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AMCNO Applauds Introduction of SB 59 – Calling for the Mandatory Arbitration of Medical Negligence Claims

The Academy of Medicine of Cleveland & Northern Ohio is pleased to once again offer our strong support for legislation that calls for mandatory arbitration of medical negligence claims. In March, Sen. Kevin Coughlin offered sponsor testimony on SB 59 to the Senate Insurance Commerce and Labor Committee, explaining that the bill establishes a northeast Ohio pilot program which would test the effectiveness of a medical malpractice arbitration process.

Sen. Coughlin noted that the bill targets several northeast Ohio counties where medical malpractice premium costs are significantly higher than the rest of the state. He said the proposal follows recent legislative efforts to stabilize rates that have driven some physicians out of practice. The legislation contains a handful of changes from last session's version, including allowing an arbitration panel to determine if a case is "complex," thereby extending timelines. The new version also puts a 21-day timeline on the arbitration hearing, eliminating concerns

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Dr. John Bastulli, Mr. Michael Jordan and Dr. John Clough in the Ohio Senate hearing room prior to giving testimony on SB 59.

The Future is Now: AMCNO Annual Seminar Tracks Trends in Medicine

"Change is the name of the game," declared AMCNO President Paul C. Janicki, MD, in his introductory remarks at the start of the day's dynamic agenda of topics relative to medicine — the 2007 Academy of Medicine of Cleveland and Northern Ohio's annual CME seminar, "Tracking Trends Impacting the Practice of Medicine."

The concept of change was indeed the subtext of the March 9th all-day program offering varied curricula of interest to physicians and their staff personnel. Ranging from existing payment policy and available healthcare software, for instance,

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President Paul C. Janicki, MD, delivers introductory remarks at the AMCNO annual CME seminar.

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AMCNO
6100 Oak Tree Blvd.
Ste. 440
Cleveland, OH 44131-0999

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AMCNO Applauds Introduction of SB 59 – Calling for the Mandatory Arbitration of Medical Negligence Claims *(Continued from page 1)*

that the process could be overly long (see sidebar on page 3).

Responding to committee questions, Sen. Coughlin said he didn't believe the arbitration process would add additional time and cost for those seeking to pursue claims. The proposed timeline, he said, generally mirrors pre-trial proceedings and gives both sides an early chance to determine if the claim has merit. When asked about the rationale for selecting the northeast Ohio counties for the pilot, Sen. Coughlin said most were identified because of the higher malpractice rates their practitioners face, however, the Senator did inform the committee that there were amendments under consideration that may address specifically how the counties would be chosen for the pilot.

On March 28th, the AMCNO sent a panel to Columbus to provide proponent testimony to the Senate Insurance Commerce and Labor Committee. The panel consisted of Drs. John Bastulli and John Clough and Mr. Michael Jordan, an attorney versed in dispute resolution practicing in Cleveland at the law firm of Walter and Haverfield.

Dr. John Bastulli, vice president of legislative affairs of the AMCNO began his testimony to the Senate committee by pointing to the recent Closed Claims Data report prepared by the Ohio Department of Insurance (ODI), which appears to provide a "glimmer of hope" that tort reform works. The report indicates indemnity payment and loss costs are lower since SB 281 became effective. The report also shows that since the inception of SB 281, which included a cap on non-economic damages, overall payments are trending downward — with average payments to claimants down from $270,000 to $170,000 and average allocated loss adjustment expenses down from $25,000 to $9,000 per claim.

Dr. Bastulli informed the Senate committee the report's "bad news" came from the statewide comparison showing more than half the claims (2,561) being filed in Northeast Ohio. In fact, one-half of the costs for both indemnity and expenses are generated from claims in Northeastern Ohio. The report shows physicians in Northeastern Ohio paying the highest average indemnity — about $303,000 per claimant. In addition, physicians in Northeastern Ohio are still paying the highest rates in the state — in some instances as much as two to three times higher than other physicians in the same specialties across Ohio. The report clearly shows that while most medical malpractice claims are closed with no payments to claimants, almost ALL claims generated expenses for investigation and defense. The ODI report also showed that nearly five percent of the claims were adjudicated through some form of alternative dispute resolution (ADR) process. Dr. Bastulli informed the Senate Committee that the AMCNO is a proponent and committed advocate for the use of ADR as a viable option to the court system. Our members support ADR incident to their unease and dissatisfaction with the current court system in which they are judged by lay persons on juries guided mainly by high priced competing medical experts, who may have limited knowledge of their individual practices or the standard of care within our community.

The proposed arbitration process outlined in SB 59 could provide such an alternative. The arbitration process allows parties to gauge how others view the case and assist in reaching a decision based upon the merits of the case. Arbitration has many positive aspects, such as relieving the backlog of cases pending in courts, cost-effectiveness, flexibility entering into the process, and decreasing the time it would take to resolve a matter. It has been shown to cost less, result in more predictable awards, and the process is much less intimidating and emotional.

Dr. Bastulli stated that arbitrators would not decide damages. The three-member panel instead would determine if a defendant deviated from the applicable standard of care in a particular incident, and whether the deviation was the main cause of a claimant's injuries. Parties still could go to trial if they reject a panel's evaluation. He then noted similar legislation cleared the Ohio Senate last session but not the House. Unlike the previous version, Dr. Bastulli said the current proposal would allow witness testimony and other evidence presented at an arbitration hearing to be admitted in any subsequent court proceeding. However, a panel's opinion would not be admissible, and panel members could not be called as witnesses in a jury trial.

Dr. Bastulli further noted the current court system does not deter medical negligence and the notion that public disclosure would reduce litigation is largely unproven and somewhat implausible. There is more convincing evidence that tort law influences the behavior of healthcare providers namely by encouraging the practice of defensive medicine which adds cost and risk to the system. The harsh reality is that greater publicity about mistakes, disclosure to patients and access to report information probably would increase litigation, not decrease it. Defending a medical liability claim is expensive and time-consuming, lasting an average of five years to resolve. The AMCNO believes that the arbitration detailed in SB 59 provides an equitable alternative to the current court system and is fair to society as a whole. It will promote efficiency within the system and provide an opportunity to improve the quality of healthcare services that our patients receive.

Dr. John Clough voiced support for the measure on behalf of the AMCNO and the Cleveland Clinic. He said although malpractice insurance premiums are not increasing as rapidly as they did a couple years ago, characterization of this phenomenon as a "stabilization of the market" and assuming that the problem is solved is an exaggeration. It does not recognize that the insurance premium crisis can only be abated by actual significant decreases in premiums, and this has not occurred. Dr. Clough stated it is unlikely liberal damage caps and other systemic measures passed previously will result in reductions in loss costs sufficient to produce the needed premium reductions, and certainly not until they are tested for constitutionality before the Supreme Court, which also has not yet happened. He informed the committee members that physicians and hospitals need something that will work quickly by immediately reducing the loss costs associated with malpractice litigation.

Dr. Clough stated that SB 59 would be an effective way to make this happen, leading to a "win-win situation." This is because SB 59 requires that a balanced panel, selected by both sides of a case, consider the evidence in any malpractice suit and render a decision in a much less expensive setting than open court. If both parties

accept the decision, that's the end of the arbitration process. The majority of cases probably won't get past this stage, since in approximately 80% of cases that currently go to court no negligence is found. In the few cases in which the parties don't agree, they can then go to court and present their evidence in a trial, including the evidence presented to the arbitration panel and the panel's decision. This protects everybody's rights, he said, and will take cost out of the system without interfering with anyone's right to a trial if they still want one.

Attorney Michael Jordan, who represents physicians in dispute resolution, said that by structuring a mandatory arbitration process that focuses on liability, meritorious cases of any size are likely to be pursued and resolved. "By contrast, frivolous claims are less likely to be pursued," Mr. Jordan said. He said the bifurcated nature of the process proposed in the bill allows for a likely resolution of the case "based upon what should be a less expensive arbitration hearing." For those cases that proceed to a jury trial, it will not be necessary for parties to duplicate their effort, as evidence considered by the arbitrators will be admissible in subsequent court proceedings. SB 59 is legislation designed to preserve the rights of litigants while promoting a more hospitable medical malpractice environment in the State of Ohio.

Many of the questions posed by the Committee revolved around the legal proceedings and focused on the statutes outlined in the bill. Mr. Jordan aptly responded to the various legal questions while Drs. Clough and Bastulli fielded queries regarding medical liability rates.

Overall, the proponent testimony was well received with several committee members indicating they would be willing to work on the bill with the parties involved.

Editor's Note: The AMCNO is working with Sen. Coughlin's office on amendments to the bill — one in particular to allow the Ohio Department of Insurance to choose the counties that will be involved in the pilot project based upon population and medical liability rates as well as an amendment to include employees and agents of health care professionals in the legislation. Additional hearings are planned on SB 59 in the future — for further information on the legislation, please contact Elayne R. Biddlestone at the AMCNO offices at (216) 520-1000, ext. 100. ■

SB 59 – Mandatory Arbitration Overview

SB 59 directs the head of the Ohio Department of Insurance in collaboration with the Ohio Supreme Court, to establish a pilot program mandating arbitration for medical negligence claims in seven counties, Huron, Erie, Lorain, Cuyahoga, Summit, Geauga and Lake. The goal of the legislation is to utilize Alternative Dispute Resolution ("ADR") to obtain a more efficient and fair resolution of claims. The pilot program will contain the following provisions:

1) Applies to claims involving health care professionals (i.e. a physician authorized to practice medicine, osteopathic medicine, or podiatric medicine, and surgery) hospitals and health care facilities.

2) Requires arbitration before the filing of a lawsuit.

3) Amends the one year statute of limitations to allow for a suit to be filed within sixty days of the conclusion of the arbitration.

4) Incorporates the requirement of an Affidavit of Merit as provided for in Ohio Civil Rule 10.

5) Provides that the three person arbitration panel shall be comprised of one medical expert chosen by the plaintiff, one medical expert chosen by the defendant and a chairperson chosen by the two experts who has expertise as an arbitrator.

6) The American Health Lawyers Association (AHLA) shall appoint any panel member or chairperson should the parties be unable to reach agreement on the appointment.

