

AMCNO 2007 Annual Meeting Highlights

The Academy of Medicine Cleveland & Northern Ohio held its Annual Meeting Dinner and Awards Presentation Friday, April 27. One of the meeting highlights was the awarding of six medical student scholarships by the Academy of Medicine Education Foundation to local medical students.

The 2007 list of honorees was led by **William J. Reinhart, MD**, receiving the John H. Budd MD Distinguished Membership Award for his exemplary accomplishments in the local healthcare community over the course of his career. **William H. Seitz, Jr., MD**, was honored with the Charles L. Hudson Distinguished Service Award in recognition of longstanding allegiance and years of service to organized medicine. The 2007 Clinician of the Year designation went to **John D. Hines, MD**, for his many

contributions in clinical medicine, his devotion and service to his patients and his longstanding commitment to the Northern Ohio Community. In recognition of his outstanding accomplishments in active practice and scientific research, **Ronald A. Savrin, MD**, received the Outstanding Service Award to acknowledge his significant contributions to the health care of the community, in particular through his work with the AMCNO *Healthlines* radio program.

(Continued on page 16)



Dr. Paul C. Janicki delivers his opening remarks at the 2007 AMCNO Annual meeting.

AMCNO President Addresses 2007 Medical School Graduates

Dr. James S. Taylor, 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 on behalf of the Academy of Medicine of Cleveland & Northern Ohio. The ceremony was held at Severance Hall on Sunday, May 20.

Dr. Taylor addressed the medical school graduates with the following remarks:

"On behalf of our 4,400 members in the Academy of Medicine of Cleveland and Northern Ohio it is my privilege to extend congratulations to you on your graduation. Welcome to the profession of medicine and to the beginning of the next step in your career. You've arrived!

"You graduate today in this magnificent home of the Cleveland Orchestra from one of our country's most innovative research and teaching medical schools, both crown jewels in their own right. Along the way your attention has been focused on the details and sacrifices, both personal and financial, of your medical and soon to begin postgraduate training. Be proud of your accomplishments but realistic of your

future responsibilities, which I hope you will look upon as an opportunity to do more. The buck now stops with you and you will be rewarded in innumerable ways if you focus on your patient as a whole as well as their disease.

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Cleveland, OH 44131-0999

ADDRESS SERVICE REQUESTED



June 15, 2007

The Honorable Sherrod Brown
463 Russell Senate Office Building
Washington, DC 20510-3504

Re: Proposed Medicare physician payment cuts

Dear Senator Brown:

As the president of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), an organization representing more than 4,400 physicians in Northeastern Ohio I am writing to alert you to the chilling effect that Medicare's flawed sustainable growth rate (SGR) formula is having on Medicare physician payments for members of the AMCNO. The SGR formula fails to keep up with the costs involved in delivering medical care to older and disabled patients, and in actuality reimbursement to physicians has already gone far below what Medicare was paying for my services in 2001. It is my understanding that in 2008, Medicare reimbursement is scheduled to fall by 10 percent. As the president of an organization representing the physicians practicing in your area of the state, I am very concerned about the continued viability of Medicare reimbursement to physician practices and the harmful impact this situation is having on patients' access to medical services.

The underlying flaw of the SGR formula is the link between the performance of the overall economy and the actual cost of providing physician services. The medical needs of individual patients are not related to the overall economy.

I appeal to you to prevent the projected payment cut for 2008 by permanently repealing the SGR formula and creating a system that provides physicians with annual increases that keep pace with overhead costs as estimated by the Medicare Economic Index (MET). The Medicare Payment Advisory Commission (MedPAC) recommended to Congress that Medicare physician reimbursement for 2008 be raised 1.7 percent, consistent with the growth in the MET and adjusted to reflect physicians' productivity. But in a perverse twist, the SGR formula responds by further reducing payment.

You should also be aware that most physician practices have contracts with private insurers that base their payment rates on the Medicare fee schedule. Therefore, another cut in Medicare payments in 2008 will mean a similar cut in reimbursement rates by other health insurers, further eroding the ability of physicians to provide medical care in Northeastern Ohio. This issue is critical to continued medical access in your community.

To be specific, Ohio will lose \$249 million in health care funds due to the projected negative update in 2008 and over 1,600,000 Medicare patients will be affected by these cuts in Ohio. Also, compared to the rest of the country, Ohio, at 14%, has an above average proportion of Medicare patients and, at 19 practicing physicians per 1,000 beneficiaries, a below-average ratio of physicians to Medicare beneficiaries, even before any cuts take effect. Further cuts to physician payment rates may hurt the senior citizens in your district because less reimbursement could result in fewer physicians agreeing to treat new Medicare patients.

The Northern Ohio physician community provides care to a large number of Medicare beneficiaries. To keep serving these patients, we must be able to meet the expenses we incur in providing their medical care. Congress must intervene on this issue — support legislation to stop the Medicare cuts that hinder physicians from seeing additional Medicare patients and permanently replace once and for all the flawed physician payment formula in Medicare with one that is realistic and reflects our ever-increasing practice costs.

Sincerely,

James S. Taylor, M.D.
President/AMCNO

The Voice of Physicians in Northern Ohio

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NORTHERN OHIO PHYSICIAN

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Medicare physician payment formula – what is on the horizon?

The Congressional Budget Office (CBO) recently announced that Medicare physician payment rates would be reduced by 10 percent in 2008 under current law. The 110th Congress, under Democratic leadership, will again be reviewing the perennial issue of Medicare's annual payment update to physicians, which is controlled by the sustainable growth rate (SGR) formula. Late last year, Congress passed H.R. 6111, the Tax Relief and Health Care Act, which intervened to stop the impending 5 percent cut to Medicare physician reimbursement. Due to a myriad of federal budgetary rules, Congress decided to push the cut, scheduled for 2007, into 2008. This, of course, has resulted in physicians now facing a 10 percent payment cut in 2008 — the original 5 percent cut they faced under the SGR in 2007 along with the additional 5 percent SGR cut for 2008.

The AMCNO has sent a letter to all Congressional leaders from our area (see sample letter on this page) and we urge our members to do the same. Members may send letters to Congress directly through the AMCNO Web site at www.amcnoma.org — click on the Legislation link. ■

Ohio Supreme Court Invalidates Regulation Involving Practice of Anesthesiologist Assistants

AMCNO SCORES A VICTORY AT THE OHIO SUPREME COURT

By Jennifer Turk and Marc Blubaugh with Benesch, Friedlander, Coplan & Aronoff, LLP

On May 23, 2007, the Ohio Supreme Court invalidated a regulation promulgated by the Ohio State Medical Board which prohibited anesthesiologist assistants ("AAs") from performing epidural and spinal anesthetic procedures and implementing medically accepted monitoring techniques. The Court held that Ohio Administrative Code § 4731-24-04(A) (the "Rule") was invalid because it conflicted with Ohio Revised Code § 4760.09, which permitted AA to perform such procedures.

The Rule stated "[n]othing in this chapter of the Administrative Code shall permit an anesthesiologist assistant to perform any anesthetic procedure not specifically authorized by Chapter 4760 of the Revised Code, including epidural and spinal anesthetic procedures and invasive medically accepted monitoring techniques." Arguing that the Rule was in direct conflict with the statute, Joseph Hoffman, an AA practicing in Cleveland, filed suit on June 10, 2003 against the Ohio State Medical Board demanding a declaration that the rule conflicted with the statute and was therefore invalid.

The trial court agreed, holding that the Medical Board specifically negated Ohio Revised Code § 4760.09 (the "Statute") which permitted AAs to assist with spinal and epidural procedures as well as medically accepted monitoring techniques by enacting a rule prohibiting AAs from performing these procedures. Additionally, the court held that it would be unreasonable to allow "assist" to mean "to carry out procedures as requested by the supervising anesthesiologist" everywhere else but in the Rule at issue here.

The trial court also found it compelling that the Ohio General Assembly had prohibited certain anesthesia related practices with regards to certified registered nurse anesthetists and medical assistants, indicating that the Ohio General Assembly chose not to limit AAs from performing spinals, epidurals and medically accepted patient monitoring techniques.

The Medical Board appealed the trial court's decision to the Tenth District Court of Appeals in Franklin County. The Board argued that resolution of this issue depended upon whether the word "assist" is defined according to its "ordinary" definition or its technical definition as used in the medical field. Mr. Hoffman

maintained that the Rule conflicts with the statute regardless of which definition is applied to the term "assist." Additionally, *amici curiae* briefs in support of Mr. Hoffman were filed by the American Academy of Anesthesiologist Assistants, the Ohio Academy of Anesthesiologist Assistants, Case Western Reserve University, University Hospitals of Cleveland, Parma Anesthesia Associates, Inc., the Anesthesia Associates of Cincinnati, Mercy Anesthesiologists, Inc. and the Members of the Academy of Medicine of Cleveland/Northern Ohio Medical Association.

