholders.

The following organizations collaborated on these guidelines:

Academy of Medicine of Cleveland & Northern Ohio (AMCNO)
Academy of Senior Health Sciences
ADAMHS Board of Cuyahoga County
Columbus Public Health
Council of Medical Deans
Council of Ohio Colleges of Pharmacy
Council for Ohio Health Care Advocacy
Center for Symptom Relief / Doctor's Hospital
Emergency Services, Inc.
Fairfield Medical Center
Hospice of Dayton
Immediate Health Associates
Molina Healthcare
National Association of Social Workers, Ohio Chapter
Ohio Academy of Family Physicians
Ohio Association of Adv. Practice Nurses (OAAPN)
Ohio Association of County Behavioral Health Authorities
Ohio Association of Emergency Management Services
Ohio Association of Health Commissioners
Ohio Association of Physician Assistants
Ohio Board of Nursing
Ohio Board of Pharmacy
Ohio Bureau of Workers' Compensation
Ohio Chapter, American Academy of Pediatrics

Ohio Chapter, American College of Emergency Physicians
Ohio Children's Hospital Association
Ohio Council of Deans & Directors (OCDD) of Baccalaureate & Higher Degree Nursing Programs
Ohio Department of Aging
Ohio Department of Health
Ohio Department of Medicaid
Ohio Department of Mental Health and Addiction Services
Ohio Foot and Ankle Medical Association
Ohio HealthCare Association
Ohio Health-Grant Medical Center
Ohio Hospice & Palliative Care Association
Ohio Hospital Association
Ohio KePro
Ohio Nurses Association and the MidOhio District Nurses Assn.
Ohio Osteopathic Association
Ohio Pain Initiative
Ohio Pediatric Medicine
Ohio Pharmacists Association
Ohio Poison Control Collaborative/Cincinnati DPIC
Ohio Public Health Association
Ohio Society of Addiction Medicine
Ohio Society of Anesthesiologists
Ohio State Board of Optometry
Ohio State Dental Board
Ohio State Medical Association
OSU College of Dentistry
OSU College of Nursing
OSU East Hospital
OSU Medical Center
Riverside Methodist Hospital
Scioto County Health Department
State Medical Board of Ohio
U.S. Dept. of Veterans Affairs, Chillicothe VA Medical Center
Wright State University, Boonshoft School of Medicine

(A portion of this article was taken from a Fact Sheet prepared by the Governor's Cabinet Opiate Action Team). ■

The AMCNO has collaborated with Case Western Reserve University and the Cleveland Clinic to offer an educational session entitled "ER/LA Opioid REMS: Achieving Safe Use While Improving Patient Care in Ohio." This course will cover the new Ohio 80 MED Guidelines developed by the Governor's Cabinet Opiate Action Team (GCOAT) as well as other opioid prescribing and pain management topics. The Cleveland session will be held at the Cleveland Marriott on Wednesday, November 6, 2013. The course is also offered at various locations around Ohio. Physicians and other healthcare providers interested in attending one of these informative sessions may download the registration flyer from the AMCNO website at www.amcno.org.



State Medical Board of Ohio

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Guidelines for Prescribing Opioids for the Treatment of Chronic, Non-Terminal Pain 80 mg of a Morphine Equivalent Daily Dose (MED) “Trigger Point”

May 9, 2013

*These guidelines address the use of opioids for the treatment of **chronic, non-terminal pain**. “Chronic pain” means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months. The guidelines are intended to help health care providers review and assess their approach in the prescribing of opioids. The guidelines are points of reference intended to supplement and not replace the individual prescriber’s clinical judgment. The 80 mg MED is the maximum daily dose at which point the prescriber’s actions are triggered; however, this 80 mg MED trigger point is not an endorsement by any regulatory body or medical professional to utilize that dose or greater.*

Recent analysis by the Centers for Disease Control and Prevention (CDC) shows that “patients with mental health and substance use disorders are at increased risk for nonmedical use and overdose from prescription painkillers as well as being prescribed high doses of these drugs.” Drug overdose deaths increased for the 11th consecutive year in 2010. Nearly 60% of the deaths involved pharmaceuticals, and opioids were involved in nearly 75%. Researchers also found that drugs prescribed for mental health conditions were involved in over half. These findings appear consistent with research previously published in the *Annals of Internal Medicine* that concluded that “patients receiving higher doses of prescribed opioids are at an increased risk for overdose, which underscores the need for close supervision of these patients” (Dunn, et al., 2010).

Health care providers are not obligated to use opioids when a favorable risk-benefit balance cannot be documented. Providers should first consider non-pharmacologic and non-opioid therapies. Providers should exercise the same caution with tramadol as with opioids and must take into account the medication’s potential for abuse, the possibility the patient will obtain the

medication for a nontherapeutic use or distribute it to other persons, and the potential existence of an illicit market for the medication.

Providers must be vigilant to the wide range of potential adverse effects associated with long-term opioid therapy and misuse of extended-release formulations. That vigilance and detailed attention has to be present from the outset of prescribing and continue for the duration of treatment. Providers should avoid starting a patient on long-term opioid therapy when treating chronic pain. Providers should also avoid prescribing benzodiazepines with opioids as it may increase opioid toxicity, add to sleep apnea risk, and increase risk of overdose deaths and other potential adverse effects.

Providers can further minimize the potential for prescription drug abuse/misuse and help reduce the number of unintentional overdose deaths associated with pain medications by recognizing times to “press pause” in response to certain “trigger points.” This pause allows providers to reassess their compliance with accepted and prevailing standards of care. The 80 mg Morphine Equivalent Daily Dose (MED) “trigger point” is one such time.

AMCNO STATEWIDE ACTIVITIES

Providers treating chronic, non-terminal pain patients who have received opioids equal to or greater than 80 mg MED for longer than three continuous months should strongly consider doing the following to optimize therapy and help ensure patient safety:

- ✓ Reestablish informed consent, including providing the patient with written information on the potential adverse effects of long-term opioid therapy.
- ✓ Review the patient's functional status and documentation, including the 4A's of chronic pain treatment:
 - Activities of daily living;
 - Adverse effects;
 - Analgesia; and
 - Aberrant behavior.
- ✓ Review the patient's progress toward treatment objectives for the duration of treatment.
- ✓ Utilize OARRS as an additional check on patient compliance.
- ✓ Consider a patient pain treatment agreement that may include: more frequent office visits, different treatment options, drug screens, use of one pharmacy, use of one provider for the prescription of pain medications, and consequences for non-compliance with terms of the agreement.
- ✓ Reconsider having the patient evaluated by one or more other providers who specialize in the treatment of the area, system, or organ of the body perceived as the source of the pain.