7) The panel shall only rule on liability. It will not rule on damages. This is called a bifurcated process and is fairly common in our court system. If there is a finding of liability, then the claim shall go to a jury for damages, if it is not settled in the interim period between the ruling and a jury damage process.

8) A party may reject the ruling of the arbitration panel and proceed to the court system. If the rejecting party is then also unsuccessful on the liability issue at trial, that party will be responsible for the costs and attorney fees of the opposing party.

9) Evidence obtained during the Arbitration may be used in a court action.

10) The Arbitration ruling is admissible in a court action but not any accompanying opinions.

11) The Ohio Rules of Evidence apply to the Arbitration. The Legislation gives discretion to the Ohio Supreme Court to pass Rules regarding the applicability of the Ohio Civil Rules.

12) If the panel deems the claim frivolous, a bond must be posted in order to proceed to the court system.

LEGISLATIVE REPORT

AMCNO legislative priorities
On the legislative front, the Academy of Medicine of Cleveland & Northern Ohio continues to be the driving force behind mandatory Alternative Dispute Resolution (ADR) in Ohio. The Bill is SB 59 and Dr. John Clough, Dr. John Bastulli and Attorney Michael Jordan were all in Columbus in March to provide proponent testimony (see cover story). Through the leadership of Sen. Kevin Coughlin, this Bill has an excellent chance of passing the Ohio Senate this spring.

The Academy has also taken on an additional legislative priority. A number of months ago, the Academy began discussions with the Center for Health Affairs about the recent challenges to the non-profit status of hospitals in northeastern Ohio. At the AMCNO board meeting in March 2007, Mr. Bill Ryan, President and CEO of the Center for Health Affairs, presented an outline of legislation that could bring clarity and certainty to these non-profit hospitals. The proposed legislation would remedy inconsistent application of current policy arising from vague and contradictory statutes and regulations. It would also respond to public concern about transparency and accountability within tax-exempt health care systems.

The Legislation is styled as the Ohio Community Benefit Hospital Act of 2007 and would provide for:
- A transparent and predictable system of charity care at tax-exempt hospitals.
- A transparent and consistent mechanism for reporting community benefit delivered in return for tax exemption.
- A statutory definition of community benefit for determining tax-exempt status.
- A consistent policy regarding property owned and used in the delivery of medically necessary services by tax-exempt hospitals.

Hospitals would establish and communicate to the community their specific charity care policies, including scope of services and pricing. Community benefit standards, for purposes of determining tax status, would be defined in law and to maintain a tax-exempt status, hospitals must meet an annually determined threshold of community benefit. Hospitals would report net community benefit to the community on an annual basis.

At the March AMCNO board of directors meeting a motion was made approving that the AMCNO work with the Center for Health Affairs on the Ohio Community Benefit Hospital Act of 2007 concept. Therefore, the Academy is now working with the Center for Health Affairs to turn this outline into legislation.

New House Committee formed to discuss health care related issues
For the 127th General Assembly, the Ohio House has formed a new Committee chaired by Rep. Jim Raussen (R-Cincinnati) deemed the Healthcare Access and Affordability Committee. Some of Rep. Raussen's stated objectives are to:
a) Evaluate current healthcare trends in the United States; b) Look at ways other states are addressing the issues of healthcare reform; c) Create reforms that are achievable within Ohio's current fiscal climate that focus on access, transparency, cost savings, improving efficiency, and increasing healthy decisions by all Ohioans.

It is expected that this Committee will have hearings on a single payer system of health care. Chairman Raussen is very concerned about the issues of the uninsured, underinsured and the fact that health care costs continue to rise at three times the rate of inflation. The AMCNO will be sure to participate in this debate

AMCNO legislative committee activities
The AMCNO legislative committee met in early April and reviewed the current list of health care-related bills under review in both the Ohio House and Senate. Listed below are several of these bills and the AMCNO legislative committee actions.
- House Bill 73/Senate Bill 58 pertain to the authority of pharmacists to administer immunizations in certain limited circumstances, and adds immunizations for meningitis, diphtheria, and pertussis to the immunizations pharmacists are permitted to administer to adults. It also lowers the minimum age to 14 (from 18) for individuals to receive influenza immunizations from pharmacists. The bill also permits pharmacists to administer epinephrine and diphenhydramine to individuals in emergency situations resulting from adverse reactions to the immunizations administered by a pharmacist or pharmacy intern. *The AMCNO legislative committee plans to contact the sponsor of the bill to request an amendment that would require a pharmacist to assure that a patient seeks appropriate physician referral and care in the event the patient has an adverse reaction to an immunization.*
- House Bill 81 requiring female students beginning in sixth grade be immunized against human papillomavirus (HPV). *The AMCNO legislative committee plans to contact the sponsor of this legislation to get clarification on the parental consent issue.*
- House Bill 122 allows a patient or the patient's representative to obtain one copy of their medical records free of charge. *The AMCNO opposes this bill — there is already clear law relative to this issue and the bill is not clear regarding the entity that may obtain the record for free.*
- House Bill 125/Senate Bill 127 both are identical key Bills that would establish uniform contract provisions between health care providers and third-party payers, to establish standardized credentialing, and to require third-party payers to provide specified information to physicians. *The AMCNO has a long history of working productively and diligently on behalf of our members on insurance-related matters and we support this legislation. This Bill could be very important to our members and we will be actively engaged in the debate and discussion on this legislation.*
- Senate Bill 65 that prohibits hospitals from mandating nurses to work overtime. *The AMCNO opposes this legislation in the belief that it will add to hospital costs and overhead as well as create additional problems with nursing shortages.*
- Senate Bill 104 – Benefit agreements — this bill would require insurers and other third-party payers to accept and honor assignment-of-benefit agreements entered into between plan beneficiaries and treating physicians. *Hospitals already have laws on the books regarding this issue but not physicians; therefore, the AMCNO is supporting this legislation and will write to the sponsor voicing our strong support.*

LEGISLATIVE REPORT

AMCNO Legislative committee meets with Attorney General Marc Dann

At the April legislative committee meeting, the committee welcomed Attorney General Marc Dann and had an opportunity to discuss several issues with him related to healthcare and physician practices. Mr. Dann had been provided with some key topics for discussion with the committee prior to the meeting — these topics were:

- Professional liability insurance for physicians – availability and affordability
- Alternative dispute resolution options (SB 59)
- Not-for-profit/tax-exempt status and charity care issues
- Access to health care/uninsured
- Physician insurance claims/reimbursement issues

Mr. Dann began his commentary by noting that he does share physician concerns about the professional liability issue in Northern Ohio and one of the things he believes we need to consider is the fact that the legislative efforts in Ohio have been successful and the Ohio Supreme Court (OSC) is likely to uphold the laws that have been passed as constitutional. He stated that there is a test case right now at the OSC level and the issue is under debate and will be argued by the OSC and he believes it will be upheld — so that part of the problem should be addressed in the near future.

Mr. Dann indicated that one area he felt that the legislature should explore is on the side of the insurance regulation done in Ohio. There are states that have a combination of tort reform and liability limits and a more open process for determination of liability rates. He questioned whether the rates in Ohio were set by an actuarial analysis and he believes physicians should have a stake as to how the rates are determined. He is concerned that the tort reform aspect has been dealt with, but there have not been any changes relative to the insurance issue to date.

Mr. Dann further indicated that he might make the same argument about the reimbursement rates for health insurance claims. One of the most frustrating things about how these companies operate is that doctors can be and are excluded from insurance panels. He indicated that when an insurance company controls a large amount of the market and they have market power this could be an

Attorney General Marc Dann spends a moment after his presentation at the legislative committee meeting with Dr. Robert Leb and Dr. John Bastulli.

issue since insurers are exempt from state and federal antitrust law and he questioned where the discussion might go regarding this issue. Dr. Bastulli noted that the AMCNO has always been a supporter of giving physicians the ability to jointly negotiate with the carriers that have 15% or more of the market share and perhaps based upon these comments we should consider starting the debate at the legislature again. Attorney General Dann stated that he has reviewed the antitrust discussions on this matter and it may be difficult to do much in this environment because of the antitrust laws.

Mr. Dann then briefly discussed his opinion relative to hospitals operating on a non-profit basis. He indicated that the economics of medicine are not operating efficiently; and he plans to try to develop some truth in pricing for hospitals and medical providers. For example, he noted that the uninsured pay the highest cost for services and pay more than an insured employee pays for the same care. He believes that there has to be change in the collection tactics and pricing to make things fairer for the uninsured. He is of the opinion that we are very close to a crisis point in this state.

Mr. Dann continued by stating that he has been frustrated regarding this issue and he is concerned that some non-profits may not be operating to the benefit of their charitable mission and the charitable mission should be well defined. Mr. Dann would encourage an effort to clarify these goals and his office is planning an aggressive effort to identify the issues in the near future. He stated that he is concerned that some of the functions of non-profit hospitals are not in the public interest and may need to be taxed differently. These charitable missions have to be looked at and he wants to be sure that non-profit hospitals serve the needs of the community. Dr. Bastulli interjected that the AMCNO plans to continue working with our partners on this issue and we would be interested in continuing to discuss this matter.

On the issue of access to the uninsured, Mr. Dann noted that the state auditors have recently found that we have about $700 million in Medicaid fraud in Ohio and that is money we could put back into expanding Medicaid in Ohio. He stated that most physicians play by the rules but if there are dishonest providers practicing in the state they should be put out of business.

Regarding arbitration for medical liability claims, Mr. Dann stated that he would express caution about whether or not it adds cost to the system and one has to be careful about limiting access to the courts. He indicated that a better avenue might be to find a way to do something about the bad actor lawyers in order to hold them accountable.

Editor's Note: The AMCNO plans to follow up with the Attorney General on some of these key points. In addition, members should note that the 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. ■

The members of the legislative committee and invited guests listen to Attorney General Marc Dann present his views on healthcare-related topics.

AMCNO Meets ODI Director Hudson, Forges Strategies for Physician Input

In early March, the AMCNO's Vice President of Legislative Affairs, Dr. John A. Bastulli and the executive vice president and CEO met with the new Director of the Ohio Department of Insurance (ODI), Ms. Mary Jo Hudson. Ms. Hudson officially took office as the 46th Director of ODI on January 8, 2007. Appointed by Gov. Ted Strickland to join his cabinet on December 21, 2006, Hudson is familiar with the Ohio insurance industry and regulatory role of the Department. She has practiced law for eighteen years, focusing on insurance regulation and liquidation law. From 1989 to 1995, Director Hudson worked as an attorney with ODI and as General Council for the Office of the Ohio Insurance Liquidator.