However, on July 21, 2005, the Court of Appeals issued its decision reversing the trial court. The Court of Appeals held the ordinary meaning of "assist" was consistent with a regulatory prohibition upon the performance of the enumerated procedures under the Rule. Although finding that the Medical Board had compromised its position by adopting a definition of "assist" that supported Mr. Hoffman's position, the Court of Appeals held that the existence of a specialized meaning within the profession was not itself dispositive of the meaning intended by the legislature in drafting the statute as the legislature clearly intended for an everyday meaning to be inferred.

On August 11, 2005, the Court of Appeals granted Mr. Hoffman's unopposed motion for a stay of the Court of Appeals' opinion pending his appeal to the Supreme Court.

On September 19, 2005, Mr. Hoffman filed his notice of appeal to the Ohio Supreme Court. The Supreme Court subsequently agreed to hear Mr. Hoffman's appeal. Mr. Hoffman's brief was filed on March 27, 2006. Once again, Case Western Reserve University, University Hospitals of Cleveland, The Anesthesia

Associates of Cincinnati, the Members of the Academy of Medicine of Cleveland/Northern Ohio Medical Association, McCallum Robinson Hoyt, MD, MBA, Mercy Anesthesiologists, Inc., the Medical College of Ohio Physicians, LLC, the American Academy of Anesthesiologist Assistants, and the Ohio Academy of Anesthesiologist Assistants filed *amici curiae* briefs in support of Mr. Hoffman.

In its decision, the Ohio Supreme Court held that the word "assist" had acquired a technical meaning in the field of anesthesiology, a meaning which the General Assembly intended to apply. Specifically, the Court agreed with Mr. Hoffman's argument that the word "assist" meant "to carry out procedures as requested by the supervising anesthesiologist." Applying the technical definition of "assist," the Court held that the Statute clearly permits an AA to carry out the performance of epidural and spinal anesthetic procedures as well as carry out the implementation of medically accepted monitoring techniques as requested by the AA's supervising anesthesiologist. Because the Rule prohibits AAs from performing procedures that the Statute permits, the Rule conflicts with the Statute and, therefore, is invalid.

The Supreme Court's decision means that AAs in the State of Ohio can continue to practice as they have been for decades. Specifically, AAs are permitted to perform epidural and spinal anesthetic procedures as well as carry out the implementation of medically accepted monitoring techniques as requested by and performed under the direction of the AA's supervising anesthesiologist who must be physically present in the room.

Editor's Note: This decision constitutes an important victory for the AMCNO and the other organizations and individuals that fought hard to maintain the practice of AAs in the state of Ohio. Many thanks to the attorneys who worked on this case as well as to the myriad of other individuals who contributed to this hard-fought victory. ■

LEGISLATIVE UPDATE

Mike Wise, JD., AMCNO lobbyist

It is an odd-numbered year in Ohio and it is late spring, early summer. That can mean only one thing...yes, it is State Budget time! Ohio has an annual budget that runs from July 1 to June 30. However, spending levels are set in two-year increments through State budget process that correspondingly occurs once every two years. Therefore, the General Assembly must pass, and the Governor must sign, a two-year budget by June 30 of each odd-numbered year.

The budget is by far and away the most important piece of legislation that is passed during each two-year session. The budget allocates and prioritizes over 25 billion dollars of spending for each of the two years. Also, increasingly the budget bill is a vehicle for major policy changes.

Historically, the majority of Ohio's budget was spent on infrastructure, and primary and secondary education. The chart below, provided to us by Senator Ron Amstutz, who is a state budget expert, provides an overview of state budget trends in just the last 10 years. The changes are stunning and indicate major policy changes and macro-economic trends. As you can see, Medicaid is not only the fastest growing item (104% over the last 10 years), it is also the largest line item and consumes by itself over a

third of the state budget. Ten years ago the state was spending more on primary and secondary education than any other line item and Ohio was trending towards additional spending for education and slower growth of Medicaid. This trend ended in 2000 and by 2003, Medicaid spending exceeded Primary and Secondary education. Over the last 10 years, spending on state government outside of education and Medicaid has not kept pace with inflation. Education has modestly exceeded inflation and the Medicaid growth rate has been double the inflation rate.

These budget trends and pressures are important to help the medical community understand the reluctance of policy makers to make changes to Medicaid that involve expanding coverage or reimbursement rates. The trends also allow the medical community to argue for other important policy changes like tort reform and clear standards for the tax exempt status of Ohio nonprofit hospitals.

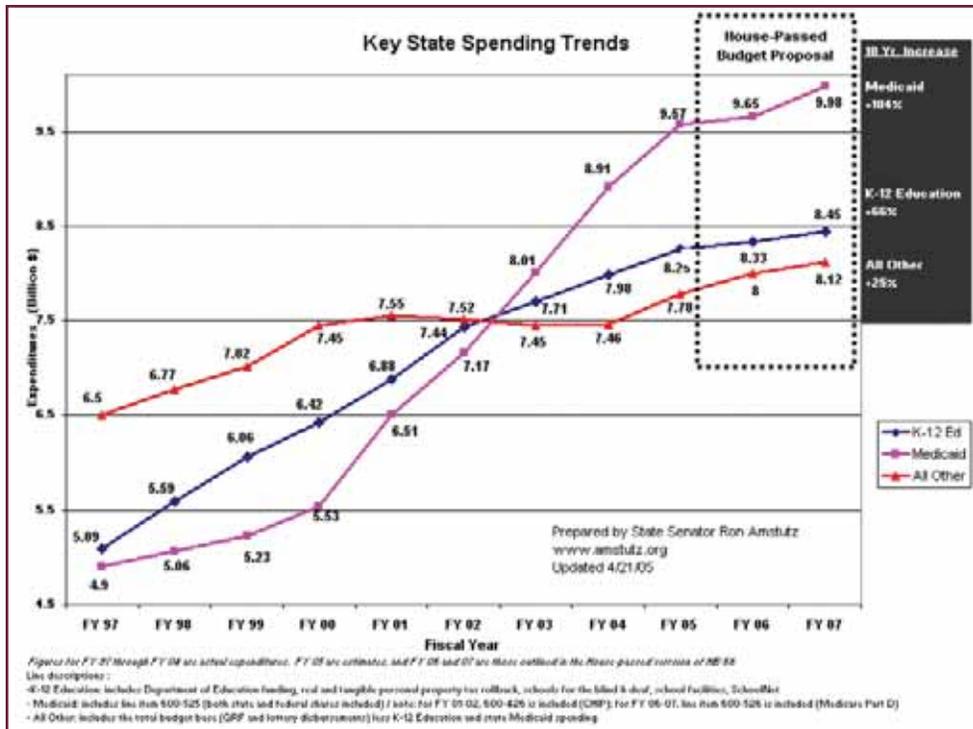
The underlying public policy argument for the House and Senate has been the budget trends and pressures noted above. At the time of this publication, the budget bill passed the House unanimously and passed the Senate with overwhelming support.

The bill will go to a conference committee to negotiate the differences between the House and Senate, then back to a full House and Senate vote before being sent to the Governor for signature before the June 30, 2007 deadline.

OHIO SUPREME COURT

As far as other news from Ohio, the Ohio Supreme Court continues to deliberate on the constitutionality of limits on noneconomic damage awards. The caps at issue are not for medical malpractice but most legal experts believe that the Court's ruling will have an impact on the similar caps in place for medical malpractice. AMCNO is a named entity in an Amicus Brief filed to support the constitutionality of the caps. This case is pending at the same time that the Ohio Supreme Court has released data showing that the number of medical malpractice cases has fallen to the lowest level since 2000. However, Northeastern Ohio continues to see both a disproportionate number of the filings and also the highest jury judgments, and most expensive medical malpractice premiums of anywhere in Ohio.

(The Ohio Supreme Court also recently rendered a 7-0 opinion in support of anesthesiologist assistants — a case where the AMCNO filed an amicus brief in support as well. — see page 3 for related story.)



MANDATORY ARBITRATION FOR MEDICAL NEGLIGENCE CLAIMS – SB 59 UPDATE

AMCNO's mandatory arbitration bill continues to await further hearings in the Senate Insurance Committee. Later in this article you can find information on how to write the chairman of the Senate Insurance Committee. Interestingly, our legislative approach has gained traction in other jurisdictions. This multi-state activity will be communicated to Ohio lawmakers in upcoming testimony.

