

## Educational Forum Offers Insights into Medical Marijuana

On June 4, The Free Medical Clinic of Greater Cleveland hosted “Medical Marijuana: Truth and Consequences,” a forum that the Academy of Medicine of Cleveland & Northern Ohio and Academy of Medicine Education Foundation co-sponsored.

In his opening remarks, **Danny Williams, JD**, Executive Director of The Free Clinic, stated that although medical marijuana can be helpful in the treatment of certain conditions, we still don’t know the full benefits and risks behind it.

**Kari Franson, PharmD, PhD**, Associate Dean for Professional Education in the Department of Clinical Pharmacy at the University of Colorado, delivered the keynote address, “Marijuana as Medicine: The State of the Science.” Dr. Franson received her Doctor of Pharmacy from the University of California, San Francisco, and PhD from Leiden University

Medical Center. Her background is in clinical research and drug development, with a focus on psychopharmacology. She serves on the Colorado Governor’s Recreational Marijuana Advisory Committee for Safety and Consumer Affairs.

During her address, Dr. Franson discussed the pharmacology of marijuana—its uses, effect on the reward pathway, acute toxicity and long-term effects. She said that the marijuana plant contains more than 400 compounds; 60 of them are cannabinoids, and some of the other non-cannabis compounds are similar to those



Dr. Kari Franson delivers the keynote address.

found in the tobacco plant. She described several common cannabinoids, such as THC and CBD, and said most of them interact with G-protein-coupled cannabinoid receptors CB1 and CB2. The effects of the drug include antinausea, impaired coordination, increased appetite and euphoria.

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## Awardees Shine at the 2015 AMCNO Annual Meeting

On Friday, April 24, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) physician members gathered to celebrate another year of accomplishments and to recognize a handful of their fellow colleagues who have made a difference in the field during the past year.

The AMCNO Annual Meeting and Awards Presentation took place at the Wyndham Cleveland at PlayhouseSquare. Bright decorations and a colorful backdrop of the city helped create a festive mood for the occasion.

**Stanton L. Gerson, MD**, the evening’s first honoree, received the John H. Budd, MD,

Distinguished Membership Award for his cutting-edge research and exemplary leadership skills. He was also honored for his commitment and dedication to Cleveland’s medical community and to the AMCNO.

**David L. Bronson, MD**, received the Charles Hudson, MD, Award in recognition of his work

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The evening’s honorees gather together. (l-r) Dr. David Bronson; Dr. Richard Stein; Terry Allan; Toinette Parrilla; Dr. Stanton Gerson; Hon. George V. Voinovich; Kimberly Anderson; Dr. Joan Papp; Dr. Victor Bello; and Dr. Anthony Bacevice, Jr.

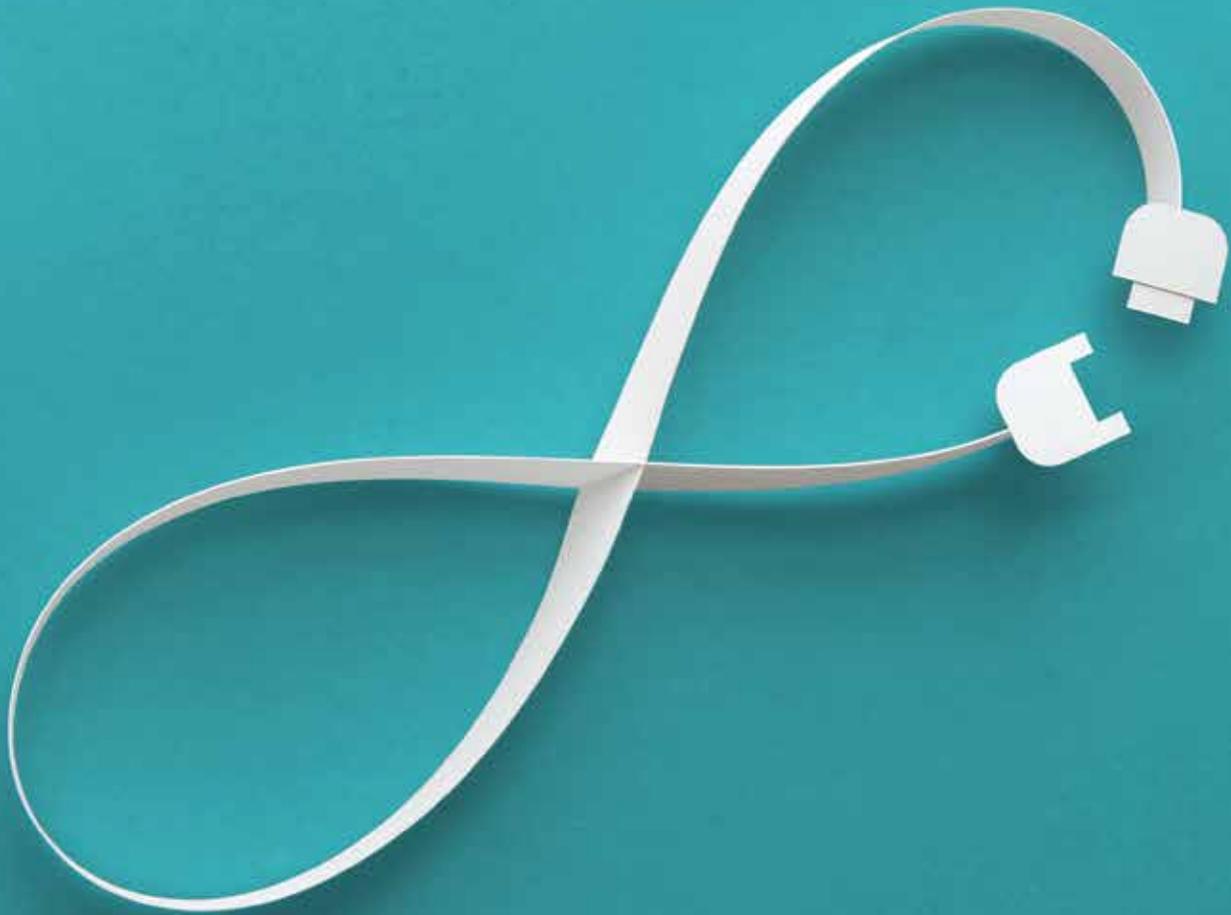
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# AMCNO/AMEF COMMUNITY ACTIVITIES

## Educational Forum Offers Insights into Medical Marijuana

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Medical marijuana is being studied primarily with products grown at the University of Mississippi in a controlled environment to aid in various ailments, including chemo-induced nausea and vomiting, multiple sclerosis and chronic pain.

The drug can be beneficial in pediatric epilepsy cases, she noted. One small study looked at 13 patients with Dravet and other seizure syndromes. The medical marijuana they used contained medium to high levels of CBD and low levels of THC. Patients reported an 84% reduction in seizure frequency. Most of the patients were then weaned from other medications.

Dr. Franson acknowledged that marijuana has acute CNS symptoms; however, there's not a lot of danger in "overdosing" on marijuana, she said. The lifetime dependency risk for marijuana is relatively low at 9%, whereas nicotine is at 32%. Heroin, cocaine and alcohol fall in between those two points. The Substance Abuse and Mental Health Services Administration reported 360,000 people were admitted for addiction treatment in 2010, and marijuana was listed as the primary drug. Teens have a 1 in 6 chance for addiction, Dr. Franson said. Colorado currently prohibits the sale or use of cannabis to those who are under 21 years of age, unless two physicians sign off on the usage.

Long-term exposure to cannabis can effect memory and learning, disrupt short- and long-term memory and lead to cognitive decline. Dr. Franson also said that exposure during development can cause alterations to the brain's structure and function; therefore, even prenatal exposure can leave lasting effects.

She also discussed the pharmacokinetics associated with marijuana use. When inhaled, the bioavailability is 10-25%. When ingested, the bioavailability is 5-20%, and the onset can take 1-3 hours, because of slow absorption from the gut. Edibles increase toxicity risk, because a person will continue to ingest it if they don't feel the effects right away. And, a tolerance is developed with chronic use.

The first panel discussion, "Lessons Learned: Intended and Unintended Consequences" was moderated by Michael Shafarenko of ideastream. The panel participants were **Derek Siegle**, Executive Director for the Ohio High

Intensity Drug Trafficking Area; **Jessie Hill**, Associate Dean for Faculty Development and Research and Judge Ben C. Green Professor of Law at Case Western Reserve University School of Law; **Jason M. Jerry, MD**, Alcohol and Drug Recovery Center, Lutheran Hospital; and **Dr. Franson**.

Dr. Jerry clarified that marijuana itself is not a medicine but some of its components may be. And when asked how marijuana entered the medical arena, Dr. Franson said that is known that the drug does have pharmacologic effects.

In response to the question of what the challenges are in classifying marijuana as a medication, Dr. Jerry said, "Some of the substances in marijuana, such as CBD, are going through the Food and Drug Administration approval process, which begs the question, 'Why do we need to go through the individual states?'"