Access to Care

During the meeting, Ms. Hudson indicated that ODI is looking closely at access to health care and the uninsured issue in Ohio — with an eye toward trying to find out the root cause for the problem as well as providing a clear definition as to who are the "uninsured" in Ohio. In response to a question from the AMCNO representatives as to how the ODI views the role of physicians on this issue, Ms. Hudson stated that she sees this matter as a "multi-agency" issue for the state government — she believes that everyone will have to shift what they are doing to make access work. She further stated that when ODI reviews a proposal they want to make sure stakeholders are at the table — including physicians. She indicated that physicians know the patient/consumer perspective plus the key vendor perspective since they treat the patients. She is of the opinion that physicians have a business to run and if you provide the service you should be paid for the service — and since physicians have to pay for supplies and overhead while treating the patients — they should have a key role in this discussion.

Insurance regulations

Ms. Hudson further discussed the issue of insurance market regulation and market conduct — such as prompt pay issues. Over the next six months she plans to address this issue and to help achieve that goal she has placed new leadership in the market regulation division. She would like to provide for a much simpler point of entry on the ODI Web site for providers — so that if someone has a prompt pay or a regulatory issue they would like to report this can be done easily. The AMCNO representatives indicated that our organization would be willing to work with ODI on this issue since it is of importance to our members.

Dr. Bastulli provided Director Hudson with a brief history of the AMCNO and our many legislative initiatives, including work on tort reform laws, Supreme Court candidate races and the medical liability crisis dating back to 1999. He then provided the Director with an overview of the alternative dispute resolution (ADR) concept outlined in SB 88 in the last General Assembly that is once again up for debate in this General Assembly as Senate Bill 59. Dr. Bastulli informed Director Hudson that the AMCNO representatives and lobbyists would be very involved in the debate on this legislation. Director Hudson was provided with a copy of SB 59 and she was shown where in the bill ODI and the Ohio Supreme Court would work to set up the pilot program in Ohio and oversee the concept with the intent that ODI would provide reports to the Governor and the legislature in a certain time frame. Dr. Bastulli further explained the arbitration process and the panel make-up contained in the bill.

Director Hudson noted that she used to work on the business side in her law practice and she could understand how time and money could be saved in an alternative dispute process vs. going to court. She expressed an interest in the concept contained in SB 59 and indicated that she would have her staff evaluate the legislation.

Charity Care

Dr. Bastulli further discussed the issue related to access to care with Director Hudson. He informed her that the AMCNO was working with area hospitals on how to address this issue in our community. We plan to work with other organizations to determine how hospitals provide community benefit and charity care. He further stated that many people have underestimated the cost to provide care to the uninsured and the last thing we would want would be a provider tax of some kind considered in Ohio to cover the uninsured.

Director Hudson indicated that the ODI is currently looking at the Medicaid programs and the dollars that have been left on the table in that program in Ohio. She indicated that physicians have been asked to take reduced payments — she understands that they do not receive the full amount for care — and she further stated that to add on a tax understandably would be difficult. What ODI has been doing is to take a look at what has been done or proposed in other states — such as Massachusetts, California etc., and Director Hudson has set up a task force at ODI and they are currently reviewing the issue. She further stated that she plans to ask for additional money in the budget for spending authority to conduct actuarial studies to see what concept might work in Ohio. Director Hudson also noted that she has hired a staff person to set up and coordinate provider and community outreach to assist with obtaining broad based input.

Editor's note: The AMCNO leadership has been in contact with Director Hudson since this meeting offering to send representatives to task force or other meetings of the ODI to provide input on the physician viewpoint from Northern Ohio. The AMCNO will continue to pursue these matters with the Director in the future. ■

The Future is Now: AMCNO Annual Seminar Tracks Trends in Medicines

(Continued from page 1)

to indications of future implementation of quality reporting and its link with reimbursement, to name a few. Local and national speakers enlightened the group on regulatory initiatives that will have an effect on the practice of medicine both today, and in the future. Dr. Janicki also framed the discussion at the onset of this year's AMCNO conference by stating, "Although we're all interested in national trends, the delivery of health care is local." The goals of all the presenters were to distill the big ideas into workable, tangible information for Northern Ohio practicing physicians in attendance.

The AMCNO organized this event in the hope of adding voices to the debates, here and across the country, on what the future of healthcare in the United States will look like, who will be involved, and how improvements in technology will drastically affect them all. Dr. Janicki reminded those gathered that even in assimilating all the information about to be disclosed, "The doctor-patient relationship is at the core of all that is good in medicine. It is a unique relationship and is sacred," he said. "Only a physician can take all the information that emanates from the patient, whether it comes from a clinical history, physician examination, lab and imaging tests, or from computer data — and give it meaning. Meaning that will make a lasting difference."

Consumer Driven Health Care: The Changing Role of the Patient and the Impact on Physicians

Presenting a synopsis of his study findings, health economist Devon M. Herrick, Ph.D., was first on the day's schedule, a senior fellow at the National Center for Policy Analysis, who also serves as chair of the Health Economics Roundtable of the National Association for Business Economics (NABE). Dr. Herrick began with a brief historical look at payment structures in health care, noting that only in the last half-century or so has medicine been transformed from a payment-in-kind or fee-for-service paradigm to today's inextricable tying of health care to health insurance. He critically examined this change, and his understanding of the negative outcrops of a third-party payment structure that now dominates the landscape of medicine.

Health care inflation coupled with the shortcomings of government-run Medicare and Medicaid, he offered, have created a poorly implemented delivery and payment system, that only a complete re-thinking of the way we pay for medical services could begin to address the disparities. Among his suggestions were Health Savings Accounts, wherein the patient, he claimed, (or consumer of health care) being more in control of spending would become more discriminating in agreeing to services rendered, especially expensive diagnostic

Devon Herrick, Ph.D., fields questions from a resident regarding HSAs and their feasibility for patients of all income levels.

procedures if deemed unnecessary, etc. He utilized the compelling example of the striking rise in cosmetic surgical procedures and the price decreases in such over the last decade. Here, he pointed out, a medical service generally not covered by an insurance company or other third-party payor model but from patients' out-of-pocket resources, both patients and providers were influenced by pure market forces resulting in competition and lower prices over time.

Dr. Herrick used the purchasing trends of prescription medications to bolster his idea that consumers, given the means, will seek out the best product/service for the best price and the supply side of the equation will follow suit in becoming and remaining viable and competitive in the marketplace. Online pharmacies for example, have exploded in popularity in recent years, and for good reason — they offer bargains and bulk purchasing options that attract price-conscious consumers. He argued repeatedly that patients of the future must make more informed, educated and low cost decisions with regard to their medical care as the population ages, moves into retirement and gains greater autonomy over their medical care. He believed "patients will spend less if they have a stake in the decision on how their health care dollars are spent," and that "Quality will improve when providers look to patients for payment rather than third parties." Dr. Herrick also acknowledged that while HSAs in some cases will ease debt collection, others will have difficulties when HSAs are under-funded, causing doctors to rely on the patient's word for payment. And certainly there is the "risk assessment" in the long term that given the choice, people may spend money meant for medical care on other expenses, as there are no tax penalties for withdrawing funds.

With respect to physician providers of health care, he suggested that the best way to adapt to impending changes was to look for creative ways to collaborate in the delivery of care as it develops and reinvents itself in the near and distant future. One example he offered was the rising incidence of retail medical clinics in the "big box" stores, and how doctors could insert their concerns on this matter by addressing how they could remain a vital link in the continuity of care for patients who utilize these "convenience" services. He suggested the same in considering the pharmaceutical industry, and a consumer's increasing power to search out less expensive alternative medications, and the like, as well as the concept of global, or travel medicine, in which patients have surgeries performed in other countries to save money. Doctors can remain abreast of such trends, and the effect they'll have on their patients and practice, if they acclimate to this ever-changing marketplace, he said. Doctors should consider collaborating with the alternative providers of care and counsel, look into outsourcing opportunities for disease management, and foster new discussions with their patients regarding all such changes in the new "corporate practice of medicine," Herrick said. The corporate practice doctrine was said to be in greater use as many states are relaxing their regulations governing it. "This model is here to stay," he concluded in his presentation on the many economic drivers behind modern health care reform.

During a spirited question-and-answer period that followed, several physicians countered Dr. Herrick's hypotheses, arguing his picture of the future of healthcare did not consider the extremely important factor of the medical home, the fact that *seeing* a patient in the primary care setting was paramount to care, that it was utterly unreasonable for HSAs and the like to be applicable to low and middle income patients, and that none of these measures were a guarantor that people would make better decisions, just because the money was in their control (or not). Another criticized the idea that shopping around for cheaper drugs in fact likely created more medical errors in the aggregate and that the legal ramifications of such notions as Internet/email consults simply haven't been legislated or standardized yet to be of use to either doctors or their patients. Others expressed concern that patients would not seek necessary care or treatments due to the out-of-pocket costs associated with HSAs.

Dr. Herrick responded that as an economist who looked at greater trends, he maintained that his study findings would bear out — give people choices and they will get more involved with their care and health, creating the "consumer sovereignty" his studies envision.

The Institute of Medicine (IOM) Report on Pay-for-Performance in Medicare: Overview and Current Status

The Academy of Medicine of Cleveland & Northern Ohio was pleased to welcome Alan R. Nelson, MD, MACP, as seminar presenter that day, with his informed commentary on the political background and reasoning behind changes and policy initiatives of the Medicare system. Dr. Nelson was appointed to the Medicare Payment Advisory Commission serving on it from 2000 to 2006, and more recently, he represented the American College of Physicians on the Institute of Medicine (IOM) report to Congress, outlining a total of ten key recommendations for overhauling the "broken"

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Medicare system and highlighting the idea that "fundamental change requires a commitment by all Medicare providers to deliver high quality care efficiently." Dr. Nelson is also a past president of the American Medical Association.