Arbitration legislation under review in other states

In Florida, lawmakers have approved legislation to amend the state's law on nonbinding court arbitration. Courts are currently authorized to order parties into nonbinding arbitration but the statute does not provide much guidance on how the arbitrations should be conducted — statutory

nonbinding arbitration is primarily used in medical malpractice and tort cases. The bill would change the statute by including specifics on how a statutory arbitration proceeding would be conducted once a court orders parties into the process. More importantly for us in Ohio, the bill provides that parties who request a trial *de novo* but do not obtain a more favorable judgment at trial may be assessed court and arbitration costs and attorney's fees. The bill states, "Upon motion made by either party within 30 days after entry of judgment," the court may assess costs, "including arbitration costs, court costs, reasonable attorney's fees, and other reasonable costs such as investigation expenses and expenses for expert or other testimony which were incurred after the arbitration hearing and continuing through the trial of the case," on a plaintiff who requested a trial *de novo* where the judgment at trial is "at least 25 percent less than the arbitration award."

In North Carolina, legislation was introduced aimed at encouraging parties to a medical negligence claim to agree to arbitrate after the dispute arises. The bill would make predispute agreements to arbitrate professional negligence claims void and unenforceable while authorizing post-dispute arbitration agreements. The bill is designed to move parties to medical negligence claims to arbitration, in the hope that it will limit the costs and time of resolving a dispute while still getting a fair result. The bill contains extensive procedures detailing how a medical negligence arbitration based on medical malpractice should be conducted. The bill would give arbitrators the flexibility to structure the process, while providing specific procedural guarantees for parties. The bill would require arbitrators to

issue a written award within 14 days of the close of the last hearing. An arbitrator who awards damages to the claimant would be required to make a finding as to whether the claimant suffered serious mental or physical injury as a result of a defendant's professional negligence. Awards would be limited. The bill requires that the losing party would pay the arbitrator's fees and expenses and the bill would require the arbitrator to review the reasonableness of the attorneys' fees. An award could be overturned only for evident partiality, corruption, misconduct, or if an arbitrator exceeded his or her powers.

Finally, in Pennsylvania the House of Representatives is considering a bill that would require mandatory arbitration of medical malpractice disputes and cap noneconomic damages in arbitration at \$250,000, while allowing the right to a trial *de novo* with no caps. The bill, HB 1343, was introduced in the House on May 24th and includes provisions that are meant to discourage consumers and providers of health care services from requesting a trial *de novo*. The decision of an arbitration panel, as well as the inability of an arbitration panel to reach a decision, shall be introduced at trial either by the testimony of one of the arbitrators or by stipulation of the parties. Under the bill, the arbitration panel would be selected randomly by a judge and would consist of a lawyer who practices law in the jurisdiction, a medical professional and a retired judge. The sponsor of the bill hopes that the mandatory arbitration concept would stem the tide of medical professionals leaving the state. The sponsor is also confident that mandatory arbitration could lower insurance rates and reduce the caseload of the courts.

Health Care Access and Affordability
In the Ohio House, the new Healthcare Access and Affordability Committee has held a number of hearings this spring. UnitedHealthcare testified that top doctors and wellness programs have reduced the level of increases in medical costs. Qbase, Inc. and a number of other companies have testified that data management has a direct relationship to healthcare access and affordability and that proper management could actually transform Ohio's health care. Finally, an OB/GYN from Toledo testified that the current system is structurally flawed and that Ohio was now an exporter of physicians. He advocated for universal coverage of basic services and pointed out to the Committee that there are 1.3 million Ohioans without health insurance and in 2007, 3.6 billion was spend to provide on services for those uninsured.

The legislators will be in session through June and then out for the summer. AMCNO has a comprehensive tracking system of all health care-related legislation in the General Assembly. If you are interested in receiving a copy of this document, please contact Elayne Biddlestone at (216) 520-1000.

Support for SB 59 Growing

SB 59 has garnered additional support from the Ohio Hospital Association, the Ohio Podiatric Medical Association, the Ohio Chapter of the American College of Obstetricians and Gynecologists as well as the Summit County Medical Society.

AMCNO members are strongly encouraged to write to the Chairman of the Ohio Senate Insurance Commerce and Labor Committee — Senator Steve Stivers — to voice your support of SB 59 — the mandatory arbitration legislation. Letters should be sent to Senator Steve Stivers, Chairman of Senate Insurance, Commerce and Labor Committee. A sample support letter and information on what to send to Senator Stivers can be viewed at our Web site at www.amcnoma.org — go to the Legislation link and Eye on the Statehouse to view our Action alert on SB 59.

Write Senator Stivers today. ■

MARK YOUR CALENDAR CITY CLUB DEBATE

Dr. John A. Bastulli, vice president of legislative affairs for the AMCNO will debate Peter Weinberger, JD, on Wednesday, August 22nd at the City Club. The topic of the debate will be SB 59 — the mandatory arbitration legislation — a bill spear-headed and strongly supported by the AMCNO and the outcomes documented since malpractice tort reform measures were passed in 2002. For more information on the program go to the City Club Web site at www.cityclub.org or contact the AMCNO at (216) 520-1000, ext. 100.

The Academy of Medicine of Cleveland & Northern Ohio Legislator Spotlight on State Senator Kevin Coughlin

A fourth generation resident of Cuyahoga Falls, Kevin Coughlin's career in state government began in the Ohio House of Representatives where he was elected to three terms in office, serving from 1997-2001. In 2001, he was selected by the Ohio Senate to fill the unexpired term of State Senator Roy Ray, and the following year, the voters of Ohio's 27th District returned Sen. Coughlin to the seat for a full term. In 2006, he was elected to serve a second term as state senator.

Throughout his 10 years in Columbus, Sen. Coughlin has championed policies that work to address the health care issues facing Ohio's hospitals, medical professionals and families, particularly in building a health care system that provides the best quality of care for Ohioans while increasing access to all who need it. His experience and dedication in this area has elevated him to the position of Chairman of the Senate's Health, Human Services and Aging Committee, where he has a direct impact on shaping health care policy in Ohio.

Most recently, Sen. Coughlin introduced Senate Bill 59, important legislation designed to keep doctors practicing medicine in Ohio by bringing predictability back to medical malpractice insurance rates. Citing statistics from the Ohio Department of Insurance that show an increase in the number of doctors expected to retire because of rising insurance premiums, Sen. Coughlin explained that his bill would establish a pilot program to determine the benefits of using arbitration in medical negligence disputes. In addition, Sen. Coughlin introduced Senate Bill 58, which expands the authority of pharmacists to allow them to administer immunizations to adults for conditions like meningitis, diphtheria and pertussis.

Over the years, Sen. Coughlin has also worked with his colleagues and those in the medical community to enact comprehensive medical malpractice tort reform legislation that protects the rights of patients, while working to eliminate frivolous lawsuits that drive up health care costs and threaten the overall quality of Ohio's health care system. Sen. Coughlin continues to work with all interested parties to strengthen these reforms.

As the 127th General Assembly moves forward and discussion continues over the direction of Ohio's health care system, Sen. Coughlin plans to work with the House and the Governor to address this very important issue, while using the Senate Health Committee as a forum for public discussion and debate on the question of health care access and affordability and how we can improve the system for all Ohioans.

Aside from his work on health care issues, Sen. Coughlin also serves on the Energy and Public Utilities Committee, the Highways and Transportation Committee and the Ways and Means and Economic Development Committee.

Sen. Coughlin has also proven to be a strong leader outside of his daily work in the General Assembly. In 2005, he was named Chair of the Council of State Government's (CSG) Midwestern Legislative Conference, an organization that provides lawmakers and staff from around the Midwest and Canada the tools to effectively address today's public policy challenges. In addition, he co-chaired the CSG's Bowhay Institute for Legislative Leadership Development, which trains 33 Midwestern legislators every year to be strong leaders.

Closer to home, Sen. Coughlin is actively involved in the community. He is an auxiliary faculty member at the University of Akron, as well as a member of Immaculate Heart of Mary Church, the Blossom Music Center Board of Overseers, the Akron Civic Theatre Advisory Board, Fraternal Order of Police Associates, Darrow Street Grange, and several other community groups. In addition, Sen. Coughlin is a member of several chambers of commerce.



State Senator Kevin Coughlin

A graduate of Woodridge High School, Sen. Coughlin holds a BA and a master's in public administration from Bowling Green State University. He and his wife, Anne Coughlin, a physical therapist, live in Cuyahoga Falls with their daughters, Kathryn and Elizabeth.

Senator Coughlin serves on the following committees:

- Health, Human Services & Aging, *Chair*
- Highways & Transportation
- Ways & Means & Economic Development
- Energy & Public Utilities

Editor's Note: Senator Coughlin has worked closely with the AMCNO on several health care-related bills — including SB 59 — the mandatory arbitration legislation. We look forward to working with him in the future. This article is a new feature in the Northern Ohio Physician magazine. Each issue we will try to highlight an area legislator. ■

LEGISLATIVE ACTIVITIES

AMCNO Hosts Legislative Breakfast at Saint Vincent Charity Hospital

A key component of the AMCNO legislative agenda for 2007 is to coordinate meetings with hospitals/groups in the region. These meetings are to educate physicians and legislators on the ongoing impact of medical issues on access to care, physician practice, hospital care and reimbursement issues. On Friday, May 4th the AMCNO sponsored a Legislative Breakfast at Saint Vincent Charity Hospital (SVCH).