The 80 MED "trigger point" is an opportunity to review the plan of treatment, the patient's response to treatment, and any modification to the plan of treatment that is necessary to achieve a favorable risk-benefit balance for the patient's care. If opioid therapy is continued, further reassessment will be guided by clinical judgment and decision-making consistent with accepted and prevailing standards of

care. The "trigger point" also provides an opportunity to further assess addiction risk or mental health concerns, possibly using Screening, Brief Intervention, and Referral to Treatment (SBIRT) tools, including referral to an addiction medicine specialist when appropriate.

For providers treating acute exacerbation of chronic, non-terminal pain, clinical judgment may not trigger the need for using the full array of reassessment tools.

Providers treating patients with acute care conditions in the emergency department or urgent care center should refer to the *Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances Prescribing Guidelines* at <http://www.healthyohioprogram.org/ed/guidelines>.

Approved by Medical Board: May 9, 2013

Ohio Automated Rx Reporting System

As noted on page 3 of this issue, the state regulatory boards have adopted **clinical prescribing guidelines**. Over the next 15 months, OARRS data will be used to assess the impact of these guidelines. Using the recently adopted 80 MED guidelines in coordination with OARRS reports is a best practice that offers insight into a patient's use of controlled substances while also alerting prescribers to possible medication conflicts as well as signs of abuse, addiction or diversion. OARRS reports have recently been enhanced to include a dosage calculator to assist prescribers in determining whether patients are at, near or over the daily 80 MED.

Ohio's Automated Rx Reporting System (OARRS) can help physicians improve patient care, reduce prescription abuse, and prescribe safely. OARRS can help prescribers: provide better patient care; identify patients with potential drug seeking behaviors; ensure that the patient's drug therapy is appropriate; comply with "press pause" clinical guidelines at 80 morphine equivalent dose (MED); and demonstrate the effectiveness of clinical guidelines making adoption of prescribing rules unnecessary. Are you registered for OARRS? If you are not using OARRS, you need to start today. To register for OARRS go to: <https://www.ohiopmp.gov/portal/default.aspx>

The Professional Education Reforming Prescribing Practices Workgroup of the Governor's Cabinet Opiate Action Team (GCOAT) has identified OARRS registration and usage as one of the three key initiatives to reduce the misuse and abuse of prescription opioids in Ohio and to decrease the number of negative consequences from the use of Schedule II drugs. For more information on the work being done by the GCOAT, please visit Ohio's at <http://www.med.ohio.gov/webhost/ooat.html>

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AMCNO Participates in Evolution of Patient Navigation Program

Since its inception in 1990, the concept of patient navigation has evolved to include eliminating barriers to timely cancer screening, diagnosis, treatment and supportive care; addressing the timely movement of individuals across the entire healthcare continuum; and most recently connecting patients and families with health insurance.

Such significant evolution, in a short period of time, has raised many questions about the different types of patient navigators. To address these questions, The Northeast Ohio Patient Navigation Collaborative, spearheaded by The Center for Health Affairs and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) hosted a panel discussion entitled, *The Evolution of Patient Navigation*. Presenters at the session provided an update on federal and state legislation related to patient navigation; clarified the difference between lay, clinical and insurance navigators, and shared the continued impact of patient navigation in Northeast Ohio.

Dr. George Topalsky provided opening remarks on behalf of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO). He noted that patient navigation is an important component of health care and the AMCNO is pleased to be a part of this initiative. It is important for physicians to work with a team of healthcare providers to enhance continuity of care and improve transitions of care. The AMCNO is committed to the patient navigation project working in tandem with the Center for Health Affairs (CHA) to provide information to the health care community about the patient navigation initiative.

Other presenters included: Natalie Joseph, MD, Surgical Oncologist, MetroHealth Medical Center with input from Patient Navigator, Natalie Williams Mary McLaughlin Davis, RN, ACNS-BC, CCM, Director of Case Management, Lakewood Hospital with input from Patient Navigator, Jessica Roberts Timia DelPrete-Brown, Ph.D., LPCC-S, Director, High Risk Care Management, CareSource with input from Patient Navigator, Christine Rihtar Ginny Pate, Community Health Navigator, Carmella Rose Health Foundation Panel Moderator: Carol Santalucia, Vice President, CHAMPS Patient Experience / Santalucia Group. Updates provided by Tony Gutowski, Public Policy Development Manager, The Center for Health Affairs, Sarah Hackenbracht, Executive Director, Cuyahoga Health Access Partnership.

Presenters provided background on HB 3, recent legislation passed in Ohio which outlines the role of navigators working in the health



Dr. George Topalsky, AMCNO President, delivers the opening remarks at the patient navigation event.

care marketplace. The navigators are to provide educational materials and consumer assistance and inform them about the plans that are part of the exchange. The audience also received an update on work being done by the Cuyahoga Health Access Project (CHAP). CHAP is operating under the Ohio Association of Foodbanks as a navigator in Ohio.

A panel discussion followed with presenters discussing their experiences with lay navigators in two area hospitals. The lay patient navigator works with patients who may not have resources such as the uninsured or underinsured to help guide them through the system and eliminate barriers to care. Their role is to support and enhance communications with the health care providers. Presentations were also provided by physicians who have worked with lay navigators which has resulted in reduced no-show and cancellation rates. In addition, the return on investment has already exceeded the costs of setting up the navigator program. Other members of the panel were from CareSource. CareSource has developed a navigator program for high-risk care management members and they provide guidance to high-risk patients and help coordinate care. They work to build a relationship with the member and their families and assist with appointments, transportation issues, reminder calls and determine if other resources are needed.

The AMCNO is pleased to be a part of the Northeast Ohio Patient Navigation Collaborative and we plan to continue to work with the CHA to provide additional information on this project to our members. ■

Save the Date

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AMCNO Participates in Region V State Medical Society Meeting

In September, staff from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) participated in the Centers for Medicare and Medicaid Services (CMS) Region V State Medical Society quarterly meeting. Some of the topics covered during the meeting included ICD-10, incarcerated beneficiaries, the value-based payment modifier, and the Affordable Care Act.