*Lessons Learned: Intended and Unintended Consequences panelists – (l to r) Derek Siegle, Dr. Franson, Dr. Jason Jerry, Jessie Hill and Michael Shafarenko.*

There's a notion of medical marijuana being a gateway drug, Shafarenko said, and he asked whether that was truth or myth. Dr. Jerry responded, "Epidemiological studies show that those who smoke marijuana can move onto other drugs, but the same can be said for cigarettes or alcohol (as gateway drugs)." Hill added, "There will have to be very careful regulation if it's legalized in Ohio. This is the concern—that it will lead to something else."

"Is there evidence that people are moving to states that have legalized medical marijuana?" Shafarenko asked. "Yes," Dr. Franson said. "Some are moving for medical purposes; others for economic reasons, to work in the industry." She added that part of the regulation in Colorado is knowing where each plant came from, so everything is done through seed to sale. There's not a generalized agreement on



*Economic Impact panelists – (l to r) Patrick McManamon, Candi Clouse, Arett Fortune, Ari Seaman and Brian Tucker.*

how to standardize the product, however, so more research is needed, she said, adding that \$9 million was set aside for the Department of Health to distribute to medical marijuana research, so they are studying it but not what's on the street.

The other panelists agreed that what's happening in Colorado should be analyzed before medical marijuana is legalized in other states.

The next panel discussion, "Medical Marijuana: The Economic Impact," was moderated by Brian Tucker of Dollar Bank. The panelists were **Ari Seaman**, founder of iGROW Induction Lighting, a Cleveland-based manufacturer of agricultural lighting technology; **Garett Fortune**, CEO of FunkSac, a packaging solutions for the cannabis industry; **Candi Clouse**, Program Manager for the Center for Economic Development at the Levin College of Urban Affairs, Cleveland State University; and **Patrick McManamon**, CEO of Cannasure, which insures cannabis-related businesses.

Clouse reported that data analysis of the economic impact shows benefits from legalization, but it will not "save" the economy. The tax dollars raised would potentially increase revenue—an estimated \$51 million—which could be used for public services, such as roadways and response teams, she said. Legalization would also create new jobs in various avenues, especially because the product will have to be grown and sold in Ohio.

Seaman, Fortune and McManamon have experienced increases in their workforces and sales throughout the last few years. However, the three men discussed the dangers of having to do business in cash because many banks will not back this type of business. It is a concern that the government will need to look at as more states pass marijuana legalization, they said.

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# AMCNO/AMEF COMMUNITY ACTIVITIES

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The forum concluded with a debate between **Marcie Seidel**, Executive Director for the Drug-Free Action Alliance, and **Ian James**, Executive Director for ResponsibleOhio. **David Abbott**, Executive Director of the George Gund Foundation, served as the moderator. The focus of the discussion—"Would Medical Marijuana Improve Health Outcomes in Ohio?"

In Seidel's opening statement she said her answer to that question is, "Yes. No. Maybe."

"The real question is, 'How do we define medical marijuana?'" she said. "The answer would be 'yes' if it truly is a medicine. One that has gone through proper protocol of scientific research and trials, one that has followed the gold standard of modern medicine, to become medicine as all other medications do." She then cited several marijuana-based medications that have been approved and are legal in the United States.

"The answer is 'no,'" she said, "if it's defined as legalizing raw plant material through an initiative or legislative action." Legalizing a raw plant could create a serious risk for patients. "No medical groups believe this is a safe and good way of doing medicine," Seidel continued. "The doses aren't standard. The interactions with other medications are not known. The toxins and components that make up the plant could easily compromise already fragile systems. And potential side effects may not be known to the individuals taking it."

"Now, the 'maybe' part," she said. "Research and controlled studies are starting to show some really promising components within the complex medical marijuana plant, and these new compounds will start to unfold with proper scientific research. So at the Alliance, we support the increased research to reveal its potential, and we support putting this in the hands of scientists and not pot profiteers."

In his opening statement, James said that cannabis has been around for a very long time. And it was legal throughout most of our country's history, until alcohol prohibition and the war on drugs occurred. "Through the last 18 years, however, 23 states have legalized medical marijuana to provide the passionate care that it provides to the chronically ill," he said. "This year, HB 33 was introduced to help epileptic kids, but it only had 9 co-sponsors, and it hasn't gotten out of committee.

He shared several stories of patients who have been positively impacted by the use of medical marijuana. "You're going to hear a lot of folks say we need to wait," he said. "We need to wait because we don't have Congress rescheduling marijuana. We need to wait for the FDA to do more studies that they cannot do because it's not rescheduled. And we need to wait for the Statehouse to catch up and take action. We cannot continue to tell cancer patients, epileptic patients, Alzheimer's, Parkinson's patients to wait because we're not ready yet to help you."

In her rebuttal, Seidel agreed that marijuana has been around for a long time, but it has been genetically modified to contain higher THC levels. As a public health official, she said she feared that without proper research, patients would be in danger. "Let's get it in the hands of the people who really care, to make sure we do this right," she said.

Additional points were discussed during the debate, such as the reasoning behind calling for



David Abbott moderates the debate between Marcie Seidel (left) and Ian James.

the legalization of both medical marijuana and recreational use and the need to create safe patient-physician relationships. ■

**Editor's note:** Neither the AMCNO nor the AMEF have taken an official position on this issue—this forum was for educational purposes only.

The Free Clinic plans to post a video of the entire forum on their website at [www.thefreeclinic.org](http://www.thefreeclinic.org).



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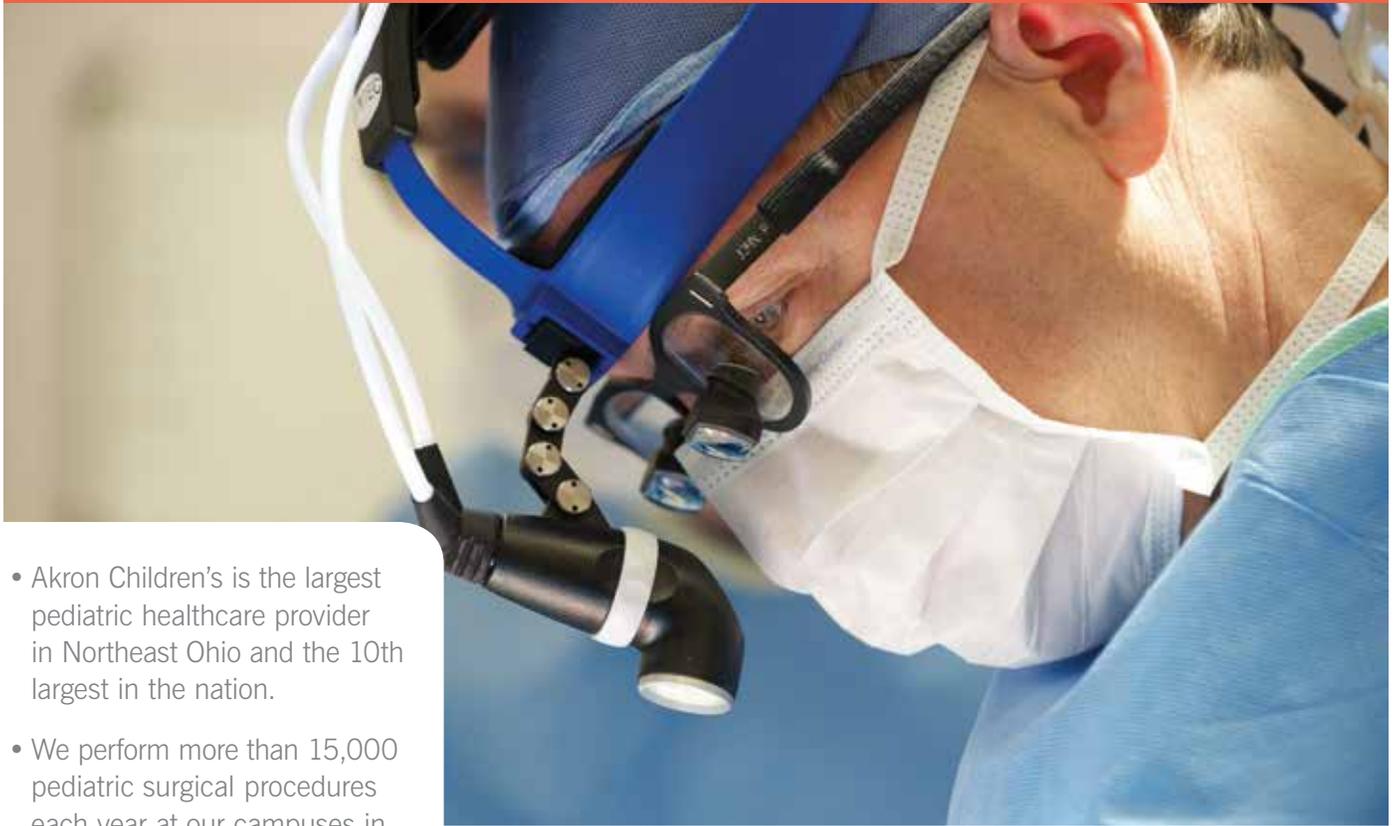


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# AMCNO AWARD CEREMONY

## Awardees Shine at the 2015 AMCNO Annual Meeting

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as a physician leader in the Northern Ohio community and in appreciation for his longstanding involvement in organized medicine at the regional and national levels.