Dr. Nelson discussed many of the chief messages of the work done by the IOM, stating that Pay-for-Performance (P4P) has never been regarded as the sole "magic bullet" for mending the failing Medicare system, but does offer "significant promise" if such programs are built upon previous strategies for improvement. Initially, Dr. Nelson said, widespread P4P should be introduced slowly, with careful consideration given to unintended consequences and continuing evaluation of their impact. He went on to enumerate committee recommendations which included some new, potentially controversial suggestions.

Alan Nelson, MD, dissects the IOM report on quality for those gathered during his presentation.

Among these were:

- The Secretary of Health and Human Services (HHS) should implement P4P in a phased approach, fostering tangible, systemwide quality improvements;
- Congress should use existing Medicare funds in the beginning, *then* create provider-specific pools from a reduction in the base Medicare payments for each class of provider;
- Because of the unique challenges to physicians due to the determination of the SGR, investment dollars may be necessary to create adequate resources to effect the needed change;
- Congress should give HHS the authority to aggregate pools for different care settings into one, allowing for shared accountability and increased coordinated care;
- The P4P program should reward both those physicians who already achieve high quality/performance and those who improve significantly in their measurable performance;
- Reporting should be public, fostering transparency that is meaningful and useful to consumers;
- Institutional providers should begin reporting immediately, while physicians' requirements should be voluntary, and be sensitive to the operational challenges faced by those in small practice settings — then after three years the HHS should determine whether to mandate all provider participation;
- HHS should assist providers in implementing electronic health data transfer systems, making collection and reporting data consistent for all performance measures; and finally,
- Implement an ongoing monitoring system, to assess early problems and identify best practices to share with others throughout the country as P4P matures and develops.

Dr. Nelson transitioned into what is believed to be the consensus view among physicians of these program initiatives, that they be fair and evidence-based, that their administrative burden and cost of the necessary information technology be recognized, or even recompensated, that practice setting and geographic location make huge differences and that many specialties have no policy framework from which to draw, so that efficiency measures may not be adequately risk-adjusted. He acknowledged these concerns, noting that the "policy wonks" in Washington are acutely aware of how primary care in this country is "under stress" — hence the importance of physicians like himself serving on advisory committees and assuring the unique challenges to solo practitioners, for example, are considered.

Dr. Nelson also indicated that proponents of P4P include large purchasers who are insisting on better value, policymakers with concerns of cost and geographic variations and certainly beneficiaries themselves, many with extreme out-of-pocket expenses. However, he said, CMS may do well to carry out demonstration projects first as the large purchasers of care can have "short attention spans" and interest in these provider-centered programs may be waning, with more of the onus put on the patient. "Medicare's position should be until measures can be applied that accurately differentiate waste from uncompensated care, the country should proceed with caution. And remember, the bond between the physician and the patient goes beyond this concept — that bond started way before P4P and it still has an impact. We should not lose sight of that."

CMS Quality Programs and Initiatives Related to HIT and P4P

Ohio KePRO's Chief Medical Officer, Alice Stollenwerk Petrulis, MD and Ronald Savrin, MD, the Quality Improvement Organization's Medical Director (and AMCNO Past-President) delivered presentations on payment incentive programs — their past, present and potential future.

Dr. Petrulis began by detailing some of the motivating impetus behind performance-based studies in consideration of the impact on patient care. Her experience both with the Centers for Medicare & Medicaid Services' (CMS) Doctor's Office Quality-Information Technology (DOQ-IT) program and her service on a National Quality Forum (NQF) committee to standardize measures informed a pointed look at the directives of government on the practice of medicine today.

Ohio KePRO is charged with ensuring quality and cost-savings for the state's 1.8 million Medicare beneficiaries. And chief among their current focus is the issue of public reporting/transparency of care quality. Dr. Petrulis maintained that with preventable deaths just under 100,000, standardizing is essential to higher quality delivery and follow-through of patient care. Such must be coupled, of course, with information technology that not only enables quality but itself works to streamline and transform it.

While the DOQ-IT was admittedly a feasibility study, it provides a greater understanding of challenges in the physician office setting. Her organization was to recruit 5% of small-to-medium practices in the state for participation, or about 140, to consult on selection, installation, transformation and reporting of EHRs. From her work with the NQF, Dr. Petrulis shared insights into the importance of consensus standards, for consumers in light of public reporting, and care providers for quality achievement. Likewise, she acknowledged that existing measures and the development process for newer, specialty measures have not been perfect, but collaborations are ongoing in the quest for those to come — including the anticipated 2009 buzz phrase — Pay-for-Efficiency. She said CMS' Chief Medical Officer Barry Straube recently confirmed that the following program timelines are in effect: Pay for Reporting, this year, Pay-for-Performance in 2008 and Pay for Efficiency slated for 2009.

It was here Dr. Savrin continued the presentation with an in-depth examination of the phases of these programs and their incentives to the practicing physician. The Physicians Quality Reporting Initiative (PQRI), he explained, is effectively replacing the Physician Voluntary Reporting Program (PVRP), with a start date of July 1, 2007. He distinguished between process and outcome measures, even down to the submission minutia of G-coding versus CPTII entries, and offered a cursory look at new measures by newly added specialties including ophthalmology, hematology-oncology and more.

Dr. Savrin candidly addressed his fellow physicians and offered concrete clinical advice on achieving the goals as laid out by CMS, (and by which most other insurers like UHC and Aetna follow-suit) in an effort to encourage compliance. He counseled that incorporating reporting into the office workflow would make it less conspicuous, yes, but also ease its success and increase its value for the practitioner and the payor as well. Dr. Savrin encapsulated the Tax Relief and Health Care Act of 2006, under which caps on bonus payments will be based on the number of measures reported — and stressed the importance of obtaining one's NPI, the necessary identifier beginning May 23 of this year, that will also determine eligibility for PQRI bonus payments. Key points to consider:

- Any bonus payments under the PQRI will be tracked and paid by the individual physicians'

Physicians, practice managers and others listened during the luncheon presentation to Dr. Brian Keaton's NEORHIO update.

NPI, but any 1.5% bonuses will still come in a lump-sum check to the group practice based on its tax identification number (TIN).
- CMS has asserted that the projected $300 million in bonus payments will not rob future fee schedule updates for 2007.
- Quality codes must be reported on the same claim(s) as the payment (ICD-9 and service) codes for these measures (see sidebar).
- To be considered for 2007 quality bonus payments, all claims with dates of service from July 1 to Dec. 31 must be submitted to the National Claims History file by Feb. 29, 2008.
- Specifications on the final 2007 list of 74 quality measures, including the ICD-9 and G/CPT-II codes that coincide with them, can be reviewed at www.cms.hhs.gov/PQRI

For more updated information on PQRI, see article on page 15.

Status of the Northeastern Ohio Regional Health Information Organization (NEORHIO) and State Initiatives

Brian Keaton, MD, provided a thorough report on where the NEORHIO project is to date, and when physicians specifically will begin to participate in meaningful ways. On this, the AMCNO has since the RHIOs' inception supported the rationale and goals of the organization, with the ongoing caveat that doctors, as individuals in this perceived electronic community, have access and input into its development and success. Dr. Keaton explained that this region possessed particular nuances with regard to the health care systems in coexistence here, necessitating an initial focus on their concerns. However, moving forward, he envisions collaboration among all stakeholders, hospitals, physician offices, major insurers as well as their integration into the RHIOs of surrounding, even national networks. A dynamic slide presentation illustrated the virtues of health information exchange, not the least of which included data mining for state health departments, national disease surveillance efforts and an easily accessible boon to medical research. On the question of funding, Dr. Keaton replied that creating and maintaining an entity such as this will require revenue from member fees phased into transaction fees as interconnectivity increases and improves. Individual practices may average $1500 a year, while hospitals and groups of 10 or more physicians participate for $10,000 and insurers at $50,000 per year.

Editor's Note: The NEORHIO initiative has been covered in-depth in previous issues of this magazine. The AMCNO Board of Directors recently approved the NEORHIO business plan, with the stipulation that physicians be incorporated in policy discussions and developments at every phase of the project. The AMCNO will continue to advocate for minimizing the financial burdens of IT adoption to practices, support interoperability standards and any legislation that may provide incentives for doctors to acquire health information. The AMCNO will continue to work with the NEORHIO assuring physicians are involved at critical levels.

Bridges to Excellence (BTE) — A Successful Employer Initiative

Edison Machado, MD, describes the Bridges to Excellence program and its impact on physician behavior."

Edison Machado, MD, National Accounts Manager for Bridges to Excellence (BTE), a program focused on rewarding physicians for better quality care, delivered his presentation on the implementation of BTE pilot programs across the country and what the participating organizations and physicians have learned to date. As a not-for-profit company, BTE designs programs for plans and employers, offering monetary incentives to physicians who agree to "self-assess" their performance in efforts to improve quality. The overriding philosophy is focused on outcomes, lowering costs and increasing transparency/quality for the consumer, he said. In Ohio, BTE is in full swing in Cincinnati, and moving into the Akron-Canton area soon, specifically targeting diabetes patients' care.

BTE lends an analytical eye toward the supply and demand elements of the national healthcare arena, helping companies manage and encourage healthier living and disease management within, then rewarding providers of care for high-efficiency as defined by the particular performance program. BTE takes its cue from programs developed by the National Committee for Quality Assurance (NCQF) and is funded by the Robert Wood Johnson Foundation. Initially generalized for the primary care setting, with programs entitled Physician Office Link, then Diabetes Care Link and Cardiac Care Link, BTE anticipates expansion in the next few years to include cardiac care, cancer care and more.

Dr. Machado's essential message to the audience was that incentives have proven thus far to be positively received by doctors — especially when measures are standardized and consistent across care settings. Dr. Machado then articulated what BTE achieved, and learned in the pilot phase (see sidebar).

He also said BTE has found that employers seeking cost savings have met with success when they banded together in a certain market in attempts to 'impact physician behavior." Yet he acknowledged that while money may be a catalyst for some, "It is the professionalism of the practice of medicine that also drives the (program's) success." Dr. Machado then shared case-study data from an Albany, NY, pilot which seemed to support BTE's results-oriented mission. Interesting about this was the sharp rise in health IT compliance among practices in the program, ahead of schedule, as he said, and their launch of self-reporting regulations within the practice to increase efficiency. Dr. Machado indicated that

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What BTE Proved in Our Pilot Stage

- Incentives work and can lead to practice reengineering, but practices need help to reengineer.
- Better quality can cost less, but you need to focus on the right measures.
- Self-assessment of performance leads to focused quality improvement, but it's resource-intensive to pull charts.
- Employers banding together can create enough critical mass to impact physician behavior, but you need the plans to really make it work.