ICD-10

An update was provided regarding the implementation of ICD-10 in 2014. At this time this is a hard date and there is no indication that the implementation of ICD-10 will be postponed. All health care providers covered by HIPAA must make the transition from ICD-9 to ICD-10 codes by the October 1, 2014, compliance deadline. ICD-10 will affect every aspect of how a physician or group provides care, from software upgrades and patient registration and referrals, to clinical documentation and billing.

Key Steps to Prepare for ICD-10

1. Inform and educate staff about the transition to ICD-10: Suggestions include appointing an ICD-10 coordination manager and CMS recommends that your staff be notified about upcoming changes and the transition plan. CMS also recommends that you educate your staff regarding the changes in documentation requirements from health plans. Finally, seek resources from CMS and professional and membership organizations to help with the transition.
2. Perform an impact assessment: Identify potential changes to existing work flow and business processes by looking at your current use of ICD-9; make a list of staff members who need ICD-10 resources and training, such as billing and coding staff, clinicians, management and IT staff; and evaluate the effect of ICD-10 on other planned or ongoing projects (e.g., electronic health records).
3. Plan a comprehensive and realistic budget: Estimate your budget and secure funding for items such as software, hardware, staff training, and production costs.
4. Contact system vendors, clearinghouses, and/or billing services to assess their readiness and evaluate current contracts: Ask your vendors how they will support you in the transition to ICD-10 and request a timeline and cost estimate.

Once physicians have completed these planning steps prepare to test ICD-10 within your office environment. It is important to

conduct internal testing of ICD-10 within a clinical practice as well as external testing with payers and other external business partners.

Incarcerated Beneficiaries

CMS initiated recoveries from providers and suppliers based on data that indicated a beneficiary was incarcerated on the date of service. Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated when the items and services were furnished. A beneficiary may be "incarcerated" even when the individual is not confined within a penal facility, such as a beneficiary who is on a supervised release, on medical furlough, residing in a halfway house, or other similar situation.

Medicare has evaluated and identified previously paid claims that contain a date of service partially or fully overlapping a period when a beneficiary was incarcerated based on information received from the Social Security Administration (SSA). As a result, a large number of overpayments were identified, demand letters released, and, in many cases, automatic recoupment of overpayments made. CMS has since learned that the information related to these periods of incarcerations was, in some cases, incomplete for CMS purposes.

CMS is working on restoring the original data on the Medicare Enrollment Data Base, identifying all of the claims that were incorrectly demanded or collected, and making changes to claims processing system utilities to effectuate the necessary changes. This automated process will identify the claims that were denied in error and reprocessing will be completed by the Medicare Administrative Contractors.

Value-Based Payment Modifier

Another presentation addressed the 2015 physician value-based payment modifier. A provision of the ACA requires Medicare to establish a value-based payment modifier (VBPM) that provides for differential payment under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared with cost during a performance period. The VBPM is directly tied to PQRS participation. The VBPM will be applied to a

group practice of 100 or more eligible professionals (EPs) in 2015 and to all physicians in 2017. The 2015 VBPM will be based on 2013 performance in the PQRS Group Practice Reporting Option (GPRO). Groups that are subject to the VBPM and do not successfully participate in PQRS during the 2013 reporting period through the GPRO will be subject to a 1 percent payment penalty in 2015.

Health Insurance Marketplace

A good deal of the discussion at the meeting revolved around the roll out of the Health Insurance Marketplace as mandated by the Affordable Care Act. As part of the ACA, enrollment in Health Insurance Marketplaces began on Tuesday, October 1, 2013. The primary goal of the ACA is to help the 16% uninsured and eligible participants gain access to health care. Central to this goal is the Health Insurance Marketplace. The Marketplace is a new way to shop for health coverage. Health Insurance Marketplaces are one-stop shops for consumers to research, compare, and purchase comprehensive health insurance plans. Open enrollment began on October 1, 2013, and ends on March 31, 2014. Coverage can begin as soon as January 1, 2014.

Health Insurance Marketplaces will offer low cost coverage options and comprehensive plans with essential benefits. Beginning October 1, many uninsured people will have new options for health insurance coverage and all plans must cover essential health benefits such as preventive and wellness services, emergency services, maternity and newborn care, emergency room care and prescription drugs. The ACA's changes for 2014 mean that plans can no longer deny coverage due to pre-existing conditions and insurance plans will have to show exactly what is covered. Every state will have a health insurance marketplace where individuals can shop for coverage. ■

Editor's note: AMCNO members and other health care professionals can help patients understand and navigate the changing health care landscape. Take a moment to review the following resources to get informed on Health Insurance Marketplaces to help answer your patients' questions. Patients who are unaware of the ACA implementation run the risk of not being ready for enrollment deadlines and are likely unaware of the new services and benefits. There are a number of resources available on the following websites:

www.healthcare.gov

www.marketplace.cms.gov

www.getcoveredamerica.org

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Choosing Wisely Initiative Highlighted on Special Broadcast

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to be a participant in the live studio audience at the Idea Center for a special broadcast of the *Sound of Ideas*, ideastream's daily call-in radio show broadcast on 90.3 WCPN and seen statewide on the Ohio Channel.

The program featured a discussion on *Choosing Wisely*[®], an initiative that enlists physician groups to share lists of tests, treatments and procedures that are commonly overused and unnecessary. Dr. John Santa, Director of Consumer Reports Health Rating Center, and a group of expert panelists, were the featured guests. Participating on the panel with Dr. Santa were J.B. Silvers, PhD, John R. Mannix Medical Mutual of Ohio Professor of Healthcare Finance at the Case Weatherhead School of Management and the School of Medicine; Randall D. Cebul, M.D., FACP, President of Better Health; and *Deborah R. Korenstein*, Adjunct Associate Professor of Medicine, General Internal Medicine, Mount Sinai Medical Center, New York. The show was hosted by Mike McIntyre and the audience included local doctors and healthcare professionals, members and staff of the Academy of Medicine of Cleveland and Northern Ohio, as well as medical, nursing and public health students.