**Richard L. Stein, MD**, received the Clinician of the Year Award for his contributions to clinical medicine and service to his patients, which have reflected the highest ideals and ethics of, and personal devotion to, the medical profession.

**Anthony E. Bacevice, Jr., MD**, was presented the Outstanding Service Award in recognition of his work with the *Healthlines* program and the statewide health information exchange. He was also honored for his longstanding commitment to the AMCNO and the Academy of Medicine Education Foundation (AMEF).



50 Year Awardees are recognized for their longstanding dedication to medicine. (l to r) Milton B. Good, MD, and K.V. Gopalakrishna, MD, stand with Matthew E. Levy, MD.

**Joan J. Papp, MD**, received the Special Honors Award for her work in fighting heroin addiction in Cuyahoga County through Project DAWN (Deaths Avoided With Naloxone) and for her efforts to achieve passage of legislation to allow those in a position to help heroin addicts receive naloxone prescriptions.

The Honorable **George V. Voinovich** received the Honorary Membership Award for his many years of public service to Ohio's citizens—as Mayor of the City of Cleveland, Governor and U.S. Senator. His outstanding contributions certainly deserved recognition by the AMCNO's physicians and the Northern Ohio community.



The medical students receive their AMEF scholarship awards. (l to r) Ji Son, Kailin Yang, Sruti Brahmandam, Emily Holthaus, and Nicholas Pettit.

**Terry Allan** and **Toinette Parrilla** each received a Special Recognition Award for their outstanding work with local hospitals and physicians during the Ebola crisis response. Their work was of great importance to the health and welfare of our community, and they dedicated their awards to their respective team members for their assistance.

**Kimberly C. Anderson, Esq.**, received the Presidential Citation Award for her efforts to provide physicians in our community with information and training on issues of importance to the medical profession, as well as for her efforts to support and promote a working relationship between the AMCNO and the State Medical Board of Ohio.

The AMEF bestowed the John A. Bastulli, MD, Philanthropy Award upon **Victor M. Bello, MD**, for his sustained support of the AMEF.

The AMEF also awarded six \$5,000 scholarships to medical students from Cleveland Clinic Lerner College of Medicine of Case Western Reserve (Emily Holthaus and Kailin Yang), Case Western Reserve University School of Medicine (Danielle O'Rourke-Suchoff and Ji Son), Ohio University College of Medicine (Nicholas Pettit), and the Northeast Ohio Medical University (Sruti Brahmandam). This was the 10th year that scholarship monies were presented to recipients as part of the program at the Annual Meeting, with students and their respective families in attendance.

And, as always, physician members celebrating their 50th anniversary of their medical school graduation were honored during the program.

To end the evening, outgoing President James M. Coviello, MD, passed the AMCNO gavel to incoming President Matthew E. Levy, MD, to fulfill the 2015-16 term. ■



A distinguished group—AMCNO's past presidents gather before the meeting begins. (l to r) Drs. Victor Bello, Anthony Bacevice, Jr., Ronald Savrin, Dale Cowan, George Kikano, Laura David, Paul Janicki, John Bastulli, William Seitz, and Lawrence Kent.

# AMCNO AWARD CEREMONY



## Meet Matthew E. Levy, MD AMCNO President 2015-2016



Matthew E. Levy, MD  
AMCNO President 2015-2016

### Tell us about your practice.

I have a general orthopaedics practice. I treat patients from the very young to the very old. I provide fracture care. I do joint replacements. I do arthroscopic surgery.

### Why did you choose to go into medicine?

I come from a family of doctors. While I was never pushed into medicine, my father was a very positive influence on my life, and it just seemed like a natural thing to do. I strongly considered urology, as I had a practice waiting for me to join (my uncle), but the allure of orthopaedics was too much.

### What are your hobbies and interests?

I love to read for pleasure. While I would never characterize myself as an outdoorsman, I do enjoy bike riding and skiing. I enjoy long walks with my family and our dogs. Also, although I have no musical inclination whatsoever, I love live music.

### What accomplishments are you most proud of?

I am proud of my family. I have been married for 24 years this August, and I am proud to say that I am happily married. I think my wife

and I have raised three wonderful children. Professionally, I am proud that I have been able to give back to the profession despite the fact that I do not work in an academic setting. This includes my work with AMCNO, being active on the Board of my medical school alumni, mentoring students, and even mentoring resident physicians.

### What are your goals and priorities for AMCNO this year?

I hope to continue the job that has been started by my predecessors. What we do at AMCNO is work to serve the interests of our physician members, and their patients. It is hard to predict the challenges that each year will bring (see last year's Ebola crisis) but I think there are some issues that will pretty reliably be on our agenda. We will continue to be at the forefront of the effort to navigate our state through the opioid epidemic that has ravaged our state and the nation. The Affordable Care Act and Medicaid expansion will certainly be on our agenda. Helping our members navigate through the rollout of ICD-10 will be on our agenda. The change of physician reimbursements from fee-for-service to pay-for-performance, as well as the changing Medicaid fee schedule, will also be on our agenda.

### What is your biggest concern about the future of medicine?

I worry about physician autonomy. Too many of the decisions that affect the care of our patients are being made by non-physicians. Medicine is not a bottom line industry, but it is being run like one. Certainly we bear some of the responsibility for this. Fortunately, organizations like ours ensure that the voice of the physician is heard. I worry that the next generation of young people will be discouraged from a career in medicine.

### What would you ask individual physicians to do this year to support the AMCNO?

Get involved. Serve on a committee. Participate in a social event. See what we do. While we appreciate the level of membership in our organization, the vast majority of our members are silent members. Even a nominal fraction of increased participation would go a long way. Too many physicians are disgruntled by the state of our profession. I would encourage them to do something about it.

### Is there anything else you would like to add?

Medicine is still a fantastic profession. For all of the challenges that lie ahead of us, and all of the negativity about the future of our profession, the doctor-patient relationship will continue to be special and will continue to be gratifying for those of us who have chosen, and will continue to choose, a career in medicine. ■

## NORTHERN OHIO PHYSICIAN

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THE NORTHERN OHIO PHYSICIAN (ISSN# 1935-6293) is published bi-monthly by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131. Periodicals postage paid at Cleveland, Ohio. POSTMASTER: Send address changes to NORTHERN OHIO PHYSICIAN, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131. Editorial Offices: AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131, phone (216) 520-1000. \$36 per year. Circulation: 3,500.

Opinions expressed by authors are their own, and not necessarily those of the Northern Ohio Physician or The Academy of Medicine of Cleveland & Northern Ohio. Northern Ohio Physician reserves the right to edit all contributions for clarity and length, as well as to reject any material submitted.

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To view an interview conducted by Dr. Anthony Bacevice, Jr., with Dr. Levy about his presidency, visit our website at [www.amcno.org](http://www.amcno.org) and click on the President's Corner.

# AMCNO BOARD ACTIVITIES

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## Budget Debate Comes to a Close

Every odd numbered year the Ohio legislature spends months debating the items outlined in the budget. Ohio has a two-year budget cycle and the authorizing language must be passed by June 30. So in January of 2015 the Governor presented his budget outline. The Ohio House then debated the issues outlined in the budget and passed its version in April, after which time the Senate debated the budget and passed its version in June. The House and Senate then participated in a conference committee process in late June, and then the Governor reviewed the changes and issued line-item vetoes before signing the final budget bill on June 30.

The budget includes provisions to continue funding the Medicaid expansion population; however, it also includes a plan to require the administration to seek a Medicaid waiver from the federal government to create health savings accounts, with possible exclusions for some program recipients. In addition to that and many other Medicaid program changes, Medicaid managed care organizations also must implement strategies to base payments on the value received for provider services.

At press time, the budget bill contained the following key points:

- Increase the tobacco tax to 35 cents per pack and raises the tax on other tobacco products (not including e-cigarettes) from 17% to 22.5%. The intent is to use some of the new tobacco tax revenue for tobacco cessation efforts. The AMCNO has long advocated for an increase in tobacco taxes and would have preferred the amount that was included in the Governor's version of the budget—namely, an increase in cigarette taxes to \$1.00 per pack and an increase in taxes on other tobacco products, including e-cigarettes, to equal the rate on conventional cigarettes. The AMCNO will continue to push for that in the future.
- Require The Ohio Department of Insurance (ODI) to apply for a waiver to create a system that provides access to affordable health coverage and includes a request to waive the employer and individual mandates currently in place under the Affordable Care Act (ACA).
- Create a Graduate Medical Education Study Committee to study the issue of Medicaid

payments to hospitals for the costs of graduate medical education, including the feasibility of targeting payments in a manner that rewards medical school graduates who practice in Ohio for at least five years after graduation,

- Include Medicaid coverage for women in need of treatment for breast and cervical cancer;
- Include Medicaid benefits for women earning up to 200% of the Federal Poverty Level (FPL);
- Require the Medicaid Director to establish the Healthy Ohio Program under which certain Medicaid recipients, in lieu of Medicaid coverage through the Medicaid fee-for-service or managed care system, are required to enroll in a comprehensive health plan offered by a MCO under contract with the Department of Medicaid;
- Authorize the State Medical Board of Ohio to impose a civil penalty on a professional who violates the law administered by the Board and require the Board to adopt guidelines regarding the amounts of civil penalties to be imposed.