The breakfast format is not a fundraiser, rather an opportunity for physicians to meet with legislators from the hospital's district. Legislators in attendance for the SVCH breakfast were Representatives Sandra Williams, Barbara Boyd and Armond Budish. Each of the legislators spent time providing the physicians with their background as well as their ideas for the upcoming legislative agenda. Rep. Budish is part of a health care coalition working on insurance reform legislation and he indicated that there should be a bill developed in the near future — and it would not entail collecting additional taxes to implement the program — rather the plan is to utilize funds that are already available and could be redistributed.

AMCNO representatives provided information on the AMCNO legislative agenda for 2007 inclusive of work on SB 59 — the mandatory arbitration bill. Another key topic of conversation evolved around the rollout of the Medicaid Managed Care Plans (MCP) in Northeastern Ohio. Both the physician and hospital representatives in attendance expressed concern about the fact that their

established Medicaid patients were now being referred to other physicians and institutions because of the manner in which the MCP program has been developed. Everyone in attendance agreed that when these plans are implemented it should be of paramount importance to respect an established patient/physician relationship to assure continuity of care. The legislative representatives in attendance offered to facilitate a future meeting with the new head of the Ohio Department of Job and Family Services — and the AMCNO is pursuing this suggestion on behalf of our members.



Two of the state representatives in attendance at the breakfast spend a moment after the meeting with two of the physician attendees. L to R – Rep. Barbara Boyd, Dr. Charity Kankam, Dr. John Bastulli and Rep. Sandra Williams.

The AMCNO is working to set up legislative breakfasts at area hospitals across the region. If you would like to attend the event or would like to set up a breakfast at your hospital, please email the AMCNO EVP/CEO at ebiddlestone@amcnoma.org ■



Representative Barbara Boyd (seated at center) makes a point during the legislative breakfast at St. Vincent Charity Hospital. Also pictured (left of Rep. Boyd) Rep. Sandra Williams, Rep. Armond Budish, and (right of Rep. Boyd) Dr. John Bastulli and Mr. Jeff Jency, President and CEO of SVCH.



Bob Conklin, host of the "In the Spotlight" program (seated far right) on Time Warner conducts the interview on the topic of Ohio Health Care with l to r: Mr. George Stadlander, Ms. Harriet Applegate, Mr. Bill Ryan and Dr. John Bastulli.

On June 18th Dr. John A. Bastulli, Vice President of Legislative Affairs for the AMCNO participated in a panel discussion on the issue of health care access and affordability with Mr. Bill Ryan, President and CEO of the Center for Health Affairs, Ms. Harriet Applegate, Executive Secretary of the Northshore AFL-CIO Federation of Labor, and Mr. George Stadlander, Chief Underwriter for Medical Mutual of Ohio.

Dr. Bastulli provided specific insight into the issue of how medical liability and the cost of defensive medicine continues to increase the cost of health care. Joining the program for a telephone interview was Senator Kevin Coughlin, the sponsor of SB 59 — the mandatory arbitration legislation, as well as the sponsor of SB 127, the Healthcare Simplification Act — legislation aimed at reducing the administrative burden placed on physicians by health care insurance companies. Both SB 59 and SB 127 are supported by the AMCNO. More information on this program and SB 127 will be included in the next issue of Northern Ohio Physician.

The program known as "IN THE SPOTLIGHT" focusing on Ohio Health Care hosted by Bob Conklin will begin airing July 17th on Time Warner Cable's local programming channel — Sunday at 10 a.m. and 7 p.m., Tuesday at 11 a.m. and 7 p.m. Friday at 11 p.m. and Saturday at 1 p.m. and 8 p.m.

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- 24/7 Emergency Care
- Sleep Disorder Treatment Center
- Regional Center for Blood Conservation
- Primary Care Network
- Geropsychiatry
- Rosary Hall



St. Vincent Charity Hospital ■ 2351 East 22nd Street ■ 216.861.6200 ■ www.stvincentcharity.com

SAVE THE DATE

There is STILL TIME to register for the 4th Annual

Marissa Rose Biddlestone Memorial Golf Outing on

Monday, August 13, 2007

at the Mayfield Country Club

Members: Watch your mail for a registration flyer or call the AMCNO to sign up your foursome now!

"Solving the

Third Party Payor Puzzle"

A seminar intended to educate physicians and their staff regarding the many third party payor claims and managed care issues.

Wednesday, November 14, 2007

at the AMCNO Executive Offices

Contact Bette Robinson

(216) 520-1000 ext. 102

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UnitedHealth Premium® Designation Program and UnitedHealth Practice RewardsSM

By Giesele Robinson Greene, MD, Market Medical Director Northern Ohio UnitedHealthcare

Today's health care system is fraught with wide variation in medical practices that often leads to inconsistent clinical outcomes, inefficient care delivery for consumers and increased costs for employers. As those health care costs continue to rise, significant pressure is placed on benefit leaders to identify solutions aimed at limiting their companies' financial exposure while providing affordable health care to their employees. Most are looking to the vendors of health care to develop strategies that promote high quality and efficient care, build consumer trust and enhance the personal experience, while managing total health care spend.

UnitedHealth Premium® designation is a consumer information tool recognizing physicians and hospitals for their adherence to evidence-based medicine and delivery of cost-efficient care. This tool is Internet based and can be viewed by the public and UnitedHealthcare members at the Internet site myuhc.com. Physicians designated as Quality or Quality & Efficiency are represented for ease of consumer identification by one star for quality, or two stars for quality & efficiency in the UnitedHealthcare online directory.

The UnitedHealth Premium designation program administered by UnitedHealthcare is a physician performance assessment initiative that uses evidence- and expert-based physician consensus standards to evaluate network physicians in 21 specialties for quality and efficiency of clinical care. Incorporating extensive and continuing input from physicians and state and medical professional societies, this program is available in 94 markets including the Cleveland Market. The UnitedHealth Premium program is a resource for practice improvement providing evidence-based guidelines, physician data sharing and data-driven clinical management to reduce variability and enable high quality and affordable outcomes.

The primary focus of the designation program is the evaluation of the quality of care delivery as measured against evidence-based and expert physician-approved standards. The program specifically incorporates "industry standard" criteria such as those approved by the Ambulatory Care Quality Alliance (AQA) which enjoys the considerable input of more than 35 leading medical societies, specialty society and external expert physician advisory committee input.

Only those physicians who meet the quality standards will proceed to the evaluation for efficiency of care. The efficiency of care criteria for UnitedHealth Premium incorporates the AQA definition of efficiency, and is calculated by comparing a physician's actual episode of care costs against the geographic norm

specialty specific case mix, risk, and severity adjusted market average episode costs.

Physicians whose performance meets or exceeds the national consensus standards for quality, and the geographic area norms for efficiency, are designated Premium providers. As further national evidence-based consensus standards in more specialties become available, they will be incorporated into the designation program. Physicians who have successfully met the quality criteria or the quality and efficiency of care criteria will receive the designations and will be identified to consumers in online directories by the one or two star designation. Narrative information is provided in the directory explaining that physicians who are non-designated may be non-designated for many reasons, the most common being insufficient information due to low volume or an a specialty not evaluated under the program. On a national basis, 56% of physicians eligible for designation status have received the UnitedHealth Premium designation for quality and/or quality & efficiency.

Unlike many other programs, the UnitedHealth Premium Designation Program does not require physicians to administratively participate in data gathering for the purpose of designation. Physicians receive written documentation from UnitedHealthcare confirming their UnitedHealth Premium designation status. Physicians may view their detailed results of the assessment analysis by accessing a secured Web site using the user ID and password provided to them by UnitedHealthcare. Physicians have the opportunity to review the data and provide clarification and provide additional self-reported data prior to publication of results in the online directory. Based on additional self-reported data, quality and efficiency determinations will be recalculated and may result in revised designation status based on the additional self-reported information.

UnitedHealth Practice RewardsSM is the financial recognition for designated physicians meeting additional specified criteria beyond

quality and efficiency. UnitedHealth Practice RewardsSM is an innovative approach that recognizes and rewards physicians who meet defined quality, efficiency and administrative criteria by providing them with an enhanced fee schedule. This is not a bonus program. Rather, it is a financial recognition of physician performance.

Eligibility for UnitedHealth Practice Rewards begins with physicians who have received the quality and efficiency designation through the UnitedHealth Premium designation program. Medical Groups are also eligible as long as one or more of the group's physicians have received the quality and efficiency designation.

In addition to considering performance against quality and efficiency criteria, UnitedHealth Practice Rewards considers a practice's use of eligible standard contract templates, reimbursement schedules and efficient use of technology in areas such as electronic claims submission. Eligibility for UnitedHealth Practice Rewards fee schedule adjustments occurs annually for all physicians, regardless of specialty, who bill at the contract level. Physicians who do not meet the criteria will continue to be reimbursed in accordance with the terms of their existing contracts and fee schedules.