The Choosing Wisely initiative brings together national physician groups to identify specific tests, treatments and procedures that are common and often may not be necessary. Since launching in 2012, more than 80 national medical specialty societies, state medical associations, consumer groups and

health collaboratives, including *Better Health*, have become *Choosing Wisely* partners. *Better Health Greater Cleveland* is one of 21 organizations that have been funded by the *American Board of Internal Medicine (ABIM) Foundation* to help advance its national *Choosing Wisely* initiative. The Academy of Medicine of Cleveland & Northern Ohio is among 18 partner organizations working with BHGC on this initiative.

In Ohio, Better Health is focusing on five health care situations that are familiar to thousands of Ohioans, along with the associated tests and treatments that often can be avoided. The five health care situations targeted are lower back pain, headache testing, sinus infections, PAP smears and cardiac testing. The tests and treatments are among more than 150 that are included in evidence-based lists of "Five Things Physicians and Patients Should Question" produced by medical societies as part of the national *Choosing Wisely* program and supported by *Consumer Reports*.

During the broadcast the host and panel members discussed an Institute of Medicine report which showed that over \$750 billion is wasted per year on inefficient care and unnecessary services in the United States.



Dr. John Santa (far right) spends a moment with Dr. George Topalsky, AMCNO President, (left) and Dr. Robert Hobbs, AMCNO board member.

Members of the panel agreed that overuse in medicine is a quality issue and it is important to remember that everything done in medicine is a balance of help or harm and if a patient is given a treatment that is unnecessary they may be exposed to harm without benefit.

Panelists also commented that there may be occasions when a test is done on a patient but the results of the test may not warrant conducting additional tests or procedures. For example, many abnormalities can show up as part of the normal aging process and at times it may be better to wait before doing anything further. Physicians can identify their high risk patients on the front end and keep track of them to determine if they need additional testing. This issue has to be dealt with by physicians — the insurance companies and the government cannot do it — there has to be a way for physicians to make quality decisions based on evidence based medicine.

One of the panelists noted that although patients may arrive at the physician's office with medical information they found on the Internet or elsewhere and then proceed to make specific requests to have a test done or a medication prescribed, the burden is on the physician to explain the purpose of the test or procedure and then determine whether it is necessary and communicate that information to the patient. The *Choosing Wisely* initiative is all about providing patients with this type of information in a manner in which they can understand it. Physicians in training also need to aware of these issues and one of the goals of the *Choosing Wisely* campaign is to try to

(Continued on page 11)



*Dr. Ronald Savrin (left), AMCNO Past President, conducts a Healthlines interview with Dr. John Santa prior to the *Choosing Wisely* initiative broadcast.*

HIPAA Compliance: Reminder of “Final Rule” Changes Are You Ready?

By David Valent, Esq., Reminger Co., LPA

This year the Federal Government published changes to HIPAA that will require “covered entities” (health care providers) to update their procedures related to the protection of patient health information. The changes became enforceable and may result in a penalty if not complied with beginning September 23, 2013. This article serves as a reminder of this recent deadline, and to further inform health care providers of some of the basics surrounding these new rules.

The HIPAA Final Rule mandates many changes, including but not limited to requiring that providers: have up to date Business Associate Agreements (containing specific new language regarding the protection of health information); make available a Notice of Privacy Practices form to all patients; implement a Breach Notification policy; honor a patient’s right to obtain his/her electronic health records; and, that providers perform a “risk analysis” to address the risks of the health care practice’s current procedures regarding the storage and transmission of protected health information, and to make improvements with regard to same, when reasonable. The Final Rule also provides new monetary penalties for failure to comply with these changes.

It should further be understood that many of the provisions of the Final Rule are “required” to be implemented, while many provisions are merely “addressable.” That said, the addressable provisions cannot be ignored. In the event of a government audit and/or investigation, your practice will need to establish that it did indeed “address” all the aspects of the Final Rule — specifically including undertaking of a risk analysis to determine if your practice can improve with regard its administrative safeguards, technical safeguards and/or physical safeguards for protecting patient health information.

While compliance was generally required by September 23, 2013, some of the changes implemented by this new law are still being

met with challenges. In response to a recent lawsuit filed, the Department of Health and Human Services (DHHS) agreed just this week to postpone the enforcement of the new Final Rule requirements relating specifically to “marketing restrictions.” The provisions related to marketing will not become enforceable until November 7, 2013, according to the DHHS. This will give the government more time to further issue guidance and clarity regarding the Final Rule changes related to marketing. Presumably, other aspects of the Final Rule will also be challenged, postponed and/or clarified in the weeks to come.

The HIPAA Final Rule can be accessed at: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/omnibus/index.html>. For further information and/or consultation regarding your practice’s compliance with these privacy rules, please contact David Valent, Esq. at Reminger Co., LPA, dvalent@reminger.com, (216) 430-2196.

Choosing Wisely Initiative Highlighted on Special Broadcast *(Continued from page 10)*

work with them and other medical professionals on how to identify when treatments or tests may be unnecessary.

The program wrapped up with a video presentation provided by BHGC explaining their involvement in the Choosing Wisely campaign. Now that BHGC has identified the five health care situations they plan to focus on, the next step is to educate physicians, medical students and residents about the project. To that end, BHGC has created educational packets and kits that can be used in different environments — such as residency programs, grand rounds and sessions in the community. ■

Editor’s note: The AMCNO has been a partner in the BHGC initiative since 2007 and we also have physician representation on the BHGC Leadership Team and Clinical Advisory Committee.



Dr. Robert Hobbs, AMCNO board member and AMCNO representative member to the Better Health Greater Cleveland Choosing Wisely (CW) Steering Committee discusses cardiac testing during a CW interview.



Members of the studio audience await the start of the program (seated in front - far right - Dr. George Topalsky, AMCNO President, and Dr. Ronald Savrin, AMCNO Past President).

Clinisync Update – The Future of the Statewide Health Information Exchange

The Chief Executive Officer for Clinisync, Mr. Dan Paoletti, was invited to the AMCNO board of directors meeting to present an update on the mission and future vision of the statewide health information exchange (HIE). Mr. Paoletti noted that as the state designated entity for HIE, Clinisync continues to guide physicians and hospitals through electronic health record adoption and meaningful use (MU). Clinisync is creating a robust network to connect physicians, hospitals and others involved in a patient's care. The intent is to manage the network so that physicians and hospitals, clinicians and laboratories can communicate with one another and coordinate care.