The AMCNO pushed throughout the budget process to stop the proposed cuts to Medicaid cross-over payments for patients with dual Medicare/Medicaid eligibility, and requested that new funds be utilized to increase Medicaid's reimbursement rates for primary care services. Unfortunately, it appears as if the proposed cuts will occur and it remains to be seen how much of an increase will be made in primary care payments going forward. We will continue to work with the legislature and the administration in an effort to address these important issues.

## Legislation Under Review

Reps. Robert Sprague (R-Findlay), Denise Driehaus (D-Cincinnati) and Nickie Antonio (D-Cleveland) have introduced a set of bills focused on prescription drug abuse and behavioral health issues. The package of bills would:

- Require insurance coverage for abuse-deterrent formulations of opioids
- Create prior authorization requirements when Medicaid patients are prescribed opioids greater than a 10-day supply for acute pain, greater than 80 morphine equivalent dose (MED) for chronic pain, or greater than a 72-hour supply if prescribed

from an emergency setting

- Create standards to track overdose deaths
- Provide immunity for certain drug users seeking emergency help for an overdose (Good Samaritan legislation)
- Provide for continuity of care related to behavioral health benefits in the Medicaid managed care system

AMCNO supported legislation in the last General Assembly that would have allowed for immunity for drug users who sought emergency assistance for an overdose (Good Samaritan legislation). This latest version of the legislation includes some items that changed the bill, and the AMCNO is still reviewing these changes. In addition, the Academy supports requiring insurance coverage for abuse-deterrent formulations of opioids. The AMCNO is still reviewing the other bill proposals and will provide input as this legislation is debated in the legislature.



*Dr. Laura David, spends a moment with Rep. Terry Johnson (left) and Rep. Steve Huffman. Reps. Johnson and Huffman are both physicians who introduced HB 124. This is the first time in the history of the Ohio legislature that a bill has been introduced by two physicians.*

## HB 124 – Patient with certain venereal diseases—prescribe for sexual partner

This legislation would allow a drug for a sexual partner of a patient diagnosed with chlamydia, gonorrhea, or trichomoniasis to be prescribed antibiotics without the partner being examined.

Ohio is one of only four states that will not allow the practice of Expedited Partner Therapy (EPT) to occur when needed. EPT is the practice of providing prescription antibiotics to one or more sexual partners of a patient who has been examined and diagnosed with a sexually transmitted infection, without the physician examining and diagnosing the partner(s).

EPT involves the use of established protocols from the Centers for Disease Control and Prevention. In addition, studies from other

states have illustrated the reduction in both chlamydial and gonorrheal infection rates among young adults when EPT has been utilized.

The bill would permit up to two prescriptions to be prescribed for partners of the patient diagnosed. The bill also includes guidelines for partner education and recommendations for when the partner should seek medical treatment. The AMCNO sent written testimony to both the Ohio House and Ohio Senate supporting this legislation.

## **SB 121 – Immunizations**

This legislation would protect adolescents from contracting meningococcal infections by requiring meningococcal vaccinations.

Meningococcal infections are very serious and can lead to severe disability and death. The disease is most often contracted by infants and people between the ages of 16 and 21. The Centers for Disease Control and Prevention (CDC) recommends all 11-12 year olds should be vaccinated with meningococcal conjugate vaccine, and a booster dose should be given at age 16 years. For adolescents who receive the first dose at age 13 through 15 years, a one-time booster dose should be administered, preferably at age 16 through 18 years, before the peak in increased risk.

SB 121 would require the Ohio Department of Health to specify an age at which students should be immunized against meningococcal disease and would put a meningococcal vaccination requirement in place for students beginning in the 2016 school year. The AMCNO sent written testimony in support of this bill as well. The bill has been sent to the Governor for his signature.

## **HB 169 – Physical Therapy**

This bill would allow physical therapists to evaluate a patient and determine a diagnosis to treat physical impairments, functional limitations, and physical disabilities and plan therapeutic interventions. It would eliminate a provision specifying that the practice of physical therapy does not include the medical diagnosis of a patient's disability. The bill also permits a physical therapist to order certain tests, but requires that the tests be performed and interpreted by other licensed healthcare professionals. In addition, the bill would also eliminate a requirement that specified

activities, including the administration of topical drugs and physiotherapy, may be performed only by a physical therapist who is adequately trained.

The AMCNO has been involved in discussions with other medical associations around the state about this legislation and all participants have expressed our concerns about changes to the scope of practice for physical therapists to the Ohio House Commerce & Labor Committee.

We are especially concerned with the additional practice privileges that may be extended to physical therapists to "determine [medical] diagnoses in order to treat." It is our belief that the diagnosis of medical conditions should be performed by appropriately trained physicians or mid-level providers, such as nurse practitioners or physician assistants, who are acting under the authority of a physician. Currently, Medicare does not recognize diagnosis and treatment of conditions within scope of care for physical therapists and we believe that states should not either.

Further, we believe that it is not prudent for physical therapists to be able to "order tests that are performed and interpreted by other healthcare professionals." The argument made by the Ohio Physical Therapy Association is that this may save the health system money, however, it is our belief that diagnostic laboratory and imaging studies should be ordered by those with the appropriate training to follow-up on those results. Additionally, studies show that non-physician providers, including other allied health professionals, are more likely to order tests and utilize more resources compared with physicians. The AMCNO opposes this bill and we plan to continue to make our position known on this legislation.

## **HB 216 – Nurses**

This legislation is intended to change the practice of Advanced Practice Registered Nurses (APRNs). This bill would **eliminate**: the requirement that an APRN collaborate with a physician, giving an APRN complete independent practice authority with no collaborative agreement with a physician; the APRN/physician-developed drug formulary for APNs with prescriptive authority and the requirement that CRNAs work under the direct supervision of a physician and provide for new

prescriptive authority for CRNAs. The bill would allow APNs to prescribe Schedule II narcotics in any setting except retail convenience clinics. Finally, the bill also includes a provision that establishes a general scope of practice that would permit APNs to order and interpret diagnostic tests or procedures and diagnose medical conditions and diseases.

The AMCNO and several other medical associations across the state are deeply concerned about HB 216. While the AMCNO values the professional abilities of APRNs, we believe HB 216 threatens the reliable assurance of safe and appropriate patient care at all times, because the bill threatens to fundamentally change how physicians and APRNs collaborate.

The most concerning provisions of the bill are:

- An elimination of the current requirement that APNs collaborate with a physician. In other words, **APNs would have complete independent practice authority with no collaborative arrangement with a physician.**
- An elimination of the APN/physician-developed drug formulary for APNs with prescriptive authority. **APNs would be permitted to prescribe any drug, without formulary restrictions.**
- **Elimination of a requirement that CRNAs work under the direct supervision of a physician and new prescriptive authority for CRNAs.**
- A provision that would allow APNs to **prescribe Schedule II narcotics in any setting** (except retail convenience clinics).
- A provision that establishes a **general scope of practice** that would permit APNs to "*order and interpret diagnostic tests or procedures*" and "*diagnose medical conditions and diseases.*"

We believe that APNs provide a valuable and necessary service when working under the direction of a physician when caring for a patient. However, we have also asked the legislature to consider the following points when considering the ramifications of this bill:

- Health care works best when there is a team-based approach to patient care, with multiple healthcare professionals working together under the direction of a physician.

*(Continued on page 12)*

# AMCNO LEGISLATIVE ACTIVITIES

(Continued from page 11)

By permitting APN independent practice, the team-based approach to care is further fragmented.

- There is no compelling evidence that the current APN/physician collaboration process is unworkable or that it creates barriers for APNs to “practice at the top of their license.” Ohio law regarding collaboration merely requires a standard care arrangement between the APN and physician and that the physician must be “continuously available to communicate with the APN” either in person or by a form of telecommunication. Further, a physician may collaborate with any number of APNs or, if the collaboration includes APN prescribing, the physician may not collaborate with more than three prescribing APNs at the same time. **If difficulties exist in finding enough physicians for APNs to collaborate with, changing the ratio would be a better alternative than completely eliminating the collaboration requirement.**
- APNs suggest that studies show practicing independently will result in improved access to care, will maintain or enhance care quality and will decrease overall healthcare costs. However, there are **competing**

studies that suggest evidence backing these claims is not only weak but in many cases it is actually contradictory to these assertions.