Physicians and medical groups will have access to detailed assessment reports and communication advising the physicians and groups of the results of the UnitedHealth Practice Rewards assessment as well as the availability of their detailed assessment analysis.

UnitedHealthcare believes that quality and efficient health care depends on the effective engagement and performance of all participants: physicians, consumers, employers, and health plans. Advocacy for the practice of evidence-based medicine as the most affordable plan of care, is integral to improving health care in America.

Information about the UnitedHealth Premium designation program is available online at www.unitedhealthcareonline.com > clinician resources > performance measurement & reporting > UnitedHealth Premium designation.

Editor's Note: Dr. Greene recently presented on these and other UHC initiatives to the AMCNO Board of Directors (see pullout box on next page). ■

AMCNO board of directors meets with new medical director of UnitedHealthcare (UHC) for the Northern Region

In April the AMCNO board of directors had an opportunity to meet and talk with Dr. Giesele Greene, the new medical director of UHC for the Northern Ohio region. Among the topics discussed with Dr. Greene were UHC's practice to require participating providers to refer lab services to a participating lab network. The intent of this program is that after March 1, 2007 continued referrals to nonparticipating labs may, after appropriate notice, subject the referring physician to one or more of the following actions: 1) a financial penalty of \$50, 2) a decreased fee schedule 3) a change in eligibility for the Premium Designation program or 4) termination of network participation.

The AMCNO is of the opinion that UHC should remove the economic sanction until such time that any questions that have arisen regarding these new rules have been addressed and reviewed. It is our opinion that our members should not be subject to a change in rating or a penalty by an insurance company if the patient makes a decision to use a non-network lab. In addition, the AMCNO questions whether or not UHC even has the authority to require such financial penalties. Last, the AMCNO expressed concern as to whether or not the imposed rules to use only in-network labs would in some way impact existing referral contracts with UHC.

Dr. Greene also briefly discussed the UHC radiology notification program. Beginning April 16th, UHC will require prior notification for the following defined set of outpatient imaging procedures: CT scans, MRIs, PET scans and nuclear medicine studies, including nuclear cardiology. Dr. Greene noted that UHC is calling this process prior notification and the program contains different requirements than prior authorization or precertification. In addition, failure by a practice to notify UHC prior to performing the procedure can result in not getting paid for the service. Physicians and their staff may obtain additional information regarding the Radiology notification program at <http://www.unitedhealthcareonline.com>. If any AMCNO members have specific issues with either of these programs, please email your comments to ebiddlestone@amcnoma.org ■



Following the AMCNO board of directors meeting Dr. Giesele Greene from UnitedHealthcare spends a moment with the AMCNO President, Dr. Paul Janicki (left) and AMCNO immediate past president Dr. George Kikano.

Welcome to the 2007-2008 AMCNO Officers and Board of Directors

2007-2008

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AMCNO Offers Insurance Services to Members

HRH offers an array of insurance programs for AMCNO members. HRH offers individual and group health products through insurance carriers such as UnitedHealthcare, Anthem, Medical Mutual of Ohio, and Aetna. HRH in conjunction with AMCNO now offers FormFire as a solution for physician's practices to reduce the hard work and frustration associated with shopping for combined medical insurance.

Getting real and confirmed pricing from multiple insurance carriers involves sharing employee and employee's dependents medical history on cumbersome paper applications. Rather than having each employee fill out multiple applications for multiple carriers, FormFire simplifies this process by taking it online. Employees complete an application through the FormFire Web site that is sent to all major medical carriers. Once completed, employers receive actual confirmed medical insurance rates from each carrier, not just best case scenarios. FormFire takes the guesswork out of the application and renewal process.

FormFire is an interactive Web site, facilitating the application process through a personalized questionnaire for each employee based on their health history. Additionally, information is stored from year to year, making renewals quick and easy after updating employee profiles.

FormFire is highly secure and HIPAA compliant, and with the assistance of HRH, can transform the way your company shops for group health insurance.

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programs for physician's offices. Physicians on an individual basis also have access to disability and life insurance products at discounted association prices. Simplified underwriting is also available to members of AMCNO.

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For more information on FormFire or other insurance programs through HRH, please contact Mike Turney of HRH at (800) 873-0503 ext. 4875. You can also email him at mike.turney@hrh.com.

For a copy of the HRH brochure — see the insert in this issue of the Northern Ohio Physician magazine. ■

IRS Allowing Hospitals to Subsidize Health IT to Physicians

By Amy S. Leopard, Esq., Walter & Haverfield LLP

The federal government continues to promote health information technology ("Health IT") through hospital financial assistance to physicians. On May 11, 2007, the IRS issued an internal memo on how a tax-exempt hospital may subsidize Health IT without jeopardizing its tax-exempt status or creating private inurement to the physician. The directive follows HHS exceptions issued last fall under the Stark II law and safe harbors under the Antikickback statute. (See November/December 2006 edition of *Northern Ohio Physician*).

Under the IRS directive, 501(c)(3) tax-exempt hospitals may enter into Health IT subsidy arrangements with medical staff physicians if the benefits are permitted under the HHS rules and meet the following IRS criteria:

- Both the hospital and the medical staff physicians are required to comply with the HHS rules on an ongoing basis.
- The hospital makes the Health IT subsidy available to all medical staff physicians.
- The amount of the subsidy is either the same for *all* physicians or varies according to criteria for meeting the health care needs of the community.
- To the extent permitted by law, the hospital must be able to access all of the electronic health records created by the subsidized physicians.

The first three criteria must be understood in light of the HHS rules allowing a subsidy of up to 85% of the donor's costs for interoperable software that is necessary and used predominantly to create, maintain, transmit, or receive electronic health records. On a recent conference call, the IRS acknowledged the

impracticality of implementing the program for all physicians at once and that phased implementation for only those physicians interested would be acceptable. For example, a hospital might design an implementation plan to address unique health conditions, serve indigent populations or connect large off-site clinics.

The model for cost-sharing amounts paid by physicians must have a reasonable and verifiable basis, and the IRS wants to see whether a flat subsidy amount is used or any differences are explained by community need. From a practical point of view, how the hospital determines costs often will be driven by how it has structured its license fees with vendors. Variations in subsidy amounts should be related to improving community benefit and promoting health without directly rewarding referrals.

The final criteria must be understood in light of medical privacy laws, including HIPAA. Under HIPAA, a physician may disclose protected health information to a hospital only if an

exception permits the disclosure. So while physicians may allow access when making a referral to the hospital or when the hospital is involved in treatment, HIPAA requires the physician to limit the information disclosed outside of treatment purposes to that minimally necessary to accomplish the purpose of the disclosure. Examples of proper avenues would be disclosures necessary for software maintenance and sharing insurance coverage for payment purposes.

These criteria are not absolute requirements for EHR donations. Rather, the directive sets forth a safe harbor under which the IRS agents will not find an impermissible private benefit or private inurement if followed. Otherwise, the IRS may review arrangements on a case-by-case basis to ensure that the subsidy promotes the needs of the community, and not to benefit an individual physician. While the IRS has not opined on what tax consequences to the physician may be incurred, if any, more hospitals are reviewing whether and how to structure health IT subsidies under the new rules.

Amy S. Leopard is a partner in the health law practice at Walter & Haverfield LLP and may be reached at aleopard@walterhav.com. This article presents general information regarding legal developments and does not constitute legal advice. ■

New Report Analyzes Total Health Care Spending in State and Cost of Both Covering and Not Covering the Uninsured

A new report from the Health Policy Institute of Ohio found that in 2006, Ohioans spent a total of \$62.2 billion on noninstitutional healthcare. Of that, \$3.5 billion was spent by and on behalf of the uninsured for health care that only met approximately half of their needs.

The report *Mapping Health Spending and Insurance Coverage in Ohio*, which detailed the total cost of health spending and insurance coverage in Ohio and included an analysis of Ohio's health care system, also found that the indirect cost associated with the lack of insurance imposes a burden of \$2.1 to \$5.8 billion in lost productivity on the Ohio economy.

"In order to expand health care coverage in Ohio, we must understand the current health care terrain," said William Hayes, President of the Health Policy Institute of Ohio. "This report tells us how much Ohio is spending on health care, compares us to other states, and highlights some specific areas where we have a lot of work to do."

The Health Policy Institute of Ohio is an independent, nonpartisan organization that forecasts health trends, analyzes key health issues, and communicates current research to Ohio policymakers, state agencies, and other decision makers.