Clinisync is positioned to drawdown the last of their federal funding having received \$28.3 million for regional extension center services meant to assist providers in EHR selection, implementation and achieving MU, and an additional \$14.7 million for establishing an HIE to connect physicians, long-term care, hospitals and others to the state HIE. Clinisync is now positioned to sustain the organization without government funding. To date, Clinisync has signed up over 6,000 primary care physicians and over 3,000 that have met MU. In fact, Ohio is 6th in the nation for receipt of incentive payments. The physicians and hospitals in the State of Ohio are well on their way to EHR adoption and now they need providers to start communicating with one another electronically.

Clinisync worked with the hospitals first as a hub to connect to physicians but they are now abandoning that model and any provider can sign up for Stage 2 MU. Currently, there are over 1,400 physicians in 214 practices contracted (this does not include employed physicians). Over 800 physicians are live on the HIE and of those over 50% get their information into the EMR through the Clinisync interface. There are also over 50 practices getting their results sent directly to their EHR. Clinisync is working with their vendors to deliver live integrated results. These vendors have interfaces that can get information out for public reporting and coordination of care. Some of the vendors have also developed special pricing for these services. Clinisync also plans to provide MU services beginning in 2014.

Mr. Paoletti noted that Phase 1 has now been concluded. Phase 1 was a push for MU with delivery of clinical data to multiple locations using multiple platforms with a "push" model using direct exchange while building the Master Patient Index. Phase 2 is about continuity of care and developing a community health record (CHR) with the ability to query and retrieve clinical information across multiple providers — or a "pull" technology concept.

All physicians utilizing the CHR will have to sign the same documents for data use and treatment relationships — including uniform patient consent documents. The Clinisync consent policy was developed to ensure patient trust and proper use of the program, and patients have choices about making their information available in the CHR. Consent is not required for direct exchange between providers to coordinate care since HIPAA covers this, however consent is required to query the HIE for patient information and a provider must have a treatment relationship with the patient which is tracked in the system. In addition, patients can opt out of the system if they so choose.

Mr. Paoletti briefly outlined the data sharing workflow conducted by Clinisync including populating the HIE for an emergency room visit, hospital inpatient/outpatient visits, physician office visits, and how data is retrieved for use during these visits. Clinisync is also adding additional services such as digital imaging exchange which they hope to have functional in 2014, patient portal support with two different patient portals available, medication history with access to what prescriptions have been filled by pharmacies, and registry reporting. Clinisync has also been working with payers to enhance coordination in order to have electronic and efficient communication between those that provide care and those who pay for and manage care. They are also looking to link clinical and claims information. The wave of the future is toward the patient centered medical home (PCMH) model and primary care providers will need to coordinate care and have access to clinical and financial information for population health management purposes so this coordination could be useful.

The benefits provided by Clinisync include faster, more timely delivery of information to providers, a reduction in faxing, phone calls, and couriers, and reductions in duplicative testing and procedures which can result in reduced costs. In addition, this model can



Mr. Dan Paoletti responds to a question from an AMCNO board member.

assist with the push toward PCMHs and lead to better care coordination and transitions of care with the ability of providers and payers to communicate.

Measures requiring exchange fall into one of three basic categories. Transitions of care — measures that require hospitals and providers to share structured summary of care records electronically for each transition of care or referral; patient engagement — measures that require hospitals and providers to share or communicate information with patients electronically; and public health reporting — measures that require hospitals and providers to report information to the Ohio Department of Health (ODH) for public health reporting purposes. ODH has just rolled out MU Stage 2 information on their website about this initiative. Clinisync can provide technology to the physician offices at no cost to receive information from the system, however, if a physician wants Clinisync to do the public reporting and input into the community health record there will be a cost for that service. Mr. Paoletti noted that there may be some other minimal costs involved for physicians but it depends upon the services involved.

He also briefly described the menu measures in Stage 2 for physicians and noted that complete information on this topic is available for review on the Clinisync website. He closed his presentation stressing that Clinisync is an asset built by Ohioans for Ohio in order to connect the healthcare community to help Ohio achieve healthcare transformation. For more information about Clinisync go to www.clinisync.org ■