- Some APNs have publicly stated that they can “do everything a physician can do.” Clearly, APNs have a valuable role in care for patients, but it is our belief that **the education and training of physicians and APRNs are substantially different, and that physicians and nurses are not interchangeable.**

The AMCNO is interested in working with the APNs to discuss ways to enhance the efficiency of the collaboration process. However, as previously stated, if appropriate patient care is the goal, we believe there is no demonstrated need to make wholesale changes to that process.

Interested party meetings are planned over the summer months — the AMCNO will be participating in these discussions and providing our input on this legislation. We would welcome input from our members about this issue. If you have comments about this legislation please contact Ms. Elayne Biddlestone at the AMCNO offices at (216) 520-1000, ext. 100, or email her at [ebiddlestone@amcno.org](mailto:ebiddlestone@amcno.org). ■

## Physicians Needed for the AMCNO Annual Mini-Internship Program

The AMCNO is pleased to present our Annual Mini-Internship program from October 26 through October 28, 2015. The program 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. Interns have the opportunity to spend a half-day with four physicians, accompanying him or her through everything from office rounds to surgery. The Mini-Internship is a two-way information exchange intended to broaden the perspectives of all participants. Through shared experiences, this project allows interns to witness first-hand the demands and rewards of the medical profession during a typical physician workday.

The AMCNO needs you! We need our members to participate in the program and act as faculty for the interns. AMCNO members who are interested in participating as faculty for this year’s program may contact Abby Bell at (216) 520-1000, ext. 101, or email her at [abell@amcno.org](mailto:abell@amcno.org).



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## Hospital Patient Status, “Two-Midnight” is the Rule

By J. Ryan Williams and Isabelle Bibet-Kalinyak, Brouse McDowell

The Centers for Medicare and Medicaid Services (“CMS”) Two-Midnight Rule was crafted to put a curfew on what Medicare auditors deemed the subjective medical judgment of admitting physicians in determining the correct admission status of patients. To be or not to be “inpatient,” that is the big question! The question is indeed significant because Medicare pays significantly more under Part A for inpatient services than it does under Part B for outpatient services. Thus, improper admission means improper payment to hospitals. As the backlog of Medicare appeals mounted, CMS issued new regulations to redefine an “inpatient” for purposes of Medicare Part A payment. This article explains the Two-Midnight Rule (the “Rule”) and analyzes some of its implications for health care providers and patients.

### The Rule

Before CMS published the Rule, the benchmark was 24 hours. If the admitting physician expected that it would take 24 hours or more to treat a patient, he or she would admit the patient as an inpatient. Anything short of 24 hours was deemed outpatient. As CMS unleashed its auditors, it soon became clear that hospital inpatient status was the largest risk area for overpayments, and therefore CMS’ largest opportunity for savings. While hospitals defended their admission practices through the time-consuming appeals process, CMS sought to root out the subjectivity embedded with the then current determination of medical necessity and the Rule was born. The Rule was subsequently revised to respond to abundant criticism.

**Two for One.** The Rule includes two distinct medical review policies, a two-midnight *benchmark* and a two-midnight *presumption*. The two-midnight *benchmark* establishes that inpatient admission is generally appropriate when a practitioner

expects the patient to require a stay that crosses at least two midnights. Thus, under the two-midnight *presumption*, inpatient claims with lengths of stay greater than two midnights after formal admission following a physician order are presumed appropriate.

Consequently, CMS has directed its auditors to apply the presumption and, absent evidence of systematic gaming or abuse, they are not to review Part A claims with stays of at least two midnights. Conversely, inpatient stays of less than two midnights are presumed improper and will systematically be denied, unless the services provided belong to the “inpatient-only list” or an exception applies (e.g., death, transfer, departure against medical advice, unforeseen clinical improvement, etc.).

**Criteria.** The practitioner must clearly specify the intent to admit for Part A inpatient services at or before the time of admission in the admission order and provide supporting evidence. Formal admission pursuant to the admission order triggers inpatient status. The order can be written in advance of the formal admission for pre-scheduled surgery. Complex medical factors such as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event should weigh in on the practitioner’s decision to admit inpatient. These factors must be clearly documented in the medical record and progress notes so as to support the need for care covering at least two midnights. Documentation at the time of admission must provide the justification needed to support medical necessity of the inpatient admission regardless of the actual duration of the hospital stay and whether it ultimately crosses two midnights.

**Qualified Provider.** The admission order must be furnished by a qualified

practitioner, meaning a physician or licensed practitioner with admitting privileges at the hospital in accordance with state law and who is “knowledgeable about the patient’s hospital course, medical plan of care, and current condition.” For purposes of the Rule, such a provider is (i) the admitting physician of record, (ii) a hospitalist, (iii) the beneficiary’s primary care physician, (iv) the surgeon, (v) the emergency care provider, or (vi) the provider actively treating the patient. The practitioner may not delegate the decision to another individual who is not authorized by state law to admit patients or has not been granted admitting privileges.

**Certification (except inpatient psychiatric services).** The original Rule held that the provider must, for each admission, *certify* that the services are reasonable and necessary and provided in accordance with the Rule. Although CMS did not mandate a specific form or format, the certification requirements included all the following: (i) authentication of the practitioner order; (ii) the reason(s) for inpatient services; (iii) the estimated or actual time the beneficiary requires in the hospital; (iv) plans for post-hospital care, as applicable; (v) timing; and (vi) signature. In light of the public comments, CMS backed down from the burdensome systematic certification mandate and held that in most cases, the admission order, medical record, and progress notes would suffice to support the medical necessity of an inpatient admission. Certification is now only required for outlier and long-stay cases, i.e., 20 days or longer. The provider must, no later than 20 days into the hospital stay, certify the reasons for (i) the continued hospitalization or (ii) special or unusual services for cost outlier cases, (iii) the estimated time the patient will need to remain in the hospital, and, if applicable (iv) the plans for post-hospital care.

(Continued on page 14)

## Hospital Patient Status, “Two-Midnight” is the Rule

(Continued from page 13)

**Applicability.** The Rule applies to acute care hospitals, critical access hospitals (“CAHs”), long-term care hospitals (“LTCHs”), and inpatient psychiatric hospitals under Medicare Part A. Notably, the Rule does not apply to Inpatient Rehabilitation Facilities (“IRFs”). It is also distinct from Medicaid agencies, which have discretion to follow their own or the same guidelines.

### Inpatient Claims Denials – Now What?

After receiving notice for the denial of Part A claims, the hospital has the following options: it may (i) file for an administrative appeal (large backlog dating back to the RACs); (ii) submit the claim under Outpatient Part B services using condition code 44, which permits the hospital to change patient status from inpatient to outpatient under narrow circumstances; or (iii) submit an Outpatient Part B claim for services provided prior to the denial of inpatient status and an Inpatient Part B claim for services provided after admission.

### Implications for Health Care Providers

**Adapting to the Rule.** To adapt to the Rule, hospitals must develop new protocols to scrutinize patient admissions. This entails monitoring short inpatient stays, scrutinizing surgical procedures with average length of stay under two midnights, and correcting inappropriate admissions prior to discharge. For providers, this translates into caution and documentation.

**Common Pitfalls.** The most common reasons for payment denials include: (i) admission orders that fail to clearly state the intent to admit as inpatient; (ii) surgical

procedures with average length of stay of less than two midnights not on the inpatient-only list; (iii) dichotomy between the physician attestation and the medical record documentation; and (iv) lack of supporting documentation for the need to keep the patient for two midnights.

**Verbal Orders.** The Rule does not prohibit verbal orders. However, all verbal orders must be promptly and properly countersigned by the practitioner who gave the verbal order before discharge. CMS considers a verbal order as a “temporary administrative convenience” for physicians and hospital staff but not a substitute for a properly documented and authenticated order for inpatient admission. CMS intends to take the time to review the issue of verbal orders and provide additional guidance as it did with the Conditions of Participation.

**Cut & Paste.** With the advent of electronic medical records, the temptation is high to create templates to streamline documentation of patient care and avoid the pitfalls highlighted above. Providers should resist the urge. Technology enables Medicare auditors to audit electronic records and track patterns of cut and paste documentation. Even if the intent is perfectly legitimate, the practice of cut and paste is a red flag.

**Admitting Privileges.** Medical staff privileges were once only a condition of *participation*. Under the Rule, the provider writing the admission order must have admitting privileges as a condition of *payment*. Providers and credentialing committees must pay close attention to avoid any lapse in privileges in order to prevent overpayments.