Among the findings in the report is that:

- In Ohio, noninstitutional health care spending was \$62.2 billion in 2006. About \$31 billion of this total went to employer-sponsored health coverage; Medicare paid another \$21 billion; and Medicaid paid an additional \$4.8 billion in combined federal and state funds for noninstitutional care among those continuously enrolled in the program (Medicaid spending for dual eligibles is subsumed under Medicare).
- Approximately 12 percent of the Ohio population is uninsured, somewhat below the national average of 16 percent. This lack of insurance imposes a burden of \$2.1 to \$5.8 billion in lost productivity each year on the Ohio economy.
- In 2006, \$3.5 billion was spent by and on behalf of the uninsured for health care that only met approximately half of their needs. A six percent increase (\$3.9 billion) in total noninstitutional health spending would expand coverage to the 12 percent of the population who are uninsured. This is less than the annual cost increases in health care

(with American health care costs from 2000 to 2004 rising by 12.2 percent per year) or the costs of health insurance administration. The report states that slowing the rate of growth in health care costs or improving administrative efficiency could substantially offset the cost of covering the uninsured.

- Ohio mirrors the national health care dilemma with high costs, widespread lack of insurance coverage, insufficient investment in primary care and chronic illness management, burgeoning technology, and significant disparities — geographic, ethnic, racial, economic — in access to and quality of care.

According to William Hayes, the report is the first step in an ambitious plan by his Institute to analyze proposals to expand coverage in Ohio. Future work will involve detailed macro-simulation modeling on different plans being put forth by Ohio legislators, policymakers, and advocacy groups to cover Ohio's uninsured. The Institute is currently working with members of its policy advisory committee, the Ohio Department of Insurance, the Ohio Business Roundtable, and other organizations to move this modeling forward.

"Our estimates of how much is spent on healthcare in Ohio, and how much spending for care for the uninsured already exists in the system, paves the way for understanding policy choices for expanding health care coverage," Hayes said. "We're not advocating any particular plan to cover the uninsured. But we want to make sure that those plans being put forward have solid analysis and data to back them up."

The report also provided a detailed analysis of the health care system in both Ohio and the United States. Among the findings of this part of the analysis are:

- On most key indicators, the health status of Ohioans ranks below the national average; the number of Ohioans who smoke is particularly high.
- Ohio spends more on nursing homes than almost all other states while spending less on children than almost all other states.

- In a number of Ohio counties, more than half the working-age populations have incomes below 200 percent of the federal poverty line (FPL). In several counties at least one of five adults are uninsured, while in 29 Ohio counties, one of four children lives in poverty. These figures highlight the important link between the state of the local and regional economies and the problem of the uninsured.
- Health care spending is higher in Ohio than in many other states. According to 2004 data, Ohio premiums for employer-based health insurance rank 15th, 18th, and 32nd in cost among all states and the District of Columbia for family, employee-plus-one, and employee-only coverage, respectively. Ohio thus presents a significant gap between the cost of employee-only premiums and family premiums. Nursing home care absorbed 10.5 percent of all health care spending in Ohio — more than 46 other states, and about 42 percent above the national average of 7.4 percent.²
- There are serious questions about whether Ohio and the country are obtaining sufficient return on this significant investment in health care, even though health care spending yields enormous benefits (with medical technology alone — which is a key driver of health costs — having saved millions of lives).
- Medical errors may be more common in the United States than in many other industrialized countries. A recent study comparing Australia, Canada, Germany, New Zealand, the United Kingdom, and the U.S. found that 34 percent of American chronic care patients reported medical errors — more than any other surveyed country.
- For American workers with employer-based coverage, the loss of health insurance can be just one pink slip or premium increase away. Census data concerning U.S. residents under age 65 show that, at some point during 2002 through 2003, spells without health coverage were experienced by nearly one in three Americans (32 percent), including fully 57 percent of all households with incomes below 200 percent of the FPL.
- Health insurance coverage is growing increasingly thin for many American workers. According to a 2005 survey, 23 percent of American adults report that they had problems

(Continued on page 15)

The State of Tobacco Use in Cuyahoga County

By Katie Przepyszny, M.A., Ashley Brooks, MPH, and Elaine A. Borawski, Ph.D.

The Cuyahoga County Comprehensive Partnership for Tobacco Reduction (the Partnership) celebrated local efforts in tobacco use reduction in a press conference held on Friday, April 27, 2007 at the Cuyahoga County Board of Health. Entering its fifth year of funding from the Ohio Tobacco Prevention Foundation and the United Way's Community Vision Council, the Partnership highlighted successes in youth prevention, cessation programming, and comprehensive tobacco-free school and worksite policies. Surveillance data from the Cuyahoga County Behavioral Risk Factor Surveillance Survey presented by the Center for Health Promotion Research at Case Western Reserve University narrated the state of local tobacco use including successes attributable to the Partnership's efforts.

Declining Cigarette Smoking Rates in Cuyahoga County

Local cigarette use is on a steady decline. Though the estimates are within overlapping ranges and statistical significance cannot be concluded, the rate of cigarette use in Cuyahoga County has dropped consistently from 26.5% in 2003 to a low of 21.3% in 2006. Such a decline is mirrored at the state and national levels, with rates in Ohio dropping from 25.2% in 2003 to 22.4% in 2006 and rates nationally dropping from 22.0% in 2003 as compared to 20.0% in 2006. The drop in cigarette smoking in Cuyahoga County has brought the local estimate, not only to its lowest in the past four years, but also below that of the 2006 state average, though both the county and state rates continue to remain above the national average.

Other Tobacco Product Use

Although the majority of tobacco users in Cuyahoga County prefer cigarettes, a variety of other tobacco products are also used. Of the other tobacco products, cigar and little cigar use have the highest prevalence (2005-2006: 4% and 3% respectively), and also saw more of a decline, than both pipe and smokeless tobacco use (2005-2006: both 1%). While less than 10% of cigarette users also smoked cigars or little cigars, about half of all cigar and little cigar smokers also smoked cigarettes, and more specifically, on average, smoked a half a pack of cigarettes and one cigar a day. When all tobacco products are considered, 25% of adults or 253,000 people in Cuyahoga County regularly used at least one tobacco product in 2006.

Quit Attempts and Successes

Increasingly more Cuyahoga County adult smokers have tried to quit smoking; 50% made at least one attempt in 2003-2004 as compared to 59% in 2005-2006. More importantly, 11% of all smokers succeeded in quitting in 2005-2006, as compared to 6.7% in 2003-2004. Additionally, 91% of smokers

who made at least one quit attempt in the past year (between 2003 and 2006) said that they "plan to quit in the next six months," while even 50% of those who had not made a quit attempt in the past year stated that they were thinking of quitting in the future. Younger, female, minority, and lower income adults were the most likely to report a quit attempt; however, younger, white, higher income, and more educated adults were more likely to succeed.

The Role of Health Coverage and Primary Care in Cessation

Health care coverage was not associated with quit attempt reports. However, smokers with a primary care physician (PCP) were more likely to make a quit attempt than those without a PCP (56% vs. 50%). In contrast, among those who made at least one quit attempt in the last year, those with health care coverage were twice as likely to succeed in quitting smoking as compared to those without coverage (18% vs. 9%), and those with a PCP were slightly more likely to succeed as compared to those without a PCP (17% vs. 14%).

Changing Attitudes about Smoking

Several indicators showed trends towards stricter antismoking rules and a greater appreciation for the dangers that secondhand smoke exposure poses. Over the past four years, a positive change occurred in the percentage of households that prohibited smoking in the home, increasing from 60% in 2003-2004 to 68% in 2005-2006. Not surprisingly, more stringent rules in the home were accompanied by declining reports of exposure to secondhand smoke in the home and car during the past week. Reported exposure at home in the past week declined from 26% in 2004 to 22% in 2006, while reported exposure in the car in the past week declined from 28% in 2004 to 23% in 2006.

Regarding secondhand smoke exposure of children, smokers with children in the home were more likely to restrict smoking in the home (35% entirely; 35% restricted to some areas), when compared to smokers without children in the home (25% entirely; 24% restricted to some areas). Likewise, among smokers, those with children reported less exposure in their homes in the past week in 2006 than did smokers without children (57% vs. 72%). The messages about secondhand smoke exposure do appear to be influencing smokers with children; their rate of reported exposure has steadily declined over the past three years (69% to 60% to 57%).

Finally, even before the passage of Issue 5, increasing restrictions against smoking in the workplace were reported. Reported prohibition of smoking in work areas increased from 75% in 2003 to 81% in 2006. Most importantly, the majority of workers, both smokers and nonsmokers, were supportive of such restrictions. In fact, 88% of smokers who worked in a smoke-free work environment preferred no change to the policy. Additionally, another 5% reported support of an even stronger policy than already in place.

Continuing Success

While the rates of tobacco use remain relatively high in Cuyahoga County, with 25% regularly using at least one tobacco product, prevalence rates have steadily declined, cessation attempts and successes have increased, and attitudes regarding tobacco use and exposure have improved. Although we cannot determine the exact cause, we do know that this decline is outpacing those at the state and national levels. Cuyahoga County is fortunate to have a well-funded comprehensive tobacco control program with evidence-based programming, and it is reasonable to attribute some of the success to the efforts of the Partnership. With the progress made at the state level with the passage of Issue 5, there is reason to be hopeful that these successes will continue.