*To all Members of the
Academy of Medicine of Cleveland & Northern Ohio (AMCNO)*

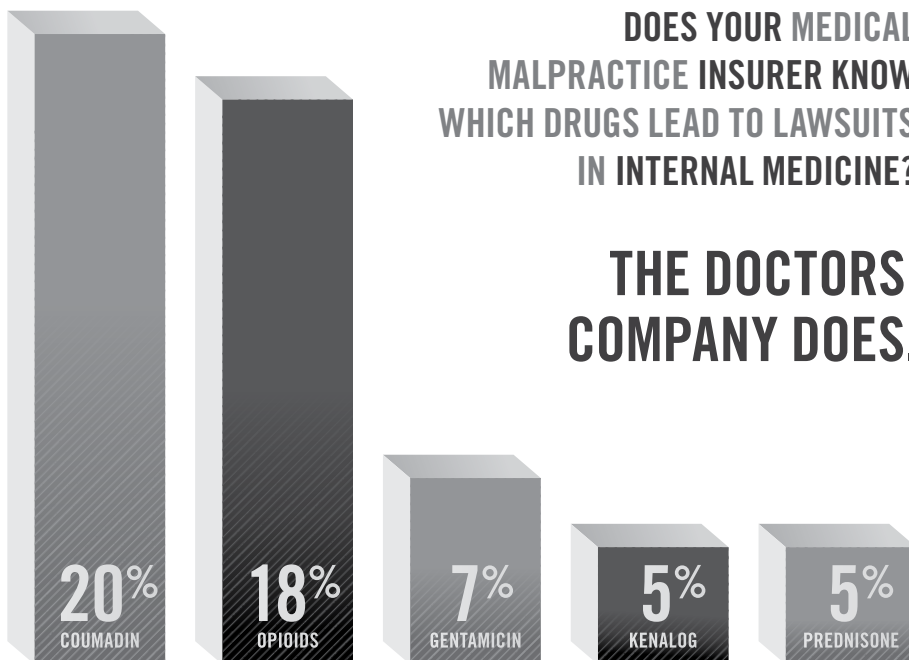
Your AMCNO Board of Directors and Staff

**WISH YOU A HAPPY
&
HEALTHY HOLIDAY SEASON**

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WHICH DRUGS LEAD TO LAWSUITS
IN INTERNAL MEDICINE?**

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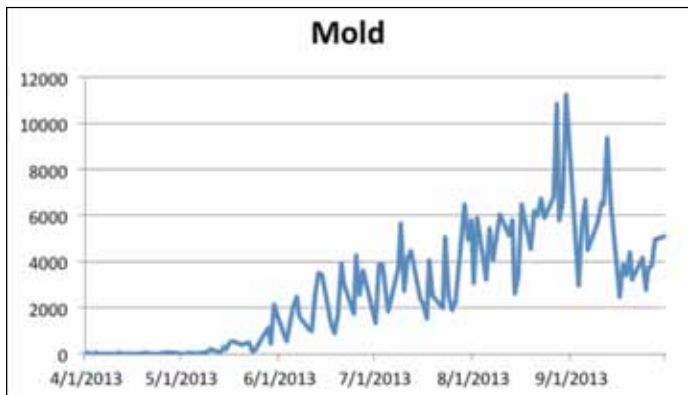
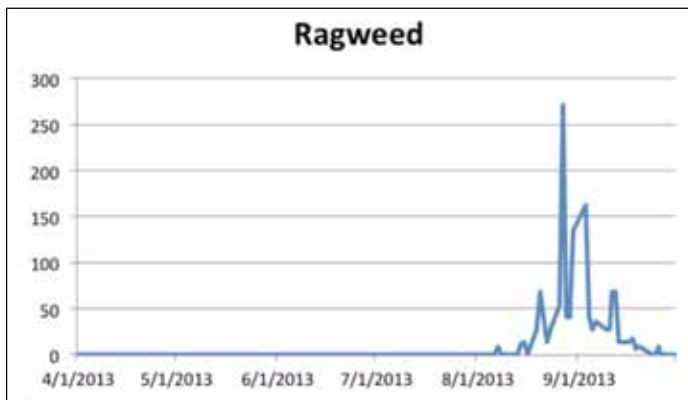
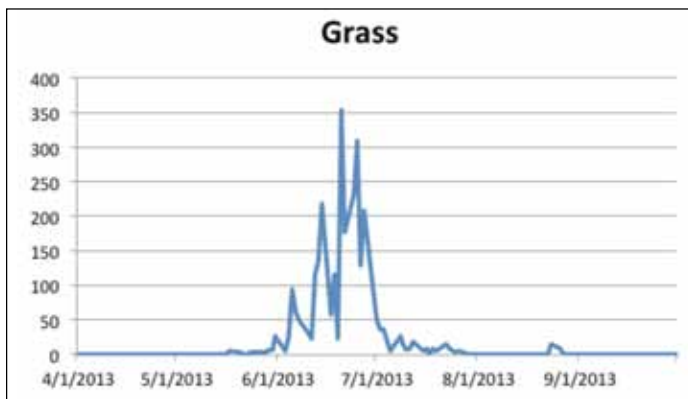
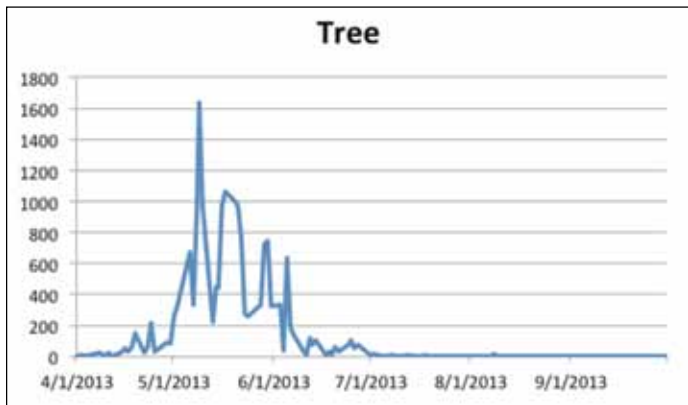
DRUGS MOST FREQUENTLY INVOLVED IN MEDICATION-RELATED MALPRACTICE CLAIMS AGAINST INTERNISTS

Source: The Doctors Company



AMCNO Pollen Line – 2013 Recap

Erin C. Toller-Artis, D.O., Kathryn Ruda Wessell, D.O., Theodore Sher, M.D., Haig Tcheurekdjian, M.D., and Robert Hostoffer, D.O.



For several years, Allergy/Immunology Associates has been dedicated to serving patients in the Greater Cleveland area through the use of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) pollen line. As in years past, the group used a Rotorod Aeroallergen device to obtain and then count the pollen levels daily throughout the 2013 pollen season. These pollen counts not only provide insight to patients, but allow allergists and physicians to have an extra tool in order to better direct therapy for their patients to achieve symptom relief. For those who suffer from allergic rhinitis, allergic conjunctivitis and asthma, the pollen season can be miserable. By following yearly trends, we can predict the timing of certain allergens and prepare our patients so that their quality of life can be maximized.

In the Greater Cleveland area, the pollen season begins with trees in April. Compared to last year, it took longer for the tree pollen levels to stay elevated. There was a very strong spike seen in early April last year, whereas this year we saw the first spike in mid to late April. This spike was significantly smaller than the spike seen in early May. This later spike was likely due to the amount of rainfall we experienced in April. The total amount of rainfall was significant enough to cause the tree pollen to stay elevated on a downward spiking trend until the first week in July. While the daily average rainfall was low, the total rainfall for June and July was higher compared to the other months of the pollen season (April-September).

Grass pollen is known to be the main offender over the summer months. It was on the rise in early June this year, which was delayed a month compared to last year. While it was a short lived season this year, it followed an upward spiking trend until it peaked in the third week of June and then fell off quickly. Even though the grass season was shorter, the pollen count was more than double the amount that was seen last year. This was likely due to the mild temperatures and large amount of rainfall in the area during June and July.

Ragweed started to appear slightly earlier last year compared to this year, however the peaks occurred at the same time. We tend to see ragweed every year around August 15th and it continues to climb from there until it starts a downward slope over the first two weeks of September. The ragweed pollen remained elevated longer last year, but the peak was about 25% higher than the peak was last year. The rainfall seen over the summer likely contributed to the strong spike seen at the end of August. The levels trailed off by the end of September.