The Rule has and continues to be widely criticized by hospitals and providers. Health systems have reported declining admissions while observation stays spiked in the second quarter of 2014. These statistics suggest that the Rule is shifting patient care from inpatient to outpatient services and not necessarily eliminating unnecessary care. For now, everyone is reacting and attempting to adjust and balance the demands of a plethora of new rules, including the Affordable Care Act, which provides stiff penalties for preventable readmissions. They are trading inpatient stays for observation stays in order to avoid preventable readmissions. Only time will tell if hospitals and providers can adapt. CMS’ recent actions demonstrate the agency’s sensitivity to the industry’s vigorous and persistent stream of complaints targeted at the Rule. In April 2015, CMS announced that it will continue the “Inpatient Probe and Educate Process” until September 30, 2015, and prohibit inpatient hospital patient status reviews for dates of admission occurring between October 1, 2013 and September 30, 2015. By effectively delaying enforcement, CMS aims to improve providers’ understanding of the Rule and perhaps, as hinted in the recently unveiled 2016 proposed prospective payment rule for acute and long-term-care hospitals, buy time to regroup and rethink. ■

*J. Ryan Williams is a partner in the Corporate Health Care Practice Group at the law firm of Brouse McDowell.*

*Isabelle Bibet-Kalinyak is an attorney in the Corporate Health Care Practice Group at the law firm of Brouse McDowell.*

# AMEF ACTIVITIES

## THE 12th ANNUAL MARISSA ROSE BIDDLESTONE MEMORIAL GOLF OUTING Proceeds to Benefit The Academy of Medicine Education Foundation (AMEF)

### Monday, August 3, 2015

#### Barrington Golf Club

350 North Aurora Road, Aurora, OH

Registration at 10:30 am  
Shotgun Start at 1:00 pm

#### Event Sponsors

Case Western Reserve University School of Medicine  
Center for Health Affairs  
Cleveland Anesthesia Group  
Clinical Technology, Inc.  
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Matthew E. Levy, MD  
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#### Hole Sponsors

Laura J. David, MD  
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Sisters of Charity Health System  
George V. Topalsky, MD

**Registration** Deadline for entry is July 27, 2015. Foursomes will be finalized on that date.

**Prepayment and Registration are Required. A portion of the sponsorship and golf fees are tax deductible.** Your entry fee of \$350 includes greens fees, cart and one caddy, lunch, dinner and prizes. Plan to arrive early—late arrival will disqualify you from participating.

Contact Name \_\_\_\_\_  
Company Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
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#### Make checks payable to AMEF and mail to:

6100 Oak Tree Blvd., #440 Cleveland, OH 44131  
Or by credit card:

Account # \_\_\_\_\_

Exp. Date \_\_\_\_\_ I.D. # \_\_\_\_\_

#### Please select your level of support:

- Diamond Sponsor \$10,000 (includes 8 golfers)
- Platinum Sponsor \$5,000 (includes 4 golfers)
- Event Sponsor \$3,000 (includes 4 golfers)
- Hole Sponsor \$1,000
- Individual golfer \$ 350
- I can't attend, but I'd like to make a tax-deductible contribution \$ \_\_\_\_\_

#### Golfers: please indicate foursome & handicap

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

By participating in this special AMEF fundraiser, your contributions will assist in expanding educational programs, including medical school scholarships, as well as implementing new initiatives to assist both physicians and the patients they serve.  
Thank you from the 2015 AMEF Golf Committee!

## AMCNO President Presents “Welcome to the Profession” Remarks to Graduating Medical Students

### Bestows Academy of Medicine Education Foundation Award

Dr. Matthew Levy, president of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), spoke at this year’s Case Western Reserve University’s School of Medicine commencement awards ceremony on behalf of the AMCNO.

The awards ceremony was held on Saturday, May 16, and included remarks by Dr. Levy to the students regarding the importance of becoming involved in the community and as a part of organized medicine. His speech also offered words of encouragement, and he congratulated the students on their achievement. Dr. Levy also participated in the

procession onto the stage at the commencement ceremony the following day at Severance Hall. As part of the commencement award ceremony, Dr. Levy was honored to present the Academy of Medicine Education Foundation (AMEF) award to a graduating student who has shown outstanding commitment to the Cleveland and Northern



*Dr. Levy (right) presents the AMEF award to Peter Surace at the Case Commencement Award ceremony.*

Ohio communities, is a strong advocate for all patients and promotes the practice of the highest quality of medicine. This year’s AMEF award recipient was Peter Surace. ■

## AMCNO Reaches Out to Local Residents to Discuss Advocacy, Legislative Activities

Fred Jorgensen, MD, Secretary/Treasurer for the AMCNO, arranged for the AMCNO to present to family medicine residents at Fairview Hospital on the topic of physician involvement in advocacy and legislative activities. Presenting on the AMCNO’s behalf was John A. Bastulli, MD, Vice President of Legislative Affairs.

Dr. Bastulli noted that many healthcare issues and medical care options are decided by the legislature and government entities, so it is imperative that physicians get engaged in the process and advocate on their own behalf.

Dr. Bastulli also outlined the advocacy activities that the AMCNO conducts on behalf of physicians, noting that the AMCNO Legislative Committee reviews all healthcare-related legislation introduced in Ohio and provides the members’ position on each bill to Ohio legislators. He outlined the extensive work that the AMCNO and other medical associations have done on the issue of Medicaid expansion and payments to physicians at the Ohio Statehouse. He noted that these types of discussions highlight why it is so important for physicians to become educated about the legislative process and get acquainted with their legislators. Dr. Bastulli also provided the residents with the AMCNO legislative tracker, which outlines the position of the AMCNO on all of the healthcare-related bills under review in Columbus.

The group also discussed the goals and value of continued graduate medical education (GME) funding. The goal is to provide Ohio’s

citizens with the right number, type and distribution of physicians able to provide high-quality, patient-centered, cost-effective healthcare. Ohio’s public health and economy are linked to the effectiveness and availability of a capable and strong physician workforce. Dr. Bastulli informed the residents that GME funding is under review at the Ohio Statehouse and it will be important to remain focused on how this debate continues. Dr. Bastulli encouraged the residents to become involved in the process in any way they can to be sure their voice is heard. He suggested that they help advocate for increased funding for the program, or lobby for a coalition to be established that includes all stakeholders (such as healthcare facilities that train residents and organizations like the AMCNO that represent physicians). And, if such a coalition is established, residents should become active participants in the development of a comprehensive plan.

### Fairview Hospital Residents Participate in State Medical Board of Ohio Meeting

Fairview Hospital residents were on hand during the May State Medical Board of Ohio meeting as participants in the *Partners in*



*Dr. Bastulli provides Fairview residents with information about AMCNO advocacy activities.*

*Professionalism* program. The Medical Board’s Partners in Professionalism program promotes professional behavior and the responsibilities of medical licensure to doctors-in-training. Attending a Medical Board meeting is an aspect of the program. As Ohio’s disciplinary actions are discussed in public session, they learn about situations involving licensees that result in disciplinary action by the Board. They also learn about policy matters discussed and established by the Board. ■



*Residents from Fairview Hospital pose for the camera following the SMBO meeting.*

## QPR Training, Co-Sponsored by the AMCNO, Offers Tips and Resources to Help Someone in Need

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has teamed up with the ADAMHS Board of Cuyahoga County to provide free Question, Persuade, Refer (QPR) Training to healthcare workers in the county who are in a position to recognize a crisis and warning signs that someone may be contemplating suicide. Funding is provided by the Margaret Clark Morgan Foundation.

Each training session lasts one to two hours and can take place in various locations throughout Cleveland, including local hospitals, the AMCNO, the ADAMHS Board or a doctor's office.

The goal of the program is to help prevent deaths by suicide in the county and reduce the stigma associated with mental illness.

Recently, AMCNO staff attended a session at University Hospitals. Paul Ernst, from the non-profit organization LifeAct, presented to a group of fellows. Ernst has received the training himself and has worked in suicide prevention for 3 years.

The statistics for suicide are grim. There are 41,000 deaths annually, with one suicide completed every 13 minutes. Adolescents have the lowest rate of suicide. The highest rates occur in the age group of 60-69 and 70 and up. And in those groups, it is most likely a white male. The three main contributing factors are loss of a spouse or family member(s), poor health and finances. Ernst said the physician group has a high rate of suicide as well — it is double that of someone who is a non-physician. Unlike other groups, however, it is mostly female physicians. Men are typically four times likely than females to die by suicide. Generally, males die by violent attempts, so the chance of survival is low.

In 2013, Alaska, Nevada and Wyoming were the top three states for suicide deaths. Three contributing factors were isolation, easy access to hand guns and high rates of alcoholism.

A QPR Training video was shown during the session. The training was created by Dr. Paul Quinnet, psychologist and author of *Suicide, the Forever Decision*.

"QPR is designed to teach people, regardless of their background, how to make a positive difference in the life of someone they know,"

Dr. Quinnett said. "Like CPR, learning what to do at the time it needs to be done can save lives. That's what QPR is about."

"The concept of repetitive training, such as CPR training or QPR training, can allow you to react instinctively to help the patient," a physician in the video said. "We don't do things by guessing, you have an organized approach to a problem, and QPR makes sense."

QPR Training is not intended to be a form of counseling or treatment, Ernst said. It is intended to offer hope through positive action.