For more information on the data presented in this article, and further information about tobacco use in Cuyahoga County, please visit <http://www.case.edu/affil/healthpromotion> or contact Elaine Borawski at elaine.borawski@case.edu.

(Continued on page 15)

The State of Tobacco Use in Cuyahoga County

(Continued from page 14)

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Local Data Source: Cuyahoga County Behavioral Risk Factor Surveillance Survey (CC-BRFSS), 2003-2006. State/National Data Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2003-2006. (See Web site: <http://apps.nccd.cdc.gov/brfss/>)

Editor's Note: The AMCNO is an active participant in the Cuyahoga County Tobacco Coalition — only one of the many groups in Northern Ohio working on this important issue. In addition, the AMCNO is proud to have been a participant in the campaign for successful passage of Issue 5 — the Smokefree Ohio initiative. The AMCNO is actively monitoring activity at the Ohio Statehouse since there are still groups in Ohio that may obtain enough signatures to place this issue back on the ballot. If that should occur we will immediately mobilize our members. ■

AMCNO President Addresses 2007 Medical School Graduates

(Continued from page 1)

"Your class has a strong tradition of volunteer and community service both in college and medical school. My second challenge to you today: Please continue to involve yourself in your profession beyond your residency training. There are innumerable ways to contribute from leadership activities in your house staff association or county and state and national medical societies; service to community, religious and governmental organizations; to treating the indigent and underserved. The impact of politics and legislation at all levels on our profession is enormous, all views are important to the debate and your active involvement critical.

"As a member of the silent generation I am optimistic that you in the millennial generation will be successful, continue to lead our profession and aspire to greatness. You will make a difference.

"Again congratulations, welcome and God speed." ■

New Report Analyzes Total Health Care Spending in State and Cost of Both Covering and Not Covering the Uninsured

(Continued from page 13)

paying medical bills, and 61 percent of these people had medical insurance. Thus, the serious problem of the under-insured must be added to the problem of the uninsured.

The complete report *Mapping Health Spending and Insurance Coverage in Ohio* may be downloaded from <http://www.hpio.net/publications/maphealthexpend.html>. Copies are also available by contacting the Health Policy Institute of Ohio at (614) 224-4950. The Institute also published two companion publications with the report: *Coverage Expansion Reform Options for Ohio* and *A Review of Health Coverage Expansion Strategies and Lessons for Ohio*. ■

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ANNUAL MEETING 2007

AMCNO 2007 Annual Meeting Highlights (Continued from page 1)



The 2007 annual meeting honorees pose for a picture prior to the meeting left to right William Reinhart, MD, Gary DeNelsky, Ph.D., Patricia Horvath, RN, Michael Jordan, Esq., Ronald Savrin, MD, William Seitz, Jr., MD, and John Hines, MD.

Two Special Recognition awards were given out during the evening. One to Gary Y. DeNelsky, PhD, for his longstanding work in the field of smoking cessation and tobacco control and the other to Ms. Patricia T.

"The AMCNO and those of you in attendance this evening are to be congratulated as well, because it was you and your organization that started the Health Museum, the first of its kind in the nation."

– Patricia T. Horvath, RN, upon receiving her award from the AMCNO.

commitment to legislative initiatives of importance to the AMCNO. Each award recipient was afforded an opportunity to thank the AMCNO for the award.

The Academy of Medicine Education Foundation (AMEF) presented six local medical students with scholarships worth \$5,000 each at this year's AMCNO Annual Meeting. The scholarships were awarded to Patrick F. Elliott, third-year student, Case Western



The AMCNO past presidents in attendance for the evening shared a moment together prior to the start of the meeting. Left to right William Seitz, Jr., MD, George Kikano, MD, Theodore Castele, MD, Ronald Savrin, MD, Hermann Menges, Jr., MD, Wilma Bergfeld, MD, Robert White, MD, Dale Cowan, MD, John Bastulli, MD and Victor Bello, MD.

"I am a member of many different organizations and you should know that I have yet to see an organization as proactive on behalf of its members as the AMCNO."

– Michael J. Jordan from Walter and Haverfield law firm.

Horvath, RN, former Executive Director for HealthSpace Cleveland for her work and achievement on behalf of the health care of the community. And Michael J. Jordan, an attorney with Walter and Haverfield was presented with the Presidential Citation award by Dr. Paul Janicki in recognition of his devotion of considerable time and personal



The AMEF scholarship recipients gather at the podium after receiving their \$5,000.00 scholarship award from Dr. Bastulli. L to R – Patrick Elliott, Julie Eppich, Joshua Nething, Jason Robertson, Laura Sponseller, Aaron Viny and Dr. John Bastulli.

Reserve University; Julie L. Eppich, third-year student, Case Western Reserve University; Joshua B. Nething, fourth-year student, Northeastern Ohio Universities College of Medicine; Jason O. Robertson, third-year student, Cleveland Clinic Lerner College of Medicine; Laura L. Sponseller, fourth-year student, Case Western Reserve University; and Aaron D. Viny, fourth-year student, Cleveland Clinic Lerner College of Medicine.

This was the second year scholarship monies were presented to recipients as part of the program of the AMCNO's Annual Meeting and Awards Dinner, with students and their respective families in attendance.

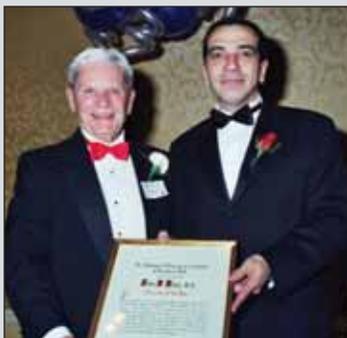
And as always, physician members celebrating the fiftieth anniversary of their medical school graduation were honored during the program as well.



The 2008 50 year awardees gather for a group photo left to right – Daniel Renner MD, Mauro Tuason, MD, Nicholas Popovich MD, Arnold Rosenzweig, MD, Elizabeth Rauchshkolb, Theodore Castele, MD, Javier Lopez, MD, Hermann Menges, Jr., MD, William Sheldon, MD, Donald Kurlander, MD, Maria Slis (accepting for her father Dr. Peralta), Harry Stiggers, DO, and Gertrude Hahnel, MD.

Following the awards ceremonies, outgoing president Paul C. Janicki, MD, passed the AMCNO gavel for the 2007-2008 year to James S. Taylor, MD. As part of his outgoing presidential address, Dr. Janicki stated "There is no other organization that can represent the physicians of Northern Ohio as well as the AMCNO." Dr. Janicki also cited the many accomplishments of the AMCNO over the course of his presidency (see page 19 Year in Review.) ■

ANNUAL MEETING 2007



Tail Insurance: Pitfalls and Opportunities that You Need to Understand

By David A. Martin, President, The Premium Group, Inc.

The only thing worse than a cat with a long tail in a room full of rockers is a doc without a "tail" in a room full of plaintiff lawyers who want to rock.

When you leave a practice, who buys the "tail"? For that matter, what is a "tail" and why does it matter?

First of all, if you happen to be one of the few physicians who are fortunate enough to carry occurrence coverage, then this article is not for you. Occurrence policies are not sold by the vast majority of medical malpractice insurers (currently only the Medical Protective Company sells the occurrence form, and even they sell far more claims-made type coverage). For those of you with claims-made coverage — and that's most of you...read on...

Generally speaking, any interruption of continuous coverage in your claims-made insurance will require an "Extended Reporting Endorsement," also known as a "Tail" to be put in place in order to cover incurred-but-not-reported ("IBNR") claims. IBNR is an insurance construct referring to claims for which the precipitating medical incident has occurred, but the patient has not yet brought suit.

Claims-made policies cover "claims that are made during the policy period." The "Tail" essentially extends the claim-reporting window on a given claims-made policy, in most cases indefinitely. Some tails are for limited time frames, most commonly with non-standard market carriers which are focused on high-risk insureds.

Consider the following example:

1. A general surgeon has a policy which has coverage dates from January 1 through December 31 of 2007.
2. A patient suffers a negative outcome following a surgical procedure performed on July 1 (thereafter until the suit is brought, the claim is IBNR).
3. The physician policyholder retires on December 31 (an interruption of continuous coverage in the claims-made policy life cycle).
4. The patient sues alleging malpractice one year after the surgery, in July of 2008.

Because the policy in this example is a claims-made policy it will not (without a tail) respond to the claim, because the claim is made outside of the policy coverage dates.

In the uninterrupted course of events, claims-made policies are renewed from year to year and accumulate coverage for prior exposures under the "retroactive date" feature of the policy. In the example, had the physician renewed their policy on January 1 of 2008, the renewal policy would respond to the claim, as the claim would be made during that renewal policy year.