Recognition is granted to eligible physicians and is accomplished via a composite score. The performance assessment process is approved by the NCQA, experienced in this oversight role.

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encouraging self-assessment itself resulted in practices making needed changes to their business, and a general streamlining of procedures with care-giving.

In the end Dr. Machado promoted the concept of BTE, which as he described, allowed doctors some autonomy in the what, how, when and why of performance measures, in collaboration with large purchasers. In sum, he described such as a "Win-Win" for providers, plans and even society with costs lowered, significantly improved outcomes for patients, lower expenses those paying out-of-pocket and a step toward transforming the way healthcare across the country is purchased, delivered and consumed.

For more information on the programs in Ohio, visit http://www.bridgestoexcellence.org/market_specific/Ohio/OhioMarket.htm.

Electronic Health Record (EHR) Certification — Helping Physicians Adopt Health Information Technology

CCHIT's Director Alisa Ray outlines the criteria used to certify ambulatory EHR for physicians.

As the Executive Director of the Certification Commission for Healthcare Information Technology (CCHIT), Alisa Ray directed attention in her session to the urgent need of physicians to adopt the electronic health record and claims data software the future of medicine will require. Following President Bush's 2004 declaration that the country should be fully utilizing EHRs within the following decade — or by 2015 — the Dept. of Health & Human Services created the HHS Office of the National Coordinator, from which CCHIT receives direction. Their work is of particular importance, Ms. Ray indicated, with an unimpressive 14% adoption rate of EHR for physicians nationwide. And while she acknowledged the very real barriers to EHR adoption (interoperability, cost, implementation, maintenance, etc), she also encouraged it in light of a growing market of products/vendors, and more and more acceptance by purchasers that the software is in fact viable, compatible and coming down in price, if not subsidized in some instances as well.

CCHIT — Frequently Asked Questions

Q. Are certification criteria universally applicable to all practices?

A. *CCHIT's criteria provides a broad foundation of capabilities in typical ambulatory care, and is beginning to be applied to specialty practice, and evaluating any special settings or populations.*

Q. For certified products, can I skip all pre-purchase evaluation steps I would have performed?

A. *No, but you can use CCHIT certification to narrow the field of vendors, assure basic functionality and allow you to evaluate any special or unusual needs of your practice.*

Q. Does CCHIT evaluate vendors support capability and/or financial viability?

A. *No, CCHIT tests only the product, not service aspects of the company, nor a vendor's financial status. You should perform any such due diligence yourself.*

Q. Can certification guarantee compatibility with other IT systems?

A. *Health IT Interoperability is at an early stage. While CCHIT criteria are just beginning to establish these kinds of requirements, choosing a certified product increases the likelihood your system will interoperate with others — but the problem will take years to completely solve.*

She described the myriad factors and interested parties involved, not the least of which are the patients, who themselves can gain better control over their health and well-being through accurate record keeping. CCHIT acts as a mediator among the vendor community, government, physicians and large purchasers in an attempt to find and refine products that meet the needs of all the above. CCHIT's certification criteria are redesigned each year, using input from physician testers, or jurors, in active practice, to the development process itself, discovering functions that may be lacking as products currently available are tested "in the field." Ms. Ray then discussed how CCHIT develops criteria by using a broad, consensus-based process for more than 250 Ambulatory EHR products. They review:

- Functionality — What the product can do
- Interoperability — How the product can connect to other medical information sources
- Security/Reliability — How the product protects the information stored in it

The organization then uses a rigorous yet efficient method for inspecting EHR/EMR products against these criteria. Ms. Ray suggested how CCHIT certification can help physicians. She noted that EHR is a major, long-term investment for a practice and physicians should take advantage of the work CCHIT has done in evaluating ambulatory EHR products — then combine it with their own due diligence. She noted that is would behoove physicians to "look for the CCHIT seal, be sure the products is CCHIT certified."

Visit www.cchit.org's "Information for Physicians and Providers" link to review the latest in certified products. CCHIT's criteria for Ambulatory EHR certification span three areas — functionality, interoperability and security. These criteria provide a foundation for selecting a comprehensive EHR for your practice. CCHIT has prepared a guidebook specifically for doctors to understand the existing criteria and how it applies to their practice. A downloadable .pdf of this document is also available at the aforementioned Web site.

Privacy and Legal Issues, Update on Federal Laws and Regulations Impacting HIT

The day's final presentation examined the legal aspects of the modern practice of medicine, with special attention given to still-developing regulations over the electronic and/or digital framework medical information is transmitted, stored and brought to bear in litigation.

A partner in Walter & Haverfield's Technology, Bioscience and Healthcare Group, Amy Woodhall, Esq., began the discussion with an historical review of HIPAA rules regarding patient information and privacy.

Ms. Woodhall noted that in her experience the most frequent HIPAA privacy complaints revolve around:

- Impermissible use or disclosure of PHI — Personal Health Information
- Lack of adequate safeguards to protect PHI
- Failing to provide individual with access to records
- Disclosing more PHI than minimally necessary for purpose of request

She went on to state that as far as HIPAA security is concerned, she suggests the following guiding points in consideration of remote access:

- Need business case for offsite access and downloading
- Use Password-protected files and encryption technology
- Medical disposal and deletion
- Timeout and lockdown mechanisms

- Policy and procedures to prevent:
  1) Unattended devices
  2) PHI over open networks
  3) PHI to public computers
- Employee signs statement to follow security policy and procedures as a condition of employment
- If security incident occurs, then mitigation:
  1) Manage harmful effects of improper use and disclosure
  2) Consider notifying affected parties of breach

She then shared some professional examples from her law practice involving entanglements over data security and the balancing act of protecting patient privacy while conducting routine business in the practice setting. Differentiations were made between what rules govern those in private practice versus those under the umbrella of an institution or health system's coverage. More examples from current events in the news were offered such as fraud and abuse issues and document cloning, recent large-scale security breaches at government agencies, and the problems arising from remote access and transmissions of private data over public networks. Ms. Woodhall then described Ohio law in relation to these matters, and her understanding of what's around the corner, too, as cases of regulatory compliance move through the states' courts. She said four new bills are set to be introduced in the Congress this year, on such matters as prescription medications on the Internet, considerations of exams in the doctor's office with regard to new privacy standards, telemedicine licensing, etc. Ms. Woodhall discussed the new Stark Law allowances for health IT donations from hospitals to referring physicians. She said a hospital or pharmacy may donate up to 85% of the cost of interoperable health IT that meets new rules for e-prescribing and EHR — provided physicians don't make receipt of the HIT a condition of doing business with the donor *and* that the donor not select a subsidy based directly on potential referrals.

Health Information Technology Donations from Hospitals

Stark Law allows:

- Hospital to provide referring physician a computer 'wholly dedicated' to use in connection with hospital services provided to hospital's patients
- Hospital can offer all medical staff members incidental benefits, including Internet access used off campus to access hospital MR
- Hospitals/Rx can license software & lease hardware with independent value to physicians at FMV $

Ohio KePRO presenters Dr. Ronald Savrin and Dr. Alice Petrulis (center) spend a moment with President Paul C. Janicki and President-Elect James S. Taylor, MD.

Ms. Leopard then turned the podium over to Alan Parker, Esq., who discussed electronic document retention and how these items are being used in discovery requests from both sides during litigations involving physicians.

In his career, Mr. Parker of Reminger & Reminger Co. has litigated cases involving professional liability, employment and breach of contract, medical negligence and personal injury. From this varied experience, Mr. Parker delivered a lively presentation on new rules and developments on what can be requested during the discovery portion of trial, with important distinctions made on what is and is not included in the official medical record. Parker then presented the language of the new rules governing such disclosures, in effect since Dec. 1, 2006. *"A party must, without awaiting a request, provide a copy of, or a description by category and location of, all documents and electronically stored information (ESI)."*

These changes in the federal rules of civil procedure will have profound implications on what doctors will be required to turn over in the course of a legal proceeding. Because we have an adversarial justice system, he said, the issue will come down to what was known and when it was known. When was the lab value put in the chart? The lab equipment and results placed in that equipment is now traceable, so if the lab result was done and available, if the information was in the record at the time of the patient's discharge, and the patient has an adverse event due to a lab result not being read and a diagnosis made — that could be a problem. "And what," Mr. Parker asked, "of the advent of swipe card technology and its role in this context? A patient claims a doctor never saw them and there was an adverse event — doctors will be 'swiping' in when they enter a hospital patient's room — that is all traceable now." Mr. Parker indicated that it is important for physicians to remember that Electronically Stored Information or ESI, can and will include such items as:

- Sound recordings (digital and audio/visual)
- Images
- Data (digital camera pictures, etc.) — Stored in ANY medium

He went on to describe a few cases in which items traditionally not considered available to turn over to a plaintiff's attorney or subpoenaed, are becoming more and more prevalent. Scribbled notes on message pads, interoffice emails, data and images stored in any medium such as the new realm of digital dictation are all viable sources now for pre-trial discovery and depositions. Mr. Parker did indicate that as the laws themselves are nascent, so are the repercussions for defying them. Fines have been levied in some instances, he said, mostly to larger institutions over sole offenders, but "times are changing" and the means by which doctors communicate and record data will soon enough come under scrutiny when the legal system is involved. Lawyers will be trained to ask for digital dictation data — if it is in the system — it is relevant. Doctors and hospitals *must* become diligent and create document retention policies on electronic media; what belongs in a patient's chart, what should be retained and what is not retained. Physicians in the audience queried Mr. Parker regarding amendments made to an EHR. He responded that CCHIT does not certify products that erase an original entry — what should happen is that the EHR accepts the amendment but retains both items. Mr. Parker concluded by advising medical practices to systematize all record keeping, to maintain consistent records across the practice and to develop strident inner-office policies on the storing and deleting of all medical information.