He offered the following suggestions for effective QPR:

- Say, "I want you to live" or "I'm on your side...we'll get through this"
- Get others involved. Ask the person who might help, such as family, friends, pastors, etc.
- Join a team. Offer to work with clergy, therapists, psychiatrists or whoever is



Paul Ernst provided the training at the QPR event.

going to provide the counseling or treatment.

- Follow up with a visit, phone call or card – in whatever way feels most comfortable to you. Let the person know you care about what happens to him or her.

Each session attendee received a folder that contained numerous resources to help a patient through QPR.

The AMCNO is pleased to be a co-sponsor of the QPR program. For more information about the program and to learn how to schedule a training at your facility visit our website at [www.amcno.org](http://www.amcno.org) or call Katie Boland at the ADAMHS Board at 216-241-3400 x812. ■

Date	Time	Title	Fee	Location
5/30/2015	9:00am-3:00pm	CPT Coding Fundamentals and More - UTC	\$237	CCE
6/1/2015	6:00pm-9:00pm	Comprehensive Professional Medical Coding Bundle- *Blended - Tues	\$3990	Westshore
6/1/2015	9:00am-12:00pm	Essentials of Electronic Health Records – Mon, Weds	\$309	MATTC
6/1/2015	9:00am-12:00pm	Comprehensive Professional Medical Coding Bundle- *Blended - Tues	\$3990	Westshore
6/15/2015	8:00am-8:00am	The Professional Medical Coding Curriculum- *Blended - Online	\$1662	Online
7/1/2015	6:00pm-9:00pm	Medical Terminology – Mon, Weds	\$332	Westshore
7/1/2015	6:00pm-9:00pm	Patient Access Specialist Fundamentals – Tues, Thurs	\$474	CCE
7/13/2015	8:00am-8:00am	Patient Access Specialist Bundle Online - Online	\$2090	Online
8/3/2015	8:00am-8:00am	Comprehensive Professional Medical Coding Bundle -Online	\$3800	Online
8/3/2015	6:00pm-9:00pm	Fundamentals of Billing Reimbursement – Mon, Weds	\$404	Westshore
10/5/15	8:00am-8:00am	Comprehensive Professional Medical Coding Bundle -Online	\$3800	Online

**\*Blended: 3 hours of classroom 1 day a week-Tuesday 6pm-9pm**

Take advantage of discounted classes for AMCNO Members and their staff. Contact AMCNO at 216-520-1000 for exclusive AMCNO member course numbers to register and obtain a discounted price.

Course Locations: Corporate College East (CCE) 4400 Richmond Rd, Warrensville Hts, OH 44128  
 Metropolitan Campus (MATTC) 2900 Community College Ave, Cleveland, OH 44115  
 Westshore 31001 Clemens Road, Westlake, Ohio 44145

**ONLINE**

## Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Overview

HR 2, the “Medicare Access and CHIP Reauthorization Act of 2015” or “MACRA,” was recently signed into law. This bipartisan legislation permanently repeals the sustainable growth rate (SGR) formula and stabilizes Medicare payments for physician services with positive updates from July 1, 2015, through the end of 2019, and again in 2026 and beyond. It replaces Medicare’s numerous quality reporting systems with a new single “MIPS” program and will make it easier for physicians to earn rewards for providing high-quality health care, and it rewards physicians for participating in new payment and delivery models to improve the efficiency of care and retains fee-for-service as an option.

Specifically the legislation will result in the following points:

- Permanently repeals the SGR.
  - Positive payment updates of 0.5% each year through 2019.
    - In 2020, payments stay flat for 6 years, and there will be a 0.0% payment adjustment through 2025.
    - In 2026, physicians will be subject to one of two conversion factors – a 0.75% rate increase for practices that are part of an alternative payment model (APM) or a 0.25% rate increase for physicians not part of an APM.
  - Provide for additional financial incentives for providers who move to alternative payment models – with physicians receiving a 5% bonus from 2019 to 2024.
  - The fee-for-service model is retained, and physician involvement in APMs is voluntary.
  - Funding is provided for quality measure development, at \$15 million per year from 2015 to 2019.
  - Technical support is provided for smaller practices, funded at \$20 million from 2016 to 2020, to assist physicians with participation in APMs or the fee-for-service incentive program.
    - Eligible physicians who participate in APMs will be exempt from MIPS. The Centers for Medicare and Medicaid Services (CMS) will develop criteria for APMs by November 2016. MACRA provides for an annual 5% bonus based on Medicare Part B payments from 2019 to 2024 to physicians who participate in APMs.
  - Streamline the Medicare quality reporting programs into the merit-based incentive payment system (MIPS).
    - Beginning in 2019, MACRA will provide bonuses to physicians who score well in the MIPS, which will be a new pay-for-performance program under the Medicare fee-for-service payment system. The penalties that are currently in place for the Physician Quality Reporting System (PQRS), Electronic Health Records/Meaningful Use (MU), and the value-based payment modifier (VBM) will stop at the end of 2018. In 2019, the MIPS program will be the only Medicare quality reporting program.
    - MIPS is comprised of four assessment categories. Category 1 – quality measures – quality will include current PQRS measures and additional measures that will be obtained from professional organizations each year by the secretary of Health and Human Services (HHS). Category 2 – resource use – this VBPM program with an enhanced methodology determined through public input. Category 3 – meaningful use – this will be based on current electronic health records meaningful use reporting requirements. Category 4 – clinical practice improvement activities – eligible physicians will be assessed on their efforts to engage in these activities.
- Performance scoring under the MIPS program also provides for performance assessment according to a sliding scale versus the current all or nothing approach now used in the PQRS and MU programs. In addition, physicians can receive credit for clinical practice improvement (CPI) activities and for improving quality of care. Also the MIPS will allow for risk adjustments for patients’ health status and other risk factors, including socioeconomic factors.

MACRA establishes far-reaching changes in how physicians will be reimbursed under the Medicare program. The specifications and regulatory rules of the new system have yet to be established and the AMCNO will provide additional information to our members as this process continues. To view detailed information about the MACRA go to [www.cms.gov](http://www.cms.gov). ■

## Be Prepared for the BWC Implementation of Prospective Billing

### Private Employers Begin July 1, 2015

The Ohio Bureau of Workers’ Compensation (BWC) is transitioning to a prospective billing system that goes into effect July 1, 2015, for private employers.

Private employers should be in receipt of their Estimate of Premium Notice from BWC, which is for the first prospective billing period that covers July 1, 2015 – June 30, 2016.

To prevent employers from being “double-billed,” BWC will help to limit the financial impact to employers during the transition by applying both a payroll transition credit and a prospective transition credit.

The payroll transition credit will be for the last reporting period of the retrospective billing era

(January 1, 2015 through June 30, 2015). Employers will receive a 100% credit towards this premium payment due in August.

The prospective transition credit will assist in your transition to the prospective billing era. The credit equates to 1/6th of the billed premium for the July 1, 2015 – June 30, 2016 period.

To receive the credit, however, your policy must be current, which means that you have done the following:

1. Paid all outstanding premiums, late fees and penalties for past due premiums (or request a payment plan from BWC for any amount that cannot be paid) prior to July 1, 2015.
2. Filed your January 1, 2015 – June 30, 2015 payroll report prior to August 31, 2015.

For resources related to the implementation of prospective billing, please also visit the website of our workers’ compensation partner, CompManagement, at [www.compmgt.com](http://www.compmgt.com) and click on the Are You Ready button under Quick Links on the home page. You will find informational podcasts to watch as well as documents outlining key dates and frequently asked questions to assist you.

If you have additional questions or concerns regarding the implementation of prospective billing, please feel free to contact CompManagement’s Customer Support Unit at (800) 825-6755, option 3. ■

# AMCNO HIGHLIGHTS AND RECENT ACTIVITIES

## The Academy of Medicine of Cleveland & Northern Ohio THE VOICE OF NORTHERN OHIO PHYSICIANS FOR 190 YEARS AMCNO Working on Behalf of Our Members and their Patients

### LEGISLATIVE/ADVOCACY ACTIVITIES

- Reviewed and took positions on all healthcare-related bills under review at the State legislature, making our position known to the legislative sponsors and committee chairman;
- Conducted candidate interviews and created and disseminated a list of candidates for our members – inclusive of information on Ohio Supreme Court Justices and Common Pleas judges running in Northern Ohio Counties;
- Developed Meet and Greet opportunities for physician members during the Ohio Supreme Court election campaign;
- Participated in a regional meeting with Congressional representatives to discuss the need for SGR reform;
- Supported appropriations on the national level to enhance overdose protection education and Naloxone distribution;
- Participated in a Lobby Day with other regional organizations to stress the importance of Good Samaritan legislation;
- Met with the Ohio Department of Medicaid Director regarding physician reimbursement issues;
- Met with the Office of Health Transformation Director about transforming health payments in Ohio;
- Provided information to our members on the new Ohio Department of Health concussion and head injury guidelines;
- Provided detailed information to our members relative to prescription drug abuse legislation and OARRS regulations;
- Met with and urged state legislators to support Medicaid expansion in Ohio and provided testimony before the House and Senate on this issue;
- Participated in a Lobby Day with other organizations to push for Medicaid expansion in Ohio;
- Provided testimony on legislation to support childhood immunizations in Ohio;
- Voiced strong support for changes to the affidavit of merit rule to encourage more rigorous and consistent enforcement of the rule and to ensure that expert affidants were qualified to render opinions;
- Urged Congress to take prompt action and advocated for a permanent change to the Sustainable Growth Rate (SGR) formula, which was achieved;
- Coordinated and participated in interested party meetings on healthcare legislation, and worked with local healthcare institutions and statewide associations on legislative initiatives coordinating testimony and strategy on legislation of importance to physicians.