When there is a significant interruption of a claims-made policy for any reason (i.e., you leave your group practice and move out of state; you change careers and go to law school (sic.); etc.), one method for dealing with the outstanding IBNR claims is to purchase a "tail."

As a rough rule of thumb, the tail will cost two times the premium of the expiring policy. The logic behind the cost is that 98% of all claims are brought within two years of the precipitating care event. If you quit today, the likelihood of receiving a lawsuit alleging malpractice, beyond two years from now, is very, very small.

Two times expiring premium can be a very large nut to crack financially. Consider this, an obstetrician in Cleveland, with no claims and no losses, may pay upwards of \$200,000.00 or more for their tail coverage. An internist performing no minor surgery may pay as little as \$25,000.00 for their tail coverage.

If you experience a significant change in the direction of your practice (you leave for example), and your claims-made policy is interrupted, you may face a substantial expense in covering your tail.

If you are contemplating joining a practice, or if you are recruiting a new physician to join your practice, there are several questions regarding tail coverage that you should keep in mind. First: who pays for the tail coverage? The answer to this question should be spelled out in your employment agreement. Either party may be held responsible to pay the entire cost of the tail, or it may be allocated according to a mutually agreeable formula. The formula for allocating the cost may take into consideration such details as the following: 1) is termination with cause?

Or without cause? 2) is the physician giving notice of termination of their employment? (in which case the physician may be required to pay for the tail), or is the practice giving notice to the physician? (in which case perhaps the practice should pay for the tail); 3) has the physician fulfilled their agreed upon minimum time commitment with the practice? or are they leaving early? (if so, they should likely pay for the tail); 4) did the practice pay for the physician's prior tail as an incentive to get the physician to sign on with them? (if so, the practice will likely not want to incur the cost for both the prior acts coverage, and the tail purchased upon the physician's departure from the group). The cheese may be sliced in a number of different ways, but one thing is clear, it is best to determine ahead of time which party will be responsible for the cost of the tail.

The particular language of your employment contract will be very important in determining and delineating who is responsible to pay for your tail, should you leave your practice. In some cases, hospitals may even help with the cost of a tail for recruiting purposes.

Most insurance carriers in the market today will provide a free tail for "D,D,R." Death, Disability, or Retirement, provided you have been insured by that particular carrier for at least five consecutive years.

For large group practices, when switching carriers it is not altogether uncommon for the new carrier to offer a few free tails in less than five years for DDR, intended to be used by members of the group who are nearing retirement.

Editor's note: Do you have questions about your malpractice insurance coverage? The Premium Group, Inc. can help. They have an experienced staff who works to ensure you have the best coverage available at the best possible rates. The Premium Group works closely with the AMCNO on issues related to medical liability matters and they can offer AMCNO members detailed and reliable information on medical malpractice coverage. Call Dave Martin at (440) 542-5020 today to learn more. You may also contact The Premium Group by e-mail through their Web site at www.gopgi.com

The Academy of Medicine Cleveland & Northern Ohio
The VOICE of NE Ohio Physicians for more than 180 Years

Highlights of 2005-06 Advocacy on Behalf of Our Members and their Patients

LEGISLATIVE ACTIVITIES

- Continued to work on passage of legislation that would create a mandatory arbitration pilot program to resolve medical liability cases in NE Ohio counties prior to going to court.
- Facilitated meetings with legislators, judges and the new Attorney General Marc Dann and the Director of the Ohio Department of Insurance to establish working relationships for the AMCNO.
- Created and disseminated a first of its kind *Voting Guide* for our members – inclusive of information on Common Pleas judges running in Cuyahoga County.
- Supported and helped achieve a reversal of the 2007 Medicare payment cuts – while continuing to advocate for a change to the Sustainable Growth Rate (SGR) formula used to calculate physician fees.
- Reviewed and took positions on over 100 health care-related bills under review at the State legislature making our position known to bill sponsors and committee chairman – inclusive of written testimony – enhancing the AMCNO presence at the Statehouse.
- Created and developed legislative breakfast concept – an opportunity for physicians at area hospitals to meet and greet legislators from their district.

PRACTICE MANAGEMENT

- Conducted meetings with the Northern Ohio medical directors of Anthem regarding the planned Anthem pay for performance programs.
- Met with and then delivered detailed comments to Anthem's medical director and audit company regarding the manner in which Anthem audits were being conducted on physicians in NE Ohio.
- Facilitated a board meeting with the new medical director of UnitedHealthcare – to discuss UHC laboratory fee policy and new radiology regulations.
- Disseminated timely and topical news to practice managers through our publication *Practice Management Matters*.
- Partnered with University Hospitals to provide a highly successful two-day program on "Managing Medicare Expectations" – a program that is being repeated in other parts of the state.
- Co-sponsored a well-attended Webinar on the Physician Quality Reporting Initiative (PQRI.)
- Provided a third party payor seminar for practice managers and physicians – an event created by the AMCNO now entering its twenty-fifth year.
- Co-sponsored a health information technology conference in conjunction with the Northeastern Ohio Health Information Management Systems Society (NEOHIMSS.)

COMMUNITY EFFORTS

- Conducted our seventh annual successful *Vote and Vaccinate* event on Election Day offering flu and pneumonia vaccines through our community partnerships in underserved areas.
- Spearheaded passage of the Smokefree Ohio legislative initiative through lobbying and physician efforts.
- Hosted the 22nd annual Mini-internship program that allows community members to shadow AMCNO physicians in their practice setting.
- Provided funding through The Academy of Medicine Education Foundation (AMEF) for the Vaccinate Before You Graduate program at an area high school.

Benefits of Membership in the AMCNO

Renowned Physician Referral Service

Representation at the Statehouse through McDonald Hopkins, Co. LPA

Specialty Listing in *Member Directory & Community Resource Guide*

Practice Promotion via *Healthlines* radio program

Reimbursement Ombudsman

CME Seminars

Peer Review

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!

- Participated in a forum regarding the uninsured and provided airtime on the AMCNO *Healthlines* radio program for a national speaker on the topic of the uninsured.
- Assisted in the planning and participated in a regional event on the topic of preparing for a flu pandemic.
- Garnered support from our members for their participation in the Ohio Medical Reserve Corps.

PUBLIC RELATIONS

- Entered the 48th year of operation for the AMCNO *Pollen Line* – currently run and maintained by longstanding AMCNO member, Dr. Arthur Varner.
- Added a second host to the award-winning *Healthlines* radio program to assist with the myriad AMCNO member interviews conducted each year.

SCHOLARSHIPS

- The Academy of Medicine Education Foundation (AMEF) awarded six \$5,000 scholarships to local third and fourth year medical school students.

ANNUAL SEMINAR

- Hosted topical CME session addressing pay for performance, electronic health records, health savings accounts, and physician performance programs.

BOARD INITIATIVES/ADVOCACY

- Agreed to an AMCNO policy for physician practice regarding healthcare information technology and provided helpful background information to members.
- Established the AMCNO as a founding partner in the Northeastern Ohio Regional Health Information Organization (NEORHO).
- Provided funding to the Ohio Alliance for Civil Justice (OACJ) a statewide organization of which the AMCNO is a member, to file an amicus brief with the Ohio Supreme Court in support of noneconomic damage caps.
- Set policy regarding retail or "quick" clinics starting business in the NE Ohio area.
- Participated in an interview with the Center for Health System Change on trends affecting physicians in NE Ohio – such as P4P and electronic health records.
- Provided input and guidance to the Ohio State Medical Board on proposed rules regarding termination of the patient/physician relationship, prescribing to persons not seen by a physician and sexual misconduct.
- Provided information to our members regarding the Ohio State Medical Board stance on usage of expert witnesses.
- Continued to pursue group membership offerings at area hospitals resulting in increased membership numbers for the organization.

CHANGES AT THE AMCNO

- Moved the AMCNO offices for the sixth time in our history to a new location in Independence, Ohio.
- Created a new name and logo for the organization in keeping with our regional presence.

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. Look for a 2008 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. 309 for details on all the benefits and services available exclusively to our members.



- #1 Investment Strategies
- #2 Appropriate Insurance Coverage
- #8 Lifetime Giving to Children and Descendants

**YOU ENCOUNTER THE 13 WEALTH ISSUES EVERY DAY.
NOW ADDRESS THEM WITH AN ADVISOR.**

Every day you have to make decisions regarding your wealth. And with a Key Private Bank advisor, you can make those decisions easier with our 13 Wealth Issues: a comprehensive way we look at your wealth and how to best manage it. Combined with our solid reputation, unbiased advice and personalized approach, this process makes sure we're not just taking care of your every day, but taking care of your tomorrows.

To learn more about the 13 Wealth Issues, call 216.563.2424 or visit key.com/kpb.

Investment Management	Private Banking	Trust Services
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