Editor's Note: The AMCNO wishes to sincerely thank all of the speakers and attendees who participated in this timely session. If an AMCNO member would like copies of the record retention information provided by Mr. Parker, please contact the AMCNO at (216) 520-1000. ■

The Crisis of the Uninsured — How Physicians Can Help

Sr. Judith Ann Karam, President & CEO of the Sisters of Charity of St. Augustine Health System and John A. Bastulli, MD, AMCNO Vice President of Legislative Affairs.

The health care community well knows that we are experiencing a crisis — a crisis in which many millions of Americans of limited economic means are unable to afford health insurance of any kind. Unfortunately, we also know this number continues to grow in part because employment, even full-time, is no guarantee of access to coverage. In fact, the majority of non-elderly uninsured across the country live in families where the head of the household is employed.

The Impact
Without a personal physician or "medical home," people without health coverage may be uninformed about basic preventative, healthy behaviors, thereby impacting the health outcomes of the community. When illness strikes, the uninsured may wait until conditions worsen and pain or other symptoms force them to seek treatment at the closest hospital emergency department.

In Ohio, the total number of uninsured residents is more than 1.3 million, including an estimated 220,000 children. 2007 marks the fifth year Cover the Uninsured Week (April 23-29) has brought together organizations and leaders across all 50 states inciting our nation's leaders to find solutions to this problem. In keeping with the goals of this initiative we offer the following suggestions on how physicians can assist in this regard.

Get Involved Through Information Sharing:
We are pleased that so many local and national organizations, including the AMCNO, have focused on addressing the policy concerns fundamental to this crisis. What you may not know is that you can help improve this situation by sharing information with your patients about available resources for care. It's not difficult — prominent placement of brochures and posters in your waiting area or treatment rooms is an easy way to get involved.

At this point, you may be thinking that few of your patients are without coverage. That's certainly possible, but chances are that they know someone who isn't covered, and they're more than willing to pass on the information you provide.

Helping Children
There are tremendous resources to assist parents in obtaining access to health care for their children. A few ways in which you can help include:

- Order free quantities of brochures on Healthy Start and other health-related programs that offer ideas and ways in which to provide health care for children. Visit the Ohio Department of Job & Family Services Web site at www.odjfs.state.oh.us/forms/ordercom.asp.

- Share information regarding federal government assistance programs. The U.S. Department of Health & Human Services provides copies of a colorful brochure written in both English and Spanish, *Protect Your Family's Health...with Confidence.* It includes answers to frequently asked questions regarding SCHIP, including eligibility, benefits and effects of immigration status. Go to www.insurekidsnow.gov or call 1-877-KIDS NOW. (877/543-7669)

- Help build awareness of the importance of providing health care to children and families. Covering Kids and Families is a national initiative of the Robert Wood Johnson Foundation to enroll more children and adults in Medicaid or SCHIP. Order free posters, bookmarks, lapel stickers and fans in English and Spanish at www.coveringkidsandfamilies.org.

Local Resources for Adults and Families
Health care services and help with the cost of prescription medications are certainly available for the uninsured in Northeast Ohio, but too many people who need assistance simply don't know where to find it.

- Obtain copies of Cuyahoga County Board of Commissioners' pamphlet *A Guide to Free & Affordable Health Care for Adults.* Recently updated, the easy-to-read format describes dozens of local programs and providers available to uninsured and underinsured adults and children. The booklet also includes RTA routes and is available to order in either English or Spanish at www.resource.cuyahogacounty.us

- Offer copies of *Worried About Getting or Paying for Your Health Care?,* a publication of UHCAN Ohio (Universal Health Care Action Network of Ohio) and the Center for Health Affairs (CHA) in Cleveland. This pamphlet details a variety of ways for Northeast Ohioans to access free or discounted medical care and financial assistance for prescription drugs. For copies, contact CHA at (216) 696-6900.

- If you have uninsured patients, suggest that they call *First Call for Help,* a free, confidential information hotline sponsored by United Way of Greater Cleveland. Callers may dial 211 (or 216/436-2000) from a land-line telephone 24 hours a day, seven days a week to learn how to access a wide range of health and human services in Cuyahoga County (such as the Academy of Medicine of Cleveland & Northern Ohio's physician referral service). For free posters, call (216) 436-2014.

Getting Involved in Public Policy
Looking to do more? For the first time in more than a decade, the debate over how to provide health care for the uninsured is integral to policy discussions in Washington. Writing letters to newspaper editors is but one way to help raise awareness of the problem. Sending e-mail missives to elected officials is an easy way to remind them why the growing numbers of uninsured children and adults must be a legislative priority. (Physician members of the AMCNO were mailed 2007-08 legislative directory listings in March, a valuable resource for contacting your representatives on issues such as this.)

As a physician, we know that you care about the fate of your patients and the health outcomes of our community. For that reason, the issues of the uninsured certainly should capture your full attention and energy. Your patients and your community are counting on you!

Editor's Note: The AMCNO's Legislative Committee tracks state and federal legislation focused on the challenges to uninsured populations. The newly formed House Healthcare Access & Affordability Committee of the 127th Ohio General Assembly is one such entity the AMCNO will closely follow and recommend recourse as appropriate with regard to their work and the impact on physician providers of care in Northern Ohio. Call (216) 520-1000 for more information and to obtain background information in the event you would be interested in writing an email letter to your representatives from www.amcnoma.org's "Eye on the Statehouse" link. ■

New Ohio Law Provides Liability Protection for Ohio Medical Reserve Corps Volunteers

Paul Bender, Ohio Medical Reserve Corps (OMRC)

We don't know when the next disaster will occur, but when it does, Ohio Medical Reserve Corps Volunteers are *ready to respond.* The landscape of emergency management has changed since terrorist attacks of September 11th and Hurricane Katrina. In these large-scale emergencies, first responders and the healthcare system quickly become overwhelmed. As a result, it was realized the only way to answer the needs of the community is to have an organized group of healthcare professional volunteers who can quickly be mobilized.

Ohio Medical Reserve Corps (OMRC) provides the structure for organized healthcare volunteers in the Buckeye State. Dr. Forrest Smith, State Epidemiologist and OMRC co-coordinator says "Ohio Medical Reserve Corps will help to ensure that if a medical crisis hits, our communities will be ready to respond and protect our citizens." Since OMRC's inception in 2003, the program has rapidly grown with more than 3,000 volunteers throughout the state. Volunteers are coordinated through local health jurisdictions or county Emergency Management Agencies. OMRC operates in most of the state's counties including all major metropolitan areas. OMRC Volunteers are willing to donate their time and expertise to prepare for and respond to emergencies and promote healthy living throughout the year.

Liability Protection for Registered Volunteers. Ohio Revised Code 121.404 provides liability protection to registered Ohio Medical Reserve Corps volunteers during local, state or federally declared emergencies, disasters, drills and trainings. The statute also protects a registered volunteer's personal information on the Ohio Medical Reserve Corps Database from public disclosure. Dr. Smith says, "The liability protection was a huge step forward for the program."

In short, a registered volunteer is not liable for damages in the event of injury, death, or loss to person or property if: 1) the volunteer is officially registered on the state's volunteer database; 2) the registered volunteer was providing services within the scope of the volunteer's responsibilities during an officially declared emergency or disaster-related exercises, testing, or other training activities; and 3) the volunteer's act or omission is not willful or wanton misconduct.

In January, the Joint Committee on Agency Rule Review (JCARR) accepted and filed rules pertaining to ORC 121.404. The rules define a four-step process to become officially registered.

1. Signing Up on the OMRC database (at www.serveohio.org)
2. Taking approved trainings
3. Verification of healthcare license
4. Verification of state driver's license or state identification card

The rules also specify criteria for a volunteer including age requirements and active and inactive status. Dr. Smith says, "Ohio's process provides definitive standards for Ohio Citizen Corps volunteers."

Approved trainings are offered at the local level and a calendar of events is available at serveohio.org. Some trainings offer education credits (CEU's). Most trainings last four hours and are valid for a 3-year period.

Introduction to Ohio Medical Reserve Corps – This training is conducted by local OMRC units, although the course maintains certain standards across the state. In the class, county level MRC operations will be discussed including volunteer expectations, local MRC operations, personal and family safety, disaster activation and response plans. The course will highlight Emergency Operations Plans within the county. Introduction to the Ohio Medical Reserve Corps classes generally last four hours.

Basic Disaster Life Support (BDLS) – BDLS is targeted to multiple disciplines including: emergency medical service (EMS) personnel, hazardous materials personnel, public health personnel, and health care providers. By teaching multiple disciplines simultaneously, a commonality of approach and language will develop, improving the care and coordination of response in weapons of mass destruction, disaster and public health emergencies.

The instructor-led presentation of BDLS is a day-long course approved for 7.5 hrs by the American Medical Association. The curricula includes: overview and disaster paradigm; natural and manmade disasters; traumatic and explosive events; nuclear and radiological weapon attacks; biological events; chemical events; the public health system and the psychosocial aspects of disasters. The class is offered free of charge for registered OMRC volunteers.

Advance Disaster Life Support (ADLS) – ADLS is an advanced practicum of the principles introduced in Basic Disaster Life Support. ADLS includes lectures on the following: MASS Triage in detail; community and hospital disaster planning; media and communications during disasters; and mass fatality management. In addition, small group interactive sessions allow students to work through a series of difficult questions of disaster management in a table top format. Day two of ADLS is the "hands-on" day of training. Four skills stations reinforce the previous day's learning. These skills stations are as follows: MASS Triage, Personal Protective Equipment and decontamination, Disaster Skills and a Human Patient Simulator. The class is offered free of charge for registered OMRC volunteers.

Other Trainings – Local units may also conduct trainings based on community needs or "hot topic issues." Examples include exercises concerning Pandemic Flu or mass vaccination drills.

Ohio's MRC system is designed to track a credentialed response of volunteers for emergency relief and to facilitate state and regional planning efforts for deployment of volunteers. Ohio Medical Reserve Corps is making Ohio's communities stronger and safer. However, more help is needed and you can make a difference! The time commitment is minimal and joining OMRC provides the opportunity to improve your skills through training as well to give back to your community when it needs you the most!