### PRACTICE MANAGEMENT

- Provided timely information to our members on managed care issues and the yearly update on the fees to be charged for transfer of medical records;
- Participated in a Region V State Medical Society meeting with the Centers for Medicare and Medicaid Services (CMS) to discuss issues of importance to our members – including implementation of the Affordable Care Act;
- Hosted CGS training and educational sessions at the AMCNO offices for practice managers and AMCNO members;
- Participated as an active member of the CGS Provider Outreach and Education Group;
- Disseminated timely and topical news to practice managers through our publication *Practice Management Matters*;
- Provided our members with services designed to resolve insurance company disputes with third-party payers in Northern Ohio;
- Provided a third-party payer seminar for practice managers and physicians – an event created by the AMCNO now entering its 32nd year.
- Provided our members with detailed information on the meaningful use rules, EHR adoption, the Affordable Care Act, accountable care organizations, ICD-10 and the statewide health information exchange.

### COMMUNITY/PUBLIC HEALTH EFFORTS

- Continued our participation on the Board of the Cuyahoga Health Access Partnership (CHAP);
- Worked with area hospitals and public health officials to develop a regional response plan and prepare for the potential of Ebola identification in our community;
- Provided representation to the Center for Health Affairs board of trustees;
- Conducted our 14th annual successful Vote and Vaccinate event on Election Day, offering flu and pneumonia vaccines through our community partnerships in underserved areas;
- Hosted the annual Mini-Internship program that allows community members to shadow AMCNO physicians in their practice setting – the longest continuous program of its kind in the county;
- Continued as an active participant in Better Health Partnership;
- Participated in advocacy efforts with the Investing in Tobacco Free Youth Coalition to engage legislators in increasing other tobacco product taxes to decrease their use and enhance anti-smoking efforts;
- Continued to provide volunteers and support for MedWorks and provide physician representation on the MedWorks Board;
- Continued our work with the Cuyahoga County Board of Health as part of their Health Improvement Plan Partnership;
- Participated in the Greater Cleveland-Cuyahoga Community Wide Heroin/Opiate Task Force.

### PUBLIC RELATIONS

- Published an Anniversary Issue of the *Northern Ohio Physician* magazine – commemorating the 190th year anniversary of the AMCNO;
- Continued to meet with Ohio state agency administrators to provide key information about the AMCNO and physician concerns in Northern Ohio;
- Entered the 53rd year of operation for the AMCNO Pollen Line, garnering extensive media attention for the service; utilized social media to provide information on the pollen counts to the community;
- Sent out news releases and utilized social media to reach the community, our members and the media;
- Provided physician presenters through our Speakers Bureau to present on medically related topics to community organizations.

### FOUNDATION OUTREACH AND YOUNG PHYSICIAN ENGAGEMENT

- The Academy of Medicine Education Foundation (AMEF) awarded six \$5,000 scholarships to local third- and fourth-year medical school students.
  - Conducted presentations to residents and other healthcare groups regarding AMCNO legislative activities;
  - Provided support for the Consortium for Healthy Communities (CHC) immunization conference;
  - Presented a "Welcome to the Profession" address to the graduating class of Case Medical School and Cleveland Clinic Lerner College of Medicine;
  - Agreed to offer additional sponsorship opportunities for educational seminars and events and promoted this opportunity to hospitals, medical schools and community associations;
  - Supported a session on how to educate the public and healthcare personnel about the implications of legalizing medical marijuana in Ohio;
  - Bestowed the AMEF \$1,000 award to a graduating student who has shown outstanding commitment to the Northern Ohio community;
  - Participated in resident orientations across the region to garner resident support and AMCNO membership;
  - Partnered with the William E. Lower Fund to present a seminar on "Preparing for the Business Aspects of Medicine" – a program designed for resident members and their spouses;
  - Presented information about the AMCNO and sent physician leadership to the Meet and Greet event for first-year medical students and recruited students for AMCNO membership.
- ### PHYSICIAN EDUCATION OPPORTUNITIES
- Hosted a CME seminar about the role of the prescriber in prescription drug abuse;
  - Partnered and presented at the annual international Academy of Breastfeeding Medicine meeting held in Cleveland;
  - Provided information to our members about the new State Medical Board of Ohio (SMBO) regulations for terminating a physician-patient relationship;
  - Collaborated with the Healthcare Information and Management Systems Society (HIMSS) and other organizations to present an event on meaningful use at the Global Center for Health Innovation;
  - Partnered with the Cleveland Metropolitan Bar Association to present the third annual Medical Legal Summit, addressing issues of importance to physicians and attorneys;
  - Participated and presented at the Northeast Ohio Patient Navigator Collaborative (NEOPNC) event to create awareness about the patient navigator network;
  - Partnered with Tri-C to offer discounted practice management classes to physicians and practice managers.

### BOARD INITIATIVES/ADVOCACY

- Agreed to survey AMCNO members regarding their need for CAHPS surveys and training;
- Agreed to partner with the Agency for Healthcare Research and Quality (AHRQ) to provide free resources on heart health;
- Worked with the Health Services Advisory Group (HSAG) to address the issue of accessing primary care;
- Signed onto a letter to the Director of the Ohio Department of Insurance regarding the need for tobacco cessation coverage by health insurers in the State of Ohio;
- Met with the leadership of the Health Services Advisory Group (HSAG) the new quality improvement organization in Ohio;
- Agreed to partner with the ADAMHS board on the Question, Persuade, Refer initiative – to train healthcare professionals who are most likely to encounter people at risk for suicide;
- Agreed to support grant proposals in the State of Ohio to obtain funds for peer-based learning and support and alignment networks;
- Agreed to file an amicus brief at the appellate level on a statute of repose issue that could impact tort reform cases in the future;
- Responded to the CMS Proposed rule to revise the timeline for Stage 2 Incentive Programs;
- Agreed to file an amicus brief to the Ohio Supreme Court on a case that could reshape the definition of medical records and impact tort reform in Ohio;
- Agreed to canvass the AMCNO membership to assist in gathering stories from patients regarding Medicaid reauthorization;
- Agreed to assign AMCNO physician representation to the Cleveland Museum of National History Health Advisory Committee;
- Supported the Ohio Hospital Association Safe Sleep Campaign;
- Agreed to work with the SMBO and other statewide medical associations on OARRS education and outreach;
- Issued a policy statement that the AMCNO agrees in principle to work with the SMBO and other medical associations as necessary on the development of content-specific CME courses to address appropriate narcotic prescribing for physicians;
- Adopted the American Medical Association guidelines for patient navigator programs;
- Continued to work with other medical organizations and the Ohio Physicians Health Program to address the suggested changes to the one-bite exemption;
- Supported the AMCNO's continued involvement in the Governor's Cabinet Opiate Action Team (GCOAT) to review and adopt acute pain guidelines;
- Strongly supported statewide efforts to increase the tax on other tobacco products.

### Benefits of Membership in the AMCNO

#### Physician Referral Service

#### Representation at the Statehouse

#### Specialty Listing in the AMCNO online Member Directory

#### Reimbursement Ombudsman

#### Informative Seminars

#### Speaker's Bureau opportunities

#### Insurance/Financial Services

#### Weekly, quarterly and bimonthly publications offering healthcare news and practice guidance

#### Member Discounts including Worker's Comp, Practice Management Classes at Tri-C, and so much more!

### Is YOUR Voice Being Heard?

**Already an AMCNO member?** Now is the time to renew your commitment to organized medicine that makes a real difference in your practice and our region. Please look for a 2016 dues billing in your mail soon!

**Not yet a member?** Now more than ever is the time to join the only regional medical association tirelessly working in the best interest of you – the NE Ohio physician. Call our membership department at (216) 520.1000, ext. 101, for details on all the benefits and services available exclusively to our members.

# WE DIDN'T JUST WRITE THE BOOK ON HOSPICE. WE CREATED THE LIBRARY.

Choose the hospice the medical community consistently turns to for end-of-life education. As the region's most experienced and preferred hospice provider, physicians and health care professionals across Northern Ohio rely on us for education, guidance and cutting-edge research in palliative care and end-of-life issues. See why more medical professionals choose the hospice of choice at [hospicewr.org/institute](http://hospicewr.org/institute).



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