While those who suffer from seasonal allergies look forward to the first frost and the end of pollination, mold spores have not given up. Mold can be seen to rise after rain at any time during the year, but it is also known to peak in the fall after the leaves have fallen. Damp leaves provide a great breeding ground for mold spores to accumulate. This year, mold started to increase around the first week of June and continued to climb to a peak seen at the end of August. This was expected given the rise in temperature. Even though levels began to increase, the level was low until the end of August. Since pollen counting was discontinued on September 30th, we likely missed the final peak for the mold count which should occur in October as the colder temperatures set in.

Each year, Allergy/Immunology Associates, in coordination with the AMCNO, is proud to provide the pollen count for the Greater Cleveland area from April 1st to September 30th. The counts are made available to the pollen line, (216) 520-1050, as well as www.amcno.org. Stay healthy and warm this winter and we look forward to helping you prepare for next year's pollen season on April 1st, 2014! ■

AMCNO LEGISLATIVE UPDATE

Medicaid Expansion Becomes a Reality Through Controlling Board Vote *(Continued from page 1)*

members of the legislature – four Republicans and two Democrats, an administrator, and a governor appointee who also served as president. Four votes were necessary to approve the measure – and just prior to the meeting House Speaker William Batchelder removed the two Republican House members from the panel - Ron Amstutz, Wooster, and Cliff Rosenberger, Clarksville - and replaced them with two other Republican legislators, Ross McGregor, Springfield, and Jeff McClain, Upper Sandusky. The final vote was 5-to-2 in favor of expanding Medicaid eligibility with Controlling Board president Randy Cole, State Rep. Chris Redfern (D-Port Clinton), State Sen. Tom Sawyer (D-Akron), State Sen. Chris Widener (R-Springfield) and McGregor voting yes. State Senator Bill Coley and State Representative Jeff McClain voted no.

The impact of the Controlling Board's decision for physicians, hospitals, and patients cannot be overstated. The Controlling Board's ruling means physicians and hospitals will now receive reimbursement by Medicaid for the healthcare services they already provide to this patient population. It also means many more patients in our community will now have access to preventive and emergency healthcare services. The expansion will be covered 100 percent by the federal government for the first three years before gradually dropping down to 90 percent by the end of the decade, where it levels off. During this period, Ohio's health care system will draw \$13 billion in federal funding to focus on preventive care, improved care coordination and chronic disease management.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) board of directors voted to support Medicaid expansion early in 2013 and at the same time we became a partner in the Northeast Ohio Medicaid Expansion Coalition – a partnership of health care providers, community organizations, medical professionals, associations and other groups committed to expanding Medicaid in Ohio. The AMCNO shared our position of support with the governor and legislative leaders, urging them to also support Medicaid expansion. The AMCNO was pleased when Governor Kasich included Medicaid expansion in his executive budget proposal, but we were disappointed when both the Ohio House and Senate did not approve of the concept and the proposal was not part of the final budget proposal that was approved in late June.

Over the course of the last few months, there have been several pieces of Medicaid reform legislation introduced in both the Ohio House and Ohio Senate. In addition, a coalition of Ohio community organizations, hospitals, businesses, labor unions, religious organizations, and others who supported extending health care coverage to 275,000 uninsured Ohioans through Ohio's

Medicaid program launched a ballot initiative through the *Healthy Ohioans Work* campaign and started collecting signatures to place the question of whether Medicaid should be expanded before voters on the November 2014 ballot. This group plans to continue to collect signatures while the discussion on Medicaid reform continues in the legislature.

The AMCNO has also continued to meet with legislators about the importance of expanding Medicaid and we participated in two Lobby Day events with the Northern Ohio Medicaid Expansion Coalition – with one Lobby Day event taking place just five days before the Controlling Board meeting.



Ms. Elayne Biddlestone, AMCNO Executive Vice President spends a moment with Ohio Senate Majority Leader Tom Patton following the NEOMECA Lobby Day Event.

Although Republican legislators voiced their opposition to Medicaid expansion and to the Controlling Board move, the Governor remained committed to expand Medicaid and he has spent time over the last few weeks attending meetings and events around the state to garner public support. The AMCNO executive staff and physician leadership were pleased to be on hand when the Governor visited the Cleveland Clinic Foundation to rally support just a few days before the Controlling Board vote. Joining together with physicians, business leaders, law enforcement officials and other advocates at the Cleveland Clinic, Gov. Kasich outlined the benefits of extending Medicaid eligibility up to 138% of the federal poverty level. During the event, the governor commented that the ability for Ohio to reclaim taxpayer dollars to help Ohioans "is the right way to proceed." He also noted that his aim is not to further dependency on entitlements but rather to "create a bridge" that will encourage Ohioans to improve their lives.

Ohio is now the 25th state to vote for an expansion of the Medicaid program. While lawsuits are likely to ensue challenging the Controlling Board's authority to authorize this expansion of the state's Medicaid program, this decision marks a huge victory for supporters of Medicaid expansion like the Academy of Medicine of Cleveland & Northern Ohio (AMCNO). The AMCNO applauds the vote of the Controlling Board and we are confident that the

health and well-being of uninsured citizens around the state and in Northern Ohio will be greatly improved by access to the medical coverage provided by an expanded Medicaid program. The AMCNO will continue to monitor the Medicaid reform issue and provide updates to our members.

Primary Care Rate Increase Update

As part of the Patient Protection and Affordable Care Act, the federal government will fully finance the difference between the state Medicaid payment rate and the current year Medicare rate for two years (January 1, 2013, through Wednesday, December 31, 2014) for eligible primary care physicians.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has received inquiries from members regarding this issue and in particular questions regarding the final list of physicians that have successfully attested for the rate increase. The final list of physicians who have successfully attested for the primary care rate increase (PCRI) can be found at <http://www.medicaid.ohio.gov/Portals/0/Providers/PCRIApprovedProviders-2013-09-24.pdf>

Payment Update

The AMCNO received the following status update regarding the enhanced payment increase for physicians eligible for the primary rate increase from the Ohio Department of Medicaid (ODM):

Fee-for-Service (FFS) enhanced payments are currently being made; however, two batch adjustments still need to be made for FFS Medicaid. Information on how that will be accomplished will be forthcoming. No action is required on the part of the physician to correct those payments.