MAKE A DIFFERENCE!
HOW TO JOIN:

- Sign up at the Ohio Medical Reserve Corps Web site: http://www.serveohio.org/
- For more information you may also E-mail David O'Reilly or Paul Bender, david.oreilly@ocsc.state.oh.us or paul.bender@ocsc.state.oh.us

Editor's Note: Look for a follow-up article presenting FAQs on the liability considerations of medical volunteers, prepared by OMRC legal counsel, in the July/August issue of Northern Ohio Physician. *The AMCNO continues to work with OMRC staff providing important updates on training and enlistment opportunities for our physician members.* ■

Physician Quality Reporting Initiative

The Academy of Medicine of Cleveland & Northern Ohio was proud to co-sponsor an extremely successful Webinar April 11 on the Physician Quality Reporting Initiative (PQRI), with more than 175 participants engaged in the interactive learning experience. The AMCNO organized this event in partnership with PalmettoGBA in an effort to clarify for our members and their practice staffers PQRI's components and requirements. Our featured speaker, Dr. Susan Nedza of the Center for Medicare and Medicaid Services (CMS) Special Program Office, meticulously went through the associated materials to explain the incentive structure and reporting details while participants followed along to an Internet slide show as they listened in to the conferenced call.

Dr. Nedza explained that medical practices will be eligible for a 1.5 percent bonus under the Tax Relief and Health Care Act of 2006, which authorized the creation of the PQRI, and that will pay physician practices a capped bonus for reporting validated quality measures during the last half of 2007. It is a voluntary program that will provide a financial incentive not only to physicians but many other eligible professionals who successfully report quality information related to services provided under the Medicare Physician Fee Schedule between July 1 and December 31, 2007. All Medicare-enrolled eligible professional may participate, regardless of whether they have signed a Medicare participation agreement to accept assignment on all claims.

There are now 74 reportable quality measures posted at www.cms.hhs.gov/PQRI as a download on the Measures/Codes Web page. Detailed measure specifications and instructions will be posted well in advance of the July 1, 2007 deadline. The form and manner of reporting will be claims-based using CPT Category II codes (or temporary G-codes where CPT Category II Codes are not yet available) for the reporting quality data. The CPT II codes are included in Appendix H of the CPT code book and these codes are also posted on the CMS Web site. Inputting modified CPT-II codes, physicians, using either the paper 1500 claim form (for which additional lines are to be added to accommodate this special reporting) or via electronic filing of claims, will automatically be enrolled in the PQRI beginning July 1. One does not need to register to participate, as was required in last year's Physician Voluntary Reporting Program (PVRP). Quality codes are to be reported with a $0.00 charge. (Physicians participating in the program should check to see if their billing software will accept a zero charge prior to beginning the program, however, CMS will allow a nominal fee to be utilized if a system will not accept the zero charge.) Quality codes must be reported on the same claim as the payment codes.

What would determine successful reporting? Physicians would have to meet reporting thresholds — i.e., if there are no more than 3 measures that apply, each measure must be reported for at least 80% of the cases in which a measure is reportable; and if 4 or more measures apply, at least 3 measures must be reported for at least 80% of the cases in which the measure was reportable. To be included in the PQRI process, the claim must include an accurate use of the National Provider Identifier (NPI). Participating physicians who successfully report may earn a 1.5% bonus, subject to a cap. The 1.5% bonus calculation is based on the total allowed charges during the reporting period for professional services billed under the Physician Fee Schedule.

The 1.5 aggregate bonus payment will come in a lump-sum payable to the Tax Identification Number (TIN) of the provider or practice in mid-2008. This is important to note that although individual providers will be reporting through their NPI number, the total bonus will not be delineated by CMS by the same identifier, should more than one in a practice setting submit measures during the six-month reporting period. ■

MODIFIERS:

1P – Medical Reasons
Not Indicated
Contraindicated

2P – Patient Reasons
Patient Declined
Economic, Social, Religious
Other

3P – System Reason
Resources Not Available
Payor Limitation
Other

CODING FOR PQRI:

G-CODES
Use ONLY if no CPTII available
Report with CPT and/or ICD-9
Report Alone — No Modifier

CPT II CODES
Report with CPT and/or ICD-9
Include on SAME Claim Form
Report Alone (or) with Modifier

MODIFIER
Medical Reason for Exclusion
Patient Reason for Exclusion
System Reason for Exclusion

PQRI: Why Doctors Should Participate

Incentive of 1.5%
Confidential Feedback on Performance
Improve Patient Care
Ensure Software Supports Process
Tests Claims Processor Reporting
Improve Healthcare System
Create Better Reimbursement System

(Slides courtesy of Ohio KePRO — presented at Tracking Trends in the Practice of Medicine seminar — 3/9/07)

CMS Extends National Provider Identifier (NPI) Compliance Deadline – AMCNO still recommends that physicians should get their NPI prior to May 23rd

Beginning May 23, physicians who bill electronically, as required under the Health Insurance Portability and Accountability Act, are required to use their new NPI number instead of their old identifier numbers on claims and other transactions. And even though it is not required by law, Medicare has decided to require physicians who bill on paper to obtain and use their NPI as well. Physicians who do not have an NPI prior to the May 23 deadline could risk compliance issues. While the Centers for Medicare & Medicaid Services (CMS) — the agency charged with NPI enforcement — will permit payers to implement "contingency plans" that allow for the continued use of old identifiers for 12 months after the deadline (through May 23, 2008) where "good faith" compliance efforts have been made, Medicare, the nation's largest payer, has not announced any contingency plans yet. In considering whether a physician has made a "reasonable and diligent" effort in complying with the NPI requirement, CMS will be looking at whether that physician obtained his or her NPI prior to the deadline. Therefore, physicians are strongly encouraged to do the following:

1. Get an NPI prior to May 23.
2. Contact each of their payers to determine what, if any, NPI "contingency plan" they may have.
3. Establish a line of credit that can be used to avert unanticipated cash flow interruptions beginning May 23 during the transition to use of the NPI.

Visit http://www.cms.hhs.gov/NationalProvIdentStand/ to learn more about NPIs.

AMCNO to link to PHIRE: new electronic emergency information system

The Centers for Disease Control and Prevention (CDC) is launching a national electronic communication service that allows health providers such as physicians to directly receive important emergency information at the time of an event. The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has been selected as one of the first organizations with whom CDC is working to secure the participation of individual physicians in the area.

Called PHIRE (pronounced FIRE) — the Public Health Information Rapid Exchange — the service is designed as a secure electronic system where physicians, health providers, hospitals and laboratories will be able to directly receive relevant health information in the event of a national, regional or local emergency. The system will also give physicians and individual health providers access to moderated forums for additional information and exchange.

Three forms of invitation will be issued to AMCNO members 1) email invitation with direct link to the registration site; 2) letters to AMCNO members sending them to the secure site; and 3) advertisements in AMCNO newsletters posting the email and phone number for more information on how to sign up.

"We hope to register all physicians and health providers across the country in order to more fully protect and preserve the health of the nation," said Kathy Skipper, acting director, division of health information at the CDC.

AMCNO hopes that a majority of its members (including resident members) will sign up for the free service, which takes only a few minutes to complete.

"This is a great opportunity for the AMCNO to be actively engaged in a strategic public health effort and the AMCNO hopes to get as many physicians as possible signed up from the Northern Ohio area," said Paul C. Janicki, MD, AMCNO president.

For more information see the AMCNO/CDC invitation letter for the program on the next page or go to www.cdc.gov/phire ■

amcno
THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

April 2007

Dear AMCNO Member:

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and Centers for Disease Control and Prevention (CDC) invite practicing physicians to voluntarily register into the national Public Health Information Rapid Exchange (PHIRE) system to:

- ⇒ allow notification of critical care and health information
- ⇒ tiered by severity (i.e., immediate action, guidance/surveillance, information, update) and
- ⇒ disseminated directly to those who can act most expeditiously to preserve and protect our nation's health.

The system is ready for registrants and seeks only to include your name, work setting, city/county and preferred email address for rapid transmission of CDC emergency health information.

The system and its content will be managed by a CDC expert who will exercise great discretion for the quantity and quality of information provided to you. Your contact information will not be shared with others. A full description of the system, its rationale and frequently asked questions (FAQs) can be found when you register at the following link:

https://wwwn.cdc.gov/phire/register.aspx?ws=3&ic=414

At this time, the CDC is engaging in a stepwise fashion for registering physicians, health care providers, hospitals and laboratories. AMCNO and the CDC appreciate your willingness to register for this free service and for agreeing to support this important public health effort.

Sincerely,

Paul C. Janicki, MD
President, AMCNO

B. Kathleen Skipper, MBA, MA, APR
Acting Director, Health Information and Dissemination Division
National Center for Health Marketing
Centers for Disease Control and Prevention

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) board of directors has approved the following amendments to the AMCNO Constitution and Bylaws. In accordance with these bylaws, the board of directors is publishing these changes to the membership for review and comment. The proposed changes are as follows:

Constitution

Article VI
Meetings

Section 1. Call to Meeting. Meetings of the AMCNO members shall be held as called by the Board of Directors BY ACTION AT A MEETING OR BY A MAJORITY ACTING WITHOUT A MEETING. ANY MEETINGS OF THE AMCNO MEMBERS CAN BE HELD WITHIN OR WITHOUT THE STATE OF OHIO BY AUTHORIZED COMMUNICATIONS EQUIPMENT IF SUCH EQUIPMENT IS AVAILABLE AND WHEN AUTHORIZED IN ADVANCE OF THE MEETING BY THE PRESIDENT. BOARD MEMBERS CANNOT PARTICIPATE IN THE VOTING PROCESS FOR ELECTION OF OFFICERS VIA COMMUNICATIONS EQUIPMENT.

Section 2. Regular Meetings. Regular meetings of the Board of Directors shall occur at least ~~six (6) times a year~~ QUARTERLY at a date, time and location determined by the President. ANY MEETING CAN BE HELD BY AUTHORIZED COMMUNICATIONS EQUIPMENT IF SUCH EQUIPMENT IS AVAILABLE AND WHEN AUTHORIZED IN ADVANCE OF THE MEETING BY THE PRESIDENT.

Section 6. Notice of Meetings. Notice giving the place, time and means by which voting members can be present and vote at the meeting can be made by means of authorized communications equipment or by mail, not less than ten (10) nor more than sixty (60) days before the meeting. Notice may be waived in writing before or after the meeting.