For earlier payments (July 1 through July 17):

- The first July Medicaid payments were short due to the new fund codes not being set up in the OAKS system. That issue has been resolved; however, those payments will need to be adjusted so physicians receive the correct payments for the first July Medicaid payment received.
- The ODM is working to automate the adjustments. Once the adjustment plan is finalized, it will be published.

For January 1 to present:

- The ODM is working on a plan to complete the adjustments in batches based on provider identification number. The plan will be published once it is finalized.

Managed Care Payments - The ODM anticipates sending the managed care plans (MCPs) PCRI payment at the end of October

(Continued on page 16)

AMCNO LEGISLATIVE UPDATE

Medicaid Expansion Becomes a Reality Through Controlling Board Vote

(Continued from page 15)

2013 for the retrospective period January – June 2013. Another payment will be made in November 2013 for the period July – September 2013. After that, the ODM will make payments to the MCPs on a quarterly rolling cycle.

The MCPs must begin paying the enhanced payments to ODM-approved physicians once MCPs receive the enhanced payment from the ODM. The MCP will pay physicians the enhanced payment directly. Once the MCP enhanced payments to eligible physicians begin, they must be made at least quarterly. MCPs have the discretion to make payments to eligible physicians more frequently, but not less frequently. For further details, please contact the MCPs directly.

Eligibility Clarification

According to the final rule published by the Centers for Medicare and Medicaid Services, physicians who qualify for the enhanced payment will not receive it when rendering services in federally qualified health centers, rural health centers, or health departments/clinics.

You Can Still Attest

Please note that physicians can still attest for the enhanced primary care payment, they will just not be eligible to receive retroactive payment back to January 1, 2013. Those attesting and approved after the August 16 deadline (those reflected on the September 24, 2013, final list) will receive enhanced payment back to their date of attestation. If you haven't attested yet, you can still do so as long as you have a current MITS account with an active login and PIN. Those who don't have a MITS account can sign up for one.

Prescription Drug Abuse Panel Holds Hearings Across the State – Releases Final Report

Continuing efforts to gather public and professional input on Ohio's growing prescription drug abuse epidemic, House lawmakers traveled around the state over the summer months to hear testimony from local officials, law enforcement, addiction professionals, physicians, and others.

The committee wrapped up their hearings in Cleveland where they heard about successful treatment options and practices that are being employed in the northeast part of the state. During their visit to Cleveland, the study committee also hosted a panel of seven treatment providers, and visited a drug court to see how it works.

The purpose of the study committee was to look more closely at the issue, and the Chairman and the other committee members have released their findings. During a press conference, Chairman Sprague indicated the steps he would



Dr. Michael Anderson, from University Hospitals, outlined the University Hospitals Standard of Care for Opioid Prescriptions in his testimony. Dr. Anderson also mentioned the medical/legal summit co-sponsored by the AMCNO and the Cleveland Metropolitan Bar Association which featured several presentations on the prescription drug abuse issue.

like to take to fight the opioid epidemic. Specifically, the committee would like to introduce legislation that would: adopt more stringent standards for prescribing opioids for pain; allowing 30 day prescriptions to be filled in weekly increments; prevent minors from being prescribed narcotics without their parents' consent; extend the use of the OARSS system in Ohio, require a photo ID to pick up a narcotics prescription; and engineer more integration between treatment programs and fund specialty court dockets. Rep. Lynn Wachtman, who chairs the House Health and Aging Committee has indicated that his committee will likely create three subcommittees to examine the several bills that are anticipated to be introduced.

Legislation Under Review

The AMCNO Legislative Committee tracks and reviews all healthcare related bills introduced in the legislature. To view the bills and the AMCNO position on legislation under review in the 130th General Assembly go to our website at www.amcno.org or contact Elayne R. Biddlestone at the AMCNO offices at 216-520-1000, ext. 100.



Members of the Prescription Drug Abuse Panel listen to testimony provided at the Cleveland hearing.



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Call for 2014 AMCNO Honorees

The AMCNO invites you to nominate an individual who is a member of the AMCNO that you believe is deserving of special recognition by the AMCNO. Any physician who wishes to nominate an individual for one or more of these awards should complete the form below and mail it to me at the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio, 44131. You may also FAX your nominations to Elayne Biddlestone at (216) 520-0999 OR you may call her at (216) 520-1000, ext. 100 to provide your honoree nominations over the phone. Deadline for submission: 12/31/13.

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

Are you Interested in Running for the AMCNO Board of Directors in 2014?

Directors are elected to represent their district, which is determined by primary hospital affiliation or at large for a two-year term. Members of the Board are responsible for addressing issues of importance to physicians and the patients we serve, and setting policy for the AMCNO. If you are interested in running for the board of directors please return this form with your name and contact information to the AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio, 44131. You may also FAX your information to Elayne Biddlestone at (216) 520-0999 OR call her at (216) 520-1000, ext. 100. Deadline: 12/31/13.

Yes, I am interested in running as a candidate for the AMCNO board of directors _____

Name and Contact information: _____

AMCNO ADVOCACY ACTIVITIES



The AMCNO continues to meet with the physician leadership of the Ohio State Medical Association (OSMA) in an effort to establish a more collaborative relationship. At the most recent meeting the group discussed including the AMCNO in House of Medicine meetings and the appointment of the AMCNO legislative chairman to the OSMA Legislative Committee. The group also discussed the possibility of establishing a regional task force to discuss additional collaborative efforts and interaction with the OSMA House of Delegates. (Pictured left to right – Dr. Laura David, Dr. James Sechler, Dr. Charles Wehbe, Dr. Mary Wall, Dr. Tom Bralliar and Dr. John Bastulli).



The AMCNO was pleased to participate in the Ohio House of Medicine meeting held at the Columbus Convention Center in October and hosted by the Ohio Chapter of the American College of Physicians. The purpose of the meeting was to have a roundtable discussion on the Ohio medical community's organizational advocacy priorities. (Above: Dr. George Topalsky, AMCNO President (right) talks with Dr. Dan Sullivan, from the Ohio ACP (center) and Dr. Peter Bell, following the Ohio House of Medicine Meeting.)

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