BYLAWS

Article I, Section 5 Item G.:

(G) Disciplinary measures of suspension or expulsion may be published in the "Elections" column of the ~~Cleveland Physician~~. *NORTHERN OHIO PHYSICIAN OR OTHER REGULAR AMCNO PUBLICATION FOR ITS MEMBERSHIP.*

Article II
Nomination and Election of Officers

Section 2. Nomination of Candidates. ~~The President, with the approval of the Board, shall appoint an Officers' Nominating Committee consisting of two (2) past presidents, and three (3) active members from the AMCNO at least one of whom is a member of the Board of Directors. No member who accepts appointment to the Officers' Nominating Committee may stand for any office in that year's election. This~~ THE EXECUTIVE committee shall prepare a slate of candidates for each elective position and submit it to the Board at least thirty (30) days prior to the election at the Annual Meeting of the Board of Directors. The President shall give the opportunity at the Annual Meeting of the Board of Directors for additional nominations from the floor for each of the elective offices; each nomination shall require two (2) recorded seconds.

Section 3. Election of Officers. At its Annual Meeting, the Board of Directors shall elect a President Elect and Secretary-Treasurer. All elections shall be conducted by ballot vote AND A BOARD MEMBER MUST BE PRESENT AT A MEETING TO VOTE. In the event no nominee receives a majority of the votes, the nominee with the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all votes cast, when he/she shall be declared elected. The President of the AMCNO shall not vote except in case of a tie; in that event the President will vote on the next ballot.

Section 4. Installation and Term of Office.
(A) The President Elect shall be formally inducted into the office of President at the Annual Meeting of the AMCNO to be held in the calendar year succeeding the year of election. The President Elect shall assume the duties of President at the close of the Annual Meeting and will serve for a term of one (1) year. THE PRESIDENT SHALL BE ELIGIBLE FOR RE-ELECTION TO ONE SUCCESSIVE TERM.

Article III
Duties of the Officers

Section 1. President. The President of the AMCNO shall be Chairman of the Board of Directors and of the Executive Committee, and an ex-officio member of all AMCNO committees. He/she shall, subject to Board approval, appoint members of all AMCNO committees in such case where the selection of such members is not otherwise provided herein. He/she shall preside at all AMCNO meetings. At the expiration of his/ her term as President, he/she becomes the immediate past President and shall remain a member of the Board of the Executive Committee for a period of one (1) year. He/she shall be the chief spokesman of the AMCNO and may share this responsibility with the other officers and executive staff of the AMCNO.

Article IV

~~(A) Staggered Terms. The following changes are necessary to accommodate the staggered two (2) year terms and to reduce the size of the Academy Board of Directors. After the 2002 election, the Board of Directors election procedures shall continue as outlined in Article IV, Section 1, of these Bylaws:~~

~~Upon adoption of these Bylaw amendments, the following term changes will apply: all Board of Directors members elected in the year 1999 shall serve a three (3) year term and are eligible to serve only one more two (2) year term beginning in 2002. All Board of Directors members serving until 2001 are eligible to serve only one more two (2) year term beginning in 2001. All Board members whose term expires in the year 2000 shall not be eligible to run for another term until the year 2001 at which time they may run in their district or at large for an open seat on the Board of Directors.~~

Article V
Duties of the Standing Committees

(3) ~~The Officers' Nominating Committee shall consist of five (5) members to include two (2) past presidents, and three (3) active members from the AMCNO/NOMA, at least one of whom is a member of the Board of Directors. The Officers' Nominating Committee~~ THE EXECUTIVE COMMITTEE shall prepare a slate of candidates for each elective position (President-Elect and Secretary-Treasurer) and submit it to the Board at least thirty (30) days prior to the election at the Board of Directors Annual Meeting. This committee shall function in accordance with Article II, Sections 1-5 of these Bylaws. ■

Welcome 2007 AMCNO Group Members

The Academy of Medicine of Cleveland & Northern Ohio gratefully acknowledges the following for their support of organized medicine in our region through group membership:

Fairview Hospital Group

Independence Surgery Center Group

St. Vincent Charity Hospital Medical Executive Committee Group

UH Richmond Medical Center

The AMCNO is pleased to have the support of these group members and hopes their commitment inspires other regional hospitals, groups and health professionals in Northern Ohio to facilitate our organization's mission to promote the practice of the highest quality of medicine. For more information on individual or group membership, contact Linda Hale at (216) 520.1000 ext. 101.

NORTHERN OHIO PHYSICIAN

THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO
6100 Oak Tree Blvd., Suite 440,
Cleveland, Ohio 44131-2352
Phone: (216) 520-1000 • Fax: (216) 520-0999

STAFF **Executive Editor,** Elayne R. Biddlestone

Executive Assistant, Kristine Snider

Membership & Marketing Coordinator, Linda Hale

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A Toast to Membership

AMCNO members and their spouses attended this year's wine tasting event held on Sunday, February 18th at La Cave du Vin. Those in attendance thoroughly enjoyed this opportunity to sample wines from Sonoma and countries such as France, Italy and Spain. La Cave du Vin wine sommelier Eric, discussed the particular flavors and ingredients of each glass of wine as well as regional stories about each wine and recommended suitable food accompaniments. The venue provided the perfect atmosphere to mingle with fellow AMCNO members and their guests.

Drs. Paul Janicki, Bill Seitz and James Taylor share a toast during the event.

L – R: Dr. William Seitz Jr., Dr. James Taylor, Mrs. Trish Taylor and Resident Member Dr. Holly Kerr with Eric of La Cave du Vin.

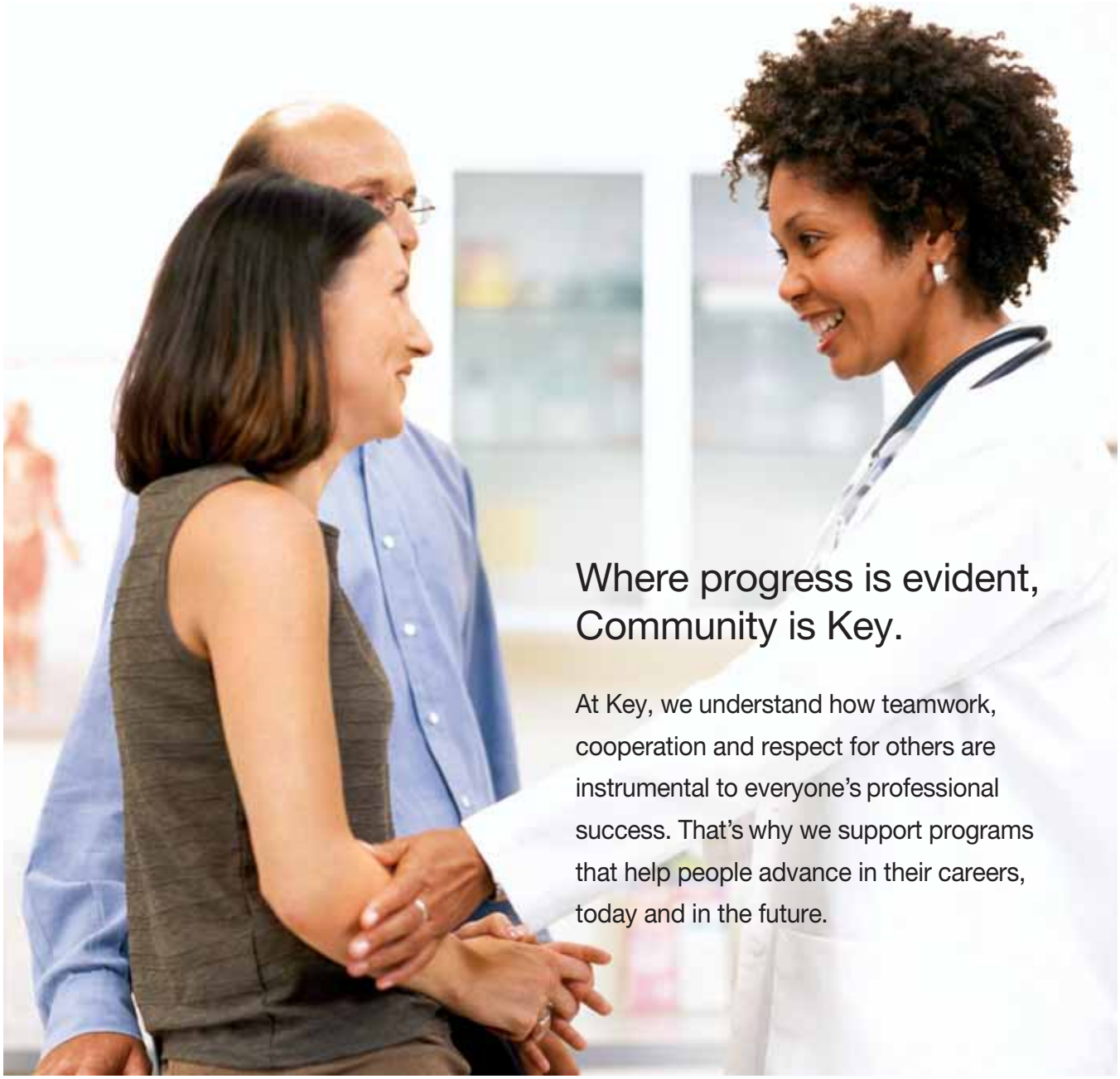
Dr. Tim Steinemann and Mrs. Susan Steinemann enjoy a moment at the wine tasting.

La Cave du Vin sommelier Eric provided detailed background on the wines that were sampled that evening.

CLASSIFIEDS

MIDWEST MEDICAL STAFFING — FT/PT/PRN Positions available in Northeast Ohio. Create your own schedule, malpractice insurance paid. Ideal for retired physicians or one just opening a practice. Please contact Sharon at Midwest Medical staffing 5273 Broadview Road Cleveland, Ohio 44134 (216) 749-3455 phone (216) 749-1077 email: midwstmed1@sbcglobal.net

PHYSICIAN OPPORTUNITIES — NO ON-CALL. PAID MALPRACTICE. FLEXIBLE SCHEDULING. Full and part-time position available in Northeast Ohio for Medicine, Surgery and Pediatrics. Please contact Carmin at Physician Staffing, Inc., 30680 Bainbridge Rd. Cleveland, Ohio 44139. (440) 542-5000, Fax: (440) 542-5005, email: clmil@physicianstaffing.com



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